Report of the

Queensland Ombudsman

QUEENSLAND
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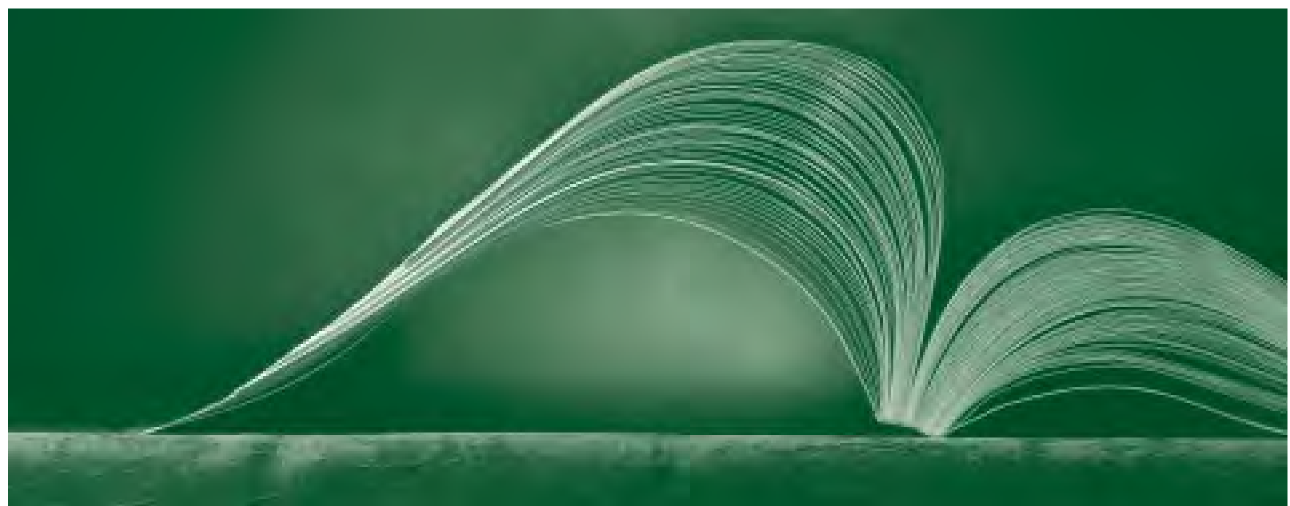

An investigation into the adequacy of the actions of certain government agencies in relation to the safety, well being and care of the late baby Kate, who died aged 10 weeks.

October 2003

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6 October 2005

The Honourable Ray Hollis MP
Speaker of the Legislative Assembly
Parliament House
George Street
BRISBANE Qld 4000

Dear Mr Speaker

In accordance with section 52 of the *Ombudsman Act 2001*, I hereby furnish to you my report on *An investigation into the adequacy of the actions of certain government agencies in relation to the safety, well being and care of the late baby Kate, who died aged ten weeks*. The investigation considers the administrative conduct of the Department of Families, Queensland Health and the Queensland Police Service.

Yours faithfully

David Bevan
Queensland Ombudsman

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Foreword

Every year my Office receives thousands of complaints. The most serious are the relatively few in which it is alleged that a public agency's actions or failure to act have contributed directly or indirectly to a person's death.

It is in the public interest that these complaints be properly considered and, if an investigation is called for, investigated professionally and impartially. These are the matters investigated by my Office's Major Projects Team, established in early 2002 for this very purpose.

Our objective in these types of cases is not solely to determine the substance of the complaint but to identify any systemic issues that may have contributed to the agency's decision-making falling below an acceptable standard.

This is a report of such a case. Baby Kate died at the age of ten weeks. At the time she was in the care of her intellectually impaired mother. The complainant alleged that decisions made by the Department of Families and Queensland Health to release baby Kate into her mother's care and about the level of support her mother needed contributed to the baby's death.

The Queensland Police Service investigated the case and sent a report to the Coroner who recommended that no inquest be held partly on the basis that the pathologist who carried out the post-mortem recorded the cause of death as Sudden Infant Death Syndrome.

My investigation provides reason to doubt the validity of that finding, which is one made when all other possible causes of death have been excluded. Although it is likely that the more appropriate finding would have been that the cause of death was "undetermined", such a finding does not provide support for the complainant's allegation that the actions of the departments contributed to the baby's death.

On the other hand, I consider that the Department of Families' decisions about certain issues associated with the baby's safety and well being were unsound and I have made recommendations to address practices that may have contributed to those decisions being made.

The case also identified inadequate communication between the Department of Families and Queensland Health in relation to child protection matters. This is an issue I identified in my report to Parliament in May 2002, titled *Report of the Queensland Ombudsman – An investigation into the adequacy of the actions of certain government agencies in relation to the safety of the late Brooke Brennan, aged three.*

I appreciate that officers in the Department of Families work in a complex and sensitive area of service delivery and have to make difficult decisions every day. I also appreciate that the officers' decisions in this case have been subjected to a high level of scrutiny.

However, it is in the public interest that an independent body scrutinise decisions of the department that has primary responsibility for ensuring the safety and welfare of children in our community, particularly where it is claimed those decisions have had tragic consequences.

It is also in the public interest that I report on my investigation to Parliament.

It should be noted that this is not a report on the rights of intellectually impaired mothers to parent their children but a report on the rights of children to protection in accordance with the Child Protection Act.

Finally, I would like to thank Assistant Ombudsman, Peter Cantwell, and Investigating Officer, Angela Ritchie, for their dedication and professionalism in conducting the investigation and preparing the report.

David Bevan
Queensland Ombudsman

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Abbreviations and dictionary

CCOCA	Coordinating Committee on Child Abuse (Qld)
CCYP	Commission for Children and Young People (Qld)
CDRT	New South Wales Child Death Review Team
Child Protection Act	*Child Protection Act 1999* (Qld)
CN	Clinical Nurse
Complainant	The person who made a complaint to my Office concerning the administrative actions taken by DOF and QH in relation to the safety, well being and care of the late baby Kate
Constables	The two police Constables (a male and a female officer) who were performing general duties at the time they were despatched by QPS Communications to attend Fernbrook in relation to the death of an infant
CPFU	Child Protection Follow Up
CPIS	DOF's Child Protection Information System
Coroners Act 1958	*Coroners Act 1958* (Qld)
Coroners Act 2003	*Coroners Act 2003* (Qld)
Crime and Misconduct Act	*Crime and Misconduct Act 2001* (Qld)
Detective Constable	The Detective Constable from the JAB who interviewed Lisa in relation to baby Kate's death on 11 September 2001 and obtained a formal signed statement from her
Detective Sergeant	The Detective Sergeant who was the Officer in Charge of the JAB responsible for the investigation of baby Kate's death
DOF	Department of Families
DON	Director of Nursing
Fernbrook	Non-government residential facility where Lisa and baby Kate were residing at the time of baby Kate's death
FOI	Freedom of Information
Forensic Pathologist	A senior Forensic Pathologist at the John Tonge Centre
Form 4	Form used by QPS for the purposes of the *Coroners Act 1958* (Qld)
Freedom of Information Act	*Freedom of Information Act 1992* (Qld)
FSO	Family Services Officer
Health Act	*Health Act 1937* (Qld)
Health Regulation	*Health Regulation 1996* (Qld)
Health Services Act	*Health Services Act 1991* (Qld)
IA	Initial Assessment
Information Standards	Issued under section 7(1)(b) of the *Public Records Act 2002* (Qld)
Internal review officer	The senior practitioner from DOF who conducted an internal review of baby Kate's case in accordance with DOF's Child Death Reviews Policy and Procedures
IPEP	Intensive Parenting Education Program conducted at Riverton
JAB	Juvenile Aid Bureau (within the QPS)

John	Lisa's partner
John Tonge Centre	QH's Scientific Services facility located at Coopers Plains, Brisbane
Libraries and Archives Act	*Libraries and Archives Act 1988* (Qld)
Lisa	Baby Kate's mother
The Manual	DOF's Child Protection Procedures Manual
Medical Superintendent	Medical Superintendent at Hospital White
My officers	Ms Angela Ritchie, BA, Investigating Officer and Mr Peter Cantwell, LL.B (Hons), Solicitor, Assistant Ombudsman
Ombudsman Act	*Ombudsman Act 2001* (Qld)
OPM	(the QPS) Operational Procedures Manual
Paediatrician	Paediatrician at Hospital Green
Pathology Registrar	The pathologist who completed baby Kate's post-mortem at the John Tonge Centre
The Policy	DOF's Child Death Reviews Policy and Procedures
Practice Guide	DOF's Practice Guide for the Assessment of Harm and Likely Harm
Public Records Act	*Public Records Act 2002* (Qld)
Public Service Act	*Public Service Act 1996* (Qld)
QAS	Queensland Ambulance Service
QH	Queensland Health
QPS	Queensland Police Service
Reporting Policy	DOF's Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures
Riverton	Riverton Early Parenting Centre located at Clayfield
RN	Registered Nurse
RSIC	Review of Significant Incidents Committee
SCAN Team	Suspected Child Abuse and Neglect Team
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexplained Infant Death
SUIDIRF	Sudden Unexplained Infant Death Investigation Report Form
VCDRC	Victorian Child Death Review Committee

Executive Summary

Investigative context

I have completed my investigation of the adequacy of the administrative actions of the Department of Families (DOF) and Queensland Health (QH) in relation to the safety, well being and care of the late baby Kate, who died aged 10 weeks.

The investigation was initiated after a written complaint was made to my Office on 14 January 2002. The complainant alleged that baby Kate should not have been released into her mother's care and that the actions, or lack of action, of DOF and QH contributed to her death.

The Ombudsman's role is to investigate administrative actions of officers of public sector agencies, in this case, primarily DOF and QH, and to consider whether the actions were (among other things):

- unlawful, unreasonable or unjust;
- taken on irrelevant grounds or having regard to irrelevant considerations;
- based wholly or partly on a mistake of law or fact; or
- wrong.

The Ombudsman is also empowered under the *Ombudsman Act 2001* (Qld) to make recommendations to the principal officer of the appropriate agency to improve administrative practice within the agency.

In this case, my investigation also led me to consider certain actions of officers of the Queensland Police Service (QPS). The Ombudsman's jurisdiction in respect of the QPS is limited in that the operational actions of a police officer are not regarded as administrative actions under the *Ombudsman Act*. However, because of the interaction in this case between QPS officers and officers from other departments within jurisdiction, the investigation has necessarily considered the actions of police officers involved for the purpose of assessing the administrative actions of DOF and QH officers.

Public report

This report summarises my investigation and contains my opinions and recommendations and is provided to the Speaker of the Queensland Legislative Assembly pursuant to section 52 of the *Ombudsman Act*[1] for tabling in the Assembly. I have taken this step because the matters raised are of considerable public interest and my investigation has identified:

- systemic problems within DOF in the management of child protection cases; and
- problems in communication and co-ordination among the public agencies involved in child protection issues, including the investigation of child deaths.

Therefore, I am satisfied that it is in the public interest to report to Parliament on the matter.

A note of caution

Throughout the report, I have referred to the baby, the mother and her partner by the pseudonyms Kate, Lisa and John respectively and, wherever possible, omitted or altered other material that could identify them. It is important that no attempts are made to publicly identify Lisa or her associates because the focus of my investigation is not their actions but the actions of the government agencies.

It should also be clearly understood that I have expressed no opinion about responsibility for baby Kate's death. That matter was investigated by the QPS and a report presented to the Coroner who recommended that no inquest be held. No person has been charged with an offence in relation to the circumstances of baby Kate's death.

Nor do I suggest that the systemic problems I have identified in DOF's management of child protection notifications or the actions of individual DOF officers contributed to baby Kate's death.

1 Section 52 of the Ombudsman Act provides that if the Ombudsman considers it appropriate, the Ombudsman may give to the Speaker at any time, for tabling in the Assembly, a report on a matter arising out of the performance of the Ombudsman's functions.

Finally, this report is not about the rights of intellectually impaired persons to parent their children but about the rights of children to appropriate protection under the *Children Protection Act 1999*.

The circumstances

When Lisa became pregnant, concerns were expressed with DOF about her ability to care for her child when it was born. Lisa had certain intellectual and physical impairments and was known to DOF because she had been brought up in foster care.

Baby Kate was born at a regional Queensland hospital. Three days after her birth, she and her mother were transferred to a smaller hospital closer to Lisa's then place of residence.

The smaller hospital was advised of Lisa's condition and the documents that accompanied her transfer stated that Lisa needed 'a lot of support and encouragement with her parenting skills'.

A few days later, nursing staff observed Lisa to shake baby Kate and swear at her. The incident was reported to the Medical Superintendent who made the notation '? child at risk' in baby Kate's medical chart.

Prior to the shaking incident, nursing staff had approached the Medical Superintendent with concerns about Lisa's ability to parent baby Kate. The Medical Superintendent contacted the Paediatrician at the larger hospital to discuss his observations and concerns, and those of the nursing staff. The practitioners agreed that baby Kate and Lisa needed to be transferred back to the larger hospital for further observation and assessment.

Accordingly, on Friday 6 July 2001, baby Kate and Lisa were transported by the Queensland Ambulance Service (QAS) to the larger hospital. The Medical Superintendent's letter of referral to the Paediatrician at the larger hospital referred to his concerns about Lisa's ability to care for her child and to his 'global concerns for both mum and baby'. He said:

> Lisa is struggling. This is day 7 post-natally and I have concerns about her ability to maintain the care of the child. She seems to bond minimally with Kate, only doing the minimum for her. Kate's crying irritates her. [He referred to her medical conditions.] She seems willing to learn but is easily frustrated and has very little spontaneous interest. I have global concerns for both mum and baby.

In accordance with the *Health Act*, the Paediatrician made a child protection notification to the local DOF Area Office. The notification was recorded by a Family Services Officer (FSO), FSO One. FSO One and another FSO, FSO Two[2], were tasked to attend the hospital to assess the situation.

Lisa acknowledged that she needed help caring for baby Kate, especially with night feeding, but she indicated that her partner, John, would help her.

The next day, the FSOs returned to the hospital and spoke to Lisa and John. They explained[3] DOF's concerns about the safety and well being of baby Kate and informed Lisa and John that baby Kate would not be able to go home unless DOF was satisfied that she had a parent who was **willing and able** to care for her. The FSOs asked John to stay at the hospital to enable nursing staff to assess his ability to care for baby Kate and support Lisa.

The matter was referred to a meeting of the Suspected Child Abuse and Neglect (SCAN) Team. The SCAN Team was advised of what had occurred and that John had not, up to that time, participated in the assessment. The SCAN Team recommended,[4] among other things, that DOF 'talk to John about committing to Lisa and baby Kate going home' and that the matter be reviewed by SCAN a fortnight later.

The Friday after the first SCAN Team meeting, John arrived at the hospital and indicated that he was there to stay for the weekend. QH informed DOF of his arrival.

DOF's case officer for the matter, FSO One, was on leave the following Monday morning and so FSO Two was tasked with attending the hospital with FSO Three[5] to receive feedback from the hospital staff about their assessment of the parenting skills of Lisa and John. The FSOs then reported their assessment to their Manager that Lisa and John should be allowed to take baby Kate home. A Child Protection Follow Up (CPFU) case was created which provided for voluntary ongoing DOF intervention with the family unit.

2 Collectively called the FSOs.
3 This information was derived from the initial assessment record contained in CPIS.
4 Minutes of SCAN Team meeting dated 12 July 2001.
5 FSO Three is no longer a DOF officer.

Baby Kate was discharged from hospital into Lisa's and John's care that afternoon.

Some four days later, DOF became aware that the relationship between Lisa and John had ended and that Lisa intended to move to Brisbane with baby Kate. DOF referred Lisa and baby Kate to a local group home near the smaller hospital, where they remained for about a week before travelling to Brisbane to stay with Lisa's former foster family.

The SCAN team reviewed the matter on the same day. The minutes of the meeting indicate that the SCAN team was advised by DOF that Lisa and baby Kate would be attending the Riverton Early Parenting Centre (Riverton), which is a QH facility located at Clayfield in Brisbane. The SCAN team recommended, once Lisa had been assessed at Riverton, that a long-term placement at either Sisters of Mercy or Fatima[6] may need to be considered. The matter was then 'closed to SCAN' (i.e. not to be the subject of any further discussion or follow-up by the SCAN Team).

Although DOF initially referred baby Kate and Lisa to Riverton, it subsequently decided not to proceed with this referral. Instead, DOF referred Lisa and baby Kate to a residential facility operated by a non-government organisation in Brisbane. That facility provides emergency accommodation for women and their children but does not provide the specialist parenting services available at Riverton.

Lisa and baby Kate resided at this facility for approximately four weeks until baby Kate's death. During this period, Lisa did not receive appropriate support, such as was available at Riverton.

One evening Lisa found baby Kate dead in her cot. The police were called. One officer completed a form relating to the death. This was provided to a Pathology Registrar at the John Tonge Centre who carried out the post-mortem on baby Kate. The form stated that the death was 'non-suspicious'. However, a detailed QPS investigation had not been conducted at that stage.

The next day, a Detective Constable from the QPS Juvenile Aid Bureau (JAB) commenced a full investigation and interviewed Lisa about the circumstances of the baby's death and took a statement from her.

The QPS did not provide the information contained in Lisa's statement or any other information from the police investigation to the Pathology Registrar at the John Tonge Centre who conducted the post-mortem. The initial finding of the post-mortem was 'not yet determined pending test results'. When the post-mortem was completed some weeks later, the cause of baby Kate's death was recorded as Sudden Infant Death Syndrome (SIDS).[7]

There is doubt about the accuracy of this finding because a finding of SIDS is a 'diagnosis of exclusion'. This means that SIDS should not be recorded as the cause of death unless all other possible causes have been excluded. My investigation indicates that a more appropriate finding in this instance would have been 'undetermined'. The difference is a significant one because the Coroner relied partly on the SIDS finding in recommending that no inquest be held.

Two weeks after baby Kate's death, DOF commenced an internal review of its management of baby Kate's child protection case. The review was completed in about three weeks. DOF advised[8] me that the internal review 'found that no negligence had occurred in relation to the management of the case by departmental staff'.

After conducting preliminary inquiries pursuant to section 22 of the *Ombudsman Act*, I subsequently accepted the complaint for investigation.

During the course of my investigation, my officers:

- obtained and examined files and medical records from DOF and QH;
- with the Coroner's consent, accessed the investigation report prepared by the QPS for the Coroner in relation to baby Kate's death;
- interviewed a large number of DOF and QH staff;
- undertook site inspections at relevant facilities; and
- interviewed relevant non-agency personnel.

6 Alternative long-term residential placements.
7 SIDS is a 'diagnosis of exclusion' - See section 4 of this report.
8 Letter dated 14 March 2002.

Maladministration

I consider that the administrative actions of DOF were, at various times, unreasonable, based wholly or partly upon a mistake of fact or wrong, within the meaning of section 49(2) of the *Ombudsman Act*.

Specific opinions about decisions and actions that I consider involve maladministration are located at the following paragraphs in the report:

- Part 6 – Decisions about intervention – at 6.3.1 to 6.3.3, 6.7.1 to 6.7.5 and 6.11.1.
- Part 7 – Case management decisions – at 7.2.1 to 7.2.4, 7.6.1 to 7.6.5 and 7.10.1 to 7.10.6.
- Part 8 – Record keeping – at 8.3.1 to 8.3.2.
- Part 9 – The child death review – at 9.4.1 to 9.4.5.

Systemic issues relating to Department of Families

As mentioned, I have decided to report to Parliament on my investigation because of the seriousness of the subject matter, the significant maladministration I identified and the systemic issues that may have contributed to the maladministration.

Those systemic issues included the following:

- Concern was expressed about baby Kate's safety before she was born but DOF's policies and procedures do not enable it to intervene until a child is born. It may be that a legislative solution is called for and it is important not to confuse this issue with pro or anti-abortion arguments.
- No protocol existed between QH and DOF to ensure that, immediately baby Kate was born, DOF would be notified so that an assessment of risk of harm to baby Kate could be conducted.
- The decision to allow Lisa and John to remove baby Kate from the hospital was based on an inadequate assessment of the risk of harm to the child. The case highlights problems in communication between DOF officers and QH officers in respect of information relevant to the assessment of risk.
- The decisions of DOF officers to release baby Kate into the care of Lisa and John and to leave baby Kate in Lisa's care when the relationship between Lisa and John ended did not give appropriate weight to the legal requirement that the welfare and best interests of the child are paramount and that a child should be placed in alternative care if it does not have a parent willing and able to protect it. In making these decisions, DOF officers gave undue weight to the principle that their approach should be the least intrusive or a minimal intervention approach in respect of the family unit. My investigation suggested that their approach may be indicative of the widespread application of this principle by DOF officers with potentially dangerous consequences for the safety of children.
- DOF officers placed Lisa and baby Kate in an inappropriate environment where they did not receive adequate support despite a Suspected Child Abuse and Neglect Team recommendation that they be placed at another more appropriate facility. The case highlighted a lack of knowledge by officers of available options for appropriate assessment and support of mothers with inadequate parenting skills.
- The delay in transferring case-work or case management responsibility from one Area Office to another may be symptomatic of widespread problems in respect of case transfers. DOF's policies and training on the transfer of cases are inadequate.
- Case records were not properly kept and the investigation indicated that these inadequacies are likely to be widespread.
- DOF's policies about the type of review to be conducted when a child dies who has been the subject of a child protection notification are unclear.
- No suitably qualified person external to DOF assesses the adequacy of child death reviews conducted by or on behalf of DOF in relation to children known to DOF.
- The internal review conducted by DOF in this case was inadequate although DOF initially believed that it was adequate. The case highlights the need for a specialist external body to supervise the conduct of child death reviews, including determining the type of review to be undertaken.

Systemic issues involving the Queensland Police Service

As I have stated, the *Ombudsman Act* effectively prohibits the Ombudsman considering operational police matters. However, the circumstances of this particular matter required my investigation to take account of the interaction of other departmental officers (within jurisdiction) with members of the QPS.

Therefore, this report contains references to and comments about actions taken or failed to be taken by police officers that, in my opinion, affect or concern the QPS.

With a view to improving the quality of QPS decision-making and administrative practice where officers interact with other agencies having child protection responsibilities, I made suggestions for consideration by the QPS and provided a copy of my report in provisional form to the Commissioner of Police for his comment.

This case evidenced inadequate communication between officers of QPS and pathologists at the John Tonge Centre. In particular:

- The form developed in connection with certain provisions of the *Coroners Act 1958* (referred to as a Form 4) and used by QPS officers who attend at a death to record details of their observations has the potential to mislead pathologists particularly in the case of the unexplained deaths of children.
- Except for the information contained in the Form 4, QPS's procedures for the investigation of the sudden unexplained death of a child do not require officers who obtain information during their investigation potentially relevant to the pathologist's findings as to the cause of death, to provide that information to the pathologist.
- In this case, the procedural deficiencies may have resulted in the pathologist recording SIDS as the cause of death when the more appropriate finding was 'undetermined'. The pathologist's finding of SIDS was partly relied on by the Coroner in recommending the no inquest be held.

Recommendations

I make the following recommendations under section 50(1) of the *Ombudsman Act*:

Department of Families

PART 6 – DECISIONS ABOUT INTERVENTION

Pre-birth intervention

6.4.1 DOF develop written policies and procedures for recording notifications in relation to unborn children, for working with the parents before the birth and for ensuring that such notifications are followed up when the child is born.

6.4.2 In consultation with QH, DOF develop a memorandum of understanding that outlines the process for DOF to notify QH that it has concerns about the safety and well being of an unborn child due to be delivered in a QH hospital and for QH to notify DOF when that child has been born.

6.4.3 The *Child Protection Act* be amended to enable DOF to intervene where it is suspected before the birth of a child that the child may be at risk of harm after birth.

The initial assessment

6.8.1 DOF evaluate the training that is presently provided to DOF officers responsible for undertaking child protection assessments with a view to identifying whether increased emphasis should be given to conducting risk assessments and considering all relevant information for that purpose.

6.8.2 DOF develop and implement procedures and processes to be observed when involving other agencies in a child protection matter to ensure that the officers of the agencies involved understand their responsibilities.

6.8.3 DOF immediately issue a written memorandum to all relevant officers advising them of the authority under section 194 of the *Child Protection Act* for authorised officers to obtain access to information that is subject to confidentiality under section 63 of the *Health Services Act* where that information is relevant to the protection and welfare of a child.

Decision-making and case planning

6.12.1 DOF refer the comments that I have made in this report about the application of the principles in section 5 of the *Child Protection Act* and the 'minimal intervention' or 'least intrusive approach' principle to the Coordinating Committee on Child Abuse (as reconstituted in accordance with my recommendations at 9.5) with a view to that body or an appropriately constituted sub-committee providing guidance on the weight officers should give to such principles when conducting child protection assessments.

6.12.2 If a sub-committee is constituted to carry out the role specified in recommendation 6.12.1 the Commissioner for Children and Young People be the Chair.

PART 7 – CASE MANAGEMENT DECISIONS

Riverton

7.3.1 In consultation with QH, DOF provide information to its officers about the services provided by Riverton and the criteria for admission there.

7.3.2 To ensure appropriate ongoing involvement by a SCAN Team, DOF review its procedures for transferring to a local SCAN Team cases that have been closed to SCAN in another area because the family or child has left that area.

7.3.3 DOF develop and maintain a comprehensive resource database that contains information about the emergency, support and residential services available in Queensland to assist officers with decisions about the placement and referral of families in need.

Fernbrook

7.7.1 The recommendation made by the internal review officer in her review that DOF consider developing a standardised referral process, including documentation outlining an agreed case plan and identifying roles, responsibilities and communication process, be implemented as a matter of urgency.

The transfer

7.11.1 DOF review its existing policies and procedures in relation to the transfer of case-work and case management responsibility with a view to developing a comprehensive policy that addresses the deficiencies I have identified.

7.11.2 The policy should include a standardised transfer summary for officers to complete to ensure that the receiving office has accurate and timely information concerning the family that it will be working with.

7.11.3 DOF provide appropriate training to all relevant staff once the policy has been developed.

7.11.4 DOF investigate the claim that transfers are generally not accorded appropriate priority and, in some cases, refused or deliberately delayed by the receiving office, by:

7.11.4.1 auditing a sample of transferred cases; and

7.11.4.2 consulting with Managers and/or Team Leaders.

PART 8 – RECORD KEEPING

8.4.1 DOF undertake a statewide audit of record keeping practices in its offices to determine whether the record keeping deficiencies identified in Area Office Green also exist in those offices.

8.4.2 DOF review whether present resourcing is sufficient to enable officers to maintain appropriate records and if not, provide administrative or other support to assist officers in the performance of this obligation.

8.4.3 DOF develop and implement consistent procedures for record keeping in order to eliminate the multiple systems presently used by officers.

8.4.4 DOF provide training on proper record keeping procedures to officers in Area Office Green and officers in other offices identified in the audit as having inadequate record keeping practices.

8.4.5 DOF investigate the use of digital recording devices to assist officers to record contemporaneous file notes while engaged in fieldwork.

PART 9 – THE CHILD DEATH REVIEW

9.5.1 A body external to DOF monitor and review the investigation of the deaths of all children known to DOF and, unless another body is established for that purpose, the Child Death Review sub-committee of CCOCA carry out this role.

9.5.2 The Commissioner for Children and Young People be a full member of CCOCA and be the Chair of the Child Death Review sub-committee.

9.5.3 If another body is established to carry out the role specified in 9.5.1, the Commissioner for Children and Young People be the Chair of that body.

9.5.4 The State Coroner be a member of the Child Death Review sub-committee or other body established to carry out the role specified in 9.5.1.

9.5.5 The body that carries out the role specified in 9.5.1 be empowered to:

9.5.5.1 give directions to DOF that a child death review be conducted and about the type of review (internal or external) to be conducted;

9.5.5.2 approve persons as child death external reviewers and maintain a register of such persons;

9.5.5.3 appoint persons from the register to supervise the conduct of external reviews; and

9.5.5.4 make recommendations to the agencies with child protection responsibilities about policies and procedures that could prevent or reduce child deaths.

9.5.6 The Office of the Commissioner for Children and Young People provide administrative support to the body that carries out the role specified in 9.5.1.

9.5.7 The body that carries out the role specified in 9.5.1 report annually to Parliament in relation to child deaths that have been the subject of review.

9.5.8 That, pending the implementation of recommendation 9.5.1, DOF amend its new 'Review Policy Procedure following the Death of a Child or Young Person' to require that:

9.5.8.1 a copy of the report of each child death review be forwarded immediately upon completion to the Commissioner for Children and Young People and that such copies not be de-identified; and

9.5.8.2 the reasons for decisions about the type of review to be conducted be appropriately recorded in the official file.

Queensland Health

Several recommendations concern QH, namely 4.4.3, 6.4.2 and 7.3.1. Each of these are set out in this Executive Summary.

Suggestions for improving administrative practice in the Queensland Police Service

Suggestions for improving administrative practice for the QPS are:

4.4.1 In consultation with the Department of Justice and Attorney General, take steps to ensure that sudden unexplained deaths of children are not described as 'non suspicious' in a Form 4 prior to the completion of the investigation.

4.4.2 Investigate if there are any systemic issues adversely impacting upon lines of communication between the QPS and pathologists as suggested by the communication failures in this instance.

4.4.3 In consultation with QH, develop and implement a standardised death scene investigation checklist (similar to the SUIDIRF[9] or the NSW Police checklist[10]) for the sudden unexplained deaths of children aged under two years and amend section 7.14 of the OPM as necessary. A copy of the checklist should

9 See Appendix F
10 See Appendix I

be provided to the pathologist tasked with making a finding as to the cause of death.

4.4.4 QPS amend its OPM to require officers investigating the sudden unexplained death of children to advise the pathologist of any information obtained that may be relevant to the pathologist's finding as to the cause of death.

4.4.5 Review the current level of training provided to QPS officers concerning the procedures contained in section 7.14 of the OPM and, if necessary, take steps to ensure that all relevant QPS officers are aware of the nature of SIDS and the circumstances in which pathologists who conduct post-mortem examinations of children who have died from unknown causes may make such a finding.

Responses to the recommendations

My provisional report was sent to DOF, QH and QPS for comment.

Department of Families

DOF did not take issue with any of the opinions that I had formed and sought only to address the recommendations that I made.

In fact, DOF conceded that 'virtually all of the issues identified' in my report were known to it. DOF immediately endorsed 14 of my recommendations and noted the balance. DOF's response to my provisional report is contained in Appendix N and parts of the response are referred to in the body of the report.

Following my consideration of the DOF response, I have:

- amended 8 recommendations; and
- formulated a further 5 recommendations

in relation to decisions about intervention in Part 6 and child death reviews in Part 8.

Queensland Health

QH advised that it would 'act co-operatively with the relevant departments to action the report recommendations as they are finalised'. QH's response to my provisional report is contained in Appendix O.

Queensland Police Service

QPS concurred with the thrust of my suggestions and agreed to review and address the deficiencies in existing practices and procedures that I identified. The QPS response to my provisional report is contained in Appendix P.

Following my consideration of the QPS response, I made one further observation relating to operational procedures dealing with the investigation of the sudden unexplained death of children.

Notices of Proposed Adverse Comment

To meet my obligations to give procedural fairness under section 55 of the *Ombudsman Act*, certain officers who could be considered to be the subject of adverse comment in the report were given notices specifying the proposed adverse comment and invited to make submissions. Their responses have been incorporated into the report at various points and have otherwise been included or fairly summarised in Appendices Q, R, S and T.

Recent Ministerial announcements

The Minister for Families, the Honourable Judy Spence MP, has made a number of media releases since my provisional report was provided to the Director-General of DOF on 3 July 2003. Some of those media releases announce initiatives that touch upon issues raised and recommendations made in my report. In particular, the Minister has made the following announcements:

- An extra 25 Suspected Child Abuse and Neglect (SCAN) Co-ordinators are to be employed.[11]
- 'Decision-making by child protection workers will come under closer scrutiny through a tougher review system and an overhaul of record keeping[12]…the number of staff in the new Quality Assurance Unit will double to 10, another 9 Senior Practitioners will help ensure any problems the unit identifies are addressed, while client information will be better managed…the Unit will also review whether any planned follow-up action did occur and whether cases have been documented and entered into the system quickly enough…'[13]
- Child protection workers 'will be made more aware of the latest practices in risk assessment, investigation, ways to involve families in decision-making, as well as case work planning and management'.[14]
- 'Client Record Improvement teams would also be deployed to area offices to ensure their filing systems and record keeping are overhauled and maintained at a high standard … to make sure that all client files are completed and it's easier to record and retrieve that information. Staff will be trained in how to manage records so that information sharing can be improved.'[15]

11 New funding to strengthen child protection, 19 August 2003.
12 See Part 8 of this report.
13 Child protection decisions face closer scrutiny, 7 September 2003.
14 Child protection decisions face closer scrutiny, 7 September 2003.
15 Child protection decisions face closer scrutiny, 7 September 2003.

1 Background

1.1 Introduction

I have completed my statutory investigation of a complaint made to my Office on 14 January 2002 about certain administrative actions taken by the Department of Families (DOF) and Queensland Health (QH) in relation to an infant who died on 10 September 2001 at the age of 10 weeks.

To the extent practicable, all identifying information in this report, including personal and place names, have been altered except in two instances. This includes references to names in interviews and records. [16]

Baby Kate was born on 1 July 2001 at Hospital Green, a large regional Queensland hospital. In accordance with standard QH procedures for the area, baby Kate and her mother, Lisa, were transferred three days after baby Kate's birth to Hospital White, a smaller hospital situated closer to Lisa's then place of residence.

In the transfer summary that was prepared, Hospital Green advised Hospital White that Lisa had certain medical and intellectual impairments. Hospital Green reported[17] that Lisa needed 'a lot of support and encouragement with her parenting skills'.

On 4 July 2001, the Acting Director of Nursing (DON) at Hospital White observed Lisa to shake baby Kate and swear at her. The DON reported the incident to the Medical Superintendent of Hospital White who made the notation '? child at risk' in baby Kate's medical chart.

Prior to the shaking incident, nursing staff at Hospital White had approached the Medical Superintendent with concerns about Lisa's ability to parent baby Kate. The Medical Superintendent contacted the Paediatrician at Hospital Green, who was also the SCAN doctor there, to discuss his observations and concerns, and those of the nursing staff. The practitioners agreed that baby Kate and Lisa needed to be transferred back to the larger Hospital Green for further observation and assessment.

Accordingly, on Friday 6 July 2001, baby Kate and Lisa were transported by the Queensland Ambulance Service (QAS) to Hospital Green. In his letter of referral to the Paediatrician at Hospital Green, the Medical Superintendent of Hospital White said:[18]

> Lisa is struggling. This is day 7 post-natally and I have concerns about her ability to maintain the care of the child. She seems to bond minimally with Kate, only doing the minimum for her. Kate's crying irritates her. [He referred to her medical conditions.] She seems willing to learn but is easily frustrated and has very little spontaneous interest. I have global concerns for both mum and baby.

In accordance with the *Health Act*, the Paediatrician at Hospital Green made a child protection notification to DOF Area Office Green. The notification was recorded by a Family Services Officer (FSO), FSO One. FSO One and another FSO, FSO Two,[19] were tasked to attend the hospital to assess the situation.

Initially, Lisa was upset and reluctant to talk with the FSOs when they attended the hospital. The FSOs were aware that Lisa had previously herself been a child in the care of DOF . Lisa acknowledged that she needed help caring for baby Kate, especially with night feeding, but she indicated that her partner, John, would help her. The FSOs told Lisa that they would need to speak with John. However, Lisa indicated that he would 'not be willing to talk to them and would be angry' that DOF was involved.[20]

The following morning, a Registered Nurse (RN) from Hospital Green contacted FSO One and advised her that John had arrived at the hospital and was threatening to remove Lisa and baby Kate. Hospital Green initiated a security alert in response to the situation. The FSOs subsequently attended the hospital that afternoon with two police officers and spoke to Lisa and John.

The FSOs explained[21] DOF's concerns about the safety and well being of baby Kate and informed Lisa and John that baby Kate would not be able to go home unless DOF was satisfied that she had a parent who was

16 See section 1.8 of this report – De-identification.
17 Transfer summary contained in QH medical records, a copy of which was provided to my Office as part of Lisa's and baby Kate's medical records.
18 Medical Superintendent's letter contained in QH medical records.
19 Collectively called the FSOs.
20 This information was derived from DOF's initial assessment record contained in the Child Protection Information System (CPIS).
21 This information was derived from the initial assessment record contained in CPIS.

willing and able to care for her. The FSOs asked John to stay at the hospital to enable nursing staff to assess his ability to care for baby Kate and support Lisa. John told the FSOs that he would return to the hospital later that evening to stay overnight. However, he did not return until 13 July 2001, two days later.[22]

The matter was referred to the Suspected Child Abuse and Neglect (SCAN) Team meeting held at 2:00pm on 12 July 2001. The SCAN Team was advised of what had occurred to date and that John had not participated in the assessment. The SCAN Team recommended,[23] among other things, that DOF 'talk to John about committing to Lisa and baby Kate going home' and that the matter be reviewed by SCAN on 26 July 2001.

On Friday 13 July 2001, John arrived at Hospital Green and indicated that he was there to stay for the weekend. QH informed DOF of his arrival.

FSO One, who was the case officer, was on leave the following Monday morning, 16 July 2001 and so FSO Two was tasked with attending Hospital Green in her absence with FSO Three[24] to receive feedback from the hospital staff about their assessment of the parenting skills of Lisa and John. The FSOs then reported their assessment to their Manager that Lisa and John should be allowed to take the baby home. A Child Protection Follow Up (CPFU) case was created which provided for voluntary ongoing DOF intervention with the family unit.

As a result of this decision baby Kate was discharged from Hospital Green into Lisa's and John's care that afternoon.

Some four days later, DOF officers became aware that the relationship between Lisa and John had ended and that Lisa intended to move to Brisbane with baby Kate. DOF referred Lisa and baby Kate to a local group home, near Hospital White, where they remained until 26 July 2001 before travelling to Brisbane to stay with Lisa's former foster family.

The SCAN Team also reviewed the matter on 26 July 2001. The minutes of the meeting indicate that the SCAN Team was advised by DOF that Lisa and baby Kate would be attending the Riverton Early Parenting Centre (Riverton), which is a QH facility located at Clayfield in Brisbane. The SCAN Team recommended, once Lisa had been assessed at Riverton, that a long-term placement at either Sisters of Mercy or Fatima[25] may need to be considered. The matter was then 'closed to SCAN' (i.e. not to be the subject of any further discussion or follow-up by the SCAN Team).

Although DOF initially referred baby Kate and Lisa to Riverton, it subsequently decided not to proceed with this referral. Instead, DOF referred Lisa and baby Kate to Fernbrook, a residential facility operated by a non-government organisation in Brisbane. Fernbrook provides emergency accommodation for women and their children.

Lisa and baby Kate resided at Fernbrook for approximately four weeks. Fernbrook is a former motel and Lisa and baby Kate occupied their own room. A person who takes up residency at Fernbrook is assigned a case-worker whose role is to provide the resident with support and assistance on a 'needs' basis. A staff member sleeps on the premises overnight and can be contacted between 10:00pm and 6:00am by telephone.

On 10 September 2001, at approximately 7:55pm, Lisa checked on baby Kate in her cot and discovered that she was not breathing and that 'the back of her head felt cool'. Lisa then rolled baby Kate onto her back and noticed that her 'face was purple and her nose appeared pushed back'.[26]

Lisa alerted Fernbrook staff who contacted the QAS. A Fernbrook employee commenced resuscitation prior to the arrival of the ambulance. QAS officers pronounced baby Kate dead upon their arrival at Fernbrook.

At approximately 8:35pm that evening, two Constables (a male and a female officer) who were performing general duties were despatched by QPS Communications to attend Fernbrook in relation to a baby's death. The Constables spoke with Lisa. Later that evening, one of the constables completed a Form 4 – 'Report concerning death by a member of the Police Service' and attended the John Tonge Centre, QH's Scientific Services facility located at Coopers Plains in Brisbane, with the Government Undertaker.

22 According to QH medical records.
23 Minutes of SCAN Team meeting dated 12 July 2001.
24 FSO Three is no longer a DOF officer.
25 Alternative long term residential placements.
26 Information derived from QPS Brief of Evidence to the Coroner.

A post-mortem was conducted on 11 September 2001. An initial finding of 'not yet determined pending test results' was recorded. On 24 October 2001, the post-mortem was completed and the cause of baby Kate's death was recorded as Sudden Infant Death Syndrome (SIDS). [27]

On 24 September 2001, DOF commenced an internal review in relation to its management of baby Kate's child protection case. The review was completed on 15 October 2001. DOF advised[28] me that the internal review 'found that no negligence had occurred in relation to the management of the case by departmental staff'.

After conducting preliminary inquiries pursuant to section 22 of the *Ombudsman Act*, I subsequently accepted the complaint for investigation.

This report contains my opinions under section 49(2) of the *Ombudsman Act* on the matters investigated and my recommendations made under section 50 of the *Ombudsman Act*.

The report is provided to the Speaker of the Queensland Legislative Assembly pursuant to section 52 of the *Ombudsman Act*[29] for tabling in the Assembly. I have taken this step because the matters raised are of considerable public interest and my investigation has identified:

- systemic problems within DOF in the management of child protection cases; and
- problems in communication and co-ordination among the public agencies involved in child protection issues, including the investigation of child deaths.

However, it should be clearly understood at the outset that I am not suggesting that these problems or the decisions made by the officers of the agencies involved contributed to baby Kate's death. Nor have I expressed any opinion about responsibility for baby Kate's death.

1.2 The complaint

The complainant raised a number of concerns in relation to the administrative actions of both DOF and QH. I have assessed those concerns and identified the following specific allegations.

Principal allegations in relation to Department of Families were that:

- DOF did not conduct an adequate assessment of baby Kate's safety, well being and care needs.
- The decision to release baby Kate from the hospital into the care of Lisa and John was not consistent with concerns recorded in the hospital records and was therefore highly questionable.
- The lines of communication between DOF and QH were inadequate.
- DOF failed to facilitate an adequate assessment of Lisa's parenting skills.
- DOF failed to ensure that Lisa was adequately supervised and supported in her care of baby Kate generally and particularly whilst at Fernbrook.
- DOF failed to transfer case management between its area offices when Lisa relocated to Brisbane.
- Fernbrook was an inappropriate placement for Lisa and baby Kate.
- DOF's contact with Fernbrook and Lisa in the period that Lisa and baby Kate were residents there was inadequate.
- DOF's records in relation to its management of this case were created after baby Kate died.
- The internal review and report completed by DOF in relation to its management of baby Kate's case were inadequate.

27 SIDS is a 'diagnosis of exclusion' - see Part 4 of this report.
28 Letter dated 14 March 2002.
29 Section 52 of the Ombudsman Act provides that if the Ombudsman considers it appropriate, the Ombudsman may give to the Speaker at any time, for tabling in the Assembly, a report on a matter arising out of the performance of the Ombudsman's functions.

Principal allegations in relation to Queensland Health were that:

- QH should have been aware of the inadequacies of Lisa's parenting skills and should have more fully conveyed the gravity of the situation to DOF.
- QH should not have discharged Lisa and baby Kate from Hospital Green when it did, particularly when she had not undergone a psychiatric assessment.

1.3 Investigative role and reporting procedures

On 15 November 2002 I advised the Directors-General of DOF and QH of my intention to conduct a formal statutory investigation of the complainant's allegations pursuant to the *Ombudsman Act*.

The Ombudsman's functions[30] under the *Ombudsman Act* are to:

- investigate complaints or grievances involving the administrative decisions and procedures of public sector agencies and to recommend remedial action where appropriate;
- make recommendations to improve the quality of public sector administration based on an examination of particular practices and procedures in agencies that have been the subject of a complaint; and
- improve the quality of decision-making and administrative practices in agencies generally, irrespective of any complaint that may have been made about a particular matter.

Principally, the Ombudsman's powers are those of investigation and recommendation. I am unable to make orders or judgments as a court is able to do. However, I am required to form opinions and, if necessary, make recommendations to address any maladministration that I identify.[31]

Recommendations are made to the principal officer of a relevant agency,[32] who is required to notify me of the steps taken or proposed to be taken to give effect to my recommendations.[33] If the recommended steps are not taken by the agency, I can report on the matter to the Premier and ultimately give a report to the Speaker for tabling in Parliament.[34]

Further, section 52 of the *Ombudsman Act* provides that I may, if I consider it appropriate, give the Speaker at any time for tabling in the Legislative Assembly, a report on any matter arising out of the performance of my functions. I have tabled this report in Parliament under this section.

1.4 Jurisdiction

Certain legislative jurisdictional limitations impact upon the content and direction of my investigations.

Firstly, the combined effect of sections 7(2), 16(2)(c) and 16(2)(d) of the *Ombudsman Act* is that I am unable to investigate alleged actions or omissions that relate to police operational matters. However, the circumstances of this particular case required my investigation to take into account the interaction of other departmental officers (within jurisdiction) with members of the QPS.

Secondly, my jurisdiction only extends to the administrative action of an 'officer'[35] of an 'agency'.[36] Both words are defined in the *Ombudsman Act* as is the expression 'administrative action'.[37] For example, Fernbrook is not an agency within my jurisdiction.

It is sometimes incorrectly assumed that I am only able to look at the procedure or process by which a decision is made rather than the **merits** of the actual decision itself. However, in my opinion, once a decision has been made that a matter does warrant further investigation, I am entitled, indeed obliged, to assess the fairness or merits of a decision that has been made, even if that decision is said to be based on a 'professional opinion or judgment'.

30 Section 12 of the Ombudsman Act.
31 Part 6 of the Ombudsman Act.
32 Section 50 of the Ombudsman Act.
33 Section 51(2) of the Ombudsman Act.
34 Section 51(3) and (4) of the Ombudsman Act.
35 Schedule 3 of the Ombudsman Act.
36 Section 8 of the Ombudsman Act.
37 Section 7 of the Ombudsman Act.

In support of this opinion, section 50 of the *Ombudsman Act* empowers me to recommend remedial action by an agency to address the effect of administrative actions I consider to be (among other things) unlawful, unjust, unreasonable or wrong. The expression 'administrative action' is broadly defined and would include actions taken consequential upon the exercise of professional opinion or judgment.

Further, the *Judicial Review Act 1991* provides that agencies cannot apply their policies inflexibly and must have regard to the merits of the particular case before them. Therefore, the fact that an agency has applied its policy in a given situation, even if that policy is generally a good one, can still mean that the agency has acted contrary to law if it has not considered the merits of the particular case in question. That is precisely what an Ombudsman investigation seeks to clarify.

I acknowledge that my Office must exercise caution when considering issues that involve professional opinions or judgments offered or made by agencies. However, this does not mean that I should not investigate such matters in appropriate cases.

Indeed, even defining the phrase 'professional opinion or judgment' is quite problematic. Numerous administrative decisions in agencies are either made by qualified professionals or based on professional advice. However, not to investigate those decisions would be to place 'professionals' in the public sector above scrutiny,[38] which, in my view, would be clearly inconsistent with the provisions[39] of the *Ombudsman Act*.

Accordingly, my investigation of this complaint entailed a review of the merits of the relevant administrative actions.

1.5 Procedure for gathering evidence

When conducting my investigations, I must act in a way that maintains confidentiality and comply with natural justice. Otherwise, I am authorised to determine my own procedure.

Section 25 of the *Ombudsman Act* provides as follows:

> **25 Procedure**
>
> (1) Unless this Act otherwise provides, the ombudsman may regulate the procedure on an investigation in the way the ombudsman considers appropriate.
>
> (2) The ombudsman, when conducting an investigation:
>
> (a) must conduct the investigation in a way that maintains confidentiality; and
> (b) is not bound by the rules of evidence, but must comply with natural justice; and
> (c) is not required to hold a hearing for the investigation; and
> (d) may obtain information from the persons, and in the way, the ombudsman considers appropriate; and
> (e) may make the inquiries the ombudsman considers appropriate.

1.6 Standard of proof and sufficiency of evidence

The *Ombudsman Act* is silent as to what standard of proof is required to be met for the purpose of forming an opinion under section 49(2). This is an important issue, particularly if I have to form an opinion that might be considered adverse to any person.

There are two standards of proof, the criminal standard and the civil standard. The criminal standard requires proof beyond reasonable doubt. The civil standard requires proof on the balance of probabilities. 'Balance of probabilities' essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true.

The civil standard of proof applies in administrative investigations.

38 See comment by Full Court of the Supreme Court of Victoria in Glenister v Dillon (1976) VR 550 at 557 per Gillard J: 'I am not prepared to accept the general proposition that because a professional man is carrying out his professional work as such, it is not therefore an administrative action taken in the government department of which he may be an officer'.
39 Sections 5, 12, 49 and 50.

The strength of evidence necessary to establish an allegation on the balance of probabilities may vary according to the seriousness of the issues involved. In the case of *Briginshaw v Briginshaw* (1938) 60 CLR 336, Dixon J remarked that:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved.

While I am not bound by the rules of evidence, the principles of natural justice must be complied with and, as far as possible, allegations that are made to me must be properly assessed and investigated.

1.7 Natural justice

Several sections of the *Ombudsman Act* require that, before I form an opinion, I must comply with the principle that persons who are the subject of proposed adverse comment should be provided with an opportunity of being heard in relation to the matter. These sections essentially comprise the 'natural justice' provisions of the Act.

As noted, section 25(2)(b) of the *Ombudsman Act* provides that when conducting an investigation, I must comply with the principles of 'natural justice'.

Section 26(3) of the *Ombudsman Act* provides that, if at any time during the course of an investigation it appears there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be offered an opportunity to comment on the subject matter of the investigation before the report is published.

Section 55 of the *Ombudsman Act* provides that any report under the Act must not make comment adverse to any person unless that person has been given an opportunity of making submissions about the proposed adverse comment. If, after assessing those submissions, I still propose to make adverse comment, I am required to ensure that person's defence is 'fairly stated' in the final report.

The terms procedural fairness and natural justice are often used interchangeably within the context of an administrative investigation. Whilst the courts have emphasised the need for flexibility in the application of the rules of procedural fairness and natural justice, depending on the circumstances of each individual case,[40] the rules generally require[41] an investigator conducting an administrative investigation to:

- inform people against whose interest a decision may be made of the substance of any allegations against them or the grounds for adverse comment in respect of them;
- provide people with a reasonable opportunity to put their case, whether in writing, at a hearing or otherwise;
- hear all parties to a matter and consider submissions;
- make reasonable inquiries or investigations before making a decision, forming an opinion or taking any action;
- ensure that a person who decides a case does not have a direct interest in it; and
- act fairly and without bias and conduct the investigation without undue delay.

Essentially, the provision of natural justice to an individual should ensure that that person's rights and interests are safeguarded.

In order to satisfy my statutory obligation under section 26(3) of the *Ombudsman Act*, this report was issued in provisional form to the Directors-General of both DOF and QH and the Commissioner of Police, Mr R. Atkinson APM on 3 July 2003. On that same day, I also advised the responsible Ministers, the Honourable Judy Spence MP, Minister for Families, the Honourable Wendy Edmond MP, Minister for Health and the Honourable Tony McGrady MP, Minister for Police, that I had taken this step. I invited the Directors-General and the Commissioner of Police to comment on the matters under investigation.

40 Kioa v West (1985) 159 CLR 550.

41 Mahon v Air New Zealand Ltd [1984] AC 808; Annetts v McCann (1990) 170 CLR 596; Ainsworth v Criminal Justice Commission (1992) 175 CLR 564; Greiner v Independent Commission Against Corruption (1992) 28 NSWLR 125; Chairperson of the Aboriginal and Torres Strait Islander Commission v Commonwealth Ombudsman (1996) 134 ALR 238; Bond v Australian Broadcasting Tribunal (No 2) (1998) 84 ALR 646.

In addition, in order to address my statutory obligation under section 55 of the *Ombudsman Act*, I provided the QPS officer referred to in this report as the Detective Sergeant and the DOF officers described in this report as FSOs One, Two, Three and Five and the Manager, Acting Manager and Internal Review Officer with notices specifying particular proposed adverse comment that was intended for inclusion in the final report. Each of these persons was invited to make submissions in response.

Responses were received from:

- the Director-General of DOF;
- the Director-General of QH;
- the Commissioner of Police;
- FSO One;
- FSO Two;
- the Manager; and
- the Acting Manager.

The Detective Sergeant, FSO Three, FSO Five and the Internal Review Officer chose not to make any individual submissions. The Commissioner of Police replied on behalf of the Detective Sergeant as he considered that 'all actions of police officers involved in the investigation of baby Kate's death were undertaken in the exercise of the police officers' powers under the *Police Powers and Responsibilities Act 2000* or in assisting the Coroner under the provisions of the *Coroners Act 1958*'.

The agencies' responses to my provisional report appear in Appendices N, O and P.

The responses of the individual officers have been incorporated into the report at various points and have otherwise been summarised in Appendices Q, R, S and T.

FSOs One and Two provided lengthy responses. Section 55(3) of the *Ombudsman Act* requires me to ensure that a 'person's defence is fairly stated in the report'. There is no obligation to include a person's entire response as long as I include a fair summary. Nor am I obliged to publish irrelevant material that is not responsive to adverse comment in the report.

This report contains recommendations made pursuant to section 50 of the *Ombudsman Act*. Section 51 of the *Ombudsman Act* states that if an agency is given a report under section 50 that makes recommendations, the Ombudsman may ask the agency's principal officer to notify within a stated time of:

- the steps taken or proposed to be taken to give effect to the recommendations; or
- if no steps, or only some steps, have been or are proposed to be taken to give effect to the recommendations, the reasons for not taking all the steps necessary to give effect to the recommendations.

In accordance with this provision, I will be asking the Directors-General of DOF and QH to advise me of the steps taken, or proposed to be taken, to give effect to the recommendations I have made.

1.8 De-identification

With two exceptions and to the extent practicable, all identifying information in this report, including personal and place names, has been altered. This includes references to names in interviews and records. I have not de-identified my references to Riverton and the John Tonge Centre, which are QH facilities in Brisbane and well known for the respective services they provide.

In order to protect Lisa's privacy, I have replaced specific information about her medical history with general descriptions. I have therefore recorded throughout my report that Lisa has an intellectual impairment and a medical condition that requires medication without disclosing the details of that impairment and condition.

1.8.1 DOF officers and Area Offices

I have not identified the DOF officers and area offices involved in baby Kate's case because to individually name officers and their area offices may lead to the identities of Lisa, John and baby Kate being made public.

1.8.2 Hospitals Green and White

Similarly, to identify where baby Kate was born could lead to Lisa's and John's identities being made public. There is also no public benefit to be gained from identifying the hospitals or the QH staff who provided evidence to my officers for the purpose of this investigation.

1.8.3 Fernbrook

Fernbrook is not an agency within my jurisdiction and I have not made any *adverse comment* about it. No public benefit is served by identifying Fernbrook or its staff and to do so may lead to the identification of Lisa and John.

1.8.4 Lisa and John

I have no jurisdiction to express opinions about Lisa's or John's conduct except to the extent that their conduct may be relevant to an assessment of the actions and decisions taken by officers of DOF and QH.

Furthermore, I have not made any adverse comment about Lisa and John in this report.

Lisa was formerly a child in care. The confidentiality provisions of section 189 of the *Child Protection Act* do not appear to apply to her because she is no longer a child in the Chief Executive's custody or guardianship. However, it is my strong view that the publication of any information that could identify her, baby Kate or John would be unfair and not in the public interest.

2 The Investigation

2.1 Initiation

In letters to DOF and QH dated 18 February 2002 and 18 June 2002 respectively, I outlined the complainant's allegations and the issues arising from the complaint.

At that time, particular information was requested from these agencies pursuant to section 22 of the *Ombudsman Act* to assist me to determine whether my Office should investigate the complaint. This section requires that principal officers of agencies must give the Ombudsman reasonable help in the conduct of a preliminary inquiry.

Having assessed the material received, on 15 November 2002 I provided DOF and QH with notice, in accordance with section 27(2) of the *Ombudsman Act*, of my intention to conduct a formal investigation of the complaint and of the possibility that I would exercise certain powers to obtain evidence under part 4 of the *Ombudsman Act*. In the event, I did not have to use any of these powers as all agencies and persons from whom information and/or documents were sought assisted my investigators.

2.2 Process – Department of Families

My officers:[42]

- obtained and examined a complete copy of DOF's files in relation to both Lisa and baby Kate;
- interviewed the complainant;
- interviewed the three FSOs, namely FSOs One, Two and Three, involved in DOF's initial assessment in relation to baby Kate. The interview with FSO Two was conducted immediately after the interview with FSO One to avoid any suggestion of collusion;
- interviewed officers in the positions of Manager, Acting Manager and Acting Team Leader[43] of DOF Area Office Green during the period that baby Kate was the subject of departmental intervention;
- interviewed the current Manager of DOF Area Office Green, although he was not employed by DOF during the relevant period;
- interviewed FSO Four from Area Office Blue who had been Lisa's case officer;
- interviewed the DOF officer who completed the internal review of DOF's handling of the matter following baby Kate's death;
- interviewed the Manager and an Intake Officer both of whom worked in Area Office White at the relevant time; and
- obtained further information from DOF.

2.3 Process – Queensland Health

My officers:

- obtained and examined a complete copy of QH's medical records in relation to baby Kate and Lisa;
- interviewed the Paediatrician at Hospital Green and the Medical Superintendent at Hospital White;
- interviewed QH staff at Hospitals Green and White, namely Registered Nurses (RNs) and/or Clinical Nurses (CNs), who were involved in the care and observation of baby Kate and Lisa;
- obtained and examined the *Post-Mortem Examination Report* in relation to baby Kate;
- interviewed a Pathology Registrar and a Forensic Pathologist, Queensland Health Scientific Services – John Tonge Centre;
- inspected the Riverton Early Parenting Centre at Clayfield and interviewed relevant staff; and
- obtained further information from QH.

42 Ms Angela Ritchie BA, Investigating Officer, and Mr Peter Cantwell, LL.B(Hons) Solicitor, Assistant Ombudsman.
43 The Acting Team Leader is also referred to in this report as FSO Five given that she was involved in the matter in both capacities.

2.4 Other investigations

My officers:

- obtained, with the Coroner's consent, a complete copy of the investigation report prepared by the QPS for the Coroner in relation to the death of baby Kate;
- requested information from QPS about its investigation, its report to the pathologist and its procedures for the investigation of sudden unexplained deaths of children; and
- interviewed the Fernbrook Manager and the Intake Officer.

2.5 Documents obtained

A list of all documents obtained for the purpose of the investigation is contained in Appendix A.

3 Relevant law, legislation, policy and procedures

3.1 Department of Families

3.1.1 Legislation

DOF's statutory obligations in relation to child protection are contained in the *Child Protection Act*. The Act provides that if the Chief Executive becomes aware, whether because of notification given to the Chief Executive or otherwise, of alleged harm or risk of harm to a child and reasonably suspects the child is in need of protection, the Chief Executive must immediately have an authorised officer investigate the allegation and assess the child's need of protection, or take other action that the Chief Executive considers appropriate. [44]

'Harm to a child' is defined to mean any detrimental effect of a significant nature on the child's physical, psychological or emotional well being. It is immaterial how the harm is caused.[45] A 'child in need of protection' is a child who has suffered harm, is suffering harm or is at unacceptable risk of harm and does not have a parent **able and willing** to protect the child from harm.[46]

An authorised officer investigating the alleged harm, or risk of harm, may take the child into the Chief Executive's custody if the officer **reasonably believes** the child is at risk of harm and is likely to suffer harm if not immediately taken into custody.[47] If a child does not have a parent able and willing to give the child ongoing protection, the child has the right to long-term alternative care.[48]

Part 4 of the *Child Protection Act* confers upon DOF the authority to make an application to the Children's Court to take a child into the custody of the Chief Executive. The Children's Court may make a child protection order if it is satisfied that:

> **59 Making of a child protection order**
>
> …
>
> (1)
>
> (a) the child is a child in need of protection and the order is appropriate and desirable for the child's protection;
>
> …
>
> (3) In addition, before making a child protection order granting long-term guardianship of a child, the court must be satisfied –
>
> (a) there is no parent able and willing to protect the child within the foreseeable future; or
>
> (b) the child's need for emotional security will be best met in the long-term by making an order.

Long-term guardianship expires on the day before a child turns 18 years.[49]

Part 6 of the *Child Protection Act* contains the 'Charter of rights for a child in care'. To the extent practicable, the Chief Executive must ensure the charter is complied with.[50] The charter provides, among other things, that the child in care has the right 'to maintain relationships with the child's family and community.'[51]

44 Section 14(1) of the Child Protection Act.
45 Section 9 of the Child Protection Act.
46 Section 10 of the Child Protection Act.
47 Section 18 of the Child Protection Act.
48 Section 5(i) of the Child Protection Act.
49 Section 62(2)(c) of the Child Protection Act.
50 Section 74(2) of the Child Protection Act.
51 Schedule 1 of the Child Protection Act.

3.1.2 Policies and procedures

At the time of baby Kate's notification, DOF's procedural requirements and practice standards in relation to child protection were contained in the *Child Protection Procedures Manual* (the Manual).[52] The Manual was updated to reflect the principles contained in the *Child Protection Act*, which came into effect on 23 March 2000 and replaced the *Children Services Act 1965* (Qld). However, the procedures contained in the Manual have not altered significantly. The Manual is used in conjunction with relevant policy memoranda, which are issued to implement new policies and procedures within DOF.

When DOF receives information that leads it to reasonably believe a child has suffered harm or is at risk of suffering harm due to the action or inaction of a parent, care provider or person living in the child's home, a 'child protection notification' is recorded. If the level of harm is considered to be 'significant', DOF will carry out an 'initial assessment' to determine the protective needs of the child. If the level of harm is not considered to be significant, DOF will provide 'protective advice' to the notifier, but will not make any contact with the family involved. However, if the information does not give DOF sufficient reason to believe that the child has been harmed or is at risk of harm the matter is recorded as an 'intake' and responded to appropriately (e.g. the provision of information and appropriate referrals, brief counselling or support services).

At the relevant time, DOF's Policy Memorandum PM00/03, entitled *Child Protection Notification (Initial Assessment) Response and Specific Workload Management Strategy*, outlined DOF's strategy for prioritising responses to child protection notifications requiring initial assessment. Essentially, notifications were prioritised according to an assessment of the level of likely significant harm, and the urgency/immediate danger associated with that significant harm.

Notifications with a high risk of immediate danger and a high or low risk of future significant harm were classified as 'priority one' notifications. Notifications with a low risk of immediate danger and a high risk of future significant harm were classified as 'priority two' notifications. Notifications with a low risk of immediate danger and a low risk of future significant harm were classified as 'priority three'. Specific criteria for determining the level of harm were outlined in a document titled *Practice Guide for Assessing High/Low Level of Risk – Notifications Requiring Initial Assessment*.

PM00/03 required that initial assessments of priority one notifications be commenced within 24 hours. Initial assessments of priority two and three notifications had to be commenced within a fortnight of receiving the notification, and completed within one month of commencing the assessment.

PM00/03 also outlined DOF's procedure for managing and processing notifications that could not be responded to in an appropriate time period because of resourcing limitations. This procedure was called the Specific Workload Management Strategy (the strategy). This strategy was not utilised in baby Kate's case. I am pleased to report that DOF has confirmed that use of the strategy ceased in April 2003. The use of the strategy was the subject of considerable criticism by me during my investigation and report into the adequacy of the actions of DOF in relation to the safety of the late Brooke Brennan.[53]

DOF's practice is that an initial assessment is carried out by two FSOs, who visit the child and family to discuss the concerns and assess the 'child's protective needs'. The term 'child's protective needs' refers to those specific things that a child requires in order to be safe and to experience an adequate standard of physical and emotional health.[54] Where it is possible that a criminal offence has been committed, a police officer may be asked to attend the visit, in which case only one FSO is required.

The purpose of the initial assessment is to gather information relevant to determining whether a child has been harmed or is at risk of harm. A risk assessment requires the extensive gathering and interpretation of information to determine a child's protective needs. The aim of assessment is to guide action. The assessment process includes 'identifying the problems and their severity and gathering other relevant information to help form an opinion about the degree of risk to the child.'[55]

52 The Manual (in hard copy form) has since been replaced by various policies and procedures that are accessible through the DOF Infonet.
53 Report of the Queensland Ombudsman: An investigation into the adequacy of the actions of certain government agencies in relation to the safety of the late Brooke Brennan, aged three, May 2002.
54 Child Protection Procedures Manual – Chapter 14 – Departmental intervention.
55 P. Reder, S. Duncan, M. Gray, Beyond Blame: Child Abuse Tragedies Revisted, Routeledge, London, 1993, p.83.

In November 1999, DOF published *A Practice Guide for the Assessment of Harm and Likely Harm* (the Practice Guide) for use by DOF officers. The 'Introduction' to the Practice Guide states:

> This practice guide has been developed to assist departmental child protection workers to assess harm and likely harm and includes the following components:
>
> - information gathering (what are the key pieces of information required?);
> - risk factors (identifies and explains risk factors);
> - protective factors (identifies and explains protective factors); and
> - decisions about intervention (what helps with this?).
>
> Departmental workers must assess harm and likely harm to a child or young person at different points during the child protection process including when:
>
> - deciding about intake responses;
> - conducting an initial assessment;
> - deciding whether to remove a child or young person from home; and
> - deciding whether to return a child or young person home.
>
> When assessing harm and likely harm workers must consider:
>
> - whether the child/young person is in danger of immediate harm;
> - whether the child/young person has been harmed or is likely to be harmed at some point in the future;
> - what type of harm has been experienced or is likely to be experienced by the child or young person; and
> - the level or degree of harm experienced or likely to be experienced by the child or young person.

DOF's policies, procedures and guidelines for conducting initial assessments, and gathering and evaluating information, are contained in the various chapters of the Manual and the Practice Guide. However, the Manual and the Practice Guide contain generally consistent information.

The Practice Guide states[56] that information can be gathered in three ways:

> - review of the file material/departmental records;
> - interview with the parents, the child or young person, their siblings, other relevant family members, other significant people in the child/young person's life, and other relevant professionals e.g. teacher, doctor; and
> - observations of the child/young person, parents, harm and environment.

Once the information has been gathered, the Practice Guide provides that the information should be evaluated and/or assessed to determine:

> - whether the child/young person is in immediate danger;
> - whether the child/young person is likely to be harmed now or at some point in the future;
> - what type of harm has been experienced, is being experienced or is likely to be experienced by the child or young person;
> - parental and family functioning; and
> - factors that provide some level of protection for the child or young person.
>
> The risk factors and protective factors discussed in this guide assist in evaluating the information gathered. In addition to using the practice guide workers should:
>
> - apply their professional knowledge base to identify patterns in behaviour;
> - group factual information within a theme; and
> - group all information within the Department's child protection framework.
>
> The initial assessment process provides the basis for three decisions: the outcome of the assessment, identification of protective needs and plans for ongoing intervention.

56 The Practice Guide – Part 1 – Information Paper.

The section of the Practice Guide entitled 'Risk Factors' identifies and explains the risk factors that DOF officers need to consider when assessing harm or likely harm under the following headings:[57]

Harm/Likely future harm

- The current injury/harm/condition is severe.
- The pattern of harm is escalating.
- The pattern of harm is continuing.
- The parent or caregiver had made a threat to cause serious harm to the child/young person.
- Sexual abuse is alleged with the perpetrator still having access to the child/young person.
- Chronic neglect is identified.

The Child

- Physical harm to a child under 12 months.
- The child/young person is unprotected by self and others (age may be a critical indicator).
- The child/young person has special needs which increases their vulnerability.
- The child presents as fearful of the parent or caregiver or other household members.

The parent or caregiver – including patterns of behaviour

- The parent's or caregiver's explanation for the current injury is inconsistent or the harm is minimised.
- Inconsistent explanations, denial and minimisation can increase the likelihood of future harm.
- The parent's or caregiver's behaviour is presently violent or out of control.
- A parent or caregiver is unable to meet their child's protective needs because of mental illness, intellectual/physical disability or because they are the victim of domestic violence or are attached/dependent upon another person who has harmed their child.
- The parent or caregiver is experiencing a high degree of stress.
- The parent/caregiver has unrealistic expectations of their child or describes or acts towards their child in a negative way.
- The parent/caregiver has poor attachment to the child/young person.
- The parent/caregiver has a substance abuse problem.
- The parent/caregiver is refusing access to the child/young person, there is reason to believe that the family is about to flee or the family is highly mobile.
- The parent/caregiver is young – generally under the age of 21.
- The parent/caregiver has themselves experienced childhood abuse.
- The physical and social environment is chaotic, hazardous and non-child safe.

Further, the 'Decision about Intervention' section of the Practice Guide recommends that the following 'protective factors can be of use in assessing both the likelihood and level of future harm.'[58]

The child or young person

- vulnerability
- access to support, access of the person responsible
- presentation i.e. physical appearance and psychological functioning
- developmental level
- special needs
- child's perceptions and disclosures.

Individual profile of the parent/caregivers

- age/maturity
- parenting knowledge and skills
- behaviour e.g. violent
- substance abuse
- mental illness
- physical intellectual disability
- mobility
- history of childhood abuse
- spousal relationship – domestic violence.

57 See Appendix K for a full copy of Part 3 of the Practice Guide - Risk Factors.
58 The Practice Guide – Part 5 – Decision about intervention.

Further, the 'Decision about intervention' section of the Practice Guide states:

> The individual characteristics of the parents or caregivers need to be assessed in order to determine the likelihood of future harm. These characteristics should be assessed in context and with consideration of protective factors. As the risk indicators reveal – immature parents or caregivers with poor parenting skills, substance abuse problems, mental illness and histories of childhood abuse have a greater likelihood of harming their child or failing to protect. **A combination of risk factors increases the overall likelihood of future harm.** [emphasis added]

The instructions in the Manual for assessing the risks of harm to a child during the initial assessment process include the following:[59]

Consider the factors about the child which may influence the child's risk of future harm. These factors include:

- age of the child. The younger the child, the more vulnerable. This is due to their:
  - more fragile physical condition
  - being less able to protect themselves.

The factors about the parents which could influence the child's risks of harm include:

- the parent's relationship with the child;
- the parent's willingness to meet the child's protective needs;
- the parent's level of:
  - acknowledgement that harm has occurred
  - response to the child about the harm;
- the parent's understanding of how the injury or incident occurred and capacity to prevent recurrence. This point is relevant to both the maltreating and non-maltreating parent;
- the existence of a non-maltreating parent able to take responsibility for the child's protective needs;
- impediments to the parent's ability to act protectively eg.
  - intellectual disability
  - psychiatric disorder
  - impaired physical functioning
  - addiction which impairs day-to-day functioning;
- the parent's willingness to work with organisations offering assistance; and
- parenting patterns and the parent's past history of abuse.

Once an initial assessment has been completed, the FSOs report their findings and recommendations to the Manager or Team Leader. It is then for the Manager or Team Leader to decide what further action, if any, is required.

A notification is recorded as 'substantiated' if there is evidence that a child has actually been harmed. An outcome of 'substantiated risk' is recorded when no actual harm has been experienced but risk factors have been identified which suggest that the child may be at risk of significant harm. Alternatively, if the information gathered does not indicate harm or risk of harm, the notification is recorded as 'unsubstantiated'.[60]

When a notification is recorded as substantiated or substantiated risk, a decision has to be made about the level of intervention that is required from DOF to meet the child's protective needs. The Practice Guide provides:[61]

> The decision about the level of intervention should be based on the likelihood and significance of future harm. Intervention occurs to the extent necessary to ensure what the child or young person needs to be safe. While there can never be a prescription for intervention levels following substantiation, decision-making about the appropriate level of intervention may be assisted by considering the concepts of:
>
> - Likelihood of future harm – an estimate of the probability of occurrence and
> - Significance of harm – which incorporates the severity of the harm and the vulnerability of the child or young person.

Essentially, there are two types of intervention: voluntary intervention with the consent of the family or intervention based on a child protection order under the *Child Protection Act*. The Manual offers some guidance to DOF officers as to when voluntary or statutory interventions are appropriate.

59 Child Protection Procedures Manual – Chapter 13 – Assessment and decision-making: is there a risk of harm? Are there continuing risks?
60 DOF's Initial Assessment – Outcomes and Recording Families Practice Paper, August 1999.
61 The Practice Guide - Part 5 – Decision about intervention.

Intervention on a voluntary basis is said[62] to be appropriate when the child's protective needs are able to be met by 'the child remaining at home or the use of an emergency placement' and the parent identified as being responsible for the harm to the child 'acknowledges their role in the harm to the child and is able and willing to co-operate with DOF'. **This was the level of DOF intervention that was utilised in baby Kate's case.**

The Manual indicates that intervention on a voluntary basis is inappropriate if 'the parent's failure to adhere to the voluntary agreement would place the child at risk of harm and/or there are high risk factors associated with the parent's ability to adhere to the voluntary agreement (e.g. high mobility or current alcohol or drug abuse)'.

The Manual provides that statutory intervention in the form of a child protection order is appropriate when 'a child's protective needs cannot adequately be met by the sole use of non-departmental services and DOF intervention on a voluntary basis'. *The Child Protection Act* envisages that a child should be taken into the custody of the Chief Executive if it is **reasonably believed** that the child is at risk and is likely to suffer harm if it is not immediately taken into custody.

3.1.3 Child death reviews

When a child who has been the subject of DOF interventions dies or suffers serious injury, DOF's policy documents entitled *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures* and *Child Death Reviews Policy and Procedures* must be followed. These policies were implemented on 19 September 2001[63] and replaced the procedures set out in PM95/17 – *Procedures for Recording and Reviewing the Death or Serious Injury of Children or Young Persons*.

The Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures (the Reporting Policy) outlines the procedures that must be followed by DOF officers when an 'incident' occurs involving departmental staff and clients. An incident is defined to mean 'any event that may be either accidental or deliberate where a client, staff member or carer has died, been injured, or is missing, or an incident that may impact on public confidence in the DOF.'

An incident is further categorised as either a category 1 or category 2 incident according to the nature of the event itself. The death of a DOF client is a category 1 incident. Accordingly, the Child Death Review Policy[64] (the Policy) is applicable.

Child death reviews are required to be conducted in accordance with the terms of reference prescribed in the Policy in order to examine the circumstances leading to the death of the child. The focus of the review is on DOF's systems, practices and procedures that applied to the child.

However, the nature of the review that is undertaken depends on the actual circumstances of the child's death. In cases where the death of a child is considered to be 'accidental', the policy provides for a Level 2 review, which is completed by a senior DOF officer as an internal review. The word 'accidental' is not defined. The Policy also provides that a Level 2 review can be undertaken in cases that do not involve child deaths e.g. a category 2 incident.

A Level 1 review is completed by a Child Death Review Team lead by an appropriately qualified child protection practitioner external to DOF. The Policy provides that a 'Level 1 child death review is indicated when a child client's death relates to one or more of the following circumstances':

- suspected non-accidental death or illness;
- suicidal or self injurious behaviours;
- a death that is associated with a child protection matter where there has been a pattern of contact with the department based on similar concerns;
- **SIDS death where there have been previous contacts with the department relating to the neglect or physical abuse of the child** [emphasis added]; and
- where there are contentious circumstances or significant external criticism in relation to prior management of the case.

After baby Kate's death, DOF established a Review of Significant Incidents Committee (RSIC) to provide oversight of review outcomes. The RSIC came into effect on 26 September 2002. The RSIC considers all

62 The Child Protection Procedures Manual - Chapter 14 – Departmental intervention.
63 Baby Kate died on 10 September 2001.
64 See Appendix B for a copy of the Policy.

Level 1 child death reviews. The RSIC considers Level 2 child death reviews only at the Director-General's discretion. The RSIC is chaired by the Deputy Director-General and comprises officers occupying the following positions:

- DOF Executive Director, Policy (or nominee)
- DOF Executive Director, Operations (or nominee)
- DOF Executive Director, Corporate and Executive Services Committee (or nominee)
- Chairperson of the Coordinating Committee on Child Abuse[65] (CCOCA)
- DOF Regional Director representative (rotated on a six monthly basis)
- DOF Director, Review and Evaluation Branch
- Representative from another State Government Department[66] (rotated annually).

The RSIC did not consider the child death review in relation to baby Kate. However, DOF's Review and Evaluation Branch formulated an 'Action Plan' to give effect to the recommendations of the internal reviewer. I will discuss the Action Plan in Part 9 of this report – The child death review.

3.2 Queensland Health

3.2.1 Legislation

Section 76K of the *Health Act* imposes upon any medical practitioner who suspects a child may be suffering from abuse an obligation to notify an 'authorised person' of that suspicion within 24 hours by the most expeditious means available.

Section 76K further states that an authorised person who receives a notification from a medical practitioner under this section 'shall act in such manner as will best ensure the safety and well being of the child in question and, in doing so, may communicate the notification to other persons for the purpose of having investigations or inquiries made or other things done…'.

QH staff are also required to follow the guidelines set out in the Queensland SCAN Team Manual (the SCAN Team Manual) for referral of cases to SCAN teams. These guidelines state that QH should refer to the SCAN team all suspected child abuse and neglect matters, including every mandatory notification made in accordance with the *Health Act*, to an authorised person.

Under section 76L of the *Health Act*, a 'prescribed medical officer' has the discretionary power to issue an order requiring detention of a child in hospital for a period of not more than 96 hours (a '96-hour order') if:

- the child is in hospital or admitted to hospital; and
- the prescribed medical officer suspects on reasonable grounds that the child is being maltreated or neglected such that the child is likely to be subject to unnecessary injury, suffering or danger.

A 'prescribed medical officer' is defined as: 'the medical superintendent or…any nominee (being a medical practitioner) of such medical superintendent'.

Section 76L also gives the prescribed medical officer the power to issue a 96-hour order if a child suspected of being in danger is removed from a hospital without permission. If a 96-hour order is issued in these circumstances, the prescribed medical officer may order in writing that the child be taken and conveyed to such hospital as the officer directs and detained there as a patient for up to 96 hours.

3.2.2 Riverton Early Parenting Centre

QH operates the Riverton Early Parenting Centre (Riverton). Riverton is a public hospital that provides a 24-hour specialist residential service for Queensland families with children under three years of age who require parenting support and education. Riverton is located at Clayfield in Brisbane and has 40 beds, 20 for parents and 20 for children. It provides parents and carers with education, learning and interventions based on individual and family need in areas such as:

- breastfeeding management
- infant feeding management

65 The Chairperson of CCOCA is presently a DOF employee.
66 Currently a representative from the Department of Corrective Services.

- child growth and development
- behaviour management
- post-natal difficulties
- parenting issues.

Riverton is staffed by a multi-disciplinary team of health service professionals including a nursing team comprising a Nursing Director, Clinical Nurse Consultant, Nurse Managers, Clinical Nurses, Registered Nurses and Enrolled Nurses. The team also includes Paediatricians, Paediatric Registrars, a Social Worker and mental health workers including Psychiatric Consultants and Registrars.

Riverton provides two residential programs – the 'general' admission program, which is a four day program, and the Intensive Parenting Education Program (IPEP), which is a 12 day program. The IPEP has been designed specifically for parents or carers who provide care for a child under three years of age and who have limited parenting skills and/or in respect of whom child protection concerns have been identified. The program targets those families where there is an identified need for intensive parenting education and skill development and a comprehensive assessment of their parenting capacity. [67]

Riverton also operates a telephone support service – 'Child Health Line' – which is staffed 24 hours a day, seven days a week by experienced child health nurses. The service provides parenting and health information to parents and carers. The Child Health Line receives an average of 170 calls per day. [68]

QH has advised[69] that because of the care and protection concerns and level of parenting assistance required, all referrals from DOF are immediately considered for admission to the IPEP rather than the general program. QH said that the 'level of assessment and intervention provided in the general program are too restricted for DOF referrals'.

When a DOF client is admitted to Riverton, the referring FSO is required to participate in a weekly case conference, either in person or via telephone, to discuss the assessment and progress of the client and any identified strengths or concerns in relation to the clients' parenting ability. Following the case conference, Riverton staff and the FSO will meet with the client to discuss any ongoing concerns.

When a DOF client is discharged from Riverton, a comprehensive 'discharge summary' is completed for DOF outlining the nature of the nursing, social work and psychiatric interventions that were required during the client's admission. The discharge summary also has provision for the team involved in the assessment to outline their concerns and recommendations. A sample discharge summary is included in this report at Appendix C.

3.3 Suspected Child Abuse and Neglect (SCAN) Teams

SCAN Teams are committees of persons from the core agencies of QH, DOF and QPS. They were developed in 1980 as a means of providing a co-ordinated response by these agencies to cases of suspected child abuse and neglect. There is no legislation that confers any powers, procedures or formal status on SCAN Teams.

The role of SCAN teams is explained in the SCAN Team Manual as follows:

> The SCAN team is a forum for consultation on complex child protection cases where there is the need for a multi-disciplinary approach. The role of the SCAN team is to ensure a co-ordinated and effective response to mandatory and voluntary notifications of child abuse and neglect by the three government departments with statutory responsibility for child protection.
>
> The SCAN team does not have distinct authority. The individual core departments retain responsibility for their actions in accordance with their statutory authority. The SCAN team formulates recommendations for action based on consensus between the three core members, to ensure that the activities of the individual core departments are co-ordinated…
>
> The team has a core membership of representatives of DOF, QPS and an authorised medical practitioner as defined in the Health Act...

67 Fact Sheet – Riverton Statewide Program.
68 Fact Sheet – Riverton Statewide Program.
69 Letter dated 29 January 2003.

SCAN teams carry out the following functions:

- provide an inter-agency forum for case discussion and planning to ensure:
  - the safety of the child
  - that assistance is available for the family and child
  - that intervention is effective and co-ordinated;
- formulate recommendations for action incorporating the statutory responsibilities of the core departments represented in the multi-disciplinary team; and
- review the effectiveness of the recommendations until the team is of the opinion that the case may be closed to SCAN team consideration.

The SCAN team system is not intended to be a monitoring body sanctioning the work completed by core departments. The focus of SCAN team activity is on planning and co-ordinating initial child protection responses.

SCAN teams do not become involved in every child protection case. Rather, there are guidelines as to what types of matters should be referred to SCAN for discussion. The QPS is directed to refer all suspected child abuse and neglect matters. QH is directed to refer all suspected child abuse and neglect matters, including every mandatory notification made in accordance with the *Health Act*, to an authorised person. DOF is directed to refer matters only in certain circumstances,[70] including:

- where the use of health services or health workers is required as part of the initial assessment process; and
- where the suspected or alleged significant harm concerns a child under the age of three years.

In terms of the timing of the referral, the SCAN Team Manual states:

> All core members must refer all appropriate cases to the SCAN team as soon as it is clear that the case meets their referral criteria. For DOF[71] officers, SCAN team referrals can be made:
> - before the initial assessment, to plan and co-ordinate the initial assessment process;
> - during the initial assessment, as part of the information-gathering process;
> - after a completed initial assessment;
> - **when a notification is anticipated, for example when concerns exist prior to a child's birth** [emphasis added]; and
> - at any other point during intervention when consultation with the SCAN team will assist planning.

To refer a matter to SCAN, core members are required to contact the SCAN Team co-ordinator and advise of the referral. The SCAN team co-ordinator then ensures that the case is scheduled for discussion at the next meeting. The co-ordinator may call an emergency meeting 'if warranted'. The referring agency is required to complete a written referral for distribution to other team members prior to the meeting and ensure that the core member representing their agency is well briefed on the matter before attending the SCAN meeting. In cases where it is considered necessary to co-opt another person or agency representative to SCAN, the co-ordinator should invite and brief the co-opted members.

It is important to note that SCAN teams do not make decisions in relation to cases, but make *recommendations* for action. Each core agency retains individual responsibility for its actions based upon its own legislation. However, there is a general expectation among the participating agencies that SCAN recommendations will be implemented. In the event that a recommendation is not, or cannot be implemented, the SCAN Team Manual provides that the case should be referred back to the SCAN Team for further consideration.

70 See referral guidelines at Appendix D (extracted from the Queensland SCAN Team Manual).
71 The SCAN Team Manual was printed in June 1998 and refers to DOF as the then Department of Families, Youth and Community Care.

4 The Queensland Police Service

'The investigation of an unexpected child death requires a thorough death scene investigation and an autopsy conducted with knowledge of the child's social and clinical history' [72]

4.1 Evidence

On 10 September 2001, at approximately 8:35pm, two police Constables (a male and a female officer) who were performing general duties were despatched by QPS Communications to attend Fernbrook in relation to the death of an infant.[73]

Upon arriving at Fernbrook, the female Constable spoke[74] with Lisa and a Fernbrook Support Worker. Lisa told her that she had put baby Kate to sleep on her stomach at 4:30pm and at approximately 7:55pm, she had discovered that baby Kate was 'not breathing' and that the back of her head 'felt cool'. Lisa said that she then rolled baby Kate over onto her back and noticed that her 'face was purple and her nose appeared pushed back'.

Later that evening, the female Constable attended the QH Scientific Services Facility commonly known as the John Tonge Centre at Coopers Plains in Brisbane. Based on the information the female Constable had obtained from Lisa that evening, she signed and submitted what is known as a Form 4, a form developed[75] in connection with certain provisions of the *Coroners Act 1958* (Qld)[76] that requires the QPS to notify the Coroner of a death. The Form 4 identifies the deceased and provides details about the circumstances of the death. A copy of a sample Form 4 is included is this report as Appendix E.

The Form 4 was referred to a Pathologist Registrar responsible for performing baby Kate's post-mortem. Under the heading – 'Brief circumstances of the death so far as ascertained', the following information appeared:

> NON SUSPICIOUS – TYPE OF DEATH
> Mother has put the deceased down for a sleep at approximately 1630hrs 10/09/01. At approximately 1730hrs the mother has resettled the baby as she was grizzling. The mother has **placed the baby on her stomach and covered her with a blanket and two jumpers.** The mother has gone back in at approximately 1955hrs to discover the deceased felt cooler than usual. She has then rolled the deceased over onto her stomach [should be her back] and observed her face was purple and that her nose appeared squashed (as if she had been lying on it) and that the deceased was not breathing. [emphasis added]

This was the only information ever provided by the QPS to the Pathologist about baby Kate.

The following day, 11 September 2001, a Detective Constable[77] from the Juvenile Aid Bureau (JAB) interviewed Lisa in relation to baby Kate's death and obtained a formal signed statement from her.

In this statement, Lisa said that, at 4:30pm:

> I had a thin sheet on top of the mattress and I placed Kate in bed on her stomach, I did this because she would not settle if she was lying on her side or back. Because Kate was crying and whingeing in temper I gave her a little smack on her bottom after I placed her in the cot. She continued to cry and whinge.
>
> I then covered her over with a woollen blanket and placed two adult jumpers on top of that. **I covered her head with the woollen blanket** but made sure I left a gap between the mattress and blanket so air could get through. **I also had the two jumpers over her whole body which included placing them over her head.** [emphasis added]
>
> Kate was crying when I put her to bed and **I covered her over with the blanket and jumpers** to keep her warm and to also **muffle the sounds of her cries for a while**. She would have cried for a while. I don't remember how long. [emphasis added]

72 New South Wales Child Death Review Team, Annual Report 1996–1997, 1997, p. 120.
73 Information derived from QPS Brief of Evidence to the Coroner.
74 Evidence obtained from Constable's statement contained in the QPS Brief of Evidence to the Coroner.
75 In a letter to me dated 31 July 2003, the QPS advised that the Form 4 was 'developed by the Department of Justice and Attorney-General in accordance with section 6 of the Coroners Rules 1959. The Form 4 was approved in the Government Gazette on 11 October 1996 and has not been amended to date'.
76 Section 59 B of the Coroners Act 1958 provides that 'the Minister may approve forms for use under this Act'.
77 Not one of the Constables who were despatched by QPS Communications to attend Fernbrook on 10 September 2001.

Lisa's statement continues that at approximately 5:00pm she **'pulled the jumpers back off her** [baby Kate's] **head and spread them over her just below the shoulders'**. [emphasis added] She is then recorded as having told the Detective Constable that she left her room to have cigarettes and complete her communal chores but returned to the room to check on baby Kate intermittently. She told the female Constable on the night baby Kate died that, at about 7:55pm, she returned to her room, unlocked the door and 'looked at the cot and thought that the jumpers had shifted and went over' to check on baby Kate because she:

> …was worried that Kate may have moved and her head had gone back under the jumpers, because she did wriggle around a bit at night.

Lisa went on to say:

> **I then pulled the blanket back from over her head** and saw that she had not moved as I had thought, she was still lying as I had left her. [emphasis added]

When the information contained in the Form 4 and Lisa's subsequent statement to the Detective Constable the following day are compared, it is apparent that the Form 4 does not state that baby Kate's head was covered with any blankets or jumpers.

Given this significant difference, my officers interviewed both the Pathology Registrar who conducted baby Kate's post-mortem and a senior Forensic Pathologist[78] at the John Tonge Centre to ascertain the basis for the finding of SIDS on the post-mortem report and whether the information in Lisa's statement would have led to a different finding.

The Forensic Pathologist explained that SIDS is a 'diagnosis of exclusion', which, in effect, means that SIDS is only recorded if all other possible causes of death have been excluded. He advised that a post-mortem itself is not able to differentiate between the possibilities of accidental suffocation, intentional suffocation or SIDS. The findings of a post-mortem are considered with the results of the death scene examination and in the absence of any information to indicate any other possible cause or reason for the death, SIDS is diagnosed.

In this case, the only information about the results of the death scene examination given to the Pathology Registrar was the summary in the Form 4.

The Forensic Pathologist advised my officers that there was no information in the Form 4 to indicate that the death scene was either suspicious or unusual. In fact, in the Form 4, the female Constable had stated the death was of a **'non suspicious'**[79] type. As I have said, the information that baby Kate's head was covered was provided to police subsequent to the completed Form 4 being provided to the John Tonge Centre. [emphasis added]

Furthermore, the Pathology Registrar who completed the post-mortem advised my officers[80] that at the time[81], he was only allocated post-mortems in respect of 'non-suspicious' deaths. The Pathology Registrar said that had the QPS advised that baby Kate's death was considered to be 'suspicious', the case would not have been allocated to him but would have been given to a more experienced pathologist. He told my officers that had he been aware of the information contained in Lisa's statement, before he issued[82] the death certificate, he would have discussed the matter with his supervisor and may have 'rephrased the death certificate possibly omitting SIDS and possibly including another description such as uncertain cause of death'.

Similarly, the Forensic Pathologist said that, had he carried out the post-mortem and been given the information in Lisa's statement, he would have recorded the cause of death as **'undetermined'** and **'not as SIDS'**. He also advised that he would have made a comment in the post-mortem report about the circumstances of the death to the effect of **'it is unusual to place things over the head of a child but a sleeping accident cannot be excluded'**. [emphasis added] In this regard, the Forensic Pathologist said the term 'sleeping accident' encompasses a range of possibilities such as a child suffocating itself while sleeping or suffocating in the circumstances described in Lisa's statement to the QPS.

It should be clearly understood that a post-mortem finding of 'undetermined' does not exclude SIDS as a possible cause of death. I am simply saying that my investigation indicates that SIDS should not have been recorded as the cause of death.

78 The Forensic Pathologist specialises in child autopsies.
79 The Form itself required the officer to make a statement to this effect. See section 4.2 of this report.
80 In an interview on 19 June 2003.
81 The Pathology Registrar was only based at the John Tonge Centre for a period of approximately six weeks in 2001.
82 The death certificate that was issued on 11 September 2001 recorded an initial finding of 'not yet determined pending test results'. The post-mortem. report was completed on 17 October 2001 and an amended death certificate was issued on 24 October 2001 with SIDS being recorded as the cause of death.

Once my officers had obtained this advice, I wrote[83] to the Commissioner of Police to alert him to the following information:

- The significant discrepancy between the information that had been provided to the John Tonge Centre in the Form 4 and the information the QPS Detective Constable had obtained from Lisa the following day.
- The Forensic Pathologist's opinion given to my officers, that a finding of SIDS should not have been recorded given the information in Lisa's statement.
- The Coroner's advice to me[84] that, following his consideration of the QPS Brief of Evidence concerning baby Kate's death, he had recommended to the Chief Executive, in accordance with the *Coroners Act* 1958, that no inquest be held concerning the death of baby Kate.
- The Coroner's recommendation was based, in part, on the Pathologist's post-mortem finding of SIDS as the cause of baby Kate's death.

The Chief Executive (that is, the Director-General of the Department of Justice and Attorney-General) subsequently[85] endorsed the Coroner's recommendation.

Because of my concern that the Coroner may have been misled by the finding recorded in the Post-Mortem Examination Report, I recommended that the QPS provide the John Tonge Centre with the relevant information contained in Lisa's statement, so that the cause of death could be reassessed.

The Deputy Commissioner of QPS replied:[86]

> After reviewing all the material available to me and obtaining relevant legal advice, I have formed the view that it is **inappropriate** at this particular point in time to provide information directly to the John Tonge Centre in the manner in which you have requested in your correspondence. [emphasis added]
>
> Your correspondence indicates that the Coroner has advised you that he has notified the Chief Executive of the Department of Justice and Attorney-General that it is his recommendation that no inquest be held concerning the death of Kate. I understand that you have received correspondence from the Chief Executive confirming the Coroner's recommendation that it is unnecessary for an inquest to be held in relation to the matter.
>
> In the circumstances, I have forwarded correspondence to the Coroner requesting his advice as to whether he requires an officer of the Queensland Police Service to assist him further by forwarding a copy of the statement provided by Lisa together with the results of the checks conducted on the Child Protection Information System to the John Tonge Centre with a view to having a pathologist at the Centre revisit the findings made in the post-mortem certificate.

In a further letter dated 29 April 2003, the QPS advised that the Coroner **did not** require the QPS to assist him further in relation to baby Kate's death. In view of this, the QPS maintains that it is 'inappropriate' to forward the information to the John Tonge Centre. The QPS explained its position as follows:

> If a request for further information in relation to this matter is received from the John Tonge Centre, I advise that such a request will be dealt with upon its merits in accordance with the applicable statutory provisions and Queensland Police Service Policy regarding the release of information.

My officers discussed[87] this issue with the Chief Pathologist at the John Tonge Centre. The Chief Pathologist advised that he was not willing to request the information from the QPS. He told my officers that it was the responsibility of the QPS to ensure that all relevant information was provided.

There the matter rests for the moment as the *Ombudsman Act* does not authorise me to provide information about my investigation to the Coroner except by way of this report to Parliament.

I remain concerned that the Coroner may have been misled by the finding of SIDS recorded in the Post-Mortem Examination Report. I do not know whether a finding of 'undetermined' would have caused him to alter his recommendation to the Chief Executive that no inquest was necessary. However, it is important that Coroners make their determinations and recommendations based on accurate evidence, especially when the evidence is provided by experts such as pathologists.

83 Letter dated 21 January 2003.
84 Letter dated 8 January 2003.
85 Letter dated 20 January 2003.
86 Letter dated 13 February 2003.
87 On 17 January 2003.

4.2 Analysis of the evidence

4.2.1 Death scene investigation

The Form 4 was completed and provided to the John Tonge Centre on the evening baby Kate died. The Form 4 requires the member of the QPS who completes it to provide **'brief circumstances of the death as so far ascertained'**. In my opinion, this wording suggests that if further details relevant to the cause of death were to be ascertained during any subsequent investigation, these details should be provided to the Pathologist especially if a death certificate has not yet been issued. The Commissioner of Police, in his response to my provisional report, disagreed with this view and said that 'it would appear that the form's purpose is not to contemplate the provision of information gleaned from subsequent investigations as this material would form part of the coronial brief of evidence'.

My point is that the QPS should give the Pathologist any information it obtains that is potentially relevant to the cause of death, at least up to the time the Pathologist makes a finding about the cause of death. This is a logical position because the coronial brief of evidence is provided to the Coroner and not to the Pathologist at the John Tonge Centre who has the obligation to conduct the post-mortem. Under normal circumstances, a post-mortem examination would have been undertaken and a death certificate issued prior to the completion of a coronial brief of evidence by the QPS. In this case, for example, the brief of evidence was completed on 17 October 2002, approximately one year after the final death certificate was issued. The Pathology Registrar, who conducted the post-mortem, never had the benefit of any of the relevant information contained in the coronial brief of evidence.

The QPS Operational Procedures Manual (OPM) sets out[88] the procedures to be followed in investigations involving the sudden unexplained death of a child. The OPM provides that the local JAB or Criminal Investigation Branch (CIB) must be notified of the death of a child and that an officer from one of those units is 'to cause the death to be fully investigated'. That procedure was initiated in this case. Accordingly, the Constables who were despatched to Fernbrook on the evening of baby Kate's death, one of whom prepared the Form 4, had no further involvement in the matter apart from this initial response.

The Form 4 stated that the death was **'non suspicious'**. This opinion was expressed before the cause of baby Kate's death had been 'fully investigated'. As the Forensic Pathologist explained to my officers, SIDS is a diagnosis of exclusion, applied when no other cause of death can be confirmed.

The United States Department of Health and Human Services Interagency Panel on Sudden Infant Death Syndrome defines SIDS as:[89]

> The sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. **SIDS should not be diagnosed if these criteria are not met.** [emphasis added]

Similarly, in a recent report[90] prepared by the Victorian Department of Human Services and the Victoria Child Death Review Committee, SIDS was described as:

> …the cause of death when an infant dies suddenly, usually during sleep, and all other possible causes for the death are excluded through forensic investigations usually including an autopsy. SIDS is a medical term not a specific cause of death.

Significant evidence was provided by Lisa to the Detective Constable the day after the Form 4 was completed. On 14 September 2001, the Detective Constable briefed[91] the Detective Sergeant, who was also the Officer in Charge (OIC) of the JAB, in relation to baby Kate's death.

In my opinion, the statement made by the female Constable[92] in the Form 4 that the death was 'non suspicious' was both premature and unjustified and had the potential to mislead the Pathologist in circumstances where there was no clear explanation for the baby's death. In saying this, I acknowledge that the form itself required the officer to make a statement to this effect in that a footnote reads 'where no suspicious circumstances exist, state this fact'.

88 Section 7.14 of the QPS Operational Procedures Manual.
89 United States Center for Disease Control and Prevention, Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths: Recommendations of the Interagency Panel on Sudden Infant Death Syndrome, Morbidity and Mortality Weekly Report, 1996, 45 (no.RR-10), p.1.
90 Department of Human Services, Who's Holding the Baby? Improving the Intersectoral Relationship Between Maternity and Child Protection Services: An Analysis of Child Protection Infant Deaths 1995-1999, 2000, p.8.
91 The Detective Sergeant had been on 'rostered days off' at the time of baby Kate's death.
92 The female Constable who initially attended Fernbrook on 10 September 2001.

My concern is that such an opinion, given at an early stage by a person in authority, may inappropriately influence not only the Pathologist's finding but also subsequent investigations by other agencies or entities, such as QH, DOF and the Coroner. The Pathology Registrar, who conducted the post-mortem, told my officers that cases were categorised and allocated at the John Tonge Centre according to whether they were considered to be suspicious or non-suspicious deaths by the QPS. Non-suspicious cases, such as this one, were allocated to the less experienced pathologists.

The OPM further provides:[93]

When conducting an investigation in relation to the sudden unexplained death of a child, the investigating officer should note the following observations while at the scene, where applicable:

- the position of the body and its location in the home;
- whether there is any froth, foam or foreign matter in the mouth or nose of the child;
- full description of the pillow and what it is made of;
- full description of the mattress and what it is made of;
- full description of the cot or bed;
- full description of the bed clothing (material and its position);
- if any plastic or rubber sheeting was used on the cot or bed; and
- the position of the cot or bed in relation to any window or door and whether either; or these were opened or closed.

Investigators should obtain the following information from the parent / caregivers **to assist in establishing a cause of death:** [emphasis added]

1. action taken to revive the child (this information, the position of the body and lividity should be consistent)
2. when the child was last seen by a doctor or member of a health centre
3. whether the child was on any medication (list the type and dosage where appropriate)
4. any illness suffered by the child since birth
5. any feeding difficulties experienced by the child
6. the time the child was last fed
7. the food the child was fed
8. the position of the body in the cot or bed when located by the parent
9. the clothing the child was wearing and the type of material
10. colour of the face and hands when located by the parent
11. any fluid or vomit coming from the nose or mouth
12. the precise time at which either parent was last satisfied that the child was alive and well
13. whether any insect repellent, insecticide or room freshener was used and if so, what type and how frequently or recently.

The importance of a death scene investigation was described by one commentator in the following way:[94]

It is recognised in forensic pathology that young infants who die of external airway obstruction, accidental or otherwise, may have no pathologic changes on autopsy that indicate lethal injury by suffocation or smothering. In many cases of sudden infant death, death scene investigation may be the only way to determine why a healthy infant died suddenly and unexpectedly at home.

A death scene description in accordance with the OPM was not given to the Pathologist. Only a brief summary in the Form 4 (about eight lines) of the results of the examination of the scene of the death was provided. As I have said, this was significant because the result of a post-mortem examination largely determines the extent of investigation of a child death by the police, the Coroner and, in the case of a child known to DOF, DOF itself.

93 Section 7.14.
94 M. Bass, in G. Clarke F. Potts, 'Sudden Unexpected Infant Death', in Hugh Selby, The Inquest Handbook, p. 139.

4.2.2 CPIS search

The OPM also requires an authorised officer (of the QPS) to initiate a search of DOF's electronic Child Protection Information System (CPIS) upon receiving notification of the sudden unexplained death of a child. The investigating officer must then advise the Medical Practitioner conducting the post-mortem examination of the CPIS result **before** the post-mortem commences. I am advised[95] that the purpose of this procedure is to ensure that the pathologist has information relevant to the child's history.

While a CPIS search in relation to baby Kate was conducted by the QPS on 10 September 2001 in accordance with the OPM, the QPS has acknowledged[96] that the result of the search was **not** communicated to the Pathologist.

In response to my provisional report, the Commissioner of Police advised:[97]

> I have been informed that the investigating officer in this matter sent a computer message at 10:15pm on 10 September 2001 to the Office in Charge of the Sexual Crime Investigation Unit to request a check of the Child Protection Information System.
>
> The post-mortem was conducted on the deceased child at 8:30am on 11 September 2001 and the investigating officers received the results of the CPIS check by facsimile at 2:36pm on 11 September 2001. **Therefore, the requirement contained in section 7.14 of the Operational Procedures Manual that such information be conveyed to the medical practitioner conducting the post-mortem before that examination commenced was not met.**
>
> **Consideration will be given to reviewing the current Service policies and procedures in relation to conducting CPIS checks when investigating a sudden unexplained death of a child.** [emphasis added]

4.2.3 Lack of standardised procedures

Some years ago, the New South Wales Child Death Review Team (NSW CDRT) identified deficiencies in the investigation of sudden unexplained child deaths in NSW. In its 1996–1997 Annual Report the CDRT said:[98]

> The investigation of an unexpected child death requires a thorough death scene examination and an autopsy conducted with knowledge of the child's social and clinical history. **Several reviews raised concerns as to the adequacy of the social history that is routinely provided to the specialist forensic pathologists who conduct post-mortem examinations** on all children under five years of age at Glebe, Westmead and Newcastle Coroner's Courts. **In some instances, a social history was not given at all or what was provided was minimised**.
>
> **...If the result of the post-mortem examination is natural causes or Sudden Infant Death Syndrome, in the majority of cases no brief of evidence is called for and the inquest is dispensed with by the Coroner.**
>
> …To the contrary, if the cause of death is 'undetermined' or 'unascertained' following post-mortem, a brief of evidence is called for requiring a more detailed coronial investigation. [emphasis added]

As I mentioned earlier, the Coroner relied, in part, on the SIDS finding in recommending that no inquest be held into baby Kate's death.

During the interview with my officers, the Forensic Pathologist advised that the problems I have identified in baby Kate's case may have been avoided if the QPS officer who completed the Form 4 had been required to complete a detailed death scene examination report for the pathologist. Other police jurisdictions have developed standardised forms for police involved in the investigation of the sudden unexplained death of a child to gather information relevant to pathologist's examinations. The Sudden Unexplained Infant Death Investigation Report Form (SUIDIRF) is an example of such a standardised form. I have enclosed a copy of the SUIDIRF as Appendix F.

The Interagency Panel[99] developed the SUIDIRF to standardise procedures for collecting and evaluating information on sudden unexplained infant deaths. The following information is contained in the 'Guidelines' for the use of the SUIDIRF:[100]

95 Letter dated 13 February 2003.
96 Letter dated 13 February 2003.
97 Letter dated 31 July 2003.
98 New South Wales Child Death Review Team (1997), Annual Report 1996–1997, p. 120.
99 The United States Department of Health and Human Services Interagency Panel on Sudden Infant Death Syndrome.
100 United States Center for Disease Control and Prevention, Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths: Recommendations of the Interagency Panel on Sudden Infant Death Syndrome, Morbidity and Mortality Weekly Report, 1996.

> SIDS is the sudden death of an infant under 1 year of age which remains unexplained after a thorough **death scene examination,** including the performance of a complete autopsy, examination of the death scene, and review of the clinical history. **SIDS should not be diagnosed if these criteria are not met.**
>
> A standard protocol for SUIDs scene investigation offers several potential benefits. For example, it may assist researchers in accurately determining the cause of and risk factors for SIDS by reducing the likelihood of incorrect identification of SIDS and by enabling and facilitating the gathering of data on deaths correctly determined to be caused by SIDS. **Any SUID that has not been thoroughly investigated should be classified as undetermined or unexplained.**
>
> **Information obtained during a SUID scene investigation can help the pathologist interpret post-mortem findings and rule in or out accidental, environmental and unnatural causes of death, including child abuse and neglect.** Although the ultimate goal of a SUID scene investigation is to accurately assign a cause of death, no less important goals are identifying health risks posed by consumer products, identifying and understanding risk factors associated with SUIDs, and using the opportunity to refer families to grief counselling and support groups. These guidelines set the stage for standardised investigative procedures, data collection instruments and training for SUID scene investigation, and they underscore the central role of medical examiners and coroners. [emphasis added]

The Forensic Pathologist provided my officers with a copy[101] of a form entitled Infant Event Scene Investigation and indicated that he believed the Gold Coast JAB used the form. Had this particular form been completed in baby Kate's case, the officer filling it out would have had to complete the following question, among others, under the heading 'bedding':

'were any items covering the head?'

In many cases, the body will have been moved by the time police officers arrive and the form would direct officers' attention to the need to question persons at the scene about this issue. However, when I asked[102] the QPS to confirm whether the Gold Coast JAB or, for that matter, any other unit within the QPS used this particular form, the QPS advised that:[103]

> I am informed that the Gold Coast Juvenile Aid Bureau **does not** use the form attached to your correspondence.
>
> The investigators attached to the **Gold Coast Juvenile Aid Bureau do use a similar investigators checklist that is part of the local Standard Operating Procedure for investigating child deaths.**
>
> To my knowledge, **Logan Juvenile Aid Bureau uses a similar form. I am unaware of any other units within the Queensland Police Service using a similar form**. [emphasis added]

Although the Gold Coast JAB form is similar in some respects to the form provided to my officers by the Forensic Pathologist, it does not direct the investigator's attention to the question 'were any items covering the head'. A copy of the JAB form is enclosed at Appendix H.

As can be seen from the QPS's response, there is presently no standardised procedure in QPS for gathering and communicating the findings of an investigation of sudden unexplained infant deaths to a pathologist.

In my view, the present case highlights systemic deficiencies and a lack of consistency in the existing QPS procedures for investigating the sudden unexplained deaths of children.

The New South Wales Police Service uses a form entitled Sudden Infant Death – Death Scene Investigation Checklist (the checklist) for deaths of children under two years of age. The NSW Police Service provided me with a copy of the checklist (see Appendix I). The checklist was implemented largely as a result of the CDRT finding[104] that there was 'no system in place for the routine and timely provision of information that may be highly significant to the early investigation of a child's death' in New South Wales. The NSW form also directs the investigator's attention to whether any bedding or clothing covered the child's head.

101 See Appendix G.
102 Letter dated 21 January 2003.
103 Letter dated 13 February 2003.
104 New South Wales Child Death Review Team, Annual Report 1996–1997, 1997, p.121.

The Commissioner of Police, in response to my provisional report, agreed with my view. He said that:

> …there is scope for the development of a standardised death scene investigation report for the investigation of not only the sudden unexplained death of a child but also in relation to all sudden deaths where a medical certificate is not forthcoming. The development of appropriate forms would appear to be an effective tool for enhancing communication between the Service and pathologists, subject to the direction of the Coroner whom the police are assisting.
>
> It is noted that several units within the Service have developed such checklists similar in principle to the Appendices, and have done so as part of localised standard operating procedure.
>
> I am informed that the Coordinating Committee on Child Abuse, Child Death Sub-committee are presently considering the issue of the development of an appropriate form to be used during the investigation of a sudden unexplained child death.
>
> Consideration will be given to your recommendation in relation to the development of an appropriate form having regard to any statutory restrictions placed on the Service in relation to the release of information.

I am pleased there is general agreement about the need for the use of a standardised death scene investigation report and recommend the matter be addressed without delay.

4.3 Observations

4.3.1 The statement contained in the Form 4 that baby Kate's death was 'non suspicious' was both premature and unjustifiable and had the potential to mislead the Pathologist in circumstances where there was no clear explanation for the death.

4.3.2 The female Constable in making this statement in the form complied with the instructions in the footnote to the form.

4.3.3 The current form has the potential to mislead Pathologists and other persons / entities who investigate the sudden unexplained deaths of children.

4.3.4 The QPS did not advise the Pathologist of the results of the CPIS search before baby Kate's post-mortem examination commenced in accordance with section 7.14 of the QPS OPM.

4.3.5 The QPS should have provided the Pathologist with information obtained in the investigation potentially relevant to establishing the cause of death, including Lisa's statement, before the post-mortem was completed and the death certificate issued.

4.3.6 It is likely that the pathologist wrongly recorded SIDS as the cause of baby Kate's death instead of recording 'undetermined'.

4.3.7 There is presently no standardised QPS report that is used for notifying a pathologist of the findings of an investigation of the sudden unexplained death of a child.

4.4 Suggestions for improving administrative practice

It is suggested that the QPS:

4.4.1 In consultation with the Department of Justice and Attorney-General, take steps to ensure that sudden unexplained deaths of children are not described as 'non suspicious' in a Form 4 prior to the completion of the investigation.

4.4.2 Investigate if there are any systemic issues adversely impacting upon lines of communication between the QPS and pathologists as suggested by the communication failures in this instance.

4.4.3 In consultation with QH, develop and implement a standardised death scene investigation checklist (similar to the SUIDIRF[105] or the NSW Police checklist[106]) for the sudden unexplained deaths of

105 See Appendix F
106 See Appendix I

children aged under two years and amend section 7.14 of the OPM as necessary. A copy of the checklist should be provided to the pathologist tasked with making a finding as to the cause of death.

4.4.4 QPS amend its OPM to require officers investigating the sudden unexplained death of children to advise the pathologist of any information obtained that may be relevant to the pathologist's finding as to the cause of death.

4.4.5 Review the current level of training provided to QPS officers concerning the procedures contained in section 7.14 of the OPM and, if necessary, take steps to ensure that all relevant QPS officers are aware of the nature of SIDS and the circumstances in which pathologists who conduct post-mortem examinations of children who have died from unknown causes may make such a finding.

4.5 QPS Response

The QPS response to my provisional report is included at Appendix P.

I am pleased to report that the QPS:

- agreed that it would be beneficial if the deficiencies identified in my report in relation to the Form 4 were discussed with the Department of Justice and Attorney-General given that new forms are required to be developed once the *Coroners Act 2003* becomes fully operative;
- agreed that the development of appropriate forms 'would appear to be an effective tool for enhancing communication' between officers of the QPS and pathologists;
- agreed that there was 'scope for the development of a standardised death scene investigation report'; and
- advised it already had a commitment to review all training conducted by the JAB.

5 Department of Families, Queensland Health, the SCAN Team

5.1 Evidence

5.1.1 Lisa's background

Lisa was the subject of child protection interventions by an interstate child protection agency after her birth. She was placed into long-term foster care. When her foster parents relocated to Queensland some years later, the responsibility for management of Lisa's child protection case was also transferred to DOF.[107]

In her early years, Lisa was diagnosed as having some developmental delays and various medical conditions, including a physical condition that in adult life leads to mental and physical slowing. A family history of delayed intellect was also identified.

Over the years, Lisa had contact with a number of agencies and specialists because of problems experienced by DOF and her foster carers in coping with her difficult and challenging behaviours.

Some years ago, Lisa was further assessed to have 'clear behavioural disturbances which medication would not ease' and it was recommended that she undergo a two-week assessment in a residential adolescent facility.[108] However, because Lisa refused to participate in the residential assessment, I understand that no firm psychiatric diagnosis of her disability and/or behaviour has ever been made.

When Lisa's long-term foster placement broke down, she was placed with another foster family where she remained until her child protection order (CPO) expired when she turned eighteen. She then left the care of the State. However, DOF continued to offer assistance to Lisa as a 'support service case' for approximately one year after its statutory obligations ended.

5.1.2 DOF's action pre-birth

In February 2001, one of Lisa's former foster carers contacted FSO Four, Lisa's previous case-worker at Area Office Blue, to inform her that Lisa was pregnant, in an abusive relationship and had been drinking heavily during her pregnancy. FSO Four recorded the information (together with her assessment, based on her experience as Lisa's case-worker, of the risks to Lisa's baby when born) as an intake in DOF's electronic database CPIS. She said:

> Lisa's social and intellectual functioning is at a very low level and she is extremely vulnerable – as is her unborn baby. Lisa has difficulty managing her own hygiene, health and daily care and it is unlikely that she will be able to offer a new born baby an appropriate and safe environment. She has been drinking and also discussed physical domestic violence between her and her partner – it is unknown if this has occurred during her pregnancy.
>
> Lisa's low level of intellectual functioning, her history of abuse and her lack of basic hygiene and self-care skills place her unborn baby at significant risk of possible neglect and/or physical abuse and emotional harm.
>
> Lisa's disinterest in obtaining any prenatal care for her unborn baby suggests a serious lack of insight and understanding of the needs of both herself and the baby.
>
> Lisa has indicated that she is in an abusive relationship and has been drinking heavily and this is also placing her unborn baby at risk of physical harm.

FSO Four also contacted Area Office Green (near which Lisa was believed to be living) and discussed her concerns with an Intake Officer, FSO Five. FSO Four indicated to FSO Five that DOF needed to be at the

107 This information was extracted from a DOF memorandum in 1997, a copy of which was provided to this office as part of Lisa's DOF files.
108 Information derived from a report contained in DOF's file.

hospital and take Lisa's baby into care when it was born. FSO Five recorded the details of this conversation in a 'case note' dated 3 April 2001 in CPIS as follows:

> Expected date of confinement – July 2001. Still do not have an address for Lisa. Apparently, Lisa whose birthday is in July has said that she hopes to put the child in care for a few weeks so that she can party for her birthday. There is still the belief that the relationship is one of domestic violence and suspicion that this is occurring whilst she is pregnant.

In the section of the case note headed 'Decision and Action', FSO Five wrote 'to notify hospital SW [social worker] of EDC' [expected date of confinement]. FSO Five says[109] that she contacted the Social Worker at Hospital Green 'within a few days' of the telephone conversation with FSO Four. However, QH has advised[110] my Office that it has no record of FSO Five contacting the Social Worker, or any other employee, at Hospital Green to advise them of Lisa's expected date of delivery.

5.1.3 Events relating to child protection notification

Baby Kate was born in Hospital Green on 1 July 2001. Lisa was 20 years of age at the time and baby Kate was her first child. The Nurse Practice Co-ordinator advised[111] that immediately following baby Kate's birth, nursing staff had concerns about Lisa's 'coping ability'. The Nurse Practice Co-ordinator said the staff reported that Lisa was 'distracted and difficult to teach'. Further, Lisa spent a lot of time outside the hospital smoking and the nurses frequently had to go and find her and ask her to attend to baby Kate's care needs.

In view of these concerns, the Nurse Practice Co-ordinator made arrangements with the Acting Director of Nursing (DON) at Hospital White for Lisa and baby Kate to be transferred there rather than discharged directly from Hospital Green. The Nurse Practice Co-ordinator says she was concerned about discharging Lisa without any 'follow up' and believed it was appropriate for the hospital in the area where she resided to have 'ownership' and follow her into the community through the Child Health Service. Accordingly, Lisa and baby Kate were transferred to Hospital White on 3 July 2001. In her letter of referral the Nurse Practice Co-ordinator stated 'Lisa needs a lot of encouragement and support with her parenting skills'.[112]

On the day following her admission to Hospital White, the DON informed the Medical Superintendent that she had observed Lisa shaking baby Kate and being verbally aggressive and swearing at her.[113] Prior to this incident, other nurses had also expressed concerns to the Medical Superintendent about Lisa's parenting ability. This prompted the Medical Superintendent to contact the Paediatrician at Hospital Green to discuss the matter and the practitioners agreed that Lisa and baby Kate should be transferred back to Hospital Green for further review.[114] The Medical Superintendent says that he believed that Lisa would benefit from undergoing a psychiatric assessment and that he discussed this with the Paediatrician. However, there is no record of Lisa undertaking any form of psychiatric assessment at Hospital Green and I have ascertained that she was not assessed.

The Medical Superintendent advised my officers that Lisa 'flatly refused' to be transferred to Hospital Green and would 'not accept that there was any problem with her care of baby Kate'. However, he was eventually successful in persuading Lisa to agree to the transfer.

In his letter of referral to the Paediatrician of Hospital Green, the Medical Superintendent of Hospital White said: [115]

> Lisa is struggling. This is day 7 post-natally and I have concerns about her ability to maintain the care of the child. She seems to bond minimally with Kate, only doing the minimum for her. Kate's crying irritates her. [He referred to her medical conditions.] She seems willing to learn but is easily frustrated and has very little spontaneous interest. I have global concerns for both mum and baby.

The Medical Superintendent was surprised to learn at his interview with my officers that Lisa had not been psychiatrically evaluated or assessed at Hospital Green. He maintains that there was an understanding that would occur. However, the Paediatrician advised my officers that she was unable to recall the Medical Superintendent

109 In an email to my office dated 6 February 2003.
110 In an email dated 18 February 2003.
111 In an interview with my officers on 9 December 2002.
112 QH medical records.
113 This evidence was obtained from the DON's written record in the medical chart, a copy of which was provided to this Office by QH as part of its medical records.
114 In the interview with my officers on 9 December 2003.
115 Letter contained in QH medical records.

discussing a 'psychiatric referral' for Lisa. She said that, from her recollection, the Medical Superintendent's concerns 'revolved predominantly around Lisa's parenting skills'. The Paediatrician suggested that Lisa should have been referred directly to the Psychiatric Unit rather than the Children's Ward if a psychiatric referral for Lisa was the primary reason for her admission.

At 3:00pm on Friday 6 July 2001, Lisa and baby Kate were admitted to the children's ward of Hospital Green. The Paediatrician decided that it was appropriate to make a notification to DOF in relation to baby Kate. However, given that baby Kate was in a safe and protected environment for at least the weekend, the Paediatrician decided to wait until the following Monday morning to contact DOF.

The Paediatrician's recollection that she made the notification on the Monday, which was 9 July 2001, is corroborated by a notation in baby Kate's medical chart on that date which states 'Family Services notified'. In contrast, DOF records printed from CPIS state that the notification was received on 10 July 2001.[116]

When the Paediatrician contacted DOF, she spoke with an Intake Officer, FSO One. The information recorded upon intake was as follows:

- Mother has extensive history with the department as a child in care, neglect and limited parenting skills as a reason for removal from mother.
- Lisa is a new mother.
- Staff concerned that Lisa is unable to cope with the baby and has extremely limited parenting skills.
- Lisa was observed to shake the baby on at least one occasion.
- Transferred to Hospital Green for observation and supervision in managing baby.
- Staff remain concerned that Lisa is unable to cope and has limited ability to learn appropriate skills.
- Baby's father unwilling to assist and is very reluctant to be involved with medical staff in relation to baby's needs.
- Parents have demonstrated verbal abuse towards each other with father denigrating of mother's apparent intellectual impairment and lack of skills regarding baby.

The Paediatrician had also received a letter from Lisa's former foster mother outlining her concerns about Lisa's and John's ability and willingness to care for baby Kate. The Paediatrician gave a copy of this letter to DOF. The letter stated (in part):

> Lisa has had assessments over the years and was diagnosed with [a particular intellectual impairment]. While professional opinion on this differs, all were consistent in the belief that she displays eccentric and sometimes bizarre behaviours.
>
> There are problems in Lisa's relationship with her partner, the greatest being their inability to manage financially. They simply run out of money only days after receiving their welfare payment, thus having no means of providing formula and other necessities.
>
> While I was visiting Lisa at the hospital, she made an unacceptable remark to her baby. I explained the inappropriateness of what she had said and she replied that she was only joking. Lisa totally lacks awareness of other people's interpretation of her remarks and she displays no awareness for their reaction. Since transferring to Hospital Green, she has told her sister in law that she hears the baby cry at night but is not interested in getting out of bed to attend to it.
>
> **...I cannot express strongly enough how fearful my husband and I are for the safety of this baby if she is released into the care of her parents.** [emphasis added]

It should be noted that it has not been confirmed that John was baby Kate's father.

5.1.4 DOF's actions following notification

Following the receipt of the notification, FSO One discussed the matter with her Manager who authorised that she respond by way of an initial assessment. The notification was assessed to be a priority one case in accordance with DOF's strategy[117] for prioritising matters.

116 See Part 8 of this report – Record keeping.
117 See section 3.1 of this report.

On the morning of 10 July 2001, FSO One went to the hospital with FSO Two to initiate the initial assessment. The FSOs advised that FSO Two was the 'seconder' for the interview – that is, it was her role to observe the interview and take notes.

Both the FSOs were aware that Lisa was formerly a child in the care of DOF and were concerned that it would be difficult to engage with her. When the FSOs arrived at Hospital Green, Lisa is recorded[118] to have said to them 'If you are from Family Services you can fuck off right now'. However, the FSOs said[119] that after some discussion they were able to engage with Lisa and she told them that she would be willing to talk to them further if they came back to see her the following day.

According to the initial assessment record in CPIS, Lisa acknowledged that she had problems feeding baby Kate and 'got annoyed when she cried for nothing' but indicated that her partner, John, would help her when she went home. The FSOs asked Lisa if they could talk to John and she told them that he would be angry that DOF was involved and it would be 'a waste of time to try'.

On the morning of 11 July 2001, a registered nurse (RN), RN X called DOF and advised that John had arrived at Hospital Green and a security alert had been initiated because he was aggressive towards hospital staff and was threatening to remove Lisa and baby Kate from the hospital. As a result, DOF called the QPS and requested the presence of police officers at the hospital while Lisa and John were being interviewed.

The FSOs arrived at the hospital at 2:00pm. Two police officers and RN X were also present during the interview, but the police left after 45 minutes. The FSOs and RN X commented that John's behaviour changed when the police left. During the interview with my officers, RN X said: [120]

> During the time that the police were present at the meeting he was a totally different person. He sat, he was composed, he answered questions, he was co-operative. I don't think the police would have gotten to the ground floor in the lift and he was just unco-operative, pacing around the room.
>
> He said that the baby was not his baby – he didn't know if it was his baby or not, which Lisa had also said. She had gone out and there were a few people who possibly could have been the father of the child and he felt that he was making a big sacrifice by taking Lisa and the baby on.

At interview, the FSOs gave consistent accounts to my officers of what occurred. The FSOs claim that they explained DOF's concerns to John and told him that before baby Kate could go home they had to be satisfied that he was able to support Lisa and assist her to care for baby Kate. The FSOs say that they asked John to stay at Hospital Green to enable the medical staff to observe his ability to parent baby Kate and support Lisa. The FSOs reported that John was initially reluctant to participate in this manner. However, they said that, before they left the hospital, John indicated to them that he would return to the hospital later that evening to commence the assessment. However, John failed to return that evening. FSO Two has advised that she contacted Hospital Green on 12 July 2001 and recalls that an RN told her that John had telephoned and said that he would arrive at Hospital Green at approximately 10:00am on 13 July 2001.

5.1.5 First SCAN Team meeting

Baby Kate's case was discussed at the SCAN Team meeting held at 2:00pm on 12 July 2001. The Paediatrician attended the meeting in her capacity as SCAN doctor. FSO One attended and represented DOF. Two police officers and a representative from Education Queensland were also present. The SCAN Team was advised that John had not returned to Hospital Green to participate in the assessment. The meeting was given the following information about baby Kate's circumstances:

- Mother functions at 13–14 years
- Mother was in care of DOF
- Lisa is not a violent person – lack of ability to care for the baby
- Hospital White observed the baby and mother for three days – observed Lisa shaking baby
- Hospital White transferred mother and baby to Hospital Green
- Mother is terrified of DOF
- DOF offered support and mother eventually calmed down

118 In the initial assessment record contained in CPIS.
119 In their interviews with my officers.
120 In the interview with my officers on 9 December 2002.

- Father turned up raging. Father calmed down when police appeared at hospital. Became angry when police left
- Father was supposed to return to the hospital to stay last night so he could be observed with baby's care. Father didn't return
- No domestic violence between the parents
- Lisa keeps saying that John will help her care for the baby
- Lisa's skills have improved 200% in the last four or five days
- Lisa is now asking appropriate questions
- Lisa is highly dependent on John
- John is disparaging towards Lisa
- Lisa has no ideas on budgeting
- Lisa finds breastfeeding uncomfortable
- Lisa had agreed to do 'anything' DOF wants except go to Riverton
- Lisa will need to be taught new needs for baby – John needs to be supportive and give help

The Minutes of the meeting indicate that the SCAN Team recommended, among other things, that DOF 'talk to John about committing to Lisa and baby Kate going home by showing that he can support Lisa' and that a 96-hour order[121] be made if John attempted to remove baby Kate from Hospital Green.

5.1.6 Decision to release baby Kate from hospital

On 13 July 2001, John arrived at Hospital Green, of his own accord, and stayed in a room with Lisa and baby Kate until Monday morning 16 July 2001. The nursing staff recorded their observations regarding Lisa and, to a lesser extent, John's parenting of baby Kate in the medical chart.

On 16 July 2001, FSO One was on leave and FSO Two went to Hospital Green with FSO Three to finalise the initial assessment. FSO Three had not had any prior involvement with, or knowledge of, the matter and advised[122] that his role was to 'second' the interview. In his notes of the interview he recorded **'that there were minimal risks for the baby to return home'**. [emphasis added]

According to FSO Three, he and FSO Two were at the hospital for approximately 45 minutes before this assessment was made. The majority of that time was spent talking with John. When interviewed by my officers, FSO Three was unable to recall if he or FSO Two had spoken with Lisa. Nor could he recall FSO Two speaking with hospital staff. He indicated that if FSO Two had had any significant conversations with hospital staff, he would have recorded those details in his notes. However, when interviewed, FSO Two claimed that she spoke with a nurse who was 'positive' about how John handled baby Kate and told her that he had also interacted positively with another child in the ward.

Before leaving the hospital, the FSOs called their Manager and reported their assessment that baby Kate should be released from hospital into the care of Lisa and John. The Manager accepted their recommendation. Baby Kate was discharged from Hospital Green at 4:30pm on 16 July 2001 into Lisa's and John's care.

The outcome of the DOF officers' initial assessment was recorded in CPIS as 'substantiated risk of harm and neglect'. A recommendation was made for ongoing DOF intervention in the form of a child protection follow up (CPFU). The rationale for this decision is outlined under the heading 'Ongoing Intervention':

> Ongoing harms / future risks or concerns
>
> **Given Lisa's own disability, concerns remain in terms of her ability to make appropriate decisions for the care of Kate.** While Lisa has acknowledged shaking Kate she has been able to identify strategies for dealing with this and is able to articulate the cause of her own stress. The observed difficulty between the parents poses a concern specifically in relation to verbal and emotional harm. John has stated that he is willing to support and assist Lisa with the care of Kate, however, this has yet to be demonstrated on a long-term basis. **Without assistance it is unknown if Lisa can care for Kate independently**. [emphasis added]

121 See section 3.2.1 of this report.
122 In his interview with my officers on 12 December 2002.

Statement of child's protective needs

Kate needs to be in an environment where her emotional, psychological and physical needs are met. Kate needs to live in an environment where she is safe from aggression, both directed at her and between her parents.

Case Decisions

Kate to go home with parents. Case to be opened as a CPFU to monitor parents ability and willingness to provide for Kate on a long-term basis.

5.1.7 Events following release

On 17 July 2001, the day after Lisa and John went home from Hospital Green with baby Kate, FSO One conducted a home visit at Lisa's and John's then residence. She documented her observations in a case note in CPIS.[123] The case note records that John was not home when FSO One arrived, but he arrived approximately 20 minutes later and Lisa said that she was 'okay for short period of time without him'. FSO One also noted that the 'house was very clean' and that she watched John assist Lisa bathing and dressing baby Kate and that they were 'comfortable' in handling her.

The relationship between Lisa and John ended three days later.

Lisa's foster mother has advised my officers that when John failed to return home on the evening of 19 July 2001, Lisa immediately contacted her by telephone and asked for guidance in caring for baby Kate that evening.

The foster mother contacted FSO One the following morning and informed her of what had occurred. In response to the situation, FSO One contacted the QPS and requested police assistance while Lisa packed her belongings in case John returned to the house. FSO One also organised emergency accommodation for Lisa and baby Kate at a local group home and arranged for the home's 'House Mother' to supervise Lisa's care of baby Kate.

The SCAN team reviewed the matter at a meeting held at 2:00pm on 26 July 2001. The meeting was attended by the Paediatrician, the Manager of Area Office Green and representatives from Education Queensland and the QPS (both of whom attended the meeting on 12 July 2001 where baby Kate's case was initially discussed).

The minutes indicate that the SCAN Team was informed that Lisa and baby Kate were going to Riverton and that DOF was looking at long-term placement options after Riverton, such as the Sisters of Mercy or Fatima. The minutes record that the SCAN Team was also advised that 'John was no help to Lisa, Lisa had bonded well with baby Kate and is willing to learn skills to keep baby Kate and she is still being supervised with Kate'. The SCAN Team recommended that DOF proceed in the above manner and that the case be closed to SCAN. There was no further SCAN Team involvement in the matter from this point on.

Also on 26 July 2001, Lisa and baby Kate travelled to Brisbane where they stayed with Lisa's foster parents until 13 August 2001. The foster mother maintained a diary of her observations of Lisa's care of baby Kate during this period and provided it to FSO One at regular intervals.

On 7 August 2001, FSO One completed and faxed a referral to Riverton for Lisa and baby Kate. Upon receiving the referral, Riverton asked DOF to provide further information to support the referral. However, FSO One has advised that the referral was not progressed. Instead, for various reasons, FSO One made inquiries with other facilities in Brisbane to find alternative accommodation for Lisa and baby Kate. As FSO One had not previously worked in Brisbane and had only a limited knowledge of what resources were available in the area, she relied upon telephone inquiries and word of mouth referrals.

As a result, on 13 August 2001, DOF referred Lisa and baby Kate to Fernbrook, a residential home for women and their children operated by a non-government organisation. Lisa and baby Kate had been residing at Fernbrook for approximately one month when baby Kate died in her cot.

123 The case note was created in CPIS on 11 September 2001.

5.1.8 Child death review

Sometime in September 2001, the then Deputy Director-General of DOF initiated a Level 2 (internal) child death review. A DOF officer (a senior practitioner external to the region of Area Office Green) was appointed to undertake the review in accordance with the Child Death Review Policy[124], which took effect on 19 September 2001 – nine days after baby Kate's death. The internal review officer reviewed the material on CPIS and interviewed FSO One as well as the Manager and Acting Manager at the relevant time. The review was completed on 15 October 2001. The review officer noted that, as at the date of the review, the cause of baby Kate's death had not been determined by post-mortem.

The post-mortem was completed on 17 October 2001 with SIDS being recorded as the cause of baby Kate's death. An amended death certificate was issued on 24 October 2001.

On 19 November 2002, DOF's Review and Evaluation Branch considered the child death review conducted in relation to baby Kate's child protection case and formulated an Action Plan to give effect to the review recommendations.

124 See Appendix B for a copy of the Child Death Review Policy. The Child Death Review completed in baby Kate's case is discussed in Part 9 of this report.

6 Decisions about intervention

'Practice wisdom in child protection work is the culmination of on the job experience, pre-service and in-service training and the guidance and direction of senior experienced staff.' [125]

6.1 Principles of the Child Protection Act

When a child protection notification is assessed and it is determined that a child has been harmed or is at risk of significant harm, DOF is obliged to act in a manner that ensures the child's safety and well being. The *Child Protection Act* contains principles[126] that DOF must take into account in fulfilling its statutory obligations to protect a child from harm. Those principles are, in part:[127]

(a) every child has a right to protection from harm
(b) the welfare and best interests of the child are paramount [emphasis added]
(c) families have the primary responsibility for the upbringing, protection and development of their children
(d) the preferred way of ensuring a child's well being is through the support of the child's family
…
(f) if a child does not have a parent able and willing to protect the child, the State has a responsibility to protect the child, but in protecting the child the State must not take action that is unwarranted in the circumstances
…
(i) if a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care.

6.2 Pre-birth intervention

A number of events occurred that required DOF to make decisions about the safety and well being of baby Kate. In effect, these events were 'triggers' for DOF to assess the risks to baby Kate and determine whether she had a parent both **able and willing** to protect her from harm. If the information available indicated that baby Kate did not have a parent who was both **able and willing** to protect her, DOF had a clear legislative obligation to act in a manner to ensure her right to protection from harm.

6.2.1 The February intake

The first trigger for DOF to take action to protect baby Kate occurred before she was born, namely, in February 2001 when FSO Four received information that Lisa was pregnant. Her assessment of the situation was that Lisa's baby would be at 'significant risk of harm' when she was born. Following the receipt of this information, FSO Four approached her Team Leader and staff at the Child Protection Branch to ascertain how to record her concerns. DOF procedures do not allow an unborn child to be the subject of a notification. My officers were advised by several of the DOF officers interviewed that there were no procedural or practice guidelines in the Manual that instructed officers how to deal with concerns raised with DOF about unborn children.

In accordance with the advice that FSO Four was given, she detailed her assessment of the risks to Lisa's baby when born as an intake. Under the heading 'Assessment of Problem', FSO Four wrote 'Lisa's low levels of intellectual functioning, her history of abuse and her lack of basic hygiene and self-care skills place her unborn baby at significant risk of possible neglect and/or physical and emotional harm'.

In addition, FSO Four telephoned Area Office Green and spoke to FSO Five regarding her concerns about Lisa's ability to care for a child and suggested that DOF needed to be at the hospital when the baby was born. When asked by my Assistant Ombudsman (AO) why she contacted Area Office Green, FSO Four said:

125 P. Armytage and C. Reeves, 'Practice insight as revealed by Child Death Inquiries in Victoria and Overseas'. in G. Calvert, A. Ford and P. Parkinson (eds), The Practice of Child Protection: Australian Approaches, Hale & Iremonger, Marrickville, p.122.
126 Section 5 of the Child Protection Act – see Appendix J.
127 See Appendix J for a full extract of section 5 of the Child Protection Act.

FSO Four: I guess because sometimes with intakes – I didn't want it to get lost in the system. I was concerned enough that I felt it needed a follow up phone call. I wanted to impress upon the workers that this was really quite serious. And I was just concerned because the baby hadn't been born it might have been easy, because it was a few months down the track, for it to have lost some impact.

AO: And by suggesting to them that it would be a good idea for them to be at the hospital when the baby was born what were you trying to convey to them?

FSO Four: I thought that the baby should have been taken….I was trying to say that the baby should have been taken into care immediately.

The details of FSO Four's intake entries in CPIS clearly convey her opinion about the urgency and gravity of the situation. Indeed, when interviewed, FSO Five agreed that, from her telephone conversation with FSO Four, she realised that FSO Four was **'hugely concerned'** about the safety of Lisa's unborn child.

FSO Five advised my officers that she recorded the details of her conversation with FSO Four in a case note in CPIS. The case note is dated 3 April 2001, approximately three months prior to baby Kate's birth.

In the 'Decision / Action' section of the case note, FSO Five has written: 'Notify the hospital social worker of expected date of confinement'. There is no further note to indicate if this action was taken and if so, when, whom FSO Five spoke with and what action that person advised her they would take in relation to the matter.

In an email from my officers dated 6 February 2003, FSO Five was asked if she had completed this action. She replied[128] that she had telephoned the hospital social worker 'within a few days of receiving the information' (from FSO Four) but that she had no written record, contemporaneous or otherwise, of having made this call. However, when asked during interview with my officers[129] about what action she had taken following the telephone conversation with FSO Four, FSO Five did not mention that she had contacted the Social Worker as she now states.

QH has advised[130] that it has no record of any such contact from DOF prior to baby Kate's birth.

The relevant QH Social Worker said[131] that it is her practice to make a note of such requests in her notebook as well as the medical chart for the expectant mother. Alternatively, if there is no medical chart, the Social Worker said that she would notify the antenatal clinic but pointed out that if the expectant mother did not attend antenatal clinic sessions, there would be no mechanism to make a note for DOF to be contacted upon the child's birth. The medical records I have obtained confirm that Lisa did not attend any sessions at the antenatal clinic. The Social Worker said she has no record of any contact from DOF in her notebook concerning Lisa and no recollection of receiving such a call.

As I have said, FSO Five claims that she contacted the QH Social Worker. The Social Worker has advised that it is her practice to make a note of such contacts from DOF in her notebook. She made no such note on this occasion. It is therefore difficult for me to form an opinion as to whether or not the call was made. Phone records are of no evidentiary value to corroborate either version given the high volume of telephone traffic between the two agencies concerned.

If the call was made, as FSO Five has claimed, her failure to maintain a record of such an important request is itself a significant concern. I have discussed the issue of record keeping in Part 8 of this report.

In the circumstances, FSO Four's strong recommendation to FSO Five that Area Office Green make arrangements to be at Hospital Green if Lisa presented there for delivery was both pragmatic and appropriate. However, FSO Four told my officers that she was unaware of any written DOF procedures that applied to address such circumstances.

In my view, FSO Four made a considerable effort to ensure that appropriate action would be taken by DOF when baby Kate was born. The information she provided left no doubt about her professional opinion of the seriousness of the risk to baby Kate. The only step FSO Four failed to take was to make a specific

128 Email dated 7 February 2003.
129 On 11 December 2002.
130 In an email dated 18 February 2003 from the QH Parliamentary and Ministerial Services Unit.
131 In a letter dated 6 March 2003 received via email from QH Parliamentary and Ministerial Services Unit.

recommendation in the intake that, in her opinion, Lisa's baby should be taken into care when it was born. When asked why she did not make a written recommendation to this effect in the intake, she told my officers **'it really wasn't rocket science to figure out that this child was at grave risk'** and that she thought it was **'just so obvious**'.

FSO Four explained that because she did not have carriage of the case, she felt it was her role to pass on the information and that any decision as to what response would follow was a matter for the relevant DOF area office that had geographical responsibility for the case.

I should also point out that there is other evidence, discussed later in this report,[132] which strongly indicates that the DOF officers involved in the initial assessment were either not aware of the February intake or, at the very least, overlooked its significance. Accordingly, the inclusion of a recommendation in the intake would not necessarily have affected the decisions that were made in this particular case in any event.

During the interview with my officers, FSO Four also pointed out that, in her opinion, Lisa's lack of antenatal care was an indicator that the baby would be at risk of harm and neglect when born. She said that this is a matter that she also discussed with FSO Five. She said:

FSO Four: Depending on what the workload would be…because mum's antenatal care is so poor and it may have been enough to go out and do some home visits with mum because the antenatal care is so poor.

IO: [133] That is something that you believe that you would have discussed with FSO Five?

FSO Four: Definitely.

AO: [134] And there were options available to FSO Five to have some form of involvement with Lisa before the baby was born.

FSO Four: Definitely. Lisa said that she was expecting the department to be involved, that she wouldn't be surprised if the department turned up on her doorstep. So yeah, I wouldn't have imagined given that **this baby was at huge risk prior to birth that it wouldn't have been unusual to go out and pay Lisa a visit or even ring her and ask her to come to the office. Particularly, given that she is an ex-child in care.**

The desirability of early intervention by child protection agencies in situations where risk factors are evident before a child's birth is well supported. In August 2000, the Victorian Department of Human Services completed an analysis of fourteen deaths of infants who were the subject of child protection intervention. The results of this analysis were presented in a report entitled *Who's Holding the Baby? Improving the Intersectoral Relationship Between Maternity and Child Protection Services.*[135] The report said:

> An unborn child is not a legal entity until it is born. However, this does not preclude working with the mother/unborn infant in a meaningful way prior to delivery.
>
> …Recognising duty of care for the unborn infant is an imperative. In most cases reviewed by the panel, there were indicators of protective risk to the baby either before the birth or at the hospital shortly after birth, such as young maternal age, substance abuse, domestic violence, poor parenting knowledge, insecure attachments in infant parent dyad or a previous child abuse record.

6.2.2 DOF's position

The Manual does not contain any specific policies or procedures about intervention in the case of an unborn child. Therefore, I wrote to DOF on 7 January 2003 and asked what policies and procedures it had in place to **follow up on intakes received in relation to the safety and well being of an unborn child once that child is born.**

132 See section 6.6.2.
133 My Investigating Officer.
134 My Assistant Ombudsman.
135 Victorian Department of Human Services, Who's Holding the Baby? Improving the Intersectoral Relationship Between Maternity and Child Protection Services: An Analysis of Child Protection Infant Deaths 1995-1999, 2000, p.13, <www.dhs.vic.gov.au>.

In response DOF advised:[136]

> Authorised officers are guided by the Child Protection Procedures Manual when responding to any intake matter. If a risk of harm was evident after the child's birth, officers would then implement procedures for managing a child protection notification as contained in the Child Protection Procedures Manual.

Unfortunately, this answer does not explain what procedure DOF has for following up an intake received in relation to an unborn child. Unless there is a process in place for ensuring such an intake is assessed as soon as the child is born, there is a risk that the matter will 'get lost in the system', as FSO Four feared would occur in this particular case.

When I again asked[137] DOF to explain its position, it advised[138] that:

> Section 8 of the *Child Protection Act 1999* replicates the definition of a 'child' in the *Acts Interpretation Act 1954* under which a 'child' is defined as an 'individual under 18 years' of age. In the Acts Interpretation Act, an 'individual' is defined as 'a natural person'. As such, 'a natural person' is not a person until he or she is born.
>
> Where child protection concerns arise prior to a child's birth **in relation to a parent's capacity to safely care for the child once he or she is born, departmental officers work with the parents and the hospital/medical officers to resolve the concerns. If those concerns cannot be resolved prior to the child's birth, action is taken to protect the child upon the child's birth**. For example, under section 18 (of the *Child Protection Act*), departmental officers may make arrangements with the hospital to take the child into care upon the birth of the child. This will usually be followed by an application for a temporary assessment order in the initial instance. If the hospital has concerns about a baby, it may issue a 96-hour order under the *Health Act 1937* to detain the child until further protective action can be taken by the department. [emphasis added]

DOF's response raises the following issues:

- Why did DOF not take any action to locate and 'work with Lisa' when it received information that clearly raised child protection concerns in relation to her capacity to safely care for her child once born?

  DOF had an address for Lisa at the time in CPIS that was accessible to its FSOs. This was recorded in the February intake. When FSO Four was asked if she recorded the address in the intake contemporaneously, or if it was added at a later date, she told my officers that she was given the address by the notifier and she recorded it in the intake at the time. However, in FSO Five's case note dated 3 April 2001, she has written (following her conversation with FSO Four) 'do not have an address for Lisa'.
- Why is there no written policy within DOF about working 'with the parents and hospital/medical officers to resolve concerns' held for the safety of an unborn child?
- Should the *Child Protection Act* be amended to enable DOF to intervene where it is suspected before the birth of the child that the child may be at risk of harm after birth or can the issue be otherwise addressed by the development of a written policy outlining DOF's position as described in its correspondence?

6.3 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

6.3.1 FSO Five should have documented the telephone call that she claims to have made to the QH Social Worker asking to be notified when Lisa gave birth.

6.3.2 DOF failed to intervene and work with Lisa before baby Kate was born to resolve concerns about her ability and willingness to properly care for her baby or to follow up on the intake when Kate was born.

136 Letter dated 6 February 2003.
137 Email from my Assistant Ombudsman dated 29 April 2003 to the Director of the Child Protection Branch.
138 Letter dated 15 May 2003.

6.3.3 DOF's existing procedures for recording and managing child protection notifications received before a child is born are inadequate because:

6.3.3.1 there is no written policy to guide DOF's officers.

6.3.3.2 there is no process in place for ensuring that intakes received before a child's birth are followed up when the child is born.

6.4 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

6.4.1 DOF develop written policies and procedures for recording notifications in relation to unborn children, for working with the parents before the birth and for ensuring that such notifications are followed up when the child is born.

6.4.2 In consultation with QH, DOF develop a memorandum of understanding that outlines the process for DOF to notify QH that it has concerns about the safety and well being of an unborn child due to be delivered in a QH hospital and for QH to notify DOF when that child has been born.

6.4.3 The *Child Protection Act* be amended to enable DOF to intervene where it is suspected before the birth of a child that the child may be at risk of harm after birth.[139]

6.5 DOF's response to recommendations and Ombudsman's comments

6.5.1 DOF's response

DOF provided the following responses to recommendations 6.4.1 and 6.4.2.

Recommendation 6.4.1 – Noted

Response/Action to date

In Australia it is not usual practice to record a notification in relation to an unborn child. Currently, NSW is the only Australian jurisdiction that enables a person to report suspected risk of harm in relation to an unborn child and the recording of a pre-natal report.

The Children and Young Persons (Care and Protection) Act 1998 (NSW), Section 25, provides the following:

A person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm after his or her birth may make a report to the Director-General.

Note: The intention of this section is to provide assistance and support to the pregnant woman to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

Section 28 of this legislation outlines the following about recording and subsequent action in relation to the report as follows:

The Director-General must keep a record of:
(a) all reports made to or by the Director-General, and
(b) any action taken as a consequence of a report, and
(c) any subsequent disposition of and dealings with children and young persons to whom such reports or actions relate, subject to the regulations.

Currently, there is no legislative basis in the Child Protection Act 1999 (Qld) to intervene with the parents of an unborn child about the safety and well being of their child other than in a voluntary way.

…

Given that this recommendation is not only about having policies and procedures in place, but is a matter for broader community consultation about the rights of the unborn child, this matter will be progressed to Cabinet for consideration in due course.

139 This recommendation was amended following consideration of the response of DOF to the provisional recommendation that read: 'DOF assess whether the definition of "child" in the Child Protection Act should be amended to include an unborn child.'

Recommendation 6.4.2 – Noted

Response/Action to date

A memorandum of understanding (MOU) is currently being developed by Queensland Health, Queensland Police Service, Department of Families and Education Queensland in relation to respective roles, responsibilities and referrals to Suspected Child Abuse and Neglect (SCAN) Teams. Completion of the MOU is expected in November 2003.

Pending the outcome of consideration by Cabinet as outlined in 6.4.1, the MOU could be expanded to incorporate referral to a SCAN team of an unborn child who is assessed as being at risk of significant danger or harm following birth due to parental factors.

Recommendation 6.4.3 – Noted

In my provisional report, I had recommended that DOF assess whether the definition of 'child' in the *Child Protection Act* should be amended to include an unborn child. In response to this recommendation, DOF said:

> … child protection legislation in other Australian jurisdictions does not include an unborn child in the definition of 'child'.
>
> All jurisdictions, apart from the Australian Capital Territory, New South Wales and Victoria define a child to be a person under 18 years of age:
>
> - The ACT *Children and Young People Act 1999* defines 'child' to be a person who is under 12 years old and defines a 'young person' as a person who is 12 years old or older, but not yet an adult.
> - The Victorian *Children and Young People Act 1989* defines a 'child' to be a person who is under the age of 17 or, if there is an order in place for the child, a person who is under 18.
> - The NSW *Children and Young Persons (Care and Protection) Act 1998* defines a 'child' to be a person who is under 16 years of age.
>
> To alter the definition of 'child' in the *Child Protection Act 1999* to include an unborn child is an issue for broader community consultation and this matter will be progressed to Cabinet for consideration in due course.

Having considered these comments, I have altered recommendation 6.4.3 to read:

6.4.3 The Child Protection Act be amended to enable DOF to intervene where it is suspected before the birth of a child that the child may be at risk of harm after birth.

This recommendation more closely reflects current child protection practice in NSW and would not, in my opinion, require the definition of 'child' to be revised to enable DOF to work with a family before a child is born. The issue needs to be addressed. It is a glaring deficiency in the child protection regime in Queensland.

6.5.2 Ombudsman comment

In relation to recommendation 6.4.2, I should point out that the SCAN Team Manual already makes provision for a matter to be referred to SCAN in situations where concerns exists before a child's birth and a 'notification is anticipated'.

In my view, DOF's response, that a MOU could be developed to incorporate a referral to a SCAN Team of an unborn child who is assessed as being at risk of significant danger or harm following birth due to parental factors, **does not address the specific recommendation that I made in this case.**

In my opinion, DOF and QH should develop a MOU that allows for **DOF to notify QH if it has concerns** about the safety and well being of an unborn child that may be delivered in a QH hospital **and if and when that child is born, for QH to notify DOF to enable an assessment of that child's situation to occur.** This is different from referring a matter to a SCAN Team before the child is born.

For example, in baby Kate's case, FSO Five claims that she contacted Hospital Green and asked that she be contacted when Lisa presented for delivery. However, the Social Worker at Hospital Green advised that unless an expectant mother presents for antenatal clinics there would be no mechanism for QH to make a notation in the mother's medical chart for DOF to be contacted when the child was born. Lisa did not present at

Hospital Green for antenatal clinics. Clearly, this situation needs to be rectified and a more formalised process implemented that provides for QH to make a record that DOF wishes to be contacted if a particular child is born in a QH hospital.

Therefore, I do not believe that the implementation of recommendation 6.4.2 should be dependent upon the outcome of Cabinet's consideration of a submission in relation to recommendation 6.4.1.

In my view, DOF should give priority to progressing a submission to Cabinet to give effect to recommendations 6.4.1 and 6.4.3 and I would ask that DOF advise me in due course of the outcome of Cabinet's consideration of the matter.

6.6 The Initial Assessment

'...issues relating to the parental capacity to care for and protect the child become paramount in any risk assessment. The risk to the child is further exacerbated where other factors impacting on that level of care such as substance abuse, psychiatric illness and domestic violence are present.'[140]

The Paediatrician's notification was the second opportunity or trigger for DOF to take action to ensure the safety and well being of baby Kate. As I have already mentioned,[141] when DOF receives information that leads it to reasonably believe that a child has suffered harm or is likely to suffer harm due to the action or inaction of a parent, a child protection notification is recorded. The *Child Protection Act* requires that an assessment of the child's situation be conducted to determine what action, if any, is required.

Baby Kate's notification was rated as a priority one matter, in accordance with DOF's strategy[142] for prioritising responses to notifications. This was the most urgent category and required that an initial assessment be commenced within 24 hours of the receipt of the notification. The initial assessment was initiated within this prescribed time frame.

I should record that there is conflicting evidence concerning the date that the notification was received by DOF. Baby Kate's medical records show that the notification was made by the Paediatrician on Monday 9 July 2001 and that the FSOs commenced their initial assessment on Tuesday 10 July 2001. This evidence is consistent with the Paediatrician's recollection that she made the notification on the Monday morning following Lisa's and baby Kate's admission to Hospital Green on the previous Friday afternoon. However, there is a conflicting DOF record which states that the notification was received by DOF on 10 July 2001 and 'responded to on the same date as receipt'.

In my view, the QH record is probably correct because the DOF record was not created contemporaneously. In fact, the DOF record was created some weeks after the notification was received. The issue of record keeping in relation to this case, and generally within DOF, is a matter that I have considered separately in Part 8 of this report.

The complainant has alleged that DOF did not conduct an adequate assessment of baby Kate's safety and well being and that the decision to release her into Lisa's and John's care was 'highly questionable' and inconsistent with the information contained in the medical records.

To address the complainant's allegations, I had to consider what information was available to DOF so that I could form an opinion on whether or not:

- the risk assessment of baby Kate's circumstances was adequate; and
- if the decision about the level of intervention required was correct or at least reasonable.

140 Victorian Department of Human Services, Who's Holding the Baby? Improving the Intersectoral Relationship Between Maternity and Child Protection Services: An Analysis of Child Protection Infant Deaths 1995-1999, 2000, p. 9.
141 See section 3.1.1.
142 See section 3.1.2.

6.6.1 Actions taken to assess baby Kate's situation

DOF's initial assessment of baby Kate's situation essentially comprised three interviews at Hospital Green with Lisa and/or John on 10, 11 and 16 July 2001. However, DOF already had a significant amount of information about baby Kate's situation, which was contained in the following documents:

- the Paediatrician's child protection notification;
- the foster mother's letter (given to DOF by the Paediatrician);
- the February intake in CPIS;
- the April case note in CPIS; and
- Lisa's own case file.

In my opinion, FSO One should have collated and evaluated all of this information in a systematic manner to make a more informed assessment of the risks of harm to baby Kate and the level of DOF intervention required. Child protection experts advise that:

> …Information received from others or direct observations made during ongoing contact must be weighed up and organised in order to suggest the most appropriate response.
>
> …The assessment process only has meaning when all information is pooled together and allowed to contribute to an overall and multi-dimensional picture. Details about past history and the present circumstances need to be integrated to provide a context for understanding all knowledge.[143]

Further, FSO One failed to adequately document what information she gathered and considered when she assessed baby Kate's circumstances. The initial assessment record in CPIS merely summarised the interviews with Lisa and John that occurred on 10 and 11 July 2001. The details of what occurred at Hospital Green on 16 July 2001, when FSO Two finalised the initial assessment, and the reasons for the decision to release baby Kate were not documented in the initial assessment in CPIS.

FSOs One and Two both made submissions in relation to these issues in their individual responses to my provisional report. Relevant extracts of their responses follow:

FSO One said:

- I believe that I made every reasonable effort to gather and collate all information relevant to this Initial Assessment, and that all of my actions and decisions were discussed with, and authorised by, a supervisor.
- I believe that this Initial Assessment was conducted in accordance with the Procedures Manual and that every consideration, decision and action was not only conducted in accordance with the provisions of the *Child Protection Act 1999* (Qld), but sanctioned by the appropriate authority. I further believe that I conducted this Initial Assessment to the best of my then professional knowledge and experience, with the then available resources.
- I believe that the Initial Assessment document does show that risks to baby Kate were identified and acknowledged in the outcome section: 'the outcome of this notification is substantiated risk of neglect and substantiated risk of physical harm'.
- …a plan was developed to facilitate further assessment while ensuring that these risks were managed. This plan was put to the SCAN team on the 12th July 2001 and subsequently 'recommended' on that day.
- I feel that your report does not adequately reflect the situation in Area Office Green in terms of lack of appropriate supervision (Team Leader) for 9 weeks for all FSOs in the Initial Assessment Team, the high case loads, and the extreme time constraints on workers in relation to prioritising tasks according to their statutory roles, and the inappropriate responsibilities placed on FSOs during this time.

Whilst I accept that FSO One may have discussed her various decisions and actions with a supervisor, I am not satisfied that she evaluated and collated all of the relevant information that was available to DOF to make an accurate assessment of the risks of harm to baby Kate. I say this because both the Manager and FSO Two claimed when interviewed by my officers that they had never seen the February intake and FSO One did not bring it to their attention.

143 P. Reder, S. Duncan and M. Gray, Beyond Blame: Child Abuse Tragedies Revisited, Routledge, London, 1993, p. 69.

In her response to my provisional report, FSO Two confirmed that she was unaware that the February intake and the April case note existed until she was interviewed by my officers.

The February intake contained critical information because it was made by an FSO who knew Lisa far better than any of the officers at Area Office Green. Accordingly, I consider that any briefing FSO One may have given her supervisor and co-worker would not have apprised them of the true level of risk to baby Kate.

Next, I do not dispute that the initial assessment document records the outcome of the notification as 'substantiated risk' in accordance with DOF procedure. However, that document only contained a four line commentary and does not show if all of the information available to DOF was considered by FSO One in her assessment of baby Kate's circumstances.

In relation to my concerns about record keeping, FSO One submitted:

> In my employment within DOF (up till that time I had only ever worked in Area Office Green) it was my experience:
>
> (i) that these types of discussions were not documented as such;
> (ii) that the keeping of case notes was not a priority; and
> (iii) that workloads and the demands of statutory and non statutory intervention took priority for all workers over and above 'paper work'.

I acknowledge the guidelines contained in the Procedures Manual, however, I maintain that in practice there were extremely limited opportunities to complete and in most cases commence administrative tasks.

FSO Two claimed:

> As the secondary FSO I am not in a situation to directly input information into the IA document. This document is allocated to the officer the IA has been allocated to, and is sent by the Team Leader or Manager to their 'intray', in this case FSO One. **It is not routine practice for the seconder to ensure the required information is written in the outcome of the IA.** [emphasis added]

While I acknowledge that FSO Two was the 'seconder' for the initial assessment on 10 and 11 July 2001, in my opinion that was not her role when she attended Hospital Green in FSO One's absence on 16 July 2001 and completed the initial assessment. In these circumstances, she had an obligation to record in CPIS the reasons for her decision to release baby Kate into Lisa's and John's care. Even if FSO Two did not have access to the initial assessment in CPIS, as she said, she should have approached her supervisor or FSO One to ensure that the reasons for the decision were recorded.

Overall, in the absence of any reasonably comprehensive written or electronic records, I had substantial difficulty auditing what information was gathered and considered by the officers in Area Office Green and the reasons for the various decisions that were made.

Having regard to the documentary information available to DOF, I am of the view that there were a significant number of risk factors, as defined in the Practice Guide,[144] that should have been identified from the outset as risks to baby Kate.

I have set out in Table 1 the identifiable risk factors (referred to in the Practice Guide) and the documentary material containing information relevant to those risk factors.

144 A copy of Part 3 – Risks Factors of the Practice Guide is attached as Appendix K of this report.

Table 1

Risk factor identification

Risk factor	Lisa's DOF Case file	The February intake	The April Case note	The Notification	The letter (foster mother's)
Mental capacity	✓	✓		✓	✓
Medical condition	✓	✓			✓
Youth and inexperience	✓	✓	✓	✓	✓
Lack of antenatal care		✓			
Own childhood experiences	✓	✓		✓	✓
Little or no attachment to baby			✓		✓
Actual or risk of maltreatment / physical harm		✓		✓	
Unrealistic expectations of baby's needs	✓	✓	✓		✓
High stress levels	✓	✓		✓	✓
High mobility and transient lifestyle	✓	✓			
Lack of support	✓	✓	✓		
Substance abuse problems	✓	✓	✓		✓
Physical and social environment	✓	✓			✓

NB: The fact that some risk factors have not been marked means the information sources contain no information relevant to those risk factors.

The Practice Guide also states:

> The individual characteristics of the parents or caregiver need to be assessed in order to determine the likelihood of future harm. These characteristics should be assessed in context and with consideration of protective factors. As the risk indicators reveal – immature parents or caregivers with poor parenting skills, substance abuse problems, mental illness and history of childhood abuse have a higher likelihood of harming their children or failing to protect. **A combination of risk indicators increases the overall likelihood of future harm.** [emphasis added]

As can be seen, the information that was available to DOF from various sources raised generally consistent concerns about Lisa's capacity to adequately parent a child. Clearly, there was a combination of risk factors including the concerns expressed by Lisa's former foster mother that **'I cannot express strongly enough how fearful my husband and I are for the safety of this baby if she is released into the care of her parents'.** [emphasis added] This statement coupled with the notification, the February intake and the April case note should, in my view, have raised concern with DOF about baby Kate's safety and well being and Lisa's and John's ability and willingness to protect her.

Moreover, each of the information sources identified, or suggested, possible sources of additional information relevant to the assessment of baby Kate's circumstances. These included, but were not limited to:

- FSO Four;
- nursing staff at Hospital Green; and
- the Medical Superintendent and nursing staff at Hospital White.

6.6.2 Assessment of the information in the February intake

Significantly, while FSO One said that she read the February intake, she did not contact, or attempt to contact FSO Four after she had done so. Indeed, the Manual states[145] that, when conducting an initial assessment, information should be obtained about the child and the family, from other relevant agencies and individuals, including other area offices (if applicable). In my view, the failure to contact FSO Four was a significant omission on FSO One's part. As mentioned, Lisa had been in care until she turned eighteen and FSO Four had been the case officer at the time she turned eighteen and had continued to provide support for approximately twelve months thereafter.

When interviewed, FSO Four was asked for her assessment of Lisa and her ability as a parent. She said that Lisa:

- had a low level of intellectual functioning;
- had very limited social skills;
- could be verbally aggressive;
- had very poor levels of personal hygiene;
- had limited concentration levels and limited ability to prioritise tasks;
- needed constant reminders to complete tasks; and
- needed a mid to high range of support in daily living.

FSO Four was then asked by my Assistant Ombudsman to give her assessment of Lisa's ability to care for a baby:

AO:	**On a scale of 1 to 10 with 10 being the highest – what level of supervision and support do you believe Lisa required to adequately care for a baby?**
FSO Four:	**Eight to nine.**
AO:	You made a comment before that you don't think that she would ever have been able to care for a baby
FSO Four:	I don't think so.
AO:	**No matter what amount of training or assistance she was given?**
FSO Four:	**No I don't think so. She would need constant supervision.**

In the circumstances, FSO Four's opinion should have been sought and given appropriate weight. She appears to have been in the best position to offer FSO One an unbiased and professional opinion of Lisa's ability to parent a child. FSO Four told my officers that she was surprised she had not been contacted when the baby was born.

She said she was also surprised:

- that baby Kate was not taken into care at the hospital when she was born; and
- that baby Kate had been released into the care of Lisa and John with DOF intervention in the form of a CPFU.

When asked to give her reasons for her opinion, she said:

This is a young woman who was extremely limited, really can't complete basic tasks for herself in terms of physical hygiene or personal physical care. She was in a violent relationship with a man who drinks and hits her. She is shaking the baby. That is considered probably one of the most serious concerns for baby. I would imagine, in any office that I have worked in, that child would have been taken into care.

In response to my provisional report, FSO One was adamant that[146] she was 'not remiss' by not contacting FSO Four and submitted that:

> …it would be reasonable to expect that the information from FSO Four would have been included in the intake and case note [the April case note recorded by FSO Five]…would it not then be a case of 'reinventing the wheel' if I had to contact FSO Four for this information?

145 The Child Protection Procedures Manual – Chapter 6 – Overview of the Initial Assessment Response to a Notification.
146 See Appendix Q for a summary of FSO One's submission.

For the reasons I have outlined above, and given FSO Four's evidence, I remain of the view that FSO Four should have been contacted and this was a significant failing in FSO One's assessment of the level of risk.

6.6.3 Assessment of the information in the April case note

In addition to the February intake, there was the April case note, which was recorded in CPIS by FSO Five following her telephone conversation with FSO Four. The case note suggested that Lisa intended to place baby Kate into care when she was born to enable her to 'party' for her 21st birthday. This information should have given FSO One further cause to question:

- Lisa's maturity;
- her unrealistic expectations of baby Kate's care needs; and
- her willingness to care for baby Kate on a permanent basis.

The case note should also have prompted FSO One to contact FSO Four before the decisions were made to release baby Kate into the care of Lisa and John and, when the relationship between Lisa and John ended, to leave her in Lisa's care.

FSO Five's case note was **not** provided to this Office when I asked DOF, as part of my preliminary inquiries, to provide a complete copy of its file. When interviewed, FSO Five advised my officers that the case note she made was **not** accessible to other officers within Area Office Green. By way of explanation, she said that because Lisa already had a 'client profile' in Area Office Blue, it was not possible to create a duplicate client profile in Area Office Green when she received the information from FSO Four. Accordingly, FSO Five said she believed that she was the only person with access to the case note.

This appeared to be a significant limitation within DOF on client information being available to relevant officers. Therefore, in my letter of 7 January 2003, I asked DOF whether officers in Area Office Green had access to the case note when the notification in relation to baby Kate was received in July 2001. In response, DOF stated:[147]

> Once a case note is created in an area office database that document can be read by any authorised officer who has been granted the relevant access to that particular database.

In view of the inconsistency between DOF's and FSO Five's advice in this regard, my officers[148] sought further clarification from DOF. In response, DOF advised: [149]

> **The Department does not endorse FSO Five's advice.** FSO Five could not have created a case note without creating a client profile. A client profile had already been transferred to the Area Office Green database and was used to create a case note. The process of creating/transferring client profiles and linking documents to these is a complex process. It is possible that FSO Five may not have been fully adept at the process or may not have understood the machinations associated with the linking process.
>
> **Once FSO Five created the case note, it was available and accessible to all authorised staff at Area Office Green.** The only way to ensure that the document was not accessible to all staff was to switch on the 'sensitive' function associated with the document. This case note was not made sensitive. [emphasis added]

Given DOF's explanation, I am satisfied that the information contained in the case note was available to DOF officers in Area Office Green at the relevant time. However, FSO One acknowledged that while she may have had access to the case note, she was unable to recall reading it and that she might not have read it. FSO One said that in her experience, because of time constraints and the possible number of case notes concerning prior case management issues, DOF officers only read intakes and notifications, **not** case notes, when searching CPIS for previous history.

If DOF has had previous extensive contact with a family, there may be a significant number of case notes in CPIS regarding prior case management issues. In such a case, time constraints may prevent DOF officers from immediately reading all of the cases notes. **However, there was only one case note in Area Office Green that related to Lisa when the notification was received from the Paediatrician – FSO Five's case note. Accordingly, time constraints should not have reasonably prevented FSO One from reading the case note on this occasion.**

147 Letter dated 6 February 2003.
148 In an email from my Assistant Ombudsman to the Director Child Protection dated 13 February 2003.
149 Letter dated 4 March 2003.

In her submission in response to my provisional report, FSO One acknowledged that she had previously advised my officers that she was unable to recall reading the case note and may not have read it, but said 'it is [now] obvious to me that I did in order to provide the Manager (my then supervisor) with the information contained in the case note. This is documented in the Manager's supervision notes dated 9 July 2001'.

However, the Manager's supervision note merely says 'new baby, mother ex-child in care, intellectual delay, need to remove baby'. Therefore, the supervision note does not confirm that FSO One read the April case note in that the supervision note does not contain information specifically contained in the case note.

FSO One also submitted that 'time constraints' were relevant in this case. She stated:

> At the time of this particular Initial Assessment, I had case responsibility for 14 families consisting of 7 ongoing Initial Assessments (including this one), 5 CPFUs of which there were 1 pending application for a Child Protection Orders, and 2 families on Child Protection Orders, as well as being 'rostered on' for Intake duties for one and a half days per week. In total my case load consisted of 20 children of which 11 were vulnerable (under 5).

As I said, workload is not a strong excuse in this instance because only one document was available in CPIS. However, there is clearly a significant problem if FSOs, for whatever reason, do not routinely search DOF's principal case management system before making decisions about child protection issues. Record keeping is dealt with in Part 8.

6.6.4 Interview with Lisa and John

In order to assess baby Kate's situation, the FSOs asked John to stay at Hospital Green to have his ability to care for baby Kate assessed. In addition, DOF referred baby Kate's case for consideration at the SCAN Team meeting held on 12 July 2001.

During the interviews with my officers, the FSOs explained that DOF looks for 'a parent willing and able to care for the child'.

FSO One recorded the following account in CPIS of the interview she and FSO Two had with Lisa and John at Hospital Green on 11 July 2001.

> On arrival into the interview room, John was aware that there was police present. His behaviour was observed to be agitated and resistant to speaking with workers. He stated that he did not want the department involved and that he was embarrassed that he was the 'talk of the town'. When asked what he meant by this, John stated that the whole town was talking about how Lisa was too stupid to care for the baby and that she was a 'retard'.
>
> Workers explained that the reasons that baby had not been released from hospital, as yet, was because there was concerns for both parents' ability to care for the child and at this point Lisa has stated that she felt she would need help, especially with night feeds as Lisa does not feel confident in managing on her own. Workers then explained that baby would be able to go home with the parents if John would participate in the assessment and was able to demonstrate that he could support and assist Lisa. John became angry and stated that Lisa 'should be able to do it on her own because of her mother's instincts'.
>
> Workers attempted to explain that a maternal instinct does not mean ability or willingness, and that it would be desirable if both parents could stay at the hospital to facilitate observations of ability to care for child. John stated that he would come and stay to 'show everyone I can look after Kate then welfare can piss off out of our lives'.
>
> …Lisa remained calm throughout this meeting and was observed to calm John down on a number of occasions, stating 'you are going to make me lose Kate if you don't help. You know I can't do it on my own and we have to show them that Kate will be okay'.
>
> …At the conclusion of the interview John stated that **he would return that night** to start the process but he was not sure what time he could get there. [emphasis added]

According to an entry in baby Kate's medical chart, FSO One contacted Hospital Green on the morning of 12 July 2001 and was advised that John had not returned to the hospital that previous evening. FSO One asked that she be contacted 'when, and if, John arrives'. (He returned on 13 July 2001.)

As mentioned, baby Kate's case was referred to the SCAN Team meeting held at 2:00pm on 12 July 2001. While the SCAN Team Manual provides[150] that referrals to SCAN must be made in writing, I have not been able to locate the written referral in this case. FSO One suggested to my officers that the referral was, more than likely, made verbally and went on to explain that this is not an uncommon occurrence in Area Office Green because of workload pressures.

The Minutes of the meeting record that the SCAN Team was advised that John had failed to return to Hospital Green to participate in the assessment, as had been arranged the previous day. The SCAN Team recommended, among other things, that DOF 'talk to John' about committing to Lisa and baby Kate going home and that a 96-hour order be signed if 'John tried to take Lisa and baby Kate out of the hospital' before the initial assessment was completed.

Although FSO One confirmed that she did not contact John after she had attended the SCAN meeting on 12 July 2001, she says that she telephoned Hospital Green and spoke with an RN who told her that John had telephoned and said that he would be arriving at approximately 10:00am the next morning, 13 July 2001. There is an entry in baby Kate's medical chart on 13 July 2001 that John arrived at Hospital Green at 11:45am. He remained there until 16 July 2001.

6.6.5 Temporary Assessment Order versus 96-hour order

While the SCAN Team recommended on 12 July 2001 that a 96-hour order be signed, if necessary, one issue that remains for consideration is whether DOF should have taken baby Kate into the temporary custody of the Chief Executive of DOF while the initial assessment was being completed. As I have already mentioned, there was no medical reason for baby Kate, or for that matter Lisa, to be in hospital. A temporary assessment order would have temporarily removed Lisa's and John's parental rights and prevented them discharging baby Kate from the hospital had they attempted to do so.

The procedures contained in chapter 11 of the Manual list the circumstances in which officers should consider taking 'urgent' action in relation to a child during the initial assessment process. The options for urgent action include an immediate medical assessment, **hospitalisation with the use of a 96-hour order and taking a child into temporary custody** with an emergency placement.

These circumstances are described as follows:

> Consider taking urgent action to protect the child when the child:
>
> - is at imminent risk of physical injury if left at home
> - is under three years of age and there is evidence of physical abuse
> - cannot protect themselves due to:
>   - age
>   - physical condition
>   - emotional or psychological vulnerability
>
> Consider taking urgent action to protect the child when the child's parents or caregivers:
>
> - …are unable to provide for the child's basic needs because of their mental or physical condition …

FSO One advised my officers that she was of the opinion that baby Kate's safety and well being were ensured given that she was in Hospital Green while the initial assessment was being completed. She said that because Lisa and John were voluntarily co-operating with DOF, a temporary assessment order would have been 'intrusive' at that point.

FSO One further said that, in the event that Lisa or John attempted to remove baby Kate from Hospital Green, she had a verbal agreement with the hospital that a 96-hour order authorising baby Kate's detention would have been issued. My officers did in fact locate an unsigned and undated proforma 96-hour order in baby Kate's medical records that could have been used for this purpose.

In my view, the arrangements in place were appropriate in the circumstances.

150 SCAN Team Manual – Chapter 17 – Referral Procedure.

6.6.6 QH's role in the initial assessment

DOF essentially adopted a multi-disciplinary approach to the initial assessment. DOF requested assistance from QH to assess whether baby Kate had a parent both willing and able to care for her. Hospital Green was an appropriate facility for these purposes and there was nothing else readily available in the area as an alternative.

In my view, QH fulfilled its statutory obligations in relation to baby Kate when the Paediatrician made the notification to DOF on 9 July 2001, in accordance with 76K of the *Health Act*. Once DOF had received the notification, it was obliged to assess the situation and take appropriate action to ensure baby Kate's safety and well being.

Because DOF involved QH in the assessment process, it was imperative that the staff of each agency understood their role. In particular, QH's medical staff needed to understand that they were being relied on by DOF to observe and assess the parenting behaviour of Lisa and John and that the FSOs needed to ascertain information from the medical staff's observations and assessments.

It appears that the arrangement or understanding about the role of QH staff was a verbal one between FSO One and the Paediatrician.

Baby Kate's medical chart merely stated 'encourage mother to participate in all cares' and 'need for supervision/education'. These notes were made upon Lisa's and baby Kate's admission to Hospital Green on 6 July 2001 and hence before DOF was notified or involved in the matter. In my view, it would have been prudent for the arrangement to have been clearly documented.

My officers interviewed all of the relevant nursing staff from the children's ward who were on duty whilst Lisa and baby Kate were at Hospital Green. The reason for John's attendance at the hospital was not understood by all of the nurses. By way of example, RN Y, who was on night shift[151] on 14 July 2001, advised my officers that she presumed that John was sleeping over and helping with the care of baby Kate. She was not aware that John was staying at the hospital to enable staff to observe and assess his parenting of baby Kate and accordingly she did not make any detailed observations of this kind.

While I believe that this multi-disciplinary approach had considerable merit in the circumstances, similar arrangements in the future should be properly documented in a manner that clearly outlines each agency's expectations and responsibilities.

6.6.7 Outcome of the initial assessment

During the interview with my officers, FSO Two said that her understanding of the reason for her attendance at Hospital Green on 16 July 2001 was as follows:

> FSO One and I had discussed that if the medical staff said 'no' then we would be taking some sort of order on the baby or something. We would not be planning to release the baby if the medical staff told us that anything of major concern happened.

However, the main issue here is whether or not the FSOs spoke with the relevant staff at Hospital Green on 16 July 2001. FSO Two says that she recalls talking with a nurse at the hospital and that the nurse's opinion of John was 'positive' because he had interacted well with another child in the ward. On the other hand, FSO Three says that he does not recall FSO Two talking to nursing staff and that if she did, the details would be recorded in his notes. There is no reference to any such conversation in FSO Three's contemporaneous notes of their visit to the hospital.

In an attempt to clarify this inconsistency, my officers obtained copies of QH's rosters for the relevant period and made specific inquiries of the nursing staff who worked on 16 July 2001. None of the nursing staff interviewed was able to recall speaking with the FSOs at the hospital in relation to baby Kate on that day. However, one RN, RN Z advised that she recalled having a telephone conversation with someone from DOF regarding baby Kate, possibly on the morning of 16 July 2001.

RN Z believes that she may have contacted DOF, but cannot be certain that a DOF officer did not contact her. RN Z advised that she did not work over the weekend and therefore she was not directly involved in observing

151 The night shift is from midnight to 7am.

Lisa's and John's care of baby Kate. However, she advised my officers that following the briefing she was given at the shift change, she had gained an impression that 'there was nothing dangerous about the situation from a nursing point of view'. RN Z recollected that the nurses were 'positive' about John because he had played with another child in the ward. I note that RN Z's recollection is consistent with FSO Two's account.

From the evidence I have gathered, it seems that the feedback that the DOF officers received from QH concerning Lisa's and John's parenting of baby Kate was limited to:

- one conversation between FSO Two and RN Z (on the telephone according to RN Z and in person according to FSO Two); and
- further discussions with John at Hospital Green on 16 July 2001.

These conversations led the FSOs to conclude that there were 'minimal risks' for baby Kate in being released from Hospital Green into Lisa's and John's care.

In her response to my provisional report, FSO Two advised that she received a telephone call from the Paediatrician of Hospital Green on 16 July 2001 in relation to another child. She says that baby Kate's circumstances were also discussed during that call. However, FSO Two was unable to recall the details of the conversation. She recently provided my officers with a handwritten note that she says was made at the time of that conversation in her field book which says 'Lisa and father positive'. This is the only information that she recorded in relation to the phone call. There is no record of what matters were considered, what inquiries were made and how this assessment was formed. FSO Two also stated in her response that **John was assessed as 'both willing and able' and 'it was assessed that Lisa was willing but her abilities to be able to care for and protect her baby were in serious question'.** [emphasis added]

6.6.8 Access to medical records

The FSOs advised that they did not review, or seek to review, the observations that had been recorded in baby Kate's medical chart by the nursing staff. In fact, when interviewed, the Manager and FSOs Two and Three questioned whether they had the authority to access that information because baby Kate was not the subject of a child protection order.

Section 194 of the *Child Protection Act* provides that information that is subject to confidentiality under section 63 of the *Health Services Act* but which is relevant to the protection and welfare of a child **may be released** by health services employees to an authorised officer. DOF has advised that the DOF officers involved in the initial assessment, namely the Manager and FSOs One, Two and Three, were all authorised officers for the purpose of section 194.

I was therefore particularly concerned that the Manager and FSOs Two and Three appear to have been unaware of the powers conferred upon them by the *Child Protection Act*.

In their individual responses to my provisional report, the Manager and FSO Two made the following comments:

The Manager said:

> …Past and current personal and anecdotal experience of DOF staff requesting information relevant to the protection and welfare of a child under this section of the Act is that, outside of SCAN, Queensland Health staff either refuse or are reluctant to provide it. Written requests including reference to or accompanied by copies of section 194 can result in exchange of information.
>
> The draft 'Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the *Child Protection Act 1999* for responding to children and young people who have been harmed or who are at risk' provides clear guidelines for all staff.

As can be seen, the Manager did not respond directly to my concern that the information recorded in baby Kate's medical chart was not reviewed as part of the initial assessment process. However, the Manager's claim that QH staff would 'either refuse' or would be 'reluctant' to provide DOF officers with access to information under section 194 is of significant concern to me. Unfortunately, the Manager did not explain the basis upon which QH staff would take such a position, contrary to the intent of the legislation, nor did she provide specific examples of any incidents where this had occurred. If access to medical information had been previously refused by a QH staff member, I would have expected that, in her position as a Manager, she would have taken steps to either address the issue with QH or raise the matter in writing with her superiors.

FSO Two said:

> I did not consider the need to look at the medical files, as I had information from the SCAN Team, both the Paediatrician and the Hospital Green staff. I believe that the verbal information from the medical staff is the most appropriate form to receive this information. Medical charts are often in medical terms and, as I am not from a medical background, my interpretation of medical files and charts could be inaccurate.

As I have previously mentioned, there was no medical reason for Lisa's or baby Kate's admission to Hospital Green. DOF requested assistance from QH to assess whether baby Kate had a parent both willing and able to care for her. Accordingly, nursing staff documented their observations of Lisa's and John's care of baby Kate in the medical charts. Therefore, I do not accept FSO Two's explanation that her interpretation of the information could have been 'inaccurate' and therefore she did not access, or seek to access, the medical charts. Furthermore, there was nothing to prevent FSO Two from seeking clarification of the information from nursing staff if necessary.

FSO Two also said:

> …I would like to emphasise that it [section 194] states, 'that which is relevant to the protection and welfare of a child **"MAY"** be released by Health Services employees to an authorised officer'. Not is to be released, or shall be released. [emphasis original]

FSO One also made an identical claim in her submission. I note, however, that she wasn't at work on the day the FSOs visited the hospital and the decision was made to release baby Kate.

I acknowledge that the legislation states that the information 'may' be released. However, my concern in this case was that at no point in the initial assessment, and in particular on 16 July 2001, did DOF seek to obtain access to this information in order to make an informed decision about baby Kate's circumstances. FSO Two's submission would only be relevant had she requested the information and QH refused to release it, for whatever reason. This did not occur.

In fact, on 19 July 2001 the Manager wrote a letter of thanks to the Superintendent of Hospital Green for the support and co-operation that was provided by hospital staff in the assessment process. The explanations now offered by the Manager and FSOs One and Two appear to suggest that such support and co-operation would not necessarily extend to the provision of observations contained in the medical charts. Baby Kate, Lisa and John were at the hospital to be observed as the result of an arrangement between DOF and QH. Therefore, it is unlikely QH would have refused to provide medical records containing observations about parenting.

I have set out below some extracts from baby Kate's medical records at Hospital Green.

> **06 July 2001 – 2010hrs**
>
> Mother requiring prompting to express and feed Kate. Mother has good technique with bottle 2010hr feeding although ignores Kate while feeding her. **Mother needs encouragement to complete cares and settle Kate before going to have a smoke**. [emphasis added]
>
> **07 July 2001 – 0545hrs**
>
> Care as per care path. Awoke for feeds. All cares attended to by nursing staff overnight to allow mother to get a good night sleep. Mother to resume cares in the morning.

07July 2001 – 1300hrs

Mother attending to cares and feeds with prompting. Lisa states that she is attending to all care without prompting. Frequently downstairs for smokes. Lisa concerned re: finances and the ability to buy formula, Social worker to review financial situation on Monday. Lisa to do all cares and feeds overnight. [emphasis added]

07 July 2001 – 2130hrs

Staff attended two feeds and mum one. **Needing lots of support and encouragement. Out of ward for lots of cigarettes. Slept for two hours this pm. Lisa has difficulty prioritising what needs to be done for the baby – prefers to rely heavily on staff to attend to the baby while she is attending to other things that are not important issues.** Admitted to me she is very lazy and boyfriend does all the cooking and cleaning. [emphasis added]

07 July 2001 – 2300hrs

Baby would not settle after 2130hrs feed and mother became very agitated – crying and stated 'when I feel like this I just want to throw her (Kate) up against the wall'. I reinforced that this should not be something that she could even consider. She replied:'I would never do it to my baby, I just feel like doing it'. Discussed coping strategies, mum stated she 'feels very tired but John will help her when she goes home'.

8 July 2001 – 1310hrs

Lisa has attended to all cares and feeds for Kate. Has talked/interacted more with Kate today. Became distressed when Kate did not settle immediately after feed. I went into room and talked with Lisa as she settled Kate. Concerned about not having enough money to buy tobacco. Has made phone call to friend to organise a loan.

9 July 2001 – no time recorded

Woke Lisa at 0900hrs as baby was crying in room with Lisa. Lisa very angry and frustrated with me for waking her. Lisa has decided that she does not want to breast feed 'too much hassle expressing'. Prefer to bottle feed. Discussed pros and cons of breast feeding vs bottle feed. Lisa aware of same and has decided to bottle feed. **Problems still persist with prioritising, downstairs for cigarette and coffee despite Kate crying and due for feed and nappy change**. [emphasis added]

9 July 2001 – 2200hrs

Lisa attending to baby's need with reassurance from staff. She leaves the ward as often as possible for smoking and nursing staff need to fetch her when baby awakes. Doesn't talk much to baby. While interacting with her talked of coping when baby aggravates her.

12 July 2001 – 1230hrs

John (father of child) has not turned up or had contact with ward. Lisa has tried to contact John frequently with no answer. Has rang home, hotels, friends, places. She is very upset and feels like she does not want to look after Kate because she is so upset. I advised her that when she goes home if she has a disagreement with John – Kate must still be looked after so she must be there for Kate. Mum attending to all of Kate's needs with support and lots of encouragement. FSO One from DOF rang this am to check progress – would like to be contacted when and if John arrives.

13 July 2001 – 0620hrs

All care attended to by staff this shift…Mother slept in her room all shift. Baby stayed with staff at desk.

13 July 2001 – 2100hrs

Baby fairly settled this evening…Mother and father attending to cares. Mum observed making up formula.

14 July 2001 – 0550hrs

Baby slept till 12 midnight – heard baby crying. Mother attended to baby and nursing baby back to sleep. Baby then woke at 0110hrs for a feed and crying. Mother not very happy that she had only one hours

sleep at this stage – stated this verbally to nursing staff and didn't think that baby required a feed. After encouragement mother returned to desk with a bottle. Nursing staff changed baby's nappy with encouragement mother fed baby at the desk and went for a smoke – leaving baby in room with father. Baby slept till 0430hrs then woke and cried for 10 minutes. Mother got a bottle and started to feed baby – this time in their room. Loud voices heard from the room – swearing. Mother left room and went for a smoke. Baby crying and nursing staff checked on baby. Baby had _ bottle of milk – had vomited and was wet. Staff changed baby. Father started swearing saying the child was not his and she [Lisa] will never go home with the child and he was wasting his time being there. He had a dog dying at home and should be there not here. He stated that all the mother was interested in was her smoke. Father was never abusive to staff – just voiced his concerns angrily. Father left room saying he was going home now. Nursing staff attended to baby – settled her. Baby now sleeping. Nursing supervisor informed of all of this. She checked on parents downstairs. She stated that there were issues voiced by both parties. Mother returned to ward @605hrs stating her and the child's father needed to talk further downstairs where they can smoke. Left ward @615hrs.

14 July 2001 – 1200hrs

Mother and father went out of ward this morning but have been attending to cares whilst in attendance.

15 July 2001 (evening report)

Good evening. Cares attended to by parents. Lots of cuddles with both parents this evening.

16 July 2001 – 0630hrs

Settled night. Fed 2300 and settled. Woke @ 0300 and was crying and unsettled for approximately 30 mins and settled. Parents did not appear to wake.

My officers asked all of the RNs who were responsible for observing Lisa's care of baby Kate at both Hospitals Green and White (eleven in number) and the Medical Superintendent at Hospital White whether they had any concerns about her parenting ability. All of these persons expressed reservations about Lisa's ability to care for baby Kate, at least without ongoing support. Some of those responses appear below.

Hospital White

Medical Superintendent – qualified in 1974

MS: She did not seem to be able to appreciate the infant's needs – that the child needed to be cuddled, that she needed to be fed – her feeding was fairly cursory…Even after a few minutes that would be it – she would put the baby down and ignore it. If it cried she would become very rapidly resentful of it and expressed that the baby was getting in the way – she was frustrated by the demands of the child.

Registered Nurse – 24 years experience

RN U: Yes I did have concerns about Lisa and Kate. The fact that she did not respond to Kate's crying as most new mothers would. Most new mothers would get up and tend to the baby fairly promptly, Lisa had a tendency to sit there and let Kate cry and ignore her or seem to ignore her. As I stated in my notes, she did appear quite competent at handling the baby as though she'd handled babies before so she wasn't clumsy with it. She wasn't afraid of handling the baby but she showed no signs of bonding that this baby was hers. No cooing to it, no talking to it, no eye contact with it. It just appeared to be a baby that got changed and wrapped and put in a cot and if she had to she fed it. The bonding – I did watch her a lot during the night. She did sleep through Kate's crying at one stage, which is not necessarily abnormal – some mothers are too tired – but when she was to get up to feed the baby she wasn't very interested at all and would prefer the staff to do it.

Registered Nurse – 19 years experience

RN V: Oh yes I did…Well the concerns were that she didn't seem to want to look after the baby. She wasn't interested in changing it, feeding it, only if the mood took her at the time. Most of the time she put

it right out of the way, she was in a very long room, she was in one of the longest rooms up there and she put the baby right over the other side and just curled up and wanted to sleep or tried to go to sleep or she'd be outside the hospital smoking… new mothers usually goo and gah over their babies and Lisa wasn't doing that she didn't seem interested to learn how to do it when we tried, you know, to teach her.

Hospital Green

Clinical Nurse – 18 years experience

CN W: My initial concern, in the first few days, …Lisa was not going to cope without a lot of support. She just didn't have the attention span or the patience to do it. She was more involved in where she was going to get the money next for her smokes or the reaction from her partner. There seemed to be tension between her and her partner whenever she spoke on the phone to him. But in saying that **two to three days later I watched her talking to Kate and actually interacting with her. I thought then that if she continued to have full time support that she would manage. But I always thought she couldn't be left by herself for any length of time – she needed to have constant support.** [emphasis added]

Registered Nurse – 25 years experience

RN X: …Yes I did have concerns – that she'd be able to bring up the baby. I felt that – I didn't feel that she was a malicious person and I don't believe that she would – I don't know how to word it – I don't think she wanted to hurt the baby. I saw her as somebody that just did not have the basic skills, basic life skills to look after herself let alone look after another human being that was obviously going to need a lot of time. She just didn't seem to have the skills even in relation to finances with, you know, say in relation to formula. If she had to pick between a tin of formula and a packet of cigarettes I couldn't see that she could make the logical choice and buy the formula – I think that she'd buy the cigarettes because that's what her priority would be. But I think she was trainable. She was very keen and she really wanted to learn how to look after this baby. But I don't believe personally and professionally that she had the basic skills and I don't believe that John was the person who was going to support her in order to be able to take Kate home and look after her.

Registered Nurse – 10 years experience

RN Y: I did have some concerns with her prioritising simply because she would go down for cigarettes instead of feeding Kate. That was a concern and nappy changing and just basic care for Kate. She didn't seem to see the importance of prioritising basically or seeing the need for that over having a cigarette or a coffee.

Registered Nurse – 4 years experience

RN Z: Yes I certainly did. I guess with the attention span she could never just consistently do things. You know she needed encouragement to feed the baby, change the baby, to do all those cares alone, that sort of thing. She felt that if the baby cried she only had to do one thing minimum, you know one or the other. That she just – she couldn't understand that you had to do all of them. You had to change the baby, you had to feed the baby, and you had to make sure the baby was secure and things like that. She would only feed the baby but she needed encouragement to do that too. If she fed the baby and if the baby took too long to take the bottle, she felt that the baby had had enough. Instead of burping baby she would just say 'Maybe she's had enough and I'm going for a smoke'.

My officers also asked the RNs, the Medical Superintendent at Hospital White and the Paediatrician at Hospital Green to comment on whether, in their professional opinion, the decision for baby Kate to go home with Lisa was appropriate or inappropriate. I should mention that the Medical Superintendent, the Paediatrician and the nurses interviewed were unaware of the information contained in Lisa's statement to the QPS. A sample of their comments were:

Hospital White

MS: Lisa needed a great deal of supervision… baby Kate was at risk from Lisa despite her best efforts because the poor girl was not equipped.

RN U: … Personally I felt it wasn't right but professionally I didn't know enough of her mental status to just say yea or nay. But from what I observed and working with her over the last few nights…I felt she was perhaps just going to ignore the baby but that's a personal opinion... Having been a midwife for many years. I felt she wasn't capable of tending to the full effect of this baby's needs. She had no grasp that the baby would still be hungry because it had only finished 90mls and it might need some more. Her concept was that it had been fed why did it need some more and she couldn't quite grasp it.

RN V: No. [She needed] constant supervision and support…. I don't know how anyone could have thought that it was safe to send that poor girl home with her baby.

Hospital Green

CN W: If she had full time support it would have been appropriate.

RN X: I thought personally and professionally that it was an inappropriate decision… I was concerned for the baby's safety… I wasn't concerned that the baby was going to be hurt physically. I was concerned that the baby would be neglected. That the wrong decisions would be made. You know mum would sleep when the baby needed to be fed. Mum didn't seem to have good personal hygiene, the baby wouldn't be bathed for some time and she wouldn't get a health follow up.

RN Y: I guess there was some concern with Lisa… I don't know about Lisa and John...Lisa had improved with her care and seemed to be coping quite well but I guess in the back of my mind I had some concern.

RN Z: Definitely inappropriate…I had observed Lisa with Kate a number of times, whether I had been directly looking after her or indirectly, she showed no real affection towards the baby. I never saw her actually speak to the baby. A number of times the baby was left in the crib unattended. Like she might have fed the baby half a bottle but baby was put to bed and wasn't burped or anything like that. She just didn't seem to be getting the mother skills very well at that stage. … prior to going on days off there was talk that Lisa was to go to Riverton, which is a centre to help mothers cope with babies in Brisbane. I went on days off and when I came back Lisa had gone home. Now this was nearly 8 hours later when I came back onto an afternoon shift. I first inquired about where they'd gone and I was informed that they went to Riverton by nursing staff. They said that to me. There was no chart or anything to see and I thought that was the best place for her.

Paediatrician – qualified in 1978

Paed: I've looked at the notes and I looked at everything that was put into play and that comment about the positive and warm relationship between Lisa, John and baby Kate within the ward. I believe they were well informed of what was expected of them and that we had offered them within the hospital the best opportunity to develop those things that particularly Lisa was going to need. It is extremely unusual to have a baby in hospital for eleven days if it doesn't have a health issue and particularly unusual to admit mother and father to look after the baby unless there is going to be some gains from that. I've gone over the interviews and I've gone over the case in my own way several times…I have looked to see if there was anything we could have done differently and that answer is I still couldn't come up with anything other than the option that we all knew was there – removing baby Kate – but which we had to be certain that it was exactly the best option at that stage.

When issues about the baby Kate case were raised publicly the Paediatrician sent a letter to the Acting Manager of DOF Area Office Green in which she said:

> While in hospital Lisa received intensive help with developing appropriate parenting skills to meet Kate's needs. It was noted by the staff that she enhanced her skills significantly while under supervision and tutelage. Kate was not discharged however until it was felt that Lisa could meet her needs without extra support or direction from the nursing staff.

Other than the view expressed by the Paediatrician, there is substantial similarity between, on the one hand, the opinions and observations contained in these extracts and the medical records and, on the other hand, the opinions expressed by FSO Four and Lisa's foster mother about Lisa's ability to parent a child.

The decision to remove a child from its parent is not one lightly made. It may often require the wisdom of Solomon. My purpose in setting out the observations and opinions of so many QH staff is not an exercise in 'being wise after the event'. It is to show the considerable and consistent concern recorded in the medical records and held by almost all of the experienced nursing and medical staff. The very purpose for which Lisa and John remained in hospital over the weekend was for QH staff to assess their parenting ability. Yet the FSOs who attended Hospital Green did not take reasonable steps to ascertain the observations and assessments of the QH staff.

6.6.9 DOF's assessment of John

As I have already mentioned,[152] FSOs Two and Three attended Hospital Green on 16 July 2001 to finalise the initial assessment. FSO Three said that he had had no prior involvement with, or knowledge of the matter and advised that his role was to 'second' the interview. In his notes of the interview he concluded 'that there were minimal risks for the baby to return home'. There was no explanation in the notes how this opinion was arrived at. Baby Kate was discharged from Hospital Green at 4:30pm that afternoon into Lisa's and John's care.

The only other recorded information I have been able to identify in relation to this decision is the initial assessment record, which was not created in CPIS until 13 August 2001, some 34 days after the initial assessment commenced. This document says 'John has stated that he is willing to support and assist Lisa with the care of Kate, however, **this has yet to be demonstrated on a long-term basis.** Without assistance it is unknown if Lisa can care for Kate independently'. [emphasis added]

In their responses to my provisional report, both FSOs One and Two said that John was assessed as 'a parent willing and able' to protect baby Kate. No particulars of this assessment of John were recorded at the time, or subsequently in CPIS, but both officers claim that the assessment was sustainable.

FSO One said that this assessment was made because:

- John's ability to clearly identify his commitment to baby Kate's safety and well being was evidenced by his comments/statements and actions during the interview on 11 July 2001 that were assessed as being 'consistent and appropriate in terms of prioritising' baby Kate's needs.
- His stated intention to 'establish and maintain a solid support network for Lisa should he not be available at any given time', namely his family, was appropriate.
- His ability and awareness of baby Kate's needs were demonstrated during his 'rooming in' at Hospital Green.

Similarly, FSO Two said that she considered John was a 'parent willing and able' because:

- Nothing 'untoward' was detected.
- During two of the interviews he had become very 'emotional and tearful when talking about his commitment to baby Kate' and had 'talked about how the most special time in a couple's life, the birth of their first child, had now been spoilt and tainted by departmental intervention'.
- He said his family was supportive and that he felt comfortable with seeking that support.
- He had been unable to visit baby Kate because transport was a problem, but 'the birth of a new family member had created a great deal of excitement with his family'.
- She had no concerns for her physical safety in his presence.
- Although he had limited 'insight and skills with which to vent his feelings and thoughts orally' and his views on 'disability issues were draconian', he 'clearly voiced his love and commitment to Lisa and baby Kate.'
- He was able to recognise the 'authenticity' of DOF's concerns.
- He agreed to 'referrals to community agencies and the ongoing involvement of agencies'.

As I have mentioned, the relationship between Lisa and John ended within four days of their leaving Hospital Green.

152 See section 5.1 of this report.

The FSOs' assessment of John was, in my opinion, inconsistent with a significant amount of other information that was available to them at the time – namely:

The briefing note

In the briefing note to the Director-General of DOF which was prepared after baby Kate's death, the comment was made that:

> The family returned home on 16 July 2001 with a support plan involving home visits by FSOs and weekly visits by Child Health. Lisa was also supported by her previous foster carer, by telephone. It was noted that **mother and father did not have a good relationship. It was observed that father was undermining of mother and not understanding of department's concerns regarding the mother's care of baby Kate.** [emphasis added]

Further, the briefing note said that 'On 20 July 2001, Lisa contacted the area office requesting assistance as John was **continuing to drink** and not supporting Lisa as planned'. [emphasis added]

The February intake

It stated that:

- Lisa was in 'a violent relationship with the baby's father'.
- she planned to 'take off' to 'escape her partner'.

The April case note

It stated that:

- 'There is still a belief that the relationship [between Lisa and John] is one of domestic violence and there is a suspicion that this is occurring whilst she is pregnant.'

The notification from Hospital Green

It stated:

- 'Baby's father unwilling to assist and is very reluctant to be involved with medical staff in relation to baby's needs'.
- 'Parents have also demonstrated verbal abuse towards one another with father denigrating of mother's apparent intellectual impairment and lack of skills regarding the baby'.

The foster mother's information

The foster mother's letter, which was given to DOF by the Paediatrician on 10 July 2001, and also the information that she provided to FSO One in a telephone conversation on 11 July 2001, included:

- the statement in her letter that 'There are problems in Lisa's relationship with her partner, the greatest being their inability to manage financially. They simply run out of money only days after receiving their welfare payment, thus having no means of providing formula and other necessities'.
- her comment '…I cannot express how fearful my husband and I are for the safety of this baby if she is released into the care of her parents at this time'.
- her assessment that John 'has a huge influence over Lisa' and 'blames' her for DOF involvement and will be 'extremely aggressive towards Lisa and DOF'.

The medical records

The medical records, which neither of the FSOs sought to access, recorded that:

- On 14 July 2001, two days before Lisa and baby Kate left Hospital Green, at 4:30am:

> …Baby slept till 0430hrs then woke and cried for 10 minutes. Mother got a bottle and started to feed baby – this time in their room. Loud voices heard from the room – swearing. Mother left room and went for a smoke. Baby crying and nursing staff checked on baby. Baby had 1/2 bottle of milk had vomited and was wet. Staff changed baby. Father started **swearing saying the child was not his** and she [Lisa] will not go home with the child **and he was wasting his time being there**. [emphasis added] He had a dog dying at home and should be there not here. He stated that all the mother was interested in was her smokes…

Criminal history check

My investigation revealed that the FSOs did not conduct a criminal history check in relation to John. DOF was asked[153] to respond to this issue and advised:[154]

> The Department's records indicate that no criminal history checks were conducted for Lisa and John as the considerations in relation to baby Kate's Child Protection Follow Up Case were about the parents' ability to parent.
>
> There is no requirement for the department to request a criminal history check for a parent unless there is a suspicion or concern that would indicate the child's safety was at risk. The original allegations and assessed risk did not have any significant relevance to the criminal history record (if any) of either parent.

I do not suggest that criminal history checks would have shown that John was unsuitable as a parent. However, in this instance, it would have been prudent to conduct the checks because:

- John claimed on several occasions he was not, or did not know if he was, the father and;
- the decision to release baby Kate from hospital was based largely on an assessment of his willingness and ability to parent her.

6.7 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

6.7.1 FSO One failed to obtain and evaluate significant and relevant information that was available to DOF concerning Lisa's ability to parent baby Kate, including information that FSO Four could have provided.

6.7.2 DOF failed to clarify and document QH's role in the initial assessment of Lisa's and John's suitability as parents as a result of which not all relevant QH staff understood their role.

6.7.3 FSOs One, Two and Three, in failing to obtain available information about Lisa's parenting ability, did not fully comply with procedural and practice guidelines and good practice generally for the assessment of the risk of harm to children.

6.7.4 FSOs Two and Three should have reviewed relevant medical records and sought the views of relevant medical and nursing staff about Lisa's ability and willingness to parent baby Kate.

6.7.5 The decision to release baby Kate from Hospital Green into Lisa's and John's care was based on an inadequate assessment of the risk of harm to baby Kate.

6.8 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

6.8.1 DOF evaluate the training that is presently provided to DOF officers responsible for undertaking child protection assessments with a view to identifying whether increased emphasis should be given to conducting risk assessments and considering all relevant information for that purpose.

6.8.2 DOF develop and implement procedures and processes to be observed when involving other agencies in a child protection matter to ensure that the officers of the agencies involved understand their responsibilities.

6.8.3 DOF immediately issue a written memorandum to all relevant officers advising them of the authority under section 194 of the *Child Protection Act* for authorised officers to obtain access to information that is subject to confidentiality under section 63 of the *Health Services Act* where that information is relevant to the protection and welfare of a child.

153 In an email from my Assistant Ombudsman to DOF's Director of Child Protection dated 12 March 2003.
154 Letter dated 31 March 2003 from the Director-General of DOF.

6.9 DOF's response to recommendations and Ombudsman's comments

6.9.1 DOF's response

DOF provided the following responses to recommendations 6.8.1 to 6.8.3.

Recommendation 6.8.1 – Noted.

Response/Action to date

Since June 2002, the Department has allocated and spent well over $2.6M on learning and development for employees, almost twice the size of expenditure in previous years. The budget allocation for 2003-04 is even larger, with $3.8M set aside for learning and development for departmental employees. The real investment is even higher when you take into account internally delivered 'on the job' learning and development activities and travel and accommodation for officers attending training.

…

The Department already has plans to further increase the emphasis on risk assessment and the use of evidence in practice and decision-making. This is intended to be achieved by delivering the face to face training workshops for new Family Services Officers with a stronger emphasis on problem based learning and practical application of the risk assessment and information gathering frameworks.

As part of an ongoing approach to continuously improve learning and development of our employees, the Department is currently preparing a proposal seeking additional resources for a comprehensive professional practice and learning and development infrastructure for service delivery staff. This proposal will be informed by recommendations arising from internal and external reviews.

Finally, it must be noted that the importance of developing more effective risk assessment models remains firmly on the departmental agenda.

…

Recommendation 6.8.2 – Endorsed.

Response/Action to date

On 10 June 2003, Cabinet approved the 'Queensland Government Strategic Framework for Child Protection (2003–2006)', which provides the overarching policy framework for child protection and recognises that this issue impacts on the work of a range of government agencies. The development of the policy and accompanying action plan involved 15 state government agencies and focuses on the roles and responsibilities of these respective departments.

A project, Enhanced Collaboration in the Management and Accessibility of Client Information, is currently being co-ordinated by the Department of Families and involves Queensland Police Service, Queensland Health and Education Queensland in further development of co-ordinated record keeping and information sharing across these government agencies in child protection matters. The significant output of this project is the draft interagency protocol entitled 'Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm'. This draft protocol was signed off by the Human Services Chief Executive Officer's Committee on 6 June 2003 and is being trialled from October 2003 to March 2004 in the Sunshine Coast and Brisbane City (North) Regions.

The policy and procedure Information sharing: pre-notification (policy no: 330-1), implemented state-wide on 28 April 2003, involves other agencies in providing information to the Department of Families to enable decision-making about whether allegations constitute a child protection notification and what level of action is warranted regarding the allegations. This policy clearly outlines the responsibilities of other agencies in providing this information.

Finally, the Differential Response Trials policies and procedures acknowledge the importance of input from other agencies in child protection investigations and assessments. These policies, implemented on 28 April 2003 highlight the roles and responsibilities of other agencies and DOF when involved in joint assessments of child protection issues.

Recommendation 6.8.3 – Endorsed.

Response/Action to date

A memo has been developed regarding authority under section 194 of the *Child Protection Act 1999*. This memo was distributed to staff on 18 July 2003.

6.9.2 Ombudsman comment

Firstly, I am pleased that DOF has already taken some steps to 'increase the emphasis on risk assessment and the use of evidence in practice and decision-making' and provide training for FSOs in this area. In my opinion, effective risk assessment in the context of child protection assessments is vital and it is equally vital that DOF provide its officers with 'problem based training' on an ongoing basis.

Secondly, I have obtained and reviewed copies of the 'Information Sharing: Pre-notification' and 'Differential Response Trials' policies and procedures referred to in DOF's response to my recommendation 6.8.2. I was not provided with a copy of the draft 'Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm'.

Nevertheless, the policies and procedures appear to provide sufficient guidance to officers about the steps to be taken and matters to be observed when involving other agencies in an initial assessment. However, in relation to the policy entitled 'Differential Response Trials – Planned Joint Assessment Response', I note that it does not require that the roles and responsibilities of other agencies involved in a joint initial assessment be documented. In view of the evidence obtained from QH staff in this case that the reason for Lisa's admission and John's stay at Hospital Green was not 'universally understood', it would seem prudent that the policy provides for any such arrangements to be formally documented.

Finally, I am satisfied that DOF has taken appropriate action to give effect to recommendation 6.8.3.

6.10 Decision-making and case planning

'I think there is a lesson to be learned from child deaths. The case workers were, at least on an unconscious level, too heavily concerned about or focused upon the rights of the mother to retain her child.'[155]

Risk assessment is an ongoing process. Often, as a case progresses and new information is received, initial judgments or decisions have to be reviewed and sometimes changed.[156] It is therefore essential that new information relevant to the risks to a child is considered and evaluated with what is already known to determine if the existing case plan is adequate or if further action is necessary to meet a child's protective needs.

FSO One conducted a home visit on 17 July 2001, the day after Lisa and John had left Hospital Green. She recorded the following observations about this visit in a case note in CPIS but not until 11 September 2001, the day after baby Kate died:

> On arrival I observed that the house was very clean and Kate was in her cot. Baby's sleeping area was seen to be extremely clean and appropriate. Lisa seemed eager to show me all of Kate's clothes. Lisa was very organised in terms of formula, sterilisers, bottles etc. I asked where John was and Lisa told me that he had gone out with a friend for a little while and that **she was okay for short periods of time without him.** [emphasis added] John arrived home about 20 minutes after I arrived and stated that he had some business to do. By this time, Lisa was bathing Kate and John did not hesitate to assist in this. I observed both parents to be comfortable in handling Kate and Lisa was extremely gentle and careful when bathing and dressing her. I discussed with John and Lisa having a Child Health and Family

155 R. Clark, 'Child Protection and Social Work', in In the Shadow of the Law: The Legal Context of Social Work Practice, P. Swain (ed.), The Federation Press, New South Wales, 1995, p.10.
156 E. Munro, 'Avoidable and Unavoidable Mistakes in Child Protection Work', British Journal of Social Workers, 1996, vol. 26, p. 796.

Community Worker visit the home on a weekly basis. Both were very receptive to this suggestion and stated that they had already spoken to Child Health and they would be visiting this week.[157] At one point, Lisa asked John to get Kate's formula out of the fridge and I observed plenty of vegetables, meat and fruit. Lisa told me that they had done the shopping when they got paid so that they wouldn't run out of money. Lisa also showed me an unopened can of formula for Kate and an almost full one that she was currently using.

On 20 July 2001, Lisa's foster mother contacted DOF to advise that the relationship between Lisa and John had ended, four days after Lisa and baby Kate had returned home. John had failed to return to the home to assist Lisa in the care of baby Kate throughout the evening. Lisa had declared that the relationship had no future. I should also point out that in the briefing note prepared for the Director- General of DOF after baby Kate's death, it was also reported that Lisa had contacted Area Office Green on 20 July 2001 and requested assistance because **John 'was abusing alcohol and was not offering support' with the care of baby Kate.** [emphasis added]

In my view, these circumstances should have alerted DOF to the need to critically review baby Kate's situation. The fundamental premise that underpinned the decision to release baby Kate from Hospital Green into Lisa's and John's care was that John was a parent both able and willing to care for baby Kate. However, despite the level of concern that had been expressed to DOF by various credible sources about Lisa's capacity to adequately care for baby Kate, DOF did not, at any point, obtain a statutory child protection order.

As I have already mentioned, DOF arranged for Lisa and baby Kate to be placed at a local group home from 20 July 2001 to 26 July 2001. In a case note in CPIS, also created on 11 September 2001, FSO One has recorded that she contacted the group home on 24 July 2001 and the 'House mother' reported that:

> Lisa is in good spirits and has demonstrated that she is capable of caring for Kate. The only problem seems to be that Lisa is reluctant to get up to Kate in the night for feeding. House mother has informed Lisa that she is reporting back to the department and this could be a concern if it continues. House mother also stated that sometimes in the morning Lisa needs a bit of a 'shove' to fix Kate if Lisa is playing on the Nintendo, **but there are no significant concerns regarding Lisa's care of Kate.** [emphasis added]

My officers asked FSO One and the Manager at interview whether the options of a foster placement and/or child protection order for baby Kate were considered.

FSO One responded as follows:

> …Lisa's foster mother had contacted me and said that Lisa had contacted her and said that she had been up all night because John had been out all night and hadn't come home. He'd spent all their money on alcohol and she (Lisa) just wanted to leave him because she was sick of him spending all her money and felt that she would be better off caring for Kate on her own; or, you know, without John basically. The foster mother said that Lisa was waiting for me to call her and see what assistance we could give her in that regard. …It's very, very difficult to place a mother and a child into foster care – especially if there are other foster children in that placement. We knew that we couldn't put her – I mean we couldn't put her in a refuge[158] or a motel or something like that. The decision was made that if the local residential home could take her that would be an ideal facility given that it's a safe environment and there is somebody there 24 hours a day who could support Lisa and monitor her parenting.
>
> **…We looked at all sorts of options. We were struggling with where – finding somebody to keep the baby with her mother – which again I still maintain is Lisa's right. She was working with us and doing the right thing and the Act** [*Child Protection Act*] **very clearly states minimal intervention but supporting parents in their role if at all possible. It was how can we keep this baby with her mum so mum has the opportunity to demonstrate that she can learn what she needs to learn to be a parent.**
>
> …Well it was always there [the option of an order] but it was again **staying with minimal intervention and we've got a mum that is willing to work with us and is willing to do**

157 In a case note dated 18 July 2001, they day after the home visit, FSO One recorded that she contacted Child Health. The Child Health nurse also made a note of this request in baby Kate's medical chart. The Child Health nurse's note is also dated 18 July 2001 and says '[DOF] phoned to ask would I call on mother and baby which I agreed to do. Phoned and father said they would phone. Has not phoned'.

158 When baby Kate died she was living at Fernbrook which is a hostel for single women and their children.

> **anything we suggest or recommend.** …She acknowledged that she shook the baby but she's acknowledged why, so she was able to recognise what triggered her in that regard. And it's the – I can equate that to a family that belts a child with a belt – when you point out to the parents how inappropriate that is and the damages etc, and if they can say yes I never realised that it was so detrimental physically and emotionally to the child and help me find other ways of managing the child's behaviour, that's the ideal of an initial assessment. It's like saying this family are capable of positive change. And that's what you need. You can't go and rip the child out because they belted it with a belt.

The Manager gave the following answer:

> **Removing the baby was always an option that we tried to avoid basically, throughout the whole case. Because our policy is to work to keep them together.** We are very reluctant with a newborn to separate mother and child because you just ruin any chance of bonding. So, yes it's always a matter of always weighing up that safety factor versus – but I think all the way through that we always tried to work, because the only other option was probably removing her, we worked very hard to keep them together and make sure they were safe.

I make the following observations about the Manager's and FSO One's responses.

- Their views that it was Lisa's 'right' to retain custody of baby Kate are subject to the *Child Protection Act*. The *Child Protection Act* is, as the name suggests, an Act that provides for the protection of children and codifies the right of a child to be protected from harm. It has the effect of overriding parental rights to custody in certain circumstances. The key principle in section 5 for the administration of the Act is that:

  > (b) the welfare and best interests of the child are paramount.

- FSO One also said that the *Child Protection Act* 'clearly states minimal intervention'. In fact, the Act states[159] that 'the preferred way of ensuring a child's well being is through the support of the child's family'. This makes good practical sense. However, the words 'minimal intervention' do not appear in the Act. If a child's right to protection cannot be ensured through the support of a child's family, DOF is obliged to act in a manner to protect the child. The test for statutory intervention is a **'reasonable'**[160] belief that a child is in 'need of protection'[161] and does not have a parent both able and willing to protect the child from harm.[162]
- DOF's primary statutory obligations related to baby Kate, not Lisa. Even after Lisa's and John's relationship ended, the overriding concern of the DOF officers was to 'keep this baby with her mum so mum has the opportunity to demonstrate that she can learn what she needs to learn to be a parent'. However, the breakdown in Lisa's and John's relationship should have caused the DOF officers to re-assess Lisa's ability and willingness to care for baby Kate. In my opinion, their decisions were influenced too much by their desire to keep baby Kate with her mother, rather than by Lisa's ability to care for baby Kate.

In response to these opinions, FSO One and the Manager made the following submissions:

FSO One said:

> …it is clear that assessment was ongoing and this new situation required immediate action and response on DOF's part…Lisa's willingness was assessed as appropriate, so this was not an issue at the time, particularly as **she stated that she fully intended to take baby Kate with her from the family home and desired to continue parenting**. [emphasis added]
>
> … one of the protective factors previously identified during the initial assessment 'a person present who was able and willing to protect the child (John)' was now not valid. This situation was now not satisfactory and at this stage there were a number of available options for DOF.

159 Section 5(d) of the Child Protection Act.
160 Section 18 of the Child Protection Act.
161 Section 10 of the Child Protection Act.
162 Section 5(i) of the Child Protection Act.

1) Remove baby Kate from her mother's care.
2) Place baby Kate in her father's care as he had already been assessed as both willing and able…DOF does not make decisions about which parent should have custody of a child, this is a Family Law Court decision only. Instances where DOF makes these decisions are those where one parent has shown to be unwilling or unable to parent and this was the case at this particular time in terms of Lisa.
3) Place Lisa and baby Kate in an environment where Lisa's care of Kate would be supervised, an option which was in accordance with the risks already identified. This was in fact the option taken…

While in relation to my opinion that the DOF officers' decisions were influenced too much by their desire to keep baby Kate with her mother, FSO One said:

> I do not agree that DOF involvement with this family was based on the rights or interests of the parent, and maintain that at all times the welfare of the child was the primary consideration in terms of my actions/decisions, and that these were at all times authorised by my supervisor.

The Manager said:

The case plan for Baby Kate was based on the following factors:

- the risk assessment that her mother, Lisa, was not able to care for baby Kate without ongoing support and monitoring of her ability to parent a child;
- the mother's involvement in and consent to case plans;
- the support of family and significant others;
- consideration of bonding and attachment between baby Kate and her mother; and
- application of 'least intrusive' practice frameworks.

For the reasons I have already set out,[163] I do not accept the adequacy of DOF's assessment that John was 'a parent willing and able' to meet the care needs and welfare of baby Kate. However, it was DOF's assessment that he was such a parent. This was a significant factor (perhaps the most significant factor) in the decision to release baby Kate into Lisa's and John's care.

Once the relationship ended, Kate's ongoing care needed to be reassessed because there was nothing to indicate Lisa could cope without a high level of support.

In my view, DOF's decision at that point reinforces my concern that the officer's decisions were influenced too much by their desire to keep baby Kate with Lisa, rather than by Lisa's ability to care for baby Kate. Indeed, FSO One said 'Lisa's willingness was assessed as appropriate… she stated that she fully intended to take baby Kate with her from the family home and desired to continue parenting'. FSO One submitted that her assessment of the situation 'showed a parent willing' and 'also able with support'. Further, FSO One maintained that DOF had acted appropriately by placing Lisa and baby Kate at the local residential home where she was supported in her care of baby Kate. However, that placement was only ever intended as an interim measure.

6.10.1 Minimal intervention and the least intrusive approach

The majority of the DOF officers interviewed used the terms 'minimal intervention' and 'least intrusive approach' regularly and interchangeably to explain the rationale for the various decisions that were made concerning baby Kate. Even the internal review officer who conducted the child death review following baby Kate's death stated in the review report that:

> The *Child Protection Act* requires that departmental staff engage with families on the **least intrusive level** possible while maintaining the safety of the child. Area Office Green staff have demonstrated commitment to this principle by providing an opportunity for Lisa to demonstrate her ability to parent baby Kate in supportive environments. [emphasis added]

163 See section 6.6.9.

The only reference I can find in the *Child Protection Act* to the intrusiveness of a child protection response is in section 59. It provides that the Children's Court may make a child protection order only if it is satisfied that the protection sought to be achieved by the order is unlikely to be achieved by an order under (Part 4) on 'less intrusive terms'.

I asked[164] DOF to provide a copy of any policy relating to taking the 'least intrusive approach or minimal intervention', given that:

- These terms were not defined in the *Child Protection Act*.
- The term *less intrusive* is only referred to within the context of the Children's Court making a child protection order.
- These concepts were given such a high priority by the DOF officers involved in this case, almost to the exclusion of all other considerations.

In response,[165] DOF advised that the 'least intrusive approach' was a term that was 'commonly used/*misused* in practice' and did not appear in the *Child Protection Act*. Furthermore, **DOF advised that it did not have any policies that dealt with the application of such an approach.**[166] It said that:

> Section 59 requires that a child protection order be the order that will meet the child's needs on the least intrusive terms. Working with families under the Act is about providing responses that are warranted in the circumstances, that is providing the right response to a family at the right time. This may mean providing a highly intensive response early in the department's contact with a family in order to minimise the necessity of obtaining an 'intrusive' child protection order at a later stage.

This response was drawn from the 'Interim Report of the Child Protection Think Tank to the Director-General' dated December 2002. In addition, the Interim Report stated that:[167]

> Section 5(f) of the Act requires the Act to be administered under the principle that 'if a child does not have a parent able and willing to protect the child, the State has a responsibility to protect the child, but in protecting the child must not take action that is not unwarranted in the circumstances'.
>
> The common use of the term 'least intrusive' response or action may indicate that the principle in section 5(f) is applied in practice in a 'shorthand' way as requiring the most minimal response i.e. the Department should take the least intrusive action instead of taking action that is warranted in the circumstances. On the other hand, the 'least intrusive' course of action may not be taken because there are insufficient resources/programs to take the action that is warranted – statutory action is taken because there are no other available options.

The Interim Report recommended, among other things, that DOF needed to develop definitions for the meaning of key terms, including the phrase 'least intrusive'. I understand that preliminary work in this regard has commenced. However, the *Child Protection Act* was enacted on 23 March 2000, and if there was a general misunderstanding among DOF officers about the interpretation of the Act, that misunderstanding should have been addressed quickly.

DOF's level of intervention in baby Kate's case was characterised by an intention on the part of its officers to take a 'minimal intervention' approach. This approach was evident at all stages during DOF's involvement with the case. The need to intervene in the 'least intrusive manner' was a claim repeated by most DOF officers interviewed, including managers. As mentioned, the internal review officer also commented favourably in her review report on the commitment to this approach demonstrated by the officers at Area Office Green in baby Kate's case.

Baby Kate had been released into Lisa's care because John was available to provide the significant parenting support Lisa needed. Once he left, Lisa's ongoing need for support should have been assessed and addressed as a matter of urgency.

164 In an email from my Assistant Ombudsman to DOF's Director of Child Protection dated 25 March 2003.
165 In an email to my Assistant Ombudsman from DOF's Director of Child Protection dated 31 March 2003.
166 In her response to my provisional report, the Manager referred to Section 21.2 of the Manual where the words 'least intrusive level of departmental intervention' appear under the heading 'Have the child's protective needs been met?'
167 Interim Report of the Child Protection Think Tank to the Director-General', Department of Families, December 2002, <www.families.qld.gov.au>.

6.11 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

6.11.1 The DOF officers in making various decisions about the level of intervention in baby Kate's case:

6.11.1.1 gave too much weight to the principle that their approach at all times had to be the least intrusive one.

6.11.1.2 did not give sufficient weight to the principles that 'if a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care' and the 'welfare and best interests of the child are paramount'.

6.12 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

6.12.1 DOF refer the comments that I have made in this report about the application of the principles in section 5 of the *Child Protection Act* and the 'minimal intervention' or 'least intrusive approach' principle to the Coordinating Committee on Child Abuse (as reconstituted in accordance with my recommendations at 9.5) with a view to that body or an appropriately constituted sub-committee providing guidance on the weight officers should give to such principles when conducting child protection assessments.

6.12.2 If a sub-committee is constituted to carry out the role specified in recommendation 6.12.1 the Commissioner for Children and Young People be the Chair.

6.13 DOF's response to recommendations

6.13.1 DOF's response

In my provisional report, I had recommended that the issue dealt with in 6.12.1 be referred to the Child Protection Think Tank and further recommended at 6.12.2 that I be advised of the final recommendations of the Think Tank. However, as appears below, DOF advised that the Think Tank has finished its work and been disbanded. I have now given the matter further consideration and amended 6.12.1 and formulated a new recommendation 6.12.2.

DOF provided the following responses to provisional recommendations 6.12.1 and 6.12.2.

Recommendation 6.12.1 – Noted

Response/Action to date

As noted in the provisional report, the Child Protection Think Tank considered the concept of 'least intrusive' in 2002 and their interim report (December 2002) acknowledges that the term is not used in the *Child Protection Act 1999* and is commonly used/misused in practice.

The Think Tank recommended that the Department of Families develop definitions for the meaning of key terms including the phrase 'least intrusive'. Significant work has been undertaken in this area and the Department of Families will be finalising this work in the near future. To this end, a group will be established to:

- finalise the definitive descriptions for a number of key terms;
- draft a Practice Direction for all staff in relation to the application of the principles in Section 5; and
- develop training for Family Services Officers, Team Leaders and Area Managers throughout the State in 2004.

Recommendation 6.12.2 – Endorsed

Response/Action to date

The Department's Executive Management Committee will consider the final report of the Child Protection Think Tank and the departmental response in August 2003. The Department of Families will provide a copy of this report to the Ombudsman as soon as it becomes available.

7 Case management decisions

'While the Intensive Parenting Education Program undertakes a time limited piece of work with a family, this work should be considered as part of the overall case plan for each family.'[168]

7.1 Riverton Early Parenting Centre

The complainant has alleged that DOF failed to facilitate an adequate assessment of Lisa's parenting skills and that she should have been referred to Riverton for this purpose.

Baby Kate's case was reviewed by the SCAN Team on 26 July 2001 and the minutes state under the heading 'Discussion Summary' – 'Lisa and baby Kate will be going to Riverton'. Further, the minutes indicate that DOF advised the SCAN Team that following an initial placement at Riverton, DOF was 'looking' at Lisa and baby Kate going to either the 'Sisters of Mercy or Fatima.'[169] The SCAN Team recommended that DOF proceed in this manner.[170]

However, it was not until 7 August 2001 (some two weeks after the SCAN Team meeting) that FSO One completed and faxed a referral to Riverton in respect of Lisa and baby Kate. On the cover sheet of the facsimile accompanying the referral, FSO One wrote; '**This matter is considered urgent in terms of safety for child** and any assistance would be greatly appreciated'. [emphasis added] Following receipt of the referral, the Intake Nurse at Riverton requested, via return facsimile of the same date, that DOF provide particular information to support the referral. QH has advised[171] that DOF never provided this additional information.

QH has advised that in the absence of any further contact from DOF, the Intake Nurse attempted[172] to contact Lisa on 17 August 2001 to follow up on the referral and spoke directly with her foster mother. The foster mother informed the Intake Nurse that Lisa and baby Kate had since moved to Fernbrook. The foster mother then emailed FSO One to inform her that Riverton had been in contact with her.

QH further advised that the Intake Nurse telephoned Area Office Green on 13 September 2001 to follow up on the progress of the referral and left a message for FSO One to contact her. According to QH records, this call was not returned. Baby Kate had in fact died on 10 September 2001, some three days earlier.

Notwithstanding that the referral to Riverton was not accepted or prioritised, I sought QH's advice about a likely time frame for admission in the event that the placement of Lisa and baby Kate had been actioned by DOF. Specifically, I asked[173] QH when baby Kate and Lisa would have been admitted to the IPEP if the referral had been progressed by DOF and accepted as a priority referral by Riverton. In response, QH advised:[174]

> If the referral had reached a point of acceptance into the Intensive Parenting Education Program all efforts would have been made to prioritise as appropriate and admission may have been possible within a week.

7.1.1 Reasons for not proceeding with the referral to Riverton

When interviewed, FSO One confirmed that the referral to Riverton was not proceeded with. By way of explanation she said:

> As we moved along **it was setting Lisa up to fail was basically the thing.** We'd already identified that her parenting skills were in question and that basically she needed a lot of support and the opportunity to learn with support to do that. Whereas Riverton doesn't offer support. Riverton is basically an assessment place only and five days just wouldn't be enough for Lisa.

168 Riverton Early Parenting Centre, Review of the Intensive Parenting Program, 2002, p.29.
169 Other long-term supported placements.
170 The SCAN recommendation said 'look at Lisa and baby Kate going to Sisters of Mercy or Fatima after Riverton'.
171 Letter dated 27 January 2003.
172 Letter dated 27 January 2003.
173 Email of 26 February from my Investigating Officer to QH Parliamentary and Ministerial Services Unit.
174 Email of 7 March 2003 from QH Parliamentary and Ministerial Services Unit.

Similarly, the Manager of Area Office Green (until 27 July 2001) made the following comments at her interview with my officers:

> I think when we looked at it again Riverton was for two weeks only and I think we queried whether she [Lisa] would cope with the high level of expectations in terms of what you had to learn so quickly. I don't know what FSO One discussed with them but I think it was a matter of – **if we send her there will we set her up to fail on some level and how detrimental would that be...?**

As mentioned at section 3.2.2, the IPEP at Riverton is a 12 day residential program designed specifically for parents or carers who provide care for a child under three years of age and who have limited parenting skills and/or identified child protection concerns.

The two most important principles[175] underpinning the *Child Protection Act* are that 'the welfare and best interests of a child are paramount' and that 'every child has a right to protection from harm'. Indeed, in her facsimile to Riverton of 7 August 2001, FSO One had described the referral as 'urgent in terms of safety for the child.' Once again,[176] in my opinion, the statements of the DOF officers suggest too great an emphasis upon the rights or interests of the parent, in this case Lisa, and Lisa's presumed reaction to a comprehensive assessment at Riverton.

Furthermore, the evidence my officers obtained does not support the validity of statements made by both the Manager and FSO One in relation to Lisa being 'set up to fail' and not being able to 'cope with the high level of expectation' at Riverton. QH provided information to me about Riverton's services.

They advised that Riverton's role is not to pass or fail parents who undertake the program. Had Lisa and baby Kate been placed at Riverton, a comprehensive discharge summary[177] would have been completed at the conclusion of their admission. The discharge summary would have been available to DOF and would have provided a detailed assessment of Lisa's parenting ability and the interventions that were required during her admission (e.g. nursing, psychiatric) together with a recommendation from the team involved in the assessment. It would have been left to DOF to make the final assessment.

In the initial assessment, DOF recorded under the heading of 'Ongoing harms/ Future concerns' the comment 'Without assistance it is unknown if Lisa can care for Kate independently'. In my view, a placement at Riverton would have led to a response to this question and been of significant benefit to DOF, particularly in terms of assessing the limits of Lisa's **ability and willingness** to parent baby Kate. The Riverton discharge summary would have given DOF a clear understanding of the level of supervision and support that Lisa required to care for her baby.

In taking the view that admission to Riverton was 'setting Lisa up to fail', both the Manager and FSO One:

- demonstrated a lack of understanding of Riverton's services; and
- failed to appreciate the opportunity that Riverton provided for enhancing and assessing Lisa's parenting ability, which information would have been relevant to DOF's decision as to an appropriate placement for Lisa.

Their view also led to Lisa and baby Kate being placed at Fernbrook. Fernbrook does not have the same support services as Riverton, as explained in section 7.5 of this report.

In her submissions in response to my provisional report, FSO One said:

> ...It was clear in the initial stages of this Assessment that a parent (John) was identified as being able and willing to provide ongoing protection. As for the ongoing assessment of the other parent (Lisa), it showed a parent *willing*, and also that she was *able* with support.
>
> ...your statement suggests that up till this time in the assessment process, there was no or little information gathered about Lisa's ability to parent. I would argue that this was not the case and in fact it was this information that provided the basis for the decision not to proceed with the referral...my comment that 'Riverton would be setting her up to fail' was based on my expectation that the report from this agency would merely confirm this.

175 Section 5 of the Child Protection Act – refer to Appendix J for a full extract.
176 See section 6.10.1 – Minimal intervention and the least intrusive approach.
177 See Appendix C.

FSO One's response reinforces my concern that she failed to appreciate the opportunity that Riverton provided for independently assessing the level of support that Lisa required to ensure baby Kate's safety and well being.

The Manager did not make any submissions in relation to this point. However, at the conclusion of her interview with my officers, she said '…I'll go away and think about the value of Riverton…it is interesting because I think we thought about it in the context of helping Lisa go forward'.

I am concerned that DOF staff outside of the Brisbane metropolitan area may not have an adequate working knowledge of the services provided at Riverton. All of the DOF officers interviewed were uncertain about:

- what Riverton did
- what programs it offered
- how long these programs were
- if there were any waiting lists
- how Riverton could be accessed
- the availability of the comprehensive discharge summary to assist DOF with subsequent case planning.

I am advised that in December 2000, QH formed a steering committee and appointed a project officer to review the IPEP at Riverton. Interestingly, the reviewer identified that in that year, there were no DOF referrals to the IPEP from DOF offices (including Area Office Green) north of Maroochydore (approximately one hour's drive from Brisbane).

I asked QH to provide me with details of the number of referrals made to the IPEP according to DOF Area Offices in 2001 and 2002 respectively to determine if this situation still existed. QH gave the following data:

Table 2

Referrals to Riverton by DOF 2001 & 2002

Area Office	2001	2002
Logan	4	6
Mt Gravatt	2	1
Woodridge	2	6
Browns Plains	2	2
Gold Coast	2	2
Redcliffe	2	6
Caboolture	2	2
Fortitude Valley	1	2
Inala	1	1
Chermside	1	2
Stones Corner	1	4
Ipswich	1	3
Beenleigh	–	3
Maroochydoore	–	2
Rockhampton	–	2
Cleveland	–	2
Pine Rivers	–	1
Wynnum	–	1
Goodna	–	1
Gympie	–	1
Redland	–	1

As the data in Table 2 shows, there were only three referrals in 2002 to Riverton from DOF Area Offices west of Brisbane or north of Maroochydore. There was none in 2001. Whilst there has been a slight improvement in the use of Riverton by such offices, the level of referrals remains low.

In my provisional report, I recommended that DOF provide information to its officers about the services provided by Riverton and the criteria for admission. DOF endorsed my recommendation and issued a memorandum on 30 July 2003 about Riverton to its Regional Directors for dissemination to DOF officers within their respective regions.

7.1.2 Approval of the decision not to proceed with the referral

DOF procedure requires that an FSO's case management decisions be approved by a Manager or Team Leader. In her interview with my officers, FSO One said that the decision that 'Riverton wasn't appropriate for Lisa' was made in discussions with the Team Leader at the time. The Manager was performing a dual role of Manager and Team Leader until 27 July 2001. The Manager had attended the SCAN Team meeting on 26 July 2001. The minutes record the meeting being advised of the decision to refer Lisa and Baby Kate to Riverton.

The Manager has advised that she finished working in Area Office Green on 27 July 2001, the day after the SCAN Team meeting, and then took up another position within DOF. FSO Five was appointed to act in the position of Team Leader from that date.

As I have already mentioned, FSO One sent the referral to Riverton on 7 August 2001. As at that date, the decision not to proceed with the referral was a matter for the Team Leader, who was FSO Five. However, FSO Five claimed at interview that she never saw the referral to Riverton or the request from Riverton for additional information. She said that her recollection is that FSO One indicated to her that Riverton was 'not an option'.

I was unable to confirm whether the decision not to proceed with the Riverton referral was formally approved by a Manager or Team Leader. There is no record of this decision in CPIS or elsewhere. **In her response to my provisional report, FSO One claimed that she consulted with the Manager 'during the preparation and initiation of the referral' and with FSO Five, as Acting Team Leader, in relation to the 'decision not to proceed' with the referral. FSO One denies that she only told FSO Five that 'Riverton was not an option' and claimed that she discussed the decision with FSO Five at a meeting on 17 August 2001. However, there is no reference to any conversation about Riverton in FSO Five's supervision notes.**

In the circumstances, because of the scarcity of documented information, I am unable to resolve whether the decision not to proceed with the referral to Riverton was approved by a supervisor. If anything, this situation only serves to highlight the need for DOF officers to maintain accurate and reasonably comprehensive records of the reasons for case management decisions. I will address the issue of record keeping in Part 8 of this report.

I should also reiterate that the decision not to proceed with the referral to Riverton was contrary to the case plan for baby Kate that had been recommended by the SCAN Team. In the event that a SCAN Team recommendation cannot be implemented or circumstances change, the SCAN Team Manual envisages that the case will be referred back to SCAN for review.

This principle has also been incorporated into DOF's Manual. Chapter 15 of the Manual entitled 'Departmental intervention: use of the SCAN team' states:

> **Once a SCAN Team recommendation has been made, do not take unilateral action which contradicts the recommendation. Should you need to act contrary to the SCAN team recommendations, hold discussions with other core team members prior to taking any action.** In emergency situations, hold the discussion by telephone. **Where the child's safety is at risk, consult with your line manager.** [emphasis added]

However, baby Kate's case was never referred back to the SCAN Team for further consideration. This was a clear breach of the procedure prescribed in the Manual. Although baby Kate's case had been closed to SCAN on 26 July 2001 this did not prevent DOF from referring the matter back to the SCAN Team or to a Brisbane

based SCAN Team for consideration. This did not happen. The SCAN Manual provides[178] that 'a case which has been closed to the SCAN team may be referred again at a later date for further consideration'. It should also be understood that the case had been closed to SCAN in Area Green because Lisa and baby Kate had moved to Brisbane.

Because DOF was seeking a suitable placement for Lisa and baby Kate in Brisbane, a Brisbane based SCAN Team would have been best placed to review the matter and determine which facility was most suited to Lisa's and baby Kate's needs. The DOF officers within Area Office Green acknowledged that their knowledge of the facilities available in Brisbane was limited. The officers said when interviewed that DOF had no resource manual that would have assisted them to locate a suitable placement for Lisa and baby Kate in Brisbane.

I should also point out that among the notes made by the internal reviewer, which were supplied to my officers, the internal reviewer has recorded a statement that 'Brisbane SCAN would not have recommended Fernbrook'. This statement appears in a handwritten memorandum of a telephone conversation that the internal review officer had with a member of the QPS, who was also a member of SCAN. This advice did not appear in the child death review report.[179]

In response to my provisional report, FSO One made the following submissions in relation to this point:

> …the wording of your opinion in terms of a 'clear breach of the procedure prescribed in the Manual' suggests an element of intent on my part, which I emphatically deny. **I do however acknowledge that I was not fully aware of the requirements of the Procedures Manual in relation to the SCAN team at the time** and therefore felt that I was not in a position to question the actions and decisions of my supervisors. [emphasis added]
>
> With the benefit of hindsight, and further experience and knowledge, I am able to identify the failings you refer to here, and have ensured that I now have a very sound working knowledge of SCAN team procedures. This knowledge has been demonstrated over the past 2 years in my positions as Acting Team Leader in a number of DOF offices including Area Office Green.

7.2 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

7.2.1 DOF officers at Area Office Green did not implement the SCAN Team's recommendation that Lisa and baby Kate be placed at Riverton followed by a placement at either Sisters of Mercy or Fatima. This decision was based wholly or partly upon a misunderstanding of the services provided by Riverton and a misunderstanding of Riverton's approach, namely, that it would have 'set Lisa up to fail'.

7.2.2 The DOF officers did not comply with the SCAN Team Manual and DOF Manual that required either the implementation of the SCAN Team recommendation or the referral of the matter to a SCAN Team for further review.

7.2.3 Placement of Lisa and baby Kate at Riverton would have:

7.2.3.1 provided a more appropriate level of support for them.

7.2.3.2 led to a comprehensive professional assessment of Lisa's ability and willingness to care for her baby, that could have informed future decision-making by DOF in respect of baby Kate's safety and well being.

7.2.4 FSO One failed to record in CPIS, or elsewhere, the reasons for the decision not to refer Lisa and baby Kate to Riverton. The lack of any such record makes it difficult to identify the reasons for that decision and who approved the decision.

178 See Appendix D.
179 See Part 9 of this report –The child death review.

7.3 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

7.3.1 In consultation with QH, DOF provide information to its officers about the services provided by Riverton and the criteria for admission there.

7.3.2 To ensure appropriate ongoing involvement by a SCAN Team, DOF review its procedures for transferring to a local SCAN Team cases that have been closed to SCAN in another area because the family or child has left that area.

7.3.3 DOF develop and maintain a comprehensive resource database that contains information about the emergency, support and residential services available in Queensland to assist officers with decisions about the placement and referral of families in need.

7.4 DOF's response to the recommendations and Ombudsman's comments

7.4.1 DOF's response

DOF provided the following responses to recommendations 7.3.1 to 7.3.3.

Recommendation 7.3.1 – Endorsed

> **Response/Action to date**
>
> An information paper has been developed regarding the services provided by Riverton and the criteria for admission. This paper was distributed to staff on 1 August 2003.

Recommendation 7.3.2 – Endorsed

> **Response/Action to date**
>
> The Department of Families chairs the Coordinating Committee on Child Abuse (CCOCA), which is responsible for oversighting SCAN Team functioning and business practices across the State.
>
> The SCAN Team manual currently provides guidelines for the transfer of cases between SCAN Teams for open matters only. **Following the finalisation of the SCAN Team MOU, the SCAN Team Manual will be updated as a matter of priority. This will include reviewing the procedures for the transfer of all cases between SCAN Teams.** [emphasis added]
>
> Finally, the Integrated Client Management System (ICMS) will allow greater sharing of information and an enhanced capacity to track matters referred to SCAN teams across the State.

Recommendation 7.3.3 – Noted

> **Response/Action to date**
>
> Specific functionality for a statewide Service Directory has been included in the Department's new Integrated Client Management System (ICMS). This has been targeted for inclusion as stage 1 of this project. … Service Directory functionality will mean that the myriad of local systems that store details about support services can be replaced by one that is up-to-date and centrally maintained.

7.4.2 Ombudsman comment

While DOF has advised that the SCAN Team Manual will be updated 'as a matter of priority' following the finalisation of the SCAN Team MOU, it has not provided any indication when this will be completed.

This recommendation should be capable of immediate implementation, particularly as the current SCAN Team Manual does not make provision for 'closed' cases to be transferred between SCAN Teams. Accordingly, I believe that the other work on the SCAN Team Manual should not prevent this issue being addressed immediately.

While I am pleased to note a statewide Service Directory will be incorporated into ICMS, DOF has advised that the tender process for the development of ICMS only commenced in June 2003. In order to ensure that

DOF officers are provided with accurate and timely information about the emergency and support services that are available throughout the State, I would recommend that DOF give immediate effect to this recommendation by compiling the necessary information and making it available to its officers either in hard copy or on the DOF Infonet.

7.5 Fernbrook

'Case Management and case planning must be based on a full protective assessment. This assessment must be reassessed as the case develops to ensure original decisions and plans continue to be appropriate.'[180]

DOF referred Lisa and baby Kate to Fernbrook on 12 August 2001.

Fernbrook is a residential hostel operated by a non-government organisation and provides short-term accommodation for a maximum of 12 weeks[181] for homeless women and their children. It is a former motel. Accordingly, residents have their own private room with a bed, bathroom, refrigerator and television. There is a communal laundry and kitchen and each resident is provided with three meals a day.

A person who takes up residency at Fernbrook is assigned a case-worker whose role is to provide the person with support and assistance on a 'needs' basis. A staff member sleeps on the premises overnight and can be contacted between 10:00pm and 6:00am by telephone. The Fernbrook Manager explained that for security reasons, residents are not allowed to have guests in their rooms. Fernbrook staff are also not permitted to enter a resident's room unless invited by that resident.

7.5.1 The referral

The Fernbrook Intake Officer recorded[182] that the following information was provided to her by FSO One upon intake on 13 August 2001:

- Lisa has a very minor intellectual disability, has limited parenting skills but is doing well.
- Child Health and Family Services will be involved.
- Ex-partner has been emotionally abusive etc and won't be involved in raising the child.

On the basis of this information, the Fernbrook Manager and the Intake Officer both believed that Lisa met the criteria for placement at Fernbrook. However, the Manager advised[183] my officers that once she observed Lisa's **'high needs'**, she assessed that Fernbrook was an inappropriate placement.

When asked if she was able to recall what information FSO One told her about Lisa's and baby Kate's **'needs'** for the placement, the Intake Officer said 'She told me very little actually – just basically what I've recorded that Lisa had a minor intellectual disability. She didn't state what it was, just that she had limited parenting skills and that she was doing well with the baby'.

The Intake Officer is adamant that FSO One never told her about Lisa's medical condition and intellectual impairment. However, in a case note in CPIS dated 12 August 2001[184], FSO One recorded the details of her conversation with the Fernbrook Intake Officer and has written 'They [Fernbrook] were made aware that she has [an intellectual impairment and a medical condition] which requires medication'. FSO One recorded this case note in CPIS[185] on 11 September 2001, the morning after baby Kate died.

Apart from the subsequent CPIS record, I have not seen any documentary evidence that would confirm that DOF gave Fernbrook any information about Lisa's and baby Kate's 'needs' for the placement other than that recorded by the Fernbrook Intake Officer.

The Intake Officer advised my officers that sometime after baby Kate had died, she found out that Lisa had shaken baby Kate. The Intake Officer said 'I still bear a lot of anger about the fact that information was not provided to me upon intake'. I agree that this information was significant and relevant to Fernbrook, particularly from a supervision perspective, and should have been provided.

180 P. Armytage and C. Reeves, 'Practice insight as Revealed by Child Death Inquiries in Victoria and Overseas', in G. Calvert, A.Ford and P. Parkinson (eds), The Practice of Child Protection: Australian Approaches, Hale & Iremonger, Marrickville, p.139.
181 Fernbrook also maintains community based residential units for independent living for periods of up to six months for suitable applicants.
182 Information obtained from Fernbrook file contained in the QPS Brief of Evidence to the Coroner.
183 In an interview with my officers on 4 December 2002.
184 The handwritten note produced by FSO One in relation to this conversation records that the conversation took place on 13 August 2001.
185 See Part 8 of this report - Record keeping.

In her response to my provisional report, FSO One made the following submissions about the adequacy of the referral information:

> …In this instance, I am not able to provide a handwritten contemporaneous document to verify the matching one on CPIS, however, I would propose that it would be impossible for me to recall the date and content of this verbal referral some 4 weeks after the event without the assistance of such a handwritten case note. As stated to your officers, I do recall a number of 'loose pieces of paper' which were kept in a manilla envelope file for this family and these became the source of a number of my case notes at the time they were entered into CPIS... **I am prepared to swear to the validity and truthfulness of the particular CPIS case note referred to here, together with any others which I have made.** [emphasis original]

FSO One went on to submit that her case note which states '[Fernbrook] informed me they are an organisation who has dealt with a number of young mothers who have disabilities' demonstrates that she had a discussion with Fernbrook about Lisa's medical status. Further, she said:

> It is clear that I do not at any time refer to Lisa's intellectual impairment and medical condition as 'disabilities' anywhere else during my time as case worker for Lisa and therefore state that this word originated from my discussion with Fernbrook, a clear recognition that they were made aware of this information.

In relation to the Fernbrook Intake Officer's claim that she was not told that Lisa had shaken baby Kate, FSO One said:

> …From a DOF officers point of view, this [the shaking incident] was and would have been significant in terms of safety for baby Kate. I state very clearly here that I did provide this information to Fernbrook. The fact that this particular piece of information is not included in the CPIS case note does not in itself demonstrate that it was not done, but could be considered similar to the fact that it would be a 'given' that I had provided it along with mother and child's name, age etc.

As can be seen, FSO One and the Fernbrook Intake Officer have provided significantly conflicting recollections about what information was provided at the time of the referral. The Intake Officer's recollection is consistent with the information that she recorded contemporaneously upon intake. My officers saw these handwritten notes. On the other hand, FSO One claims that she would have relied upon a contemporaneous handwritten note detailing her conversation with the Intake Officer in order to create the CPIS record after baby Kate had died. However, FSO One was not able to provide a copy of the contemporaneous note that corresponds with the CPIS entry.

During the interview with my officers, FSO One claimed that in all likelihood, she would have destroyed her handwritten notes once she had recorded the information in CPIS. Why she would do so, when she knew, by that time, that her administrative conduct would be the subject of an internal review, is something that FSO One did not explain in her submissions. Furthermore, the retention of the contemporaneous notes was of greater significance in this case because FSO One did not create the majority of the CPIS records, including this particular case note, until after baby Kate died.

I will deal with the issue of FSO One's record keeping, and record keeping within Area Office Green generally, in Part 8 of this report.

I should record that there was a handwritten note in FSO One's note book dated 13 August 2001 which was not destroyed and which read:

> Fernbrook 24/7 staff
> 80 Mum 10 bub 20-week security refunded at end of stay.
> Foster mother taking Lisa and baby to Fernbrook today.
> Will remain in touch with Lisa and Department. Yahoo.

As I will discuss later in this report,[186] the information contained in the handwritten note is inconsistent with the CPIS record.

186 See section 8.2.4.

The DOF internal review officer also identified the inadequacy of the referral information given to Fernbrook by DOF as an issue in the child death review. She said:

> Analysis also raises the issue of whether the referral to Fernbrook was the most appropriate in the circumstances…While the verbal referral gave a general indication of suitability a more thorough, documented referral which included an indication of departmental assessment of risk and documented a jointly negotiated case plan outlining roles and responsibilities of all parties would have provided a sound basis for ongoing assessment.

The internal review officer recommended that DOF consider developing a 'standardised referral process including documentation which outlines an agreed case plan, identifies roles and responsibilities and communication processes'. [187]

I agree with the internal review officer's observations and recommendations in this regard. Clearly, had a written referral that outlined Lisa's 'needs' been provided to Fernbrook, the dispute that has now arisen between FSO One and the Fernbrook Intake Officer about the adequacy of the referral information would not have arisen.

7.5.2 Adequacy of supervision and assessment

FSO One advised my officers when interviewed that she was aware that Fernbrook provided 24 hour 'support' as opposed to 'supervision' and that Lisa was not going to be supervised in any real sense in her care of baby Kate. The provision of any supervision would only occur if Lisa contacted the support person to request assistance. This is an issue of significant concern because DOF knew that Lisa had limited ability to care for baby Kate without supervision and may not have known when she required assistance.

The evidence indicates that Lisa required constant prompting to attend to baby Kate's basic care needs such as feeding, changing and bathing. Even Lisa herself had acknowledged[188] that getting out of bed to attend to baby Kate's night feeds would be a significant problem for her.

Lisa's foster mother also maintained a diary of her personal observations of Lisa's care of baby Kate during the three-week period that they stayed with her before moving to Fernbrook. On 7 August 2001 the foster mother sent the diary to FSO One together with a covering letter containing the following comments:

> These recordings are as objective as I can make them. **We seem to be constantly nagging Lisa to do her baby chores.** She has no general housework to do other than to help with the dishes yet she never seems to be organised. **Lisa loses interest in her baby at night and is unco-operative and full of self pity if she is forced to get out of bed.** On other occasions she responds to the baby crying without any prompting from us. I have no doubt that she loves her baby.
>
> **On 3 August we had a second really bad night where Lisa literally left us 'holding the baby' because she wanted to sleep**. This she did while we paced the floor for three hours with a windy baby. Good nights only occur when Lisa goes to bed early and I give the baby her late feed. I offer to do this as Lisa simply does not function when she is tired.
>
> Lisa moves through the house at an absolute snail pace justifying her go-slow behaviour on being tired. She is getting adequate sleep and certainly does not work hard. **I believe this behaviour is deliberate to get out of doing the job.** It certainly would be easier and less frustrating to do myself.
>
> New rules apply: After breakfast no more coffee and cigarette breaks until the morning baby chores are completed. Lisa thinks this is harsh and unfair but that's the way it's going to be. [emphasis added]
>
> **26 July 2001**
>
> Lisa and baby arrived in Brisbane by train. Lisa happy and baby content on arrival. Baby unsettled for most of the evening. Lisa becomes agitated when the baby cries for what Lisa sees as nothing wrong with her. Lisa and baby share a small room. Baby slept from 10:30pm until 5:30am. Baby fed by Lisa and settled to sleep again.

187 See Part 9 of this report – The child death review.
188 Information contained in the initial assessment record in CPIS.

27 July 2001

9:15am baby woke. Lisa didn't – this being eleven hours broken by one feed. I called Lisa three times to get up and attend to the hungry baby. No response. I threatened to pull the bedcovers off her and she answered, but was slow to respond. All the while the baby cried. I believe Lisa was pretending to be in a deep sleep so I would feed the baby. Further conflict when I insisted that she change the saturated baby prior to the feed. When I challenged her bad mood she replied that she is always irritable when people wake her up. It is pension day, Lisa wants to get another PlayStation so she will have something to do while she is here. I said NO!

12:30pm Lisa and baby went to the local shopping centre. Another argument as to why the baby required feeding before going out and not at the shopping centre. Lisa always accepts our decision when she has exhausted her reasoning. The remainder of the day was good, although we are continually reminding her to do her baby related chores. Her lethargic manner could be partially caused by the lack of thyroid medication that was left in Area White. She now has medication…

In a further email to FSO One dated 8 August 2001 (five days before Lisa was referred to Fernbrook), the foster mother reported:

I have told Lisa that I will be informing you that she will not get up for her baby at night. I have threatened that if she continues to ignore Kate's needs at night, Kate will probably be placed in foster care. She was furious using the excuse that she is still learning. The days continue to improve and although much prompting is needed, there is more willingness to do the job without whining.

….Lisa loses patience and cries when the baby won't settle or when she herself wants sleep. The level of upset is equal to the upset she displays when I insist that she will help with the dinner dishes (her only non-baby job) before going out for a cigarette. [emphasis added]

I make no comment about the accuracy of the foster mother's assessment or to what extent, if any, Lisa's behaviour was affected by her medical condition.

In my opinion, the foster mother's concerns were not given adequate consideration by FSO One in her evaluation of the appropriateness of Fernbrook in terms of the risks to baby Kate. FSO One appears to have interpreted the foster mother's observations as a positive endorsement of Lisa's parenting ability. When asked by my officers if she still considered Fernbrook to have been an appropriate placement, in that Lisa had her own private room and was not directly supervised, FSO One said:

Well our information from the foster mother by that stage was that Lisa was managing Kate quite okay. Through the day the staff would be there all the time and mum and baby wouldn't be in the room as such but would be interacting with everybody else and that they would be able to monitor her from there.

When questioned by my officers about the same issue, FSO Five said:

I don't know that I had a clear understanding at the time of the level of supervision that we were talking about that may have been required. If Lisa required more intensive supervision with someone physically present then, obviously, no it wasn't an appropriate placement. I guess I wasn't really clear about the level of intensive supervision that was required at the time.

As the Acting Team Leader, it was FSO Five's role to oversee FSO One's case management decisions and actions, including the suitability of the decision to refer Lisa and baby Kate to Fernbrook. I am therefore concerned by FSO Five's evidence that she did not have a 'clear understanding' about the level of supervision that Lisa required.

In my view, the foster mother's reports do not give the overall impression that Lisa was managing Kate 'quite okay'. These reports, together with the information that DOF had gathered in the initial assessment, indicated a pattern of Lisa not coping and experiencing high levels of stress and frustration when required to attend to baby Kate's needs, particularly at night. The foster mother's information should have heightened concerns about Lisa's ability and willingness to care for baby Kate, particularly in her own private room at night without direct supervision.

There was no evidence to indicate that the decision to refer Lisa and baby Kate to Fernbrook was ever based on a comprehensive assessment of the risks to baby Kate. Although it could be argued that the evidence supports the view that **Lisa was willing** to care for baby Kate the statutory requirement[189] is that a child have a parent who is both **able and willing** to provide ongoing protection. If a child does not have such a parent, then the legislation envisages that **the child 'has a right to long-term alternative care.'**[190]

The DOF Practice Guide states:[191]

> Due to age and vulnerability, children and young people need to be supported by parents or caregivers who are willing and able to protect them from harm. **Both willingness and ability need to be assessed** i.e. if the parent is able to protect, are they willing to protect? **If the parent or caregiver is willing to protect are they able to protect?** Where these supports are missing, children and young people are left at greater risk of all forms of harm. [emphasis added]

I have seen no evidence that DOF officers properly addressed both of these issues either at the time Lisa and baby Kate were referred to Fernbrook or during their stay.

FSO One's submissions in response to my provisional report did not cause me to alter my opinion in this regard. She said:

- I believe that I did assess all of the information and maintain that there was no evidence of significant risk of harm to Kate, but supporting evidence that Lisa required support to parent.
- …any possible risks to baby Kate were assessed and were not considered significant at that time. This being the case, and combined with the information provided by Fernbrook about its services, I maintain that the decision to place Lisa and Kate there was appropriate under the circumstances.
- … the information gathered, did not support statutory intervention, as suggested by your comment here and stated earlier in your report, but provided further confirmation that Lisa required support in her care of Kate at this time. I believe that it would be reasonable to say that the majority of 'new' or 'first time' parents experience stress and anxiety in managing a new baby, and that some of Lisa's reactions were similar. The difference was that Lisa had the support of a family (foster mother) to assist and guide and it is therefore highly possible that Lisa knowingly 'took advantage of this'.
- …I believe the issue here could be seen as the foster parent's actions in taking over the care of Kate when Lisa wouldn't, thus giving Lisa the 'go ahead' to continue in this manner. I would propose that had the foster mother not done this, DOF would certainly have had a better understanding of Lisa's ability and willingness.
- …there is a relevant statement made by the foster mother where she states that **'Lisa has managed her first twenty four hours of totally caring for her baby unassisted'**. [emphasis original] Thus, your statement that 'The foster mother's information should have heightened concerns about Lisa's ability and willingness to care for baby Kate, particularly in her own private room at night without direct supervision', would appear to be somewhat negated by the statement made by the foster mother. It would appear to me that this statement in fact further supported Lisa's ability to manage Kate during the night periods without assistance and shows that the referral to Fernbrook was appropriate at that time in terms of there being no direct overnight supervision…

I make the following comments about FSO One's submissions:

- FSO One claims that 'had the foster mother not done this [taken over the care of baby Kate when Lisa wouldn't] DOF would certainly have had a better understanding of Lisa's ability and willingness'. Having read the foster mother's diary entries from 26 July to 2 August 2001, together with her covering letter to FSO One, it is apparent to me that the foster mother did everything she reasonably could have done to assist DOF to make informed decisions about baby Kate's welfare, including providing DOF with contemporaneous observations about Lisa's ability and willingness to parent baby Kate. The foster mother is an experienced carer having fostered approximately 30 children since 1975. She also holds an enrolled nursing certificate and a Diploma in Early Childhood (0-6 years).[192] She had fostered Lisa since the age of two and knew her better than anyone else.

189 Section 5 of the Child Protection Act.
190 Section 5 of the Child Protection Act.
191 The Practice Guide – Part 3 – Risk Factors. See Appendix K for a complete copy of Part 3.
192 Information derived from the foster mother's statement to the QPS contained in the Brief of Evidence prepared for the Coroner.

- FSO One has not explained who, if not the foster mother, would have assisted Lisa in her care of baby Kate and given feedback to DOF on her parenting skills.
- FSO One has submitted that the foster mother's positive comment on 1 August 2001, that Lisa had managed her first 24 hours of care without assistance, supported the decision to refer Lisa and baby Kate to Fernbrook. However, it does not appear that FSO One considered the information that the foster mother provided in her covering letter concerning Lisa's willingness to care for baby Kate on the evening of 3 August 2001, two days later, which was:

> **On 3 August we had a second really bad night where Lisa literally left us 'holding the baby' because she wanted to sleep.** [emphasis added] This she did while we paced the floor for three hours with a windy baby. Good nights only occur when Lisa goes to bed early and I give the baby her late feed. I offer to do this as Lisa simply does not function when she is tired.

After baby Kate died, two residents from Fernbrook made statements to the QPS regarding their observations of Lisa's care of baby Kate. **Their observations were consistent with those expressed by nursing staff at Hospitals Green and White and Lisa's foster mother.** In particular, they expressed concern about Lisa's standards of hygiene in her care of baby Kate, the amount of support she needed and her lack of attention to the baby's needs. Some relevant extracts from their statements appear below.

- I was constantly helping Lisa burp, feed and care for Kate. … I would often tell Lisa that she needed to bath Kate. But Lisa would seldom bath Kate.
- Another major concern was the time period that Kate was left alone. Lisa would spend hours away from Kate without checking on her. Daily Kate would be crying for long periods of time. When we would complain to Lisa about this Lisa would turn the music up so we couldn't hear Kate crying.
- Lisa would only feed Kate when she felt like it. When Lisa would feed Kate it was far too much and she wouldn't feed Kate a little at a time then wind her – it was the whole amount at once.
- I would constantly be giving Lisa advice and showing her the correct method in maternal care but Lisa did not appear to possess the ability to continue to perform these duties over long periods of time without constant reminder.
- I would constantly bring up my concerns with Lisa and try and give her advice and a hand. Lisa to me was not bonding with Kate like a mother should. She never appeared to show affection and Kate obtained more affection from the other mothers than from Lisa.

DOF officers had a continuing opportunity to obtain feedback from Fernbrook staff during the time that Lisa and baby Kate remained there. One of the complainant's allegations to my Office was that DOF's communication and follow up contact with Fernbrook was 'less than adequate'.

7.5.3 Adequacy of DOF contact with Fernbrook

CPIS records of DOF's contact with Fernbrook are limited to two telephone calls between the Fernbrook Intake Officer and FSO One on 20 and 28 August 2001 (confirmed by the Intake Officer) and two telephone calls between Lisa and FSO One on 21 and 28 August 2001 respectively.

FSO One said when interviewed that she had been in regular contact with Lisa but that she did not record the details of all telephone conversations in CPIS. When asked if she had notes of these other conversations in her diary, she said:

> There may not be – sometimes it was just to say hi Lisa how are you going, I'm here you know. I know there was one that was not documented anywhere where Lisa rang me and said 'Can you get me a worker down here, I have been to Area Office White and said I want my case to be transferred here'.

In response to my officer's question, 'Are all phone calls to clients normally generated as case notes?', FSO One replied 'Not always – it would depend on what the content was'.

On 3 September 2001, the Fernbrook Manager and Intake Officer contacted Lisa's foster mother to discuss their concerns about Lisa's ability to care for baby Kate. The foster mother recorded the telephone conversation.

During that conversation, the Fernbrook Manager advised the foster mother that she was particularly concerned that DOF was considering independent living options for Lisa and baby Kate. The Fernbrook Manager and Intake Officer both expressed concerns about FSO One's positive assessment of Lisa's ability to parent baby Kate and her expectation that Lisa would be capable of making a transition to independent living. The foster mother suggested that the Fernbrook Manager contact FSO One to discuss her concerns. In response to that suggestion, the Fernbrook Manager said:

> We would be happy to do that but as I said before – as long as she [FSO One] does take action because a little bit of the contact we've had so far – I can say there's been an inference given that she thinks there's been a wonderful change in this girl and you know what I mean and that's what we hear from her.

Following her conversation with the foster mother, the Fernbrook Manager decided to contact Area Office White (the local area office) instead of FSO One. The Fernbrook Manager explained to my officers that she dealt with Area Office White on a regular basis and had a good working relationship with the officers there.

On 3 September 2001, a DOF officer from Area Office White contacted FSO One to discuss the matter, including the Fernbrook Manager's concerns. However, Lisa and baby Kate remained at Fernbrook. According to the notes made by the DOF Intake Officer at Area Office White, FSO One advised her that Area Office Green was finalising the initial assessment and would be transferring case management to Area Office White. This information was then conveyed to the Fernbrook Manager by the DOF officer at Area Office White. The Fernbrook Manager advised that she was satisfied with this advice.

In the record of this conversation created by FSO One in CPIS, after baby Kate had died,[193] she did not make reference to the Fernbrook Manager having contacted Area Office White to express her concerns about Lisa's ability to care for baby Kate. The CPIS record indicates that the conversation was only about the transfer of case management.

In response to the opinion I expressed in my provisional report that FSO One's contact with Fernbrook about Lisa's parenting was inadequate, FSO One said:

> I strongly deny that this [communication with Fernbrook] was 'less than adequate'…[I] believe that I maintained contact with Fernbrook staff, Lisa and the foster mother to the best of my ability with consideration of distance, work loads and priorities of other cases at the time.

In my opinion, notwithstanding workloads and other priorities, two telephone calls to Fernbrook staff in approximately four weeks to monitor Lisa's progress was less than adequate. The circumstances of baby Kate's case demanded that FSO One maintain more frequent telephone contact with Fernbrook to receive feedback on Lisa's ability and willingness to parent on an ongoing basis. As the FSO responsible for baby Kate's child protection matter, FSO One was obliged to ensure baby Kate's safety and well being until such a time responsibility for the case was transferred to another officer.

7.6 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

7.6.1 The referral information provided by DOF to Fernbrook should have been confirmed in writing.

7.6.2 DOF's decision to refer Lisa and baby Kate to Fernbrook was inappropriate because:

- 7.6.2.1 it was not based on a comprehensive assessment of Lisa's ability to care for baby Kate. Lisa required direct supervision and assistance to meet baby Kate's basic care needs and Fernbrook did not provide that level of supervision and support.
- 7.6.2.2 it did not adequately take into account the significant information provided by Lisa's foster mother concerning Lisa's willingness and ability to care for baby Kate.
- 7.6.2.3 it was based on FSO One's opinion that Lisa's parenting ability had improved to the extent that she would be able to properly care for her baby at Fernbrook.

193 Record keeping is discussed in Part 8 of this report.

7.6.3 The ongoing contact by FSO One with Fernbrook staff about Lisa's parenting was inadequate.

7.6.4 FSO Five's responsibility as Acting Team Leader was to evaluate the suitability of FSO One's verbal recommendation that Fernbrook was a suitable placement for Lisa and baby Kate. She did not effectively discharge this responsibility in approving FSO One's recommendation because she did not have a clear understanding of the level of supervision that Lisa required or the type of supervision available at Fernbrook.

7.6.5 The Manual gives insufficient guidance to Team Leaders and Managers about their role in case management and decision-making.

7.7 Recommendation

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

7.7.1 The recommendation made by the internal review officer in her review that DOF consider developing a standardised referral process, including documentation outlining an agreed case plan and identifying roles, responsibilities and communication process, be implemented as a matter of urgency.

7.8 DOF's response to recommendation

7.8.1 DOF's response

DOF provided the following response to recommendation 7.7.1.

Recommendation 7.7.1 – Endorsed

Response/Action to date

A standardised referral process was developed specifically for the Future Directions trials that commenced in November 2002. The documentation that is completed as part of the referral process includes the reason for referral, identified needs of the family, goals for intervention, and area office contact.

It is anticipated that this referral process and accompanying documentation will be evaluated, amended if necessary and implemented more fully during the pilot phase of the Prevention and Early Intervention services.

In addition, the Differential Response Trials that commenced in April 2003 have also incorporated this process and documentation in the provision of the assisted referral response and will be evaluated at the completion of the trials in November 2003.

7.9 The transfer

'When a family moves, stringent processes should be in place to ensure that case-work continues with the family where there are concerns about the children.' [194]

7.9.1 Current DOF policies and procedures

It is well established[195] that children known to child protection agencies who have highly mobile parents or caregivers are at an increased risk of harm. The Practice Guide recognises that 'a highly mobile family decreases the opportunity for effective intervention and may thus increase the likelihood of future harm to a child.'[196] High mobility is therefore recognised as a risk factor that needs to be considered by DOF officers in relation to the circumstances of a particular child and family.

Both the *Child Protection Act* and the Manual reinforce the principles that a child and a child's family have a 'right to a planned and consistent service' and that in all circumstances, 'the best interests of the child are paramount'.

194 NSW Ombudsman, Special Report to Parliament, April 2002, p.16.
195 NSW Ombudsman, Special Report to Parliament, April 2002, p.15.
196 DOF Practice Guide – Part 3 – Risk Factors. See Appendix K.

The complainant alleged that DOF took an unreasonably long time to effect the transfer of case management from Area Office Green to Area Office White, thus denying Lisa and baby Kate a planned and consistent service.

A Manager or Team Leader is responsible for negotiating a transfer with a receiving office. The Manual provides[197] that case management of a child protection matter should be transferred between DOF area offices when a child and/or family relocate to another area. The 'general guideline is that case management responsibility for a subject child is held by **the area office responsible for the geographic area where the child resides**'. However, when it is 'not possible to determine a 'usual address' for the child (i.e. the child is highly mobile) case management responsibility will rest with the office for the location in which the main parent or family member is residing'. [emphasis added]

In relation to the time in which cases should be transferred, the Manual states that 'Stability in the child's living situation should be established before the transfer takes place – generally this is established at some point between eight to twelve weeks'. This statement makes good sense given that there is little point making multiple transfers between area offices pending the settlement of a family.

However, several officers interviewed interpreted this statement in the Manual to mean that they had a period of up to three months to transfer a case even if a family had clearly settled in a new location, for example in the first week. In my opinion, this interpretation of the Manual is incorrect.

The policy dealing with transfers in the Manual does not give clear guidance to officers about:

- the procedures for transfer;
- the forms needed to be completed to transfer a matter;
- the time lines to be observed; and
- the responsibilities of the sending and receiving Managers and/or Team Leaders and the original case-worker.

In New South Wales for example, when the Department of Community Services (DOCS) becomes aware that a child has moved, DOCS procedures require that the case-work file should be transferred within 21 days.[198]

When Lisa and baby Kate arrived at Fernbrook, FSO One's expectation was that they would be there for up to three months and there was no reason to believe they would be returning to Area Green. Therefore, in my opinion:

- the case should have been transferred to Area Office White as soon as practicable after they arrived at Fernbrook; or
- 'case-work', as opposed to 'case management', should have been temporarily transferred to Area Office White. In this regard, the Manual states that case-work can be 'temporarily given to an office which does not have case management responsibility if the child is temporarily residing in another area'.

The circumstances in which case-work should be temporarily transferred are not outlined. This is a matter for negotiation between Managers and/or Team Leaders of the respective area offices. Therefore, in this instance, arrangements could have been made for a local DOF officer to provide a service to baby Kate **immediately** she was relocated to Brisbane without the need for the formal transfer of the case from Area Office Green.

7.9.2 Actions taken to transfer baby Kate's case

Table 3 represents a chronology of the actions taken by the Acting Team Leader (FSO Five) and FSO One in relation to transferring case management of baby Kate's child protection case from Area Office Green to Area Office White and related events. The table shows the number of days that elapsed between each of their respective actions.

197 Child Protection Procedures Manual – Chapter 27 Case Administration and Recording. See Appendix L for a full extract of the relevant parts of the Manual.
198 NSW Ombudsman, Special Report to Parliament, April 2002, p. 15.

Table 3

Chronology of events and actions taken relating to the transfer

Date	Events and actions	Days elapsed[199] Interval in days	Total
26 July 2001	Lisa and baby Kate moved to Brisbane to stay with Lisa's foster parents.	0	0
6 August 2001	FSO Five made a supervision note in her diary to transfer baby Kate's case to Brisbane.	11	11
13 August 2001	Lisa and baby Kate commenced residing at Fernbrook.	7	18
15 August 2001	FSO One received an email from Lisa's foster mother asking her to continue as Lisa's case-worker.	2	20
17 August 2001	FSO Five made supervision note 'Wait one to two weeks to transfer to Area Office White.'	2	22
21 August 2001	Lisa told FSO One that she had been into Area Office White and asked to have a case-worker assigned to her because she wanted to see someone 'face to face'. FSO One told Lisa that Area Office Green would facilitate transfer to Area Office White.	4	26
Between 13 and 23 August 2001	On an unknown date FSO Five telephoned the Manager of Area Office White to discuss transferring case management. The Manager suggested that it might be appropriate to 'link' Lisa back in with FSO Four and hence transfer case management to Area Office Blue.	–	–
23 August 2001	FSO Five contacted Area Office Blue and ascertained that FSO Four was no longer based there.	2	28
24 August 2001	FSO Five emailed the Manager of Area Office White advising that she intended to finalise the initial assessment and transfer baby Kate's case to Area Office White because FSO Four was no longer at Area Office Blue. FSO Five instructed FSO One to finalise the initial assessment.	1	29
3 September 2001	The Fernbrook Manager contacted the Intake Officer at Area Office White to express her concerns about Lisa's parenting ability. The Intake Officer contacted FSO One to discuss the situation and FSO One advised her that Area Office Green was finalising the initial assessment and transferring the case to Area Office White.	10	39
4 September 2001	FSO One electronically submitted the initial assessment document in CPIS to FSO Five.	1	40
10 September 2001	FSO Five commenced drafting an email to the Manager of Area Office White to transfer baby Kate's case but says that she stopped the email when she realised that FSO One had not completed a transfer summary. Baby Kate died that evening.	6	46

199 Calendar days.

7.9.3 Analysis of actions taken

As Table 3 illustrates, certain actions were taken to transfer case management from Area Office Green to Area Office White. However, the transfer had not been effected at the time of baby Kate's death, which occurred 46 days after Lisa and baby Kate had moved to Brisbane.

A period of 46 days seems to be an inordinate amount of time to transfer either case management or case-work responsibility for a priority one case.

The first recorded action taken concerning the transfer occurred on 6 August 2001, some 11 days after Lisa and baby Kate had moved to Brisbane. In a supervision note on that date, FSO Five wrote 'Hand over to Brisbane office'. However, it does not appear that she took any action to facilitate that transfer until at least 13 August 2001, when Lisa and baby Kate moved to Fernbrook.

Fernbrook is situated within the geographical area of Area Office White. Prior to moving to Fernbrook, Lisa and baby Kate were residing with Lisa's foster parents. Their address in not within the area serviced by Area Office White.

When interviewed, FSO Five said that she had initial discussions with the Manager of Area Office White about the transfer but she did not make a note of the call and cannot recall exactly when the call was made. She says that the Manager suggested the case be transferred to another office, Area Office Blue, because of Lisa's 'past link' with FSO Four. When she contacted that Area Office she was told FSO Four was no longer there.

In a further Supervision Note dated 17 August 2001, FSO Five wrote 'Allow 1-2 weeks to settle before transfer to Area Office White'. FSO Five advised my officers that FSO One asked her to postpone the transfer because Lisa's foster mother had asked FSO One to continue as the case-worker.

There is an email from Lisa's foster mother contained in the DOF file that corroborates FSO Five's statement in this regard. The email is addressed to FSO One and dated 15 August 2001. The email states (in part) 'Is it possible for you to remain as Lisa's case-worker for a little longer – please, just until we see how the next few weeks go'.

In her interview with my officers the foster mother said:

> The case management was to be transferred down to Brisbane once Lisa came down. I did ask FSO One if she could hang on to it for a while because I did honestly believe she was trying at that stage to get Lisa into proper facilities [Riverton]. I thought better the devil you know than the devil you don't. With another social worker, I would have to start all over again to convince them.

There is evidence that on 21 August 2001, Lisa informed FSO One that she had personally attended Area Office White and asked for a local case-worker to be assigned to her because 'she felt it would be good to have someone close to see face to face'. FSO One told Lisa that Area Office Green would facilitate the transfer. However, Lisa's visit to Area Office White did not lead to either case management or case-work responsibility being transferred.

My officers explored this point with FSO One. She claimed that she had, in fact, 'continually asked' FSO Five to transfer the case. FSO One says that she felt that her requests were being 'ignored'. She made the following statements:

> …This is where this gets very hard for me. **I asked from the time Lisa went to Brisbane for the case to be transferred to Brisbane** – given my concerns for Lisa that she needed a worker there. My relationship with Lisa had become quite good from where we had started.
>
> When Lisa left I continued to be in contact with Lisa and her foster mother – quite a lot of contact with them. My concerns were that Lisa needed somebody there. She needed a worker that she could talk to. My understanding of Lisa by then was that Lisa had stopped thinking the department was terrible and that the workers only took the kids away and that's all they cared about. It was important to me that by then my relationship with Lisa was such where she trusted me and we hadn't tried to take her baby…and I wanted that to continue for Lisa.
>
> …It was important to me that she had a worker and also in terms of those concerns that were there I really think that this was still a priority one case and it meant ongoing constant work.
>
> …I asked continually for it to be transferred.

FSO One went on to say:

> …At one stage, a week or two before Kate died, I again asked her (FSO Five) where she was up to and I kept being brushed off. Oh, I am getting to it, I am too busy, it's not a priority – that sort of stuff. To the point where our relationship, by that point, was where I felt I couldn't go to her with anything and that makes it very difficult for an FSO when you need a Team Leader to make decisions.
>
> **She said I've spoken to Area Office White and they want the initial assessment finished. So I reported back to her when I completed the initial assessment and said 'Okay it's done its ready to go'** and still she didn't do anything that I am aware of.

This evidence raises two issues for my consideration, namely, whether the transfer of case management or case-work responsibility was dealt with in a timely manner and, if not, whether this was the result of a poor working relationship that existed between FSOs One and Five.

7.9.3.1 Timeliness of actions taken

As Table 3 shows, there is evidence that FSO Five telephoned Area Office Blue on 23 August 2001. At that time, FSO Five ascertained that FSO Four was no longer based at that office. FSO Five advised my officers when interviewed that she therefore decided that it was appropriate to proceed with transferring baby Kate's case to Area Office White. Accordingly, on 24 August 2001, FSO Five emailed the Manager of Area Office White to advise that she intended to transfer case management to that office.

The email stated (in part) **'I have given the worker the okay to go ahead with this [the transfer], so the plan is to finalise the initial assessment and case management etc, and send the material to Area Office White'.** The email implies that on, or before, Friday 24 August 2001, FSO Five had asked FSO One to finalise the initial assessment. [emphasis added]

As I mentioned earlier, when a document is created in CPIS, CPIS records the actual date and time that the document is created. CPIS also maintains a record of the date that the document is electronically submitted to a supervisor for approval. This audit trail shows that the initial assessment record was created in CPIS on 13 August 2001 but was not submitted by FSO One to FSO Five until 4 September 2001.

Accordingly, accepting FSO One's statement that FSO Five asked her to finalise the initial assessment, the evidence suggests that it took FSO One a further ten days to complete this action.

On 3 September 2001, FSO One received the telephone call from Area Office White advising that Fernbrook had contacted them with concerns about Lisa. FSO One submitted the initial assessment to FSO Five on 4 September 2001.

FSO Five says that, on the morning of 10 September 2001, she commenced drafting an email to the Manager of Area Office White to transfer the relevant documents but stopped the email when she realised that FSO One had not, in her opinion, satisfactorily completed a transfer summary. When interviewed, FSO Five said:

> On the actual morning [of baby Kate's death] I had approved documents ready to electronically transfer things through to Area Office White. I went to do that and I started an email dated that morning to actually proceed but I stopped the email when I realised that the case transfer document had not been completed [by FSO One]. I went and spoke to [FSO One] and said: 'Hey, you know I can't transfer this until you have actually done the transfer summary so can you fast track the transfer summary for me so we can get it away'.

FSO Five supplied a copy of this draft email to my officers at interview. It had not previously been supplied to my officers with DOF's file.

In contrast, when FSO One was asked whether she had completed a transfer summary, she said:

> No I was never asked to do one…I am surprised now – I've actually heard that she's [FSO Five] stating that she did ask me for one. If she asked me for one that would be in a supervision note somewhere…

At the conclusion of the interview, my officers asked FSO One if there was anything that she wanted to add. She said:

> If I can just stress that I am aware that lately [FSO Five] has been raising this thing about she asked me for a report to transfer that case and I am stating categorically that she never asked for that report. I am confused that she is now saying that she is happy to say she did not know what to do as a Team Leader but then to turn around and say I asked [FSO One] for a report is a bit of a contradiction happening there. I just want to clarify that I was never asked for that report.

There is no documentary evidence that supports the version of either of the FSOs – neither officer made any contemporaneous or later memorandum recording what they had said or done or been asked to do. FSO One was only able to point to a handwritten note in her note book dated 10 September 2001 which said, 'brief discussion with FSO Five re: transfer baby Kate to Area Office White'. After baby Kate had died, FSO One generated this handwritten note as a case note in CPIS which read 'Brief discussion with FSO Five re transfer of this case to Area Office White. IA, case work and case management completed. FSO Five to look into this'. As I have pointed out, these notes do not support any particular version of what the two officers discussed or decided.

The information contained in CPIS at that time was not comprehensive and, in my opinion, the case should not have been transferred with such scant particulars about baby Kate's circumstances. The state of the CPIS records meant that it would have been impossible for any case-worker unfamiliar with the case to gain essential information quickly without speaking to the previous case-worker. Therefore, if the case-worker had been unavailable, other officers (including officers from the receiving office) would not have been in a position to make informed decisions about baby Kate's future care.

Clearly, good practice requires the provision of a reasonably detailed transfer summary in order to ensure that a new case-worker has adequate, accurate and timely information concerning the relevant family.

My Assistant Ombudsman questioned FSO Five about the apparent delay in taking action to transfer case management for baby Kate's case from Area Office Green to Area Office White.

AO:	Given that the case was a 'priority one' and Lisa and Kate were living in Brisbane, would it have been a priority to transfer the case to ensure ongoing supervision and support for Lisa and Kate a lot earlier than what occurred or what happened?
FSO Five:	I would think that the time frames that operated were well within normal practice.
AO:	And is that because of resourcing in the office?
FSO Five:	Absolutely…some cases don't get transferred for months and months.
AO:	Even priority ones?
FSO Five:	I guess what you have to appreciate with this one – we were aware it was urgent. In view of the limited resources, and you know 50 other cases that you are discussing and like dealing with, really you know, **we had dealt with this one fairly promptly.**

In my opinion, a period of 46 days to transfer either case management or case-work responsibility of a 'priority one' or 'urgent' child protection matter cannot be termed a 'prompt response'. The circumstances of this case required a more rapid action. The circumstances included Lisa's attendance at Area Office White on 21 August 2001 requesting that a case-worker be assigned to her and the significant concerns raised by Fernbrook staff on 3 September 2001 about Lisa's parenting abilities.

My officers interviewed several DOF officers at Area Office Green about attitudes to transfers and the time taken to transfer cases generally. Their responses were fairly consistent. The following is an extract from the interview with the Acting Manager[200] (AM) of Area Office Green.

200 At the time baby Kate was the subject of DOF intervention. The Acting Manager's substantive position is Team Leader.

AO: Would a receiving office have the ability to refuse a transfer?

AM: Yes they can.

AO: On what basis could they do that?

AM: Well how they would refuse – only because I've got a case at the moment…they haven't refused to take it on, they just keep requesting that we do more and more work, even though the child's down there. They wanted something else done on this or they want something else written up or they want a more in-depth assessment of protective needs form done or something like that. **So it's not an outright refusal to take the case but it happens on occasions where it's been put off for a month or two months or whatever.**

…It's [the time allowed for transferring cases] always been three months and being three months you would expect the office in the other area are usually required to take on that case if the child has been in that area for three months. They have recently changed that to eight weeks.

…I know myself in negotiating with different area offices it depends who's been informed of what. So I usually push the eight weeks but because that's the resource stuff. **So it's not as clear as that with child protection follow-up cases but from a professional point of view you would expect that it would be done you know within a few weeks of when it was needed.**

When asked about the procedures for transferring a child protection matter, the Acting Manager said:

…It's usually a lot of to and froing because sometimes officers refuse to actually accept the cases because of resources or for whatever reasons or they want you to go back and do something else on the case before they will accept it.

…They may say we can't allocate it for five weeks or it's not as urgent as something else we've got because it's not a child on an order so it's not definitely one of our cases. I can't explain it any better.

I can appreciate that DOF staff in receiving offices may perceive transfers as an additional burden, particularly in busy offices with high case loads. Furthermore, officers in busy referring offices may be tempted to cut corners in the completion of the referral documents. However, the overriding consideration when transferring cases must surely be to provide consistent and uninterrupted services to families.

7.9.3.2 Working relationship between FSO One and FSO Five

I am aware that, at the relevant time, the working relationship between FSO One and FSO Five was strained although both officers claimed they had always conducted themselves in a professional manner despite the relationship. My officers explored whether this admitted poor relationship adversely affected the transfer of baby Kate's child protection case from Area Office Green to Area Office White.

As I have already mentioned,[201] FSO One claimed when interviewed by my officers that she asked FSO Five about the status of the transfer a week or two before baby Kate died and FSO Five said 'Oh, I am getting to it, I am too busy, it's not a priority'.

My officers also interviewed FSO Five about this issue. Although acknowledging problems with their relationship, she claimed that this had not impacted on the transfer of the case to Area Office White.

AO: OK and you don't believe that that relationship as you have described had an adverse impact upon the speed with which the transfer was processed?

FSO Five: Unless it meant that she wasn't bringing particular information to me at particular times. That may have occurred but it didn't impede me…just getting on with what was my job.

201 See section 7.9.3.

I should also mention that FSO Five expressed the following concerns about the lack of training given to Managers and Team Leaders within DOF. She said:

> From my perspective one of the huge lacks as well in the department is the incoming FSOs get induction training but team leaders and managers get no formalised training. So if people have not come up through the ranks a lot of that stuff they don't know and just have to go about their daily stuff just trying to find out verbally by asking someone else. **There are very very poor systems in place just generally. There are very few clear guidelines about processes and procedures.**

As I mentioned in section 7.9.1 of this report, the policy dealing with transfers provides little guidance to officers.

FSO One made the following submissions in response to my comments about the transfer of baby Kate's child protection matter.

She:

- agreed with my comment that a period of 46 days was an 'inordinate amount of time to transfer either case management or case-work responsibility' and suggested that FSO Five should have 'verbally' transferred case-work;
- claimed that she informed FSO Five that she did not think that the foster mother's request that she continue as the case-worker was 'satisfactory or reasonable' and that she was 'not comfortable in continuing to manage the case from such as distance'. Specifically, FSO One submitted 'I am unable to explain why she [FSO Five] failed to act on my behalf or my concerns at this stage and initiate further processes to complete the transfer then, or why she failed to document my concerns';
- reiterated the claims she made to my officers when interviewed[202] that she 'continually asked' FSO Five for the case to be transferred and that FSO Five did not give the matter 'priority';
- maintained that FSO Five never asked her for a transfer summary and that she was only asked to complete the initial assessment and she reported back to FSO Five when that was completed;
- claimed that she telephoned the Intake Officer at Area Office White on 3 September 2001 and asked her 'to conduct a home visit' with Lisa and baby Kate at Fernbrook;[203] and
- aid 'I fully support the principle of a comprehensive transfer summary, however, there are many instances where the nature of the case, or the needs of the child are best met in the interim by a verbal handover'…[including] instances where the family have moved and things were initially stable, but subsequently deteriorate thereby requiring a direct and immediate response, as was the case here'.

As I have previously mentioned, FSO Five chose not to make any submissions in response to my provisional report.

FSO One's response has not caused me to alter any of the opinions I formed in relation to the transfer of baby Kate's child protection matter. I remain of the view that case management or case-work responsibility should have been transferred earlier.

7.10 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

7.10.1 The failure of Area Office Green to transfer case management or case-work responsibility to Area Office White meant that Lisa had no face to face contact with an FSO while she was at Fernbrook and no FSO directly observed how Lisa was coping in her care of baby Kate.

7.10.2 FSO One's assessment of Lisa's progress in learning to care for baby Kate while at Fernbrook was based on inadequate feedback, namely her telephone calls to Lisa and two calls to the Fernbrook Intake Officer.

7.10.3 In the circumstances of the case, and its categorisation as a priority one matter, case management or case-work responsibility should have been transferred earlier.

202 See section 7.9.3.

203 The DOF Intake Officer at Area Office White has no recollection of this request and there is no record of such a request being made in the contemporaneous note that she made of her telephone conversation with FSO One.

7.10.4 DOF's existing policies and procedures for transferring child protection matters are inadequate because they do not clearly outline:

7.10.4.1 the process for transferring a child protection matter between area offices;

7.10.4.2 the forms required to effect a transfer;

7.10.4.3 the time frame for effecting a transfer; and

7.10.4.4 the responsibilities of the original case-worker and of the sending and receiving managers and/or team leaders.

7.10.5 DOF officers interviewed had a mistaken belief that the existing policy provided that case-workers had a period of up to three months to transfer a case even if a family had 'settled' in a new area much earlier.

7.10.6 DOF failed to provide FSO Five with any training that would have assisted her to make decisions, as an Acting Team Leader, about how the transfer of baby Kate's case should have been approached.

7.11 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

7.11.1 DOF review its existing policies and procedures in relation to the transfer of case-work and case management responsibility with a view to developing a comprehensive policy that addresses the deficiencies I have identified.

7.11.2 The policy should include a standardised transfer summary for officers to complete to ensure that the receiving office has accurate and timely information concerning the family that it will be working with.

7.11.3 DOF provide appropriate training to all relevant staff once the policy has been developed.

7.11.4 DOF investigate the claim that transfers are generally not accorded appropriate priority and, in some cases, refused or deliberately delayed by the receiving office, by:

7.11.4.1 auditing a sample of transferred cases; and

7.11.4.2 consulting with Managers and/or Team Leaders.

7.12 DOF's response to recommendations and Ombudsman's comments

7.12.1 DOF's response

DOF provided the following responses to recommendations 7.11.1 to 7.11.4.

Recommendation 7.11.1 – Endorsed

Response/Action to date

The Department's Executive Management Committee approved the policy and procedure on 'Transfer of case management and casework responsibility' in June 2003 for immediate implementation.

The new policy and procedure is a comprehensive document that clearly describes processes of case management, case co-ordination, case work responsibility, negotiation of case transfer and transfer of case management including interstate transfers of Child Protection Orders and proceedings.

The policy provides for casework responsibility to be temporarily given to another office without the transfer of case management responsibility. There is a range of circumstances outlined in the policy when this action is justified.

This policy will be reviewed in December 2003.

Recommendation 7.11.2 – Endorsed

Response/Action to date

The policy and procedure on 'Transfer of case management and casework responsibility' approved in June 2003 outlines a range of requirements for the transfer of case management responsibility to proceed. These requirements include both practice responses and various types of case recording, **including a case transfer summary, if requested by the receiving office.** [emphasis added]

The policy outlines a range of documents to be completed before case management transfer can occur. The purpose of this is to ensure that the receiving office has full and current information on the family.

The adequacy of this documentation will be included with the policy review in December 2003.

Recommendation 7.11.3 – Endorsed

Response/Action to date

The policy and procedure on 'Transfer of case management and casework responsibility' provides key principles, procedural guidance and a framework for professional decision-making to manage the transfer process effectively.

Comprehensive risk assessment and the application of Section 5 of the Child Protection Act 1999 are the critical aspects that underpin effective transfer processes.

As outlined in the response to 6.8.1, the Department of Families acknowledges the need for training regarding risk assessment and decision-making and is currently preparing a proposal seeking additional resources for a comprehensive professional practice and learning and development infrastructure for service delivery staff. This proposal will be informed by recommendations arising from internal and external reviews.

Recommendation 7.11.4 – Endorsed

Response/Action to date

The Collaborative Area Office reviews will commence in August 2003 and information about delays in case transfers will be targeted for specific review.

The Collaborative Area Office process is a mechanism that will ensure a much better quality of decision -making than has been the case in the past. The reviews will monitor, validate and evaluate professional decision-making. The Collaborative Area Office Reviews involve a number of phases including:

- The area office will undertake a process of self-assessment.
- An external review team from the Quality Assurance Unit will visit area offices for approximately five days to seek additional information to expand on that obtained from the self-assessment and also to quality assure work practices.
- The Quality Assurance unit will write a 'Collaborative Area Office Review Report' about the Office's performance.
- The Area Office Manager will write an improvement plan for the Office based on key themes highlighted in the 'Collaborative Area Office Review Report'.
- This will form the basis for the subsequent Collaborative Area Office Reviews.

In addition, the case transfer policy will be reviewed in December 2003 where information regarding priority or delaying of transfers will be examined.

The new ICMS will also provide the opportunity to electronically record the details of a client at the closest source, once only. It will also mean that any officer who deals with the same client will have the full profile of details about that client to support decision-making. The ICMS will be accessible from all work locations by all FSOs, and client records will be automatically available should a client transfer from one Area Office to another.

7.12.2 Ombudsman comment

I have reviewed the policy called the 'Transfer of case management and casework responsibility' (the Transfer Policy) that DOF advised, in its response to recommendations 7.11.1 and 7.11.2, was implemented in June 2003.

I note that the policy is generally the same as the policy and procedure that was previously outlined in chapter 27 of the Manual. The only significant difference appears to be the requirements for the 'transfer of case management responsibility' contained in section 5 of the policy which says:

> The following requirements are attended to, for the transfer of case management responsibility:
>
> - an agreement regarding when the transfer is to take place;
> - the completion and filing of case notes;
> - the completion and filing of departmental records, including Child Protection Notifications and corresponding Investigation and Assessment reports;
> - a recent/current Case Discussion Meeting and corresponding Assessment of Protective Needs Report;
> - a recent/current Family Meeting and corresponding Planning Statement;
> - a recent/current Placement Meeting and corresponding Placement Agreement, including clarification regarding Child Related Costs;
> - **the completion of a Case Transfer Summary, if requested by the receiving Area Office;** [emphasis added]
> - (where not already attended to through one of the above-mentioned meetings) an introductory visit/contact between the incoming departmental officers and the child/young person, parents and carer (facilitated by the outgoing departmental officer); and
> - the transfer of electronic and hard copy files.

While I am satisfied that the policy now clarifies what administrative matters must be attended to in order to transfer case management, it provides that a transfer summary should only be completed 'if requested by the receiving Office'. As stated in section 7.9.3.1 of my report, I am of the view that the provision of a 'reasonably detailed transfer summary' is necessary to 'ensure that a new case-worker has adequate, accurate and timely information concerning the relevant family'. Accordingly, I do not believe that such a summary should only be completed if requested. Good practice requires that a transfer summary be completed in every case where case management responsibility is transferred. A transfer summary may also be necessary where significant case-work responsibility is transferred.

8 Record keeping

'Adequate recording is part of and indicative of good practice. It can also be an aid to developing an understanding of what is happening within the individual, family or community with which the social worker is engaged.' [204]

The complainant alleged that most of DOF's records regarding its management of baby Kate's case were not made contemporaneously but after her death.

8.1 Case management documents

Table 4 is a summary of the documents contained in CPIS. The table records the date of the event or action that each record relates to, the date the document was actually created in CPIS and the period between the two dates. **The Table shows that the majority of DOF's records were created in CPIS on 11 and 12 September 2001. Baby Kate died on the evening of 10 September 2001.**

Table 4

Summary of records in CPIS

Document description in CPIS	Date of event	Date of creation of record in CPIS	Days elapsed[205]
Notification	10 July 2001[206]	25 July 2001	15 days
Initial Assessment	10 July 2001	13 August 2001	34 days
Case Note – SCAN meeting	12 July 2001	12 September 2001	61 days
Case Note – Home visit	17 July 2001	11 September 2001	56 days
Case Note – Phone call	18 July 2001	11 September 2001	55 days
Case Note – Lisa and baby Kate to residential facility	20 July 2001	11 September 2001	53 days
Case Note – Phone call to residential facility	24 July 2001	11 September 2001	49 days
Case Note – Lisa and baby Kate to Brisbane	26 July 2001	11 September 2001	47 days
Case Note – Scan meeting	26 July 2001	11 September 2001	47 days
Case Note – Phone call to Lisa	01 August 2001	11 September 2001	42 days
Case Note – Fax from foster mother	07 August 2001	11 September 2001	34 days
Case Note – Email from foster mother	09 August 2001	10 September 2001	32 days
Case Note – Phone call Fernbrook	12 August 2001	11 September 2001	30 days
Case Note – Report from a hospital[207]	14 August 2001	11 September 2001	28 days
Case Note – Email from foster mother	16 August 2001	10 September 2001	26 days
Case Note – Email from foster mother	20 August 2001	10 September 2001	22 days
Case Note – Phone call to Fernbrook	20 August 2001	11 September 2001	22 days
Case Note – Phone call to Lisa	21 August 2001	11 September 2001	21 days
Case Note – Phone call to Fernbrook	28 August 2001	10 September 2001	13 days
Case Note – Phone call Area Office White	03 September 2001	12 September 2001	9 days
Case Note – Email foster mother	03 September 2001	10 September 2001	7 days
Case Note – Discussion re transfer with FSO Five	10 September 2001	12 September 2001	2 days

204 P. Swain, In the Shadow of the Law: The Legal Context of Social Work Practice, The Federation Press, Leichhardt, 1995. p. 252.
205 Calendar days.
206 The correct date of the notification was 9 July 2001 – see section 8.2.1 of this report.
207 A medical assessment in respect of baby Kate – not conducted at either Hospitals White or Green.

Table 4 shows that:

- None of the 22 case management documents in CPIS was created contemporaneously in CPIS with the event they describe.
- There was an initial delay of 15 days in the notification being recorded in CPIS following its receipt.
- There was a delay of 34[208] days in recording the details of the initial assessment of baby Kate's circumstances in CPIS.
- Five of the 22 case notes were created in CPIS on the morning of 10 September 2001 (baby Kate died that evening).
- The other fifteen case notes in CPIS were created on 11 and 12 September 2001.

8.2 Inconsistencies

8.2.1 The date of the notification

When a decision is made that information received about a child constitutes a notification, the Manual requires[209] an officer to 'complete the notification record **immediately** the information has been received and the decision made that it is a child protection notification' and to 'record all allegations exactly as stated' (by the notifier). The officer is then required to forward the notification to the Team Leader or Manager for review or approval of the decision to notify. None of these procedures was adhered to in baby Kate's case. [emphasis added]

As I mentioned earlier, CPIS records an electronic audit trail (in the top left hand corner) of the date and time that a document is created in the system. Baby Kate's notification was not created in CPIS until 25 July 2001. The entry indicates that the notification was **received** on 10 July 2001 at 10:00am and was submitted to FSO One's supervisor for **approval** on 6 August 2001, nearly one month after it had been received.

Furthermore, the information contained in FSO One's handwritten notes about the telephone conversation she had with the Paediatrician is inconsistent with the information eventually recorded in CPIS. The handwritten record is **not dated**, is very brief and appears to have been written on a piece of scrap paper. In her submission in response to my provisional report, FSO One claimed that the handwritten note I have described was not the note that she made upon intake but her own 'brief notes' about families that she was working with at the time. She claimed that she would have recorded the intake on an 'Intake Form' and then transferred the information to CPIS. However, FSO One did not retain a copy of the completed 'Intake Form' that she claims to have used.

The failure to create contemporaneous and reasonably comprehensive records has the potential to create significant problems and embarrassment for any public agency, especially one involved with sensitive child protection issues. For example, during my Office's investigation, relevant DOF officers even disagreed about the date baby Kate's notification was received.

According to the notification record contained in CPIS, the notification was received at 10:00am on 10 July 2001, which was a Tuesday. However, the Paediatrician clearly recalls making the notification on the Monday morning after Lisa and baby Kate were admitted to the hospital, which was 9 July 2001. There is a notation in baby Kate's medical chart on 9 July 2001 stating 'Family Services notified', which supports the Paediatrician's recollection.

During the taped interview, the Manager (of Area Office Green) said that the FSOs commenced the initial assessment **the day after the notification was received**. The Manager has provided copies of her 'Supervision Notes' for FSO One dated 9 July 2001 which summarise FSO One's cases as at that date. The notes include reference to baby Kate's notification.

When asked by my officers about this inconsistency, FSO One suggested that the intake may have been received from the Paediatrician on the Monday but the information was not assessed to constitute a notification until the Tuesday. The 'date of receipt' field in the notification in CPIS is clearly intended for recording the actual date that the information is *received* not the date the information is *assessed*.

208 FSO One has submitted that the Initial Assessment screen in CPIS was not sent to her by her supervisor for completion until 13 August 2001 and that only a supervisor can create an initial assessment screen.

209 Chapter 5 of the Child Protection Procedures Manual.

Overall, the evidence suggests to me that the notification was received from the Paediatrician on Monday 9 July 2001 and the date 10 July 2001, recorded in CPIS some two weeks later, was an error. The Director-General, the internal review officer and others were given this inaccurate information. FSO One has since conceded that the date recorded in CPIS was incorrect.

8.2.2 Accuracy of the initial assessment record

As Table 4 shows, there was a 34 day delay in the initial assessment record being created in CPIS.

The Manual provides[210] that after an initial assessment has been completed, the details of the interviews and other actions taken in the course of the assessment and the decisions reached must be documented. This procedure was not followed in the present case.

The initial assessment record in CPIS contains only brief information about the interviews with Lisa and John at Hospital Green on 10 and 11 July 2001 respectively. Examination of the material has identified that the following actions/contacts that occurred as part of the initial assessment were not recorded in CPIS:

- Telephone conversation with Lisa's foster mother (recorded in a handwritten note dated 11 July 2001). In the note, FSO One has written, among other things, that the foster mother **'fears that Lisa won't or can't understand the consequence of not caring for the baby – feels not capable of caring for the baby – learning and retaining skills to care for the baby – functions as a 13-14 year old – cigarettes will come before anything'.** [emphasis added]
- Any telephone or other conversation the FSOs had with, or feedback they received from, staff at Hospital Green, including the Paediatrician. The Paediatrician advised my officers that she was in telephone contact with FSO One during the initial assessment phase.
- The visit by FSOs Two and Three to Hospital Green on 16 July 2001, for the purpose of finalising the initial assessment, and the reasons for the decision to release baby Kate into Lisa's and John's care.

The initial assessment record does not disclose the reasons for the decision to release baby Kate into Lisa's and John's care. When interviewed, FSO Two was not able to recall exactly what occurred on 16 July 2001, whom she spoke with at Hospital Green, and the reasons for that particular decision.

Furthermore, the brief handwritten notes taken by FSO Three do not provide a sufficient basis for the opinion, recorded in his notes, that there were 'minimal risks' for baby Kate in returning home. FSO Three recorded the details of his attendance at Hospital Green as follows:

- dad interacted appropriately with child – very natural
- dad has good support for baby (at home)
- dad has room ready for child to return to
- organised for mum and child to stay (near Hospital Green) one more night before going home
- mum and dad co-operative with department workers
- baby sighted – healthy and well
- assessed that there are minimal risks for baby to return home.

These handwritten notes fail to record, as required by the Manual:[211]

- the source of the information relied upon
- facts rather than personal opinions
- evidence to support the opinion there were 'minimal risks'.

The initial assessment record in CPIS did not comply with the Manual because it was neither an accurate nor a comprehensive record of the interviews and other actions taken in the course of the assessment and of the reasons for the decisions.

As I mentioned in section 6.6.1, FSO Two submitted that she was not in a position to input data in the initial assessment in CPIS because she was the 'seconder' for the initial assessment. However, I am of the view that was not her role when she attended Hospital Green on 16 July 2001 and completed the initial assessment in FSO One's absence.

210 Chapter 16 of the Child Protection Procedures Manual.
211 Section 27.7.

8.2.3 Public Records Act and the Information Standards

In the interests of accountability, both the *Public Records Act 2002*[212] and good administrative practice require that public agencies make and keep 'full and accurate records'. At the relevant time,[213] the *Libraries and Archives Act 1988* was in force and placed an identical obligation upon agencies to make and keep 'full and accurate records'.[214]

In addition to this legislative requirement, Information Standards[215] are issued under section 7(1)(b) of the *Public Records Act* which provides that an agency must have regard to any relevant policy, standard and guidelines made by the Archivist about the making and keeping of public records. The Executive Officer of the agency is responsible for ensuring the agency complies with this section of the Act. The Information Standards apply to all Queensland government agencies. The Standards incorporate the rules and recommended practice with regard to the management of Queensland government information sources.

Although these particular Standards were not in place at the relevant time, I refer to them here to bring them to notice of DOF officers for the purpose of future record keeping.

Information Standards 40 – *Record Keeping,*[216] 41 – *Managing Technology Dependent Records* and 31 – *Retention and Disposal of Government Information* are part of the whole-of-government record keeping framework. The framework has been developed for the purpose of improving the standard and consistency of government record keeping throughout Queensland. **Each public authority is responsible for implementing Information Standards**.

Information Standard 40 provides that for a record to be regarded as 'full and accurate', it must be created, captured, adequate, complete, meaningful, accurate, authentic, inviolate,[217] accessible, useable, retained and preserved. An 'accurate record' is defined to be a record that:

> correctly reflects what was communicated, decided or done (or not done). That is, the record's content, context and structure can be trusted as a true and accurate representation of the transactions, activities or facts that they document and can be depended upon in the course of subsequent use.

Information Standard 24 – *Policies for Management of Government Information Within Government* outlines the principles by which government information in the Queensland public sector is to be managed, in order that the maximum benefit can be derived from the information resource. The principles have been developed to provide a framework for agencies to adapt to their own specific needs.

This Standard describes the essential characteristics and attributes of well-managed, good quality data or information as follows:

Characteristics	Attributes
Accessible	Both findable and retrievable, and accessible in the required form.
Accurate	Corresponds to the reality it represents and is free of errors and omissions and is not misleading.
Auditable	Managed and documented in such a way that it can be audited.
Complete	Includes all the user needs to know about the situation and satisfies operational and management needs.
Compliant	Complies with relevant legislation and standards, for example the *Freedom of Information Act 1992*, *Judicial Review Act 1991*, *Criminal Law (Rehabilitation of Offenders) Act 1986*, *Information Standards, Financial Administration and Audit Act 1977* and *Financial Management Standard 1997*, and any others which may apply.
Concise	Does not include elements that are not needed.
Consistent	Can be cross-related, summarised and consolidated with confidence.
Current	As up-to-date as possible, or as required.
Effective	Collected and stored for one or more specific purposes, and meets the prescribed need.
Flexible/co-ordinated	Structured so that it can be adapted to meet new or changed requirements.
Precise	Of the appropriate degree of exactness or scale.
Relevant	Has direct bearing on the decision-making situation.
Secure	Processes are in place to ensure that data is not corrupted or misappropriated and is accessible only to those who are authorised to view or update it.
Timely	Information is available when required.

212 Part 7 commenced on 24 April 2002 and the remaining provisions commenced 1 July 2002 and repealed the Library and Archives Act 1988.
213 10 July 2001 to 10 September 2001.
214 Section 52(1) of the Libraries and Archives Act 1988.
215 Queensland State Archives is responsible for developing, leading and co-ordinating whole-of-government record keeping strategies.
216 The Standard was approved on 4 November 2001.
217 Inviolate records are time-bound and complete. To be inviolate, a record must be securely maintained to prevent alteration and unauthorised removal.

Information Standard 24 further identifies the benefits of sound information practices and well managed information to include (in part):

- improved decision-making through better quality of information;
- improved efficiencies and responsiveness to external information requests, for example FOI requests or Ministerials;
- improved accessibility to information and data, resulting in better opportunities for sharing information both internally (within an agency) and externally (with other agencies);
- greater consistency, thereby facilitating integration of information from various sources; and
- improved knowledge to form the basis for responses to situations requiring evidence of actions.

The Information Standard suggests that the inefficient use of information resources within an agency, resulting from poor information management practices, is likely to have the following outcomes (in part):

- valuable information is collected, but is inaccessible to potential users;
- information is destroyed before it has reached the end of its useful life or in breach of legal or administrative requirements;
- methods of collection, storage, retrieval and analysis are inefficient;
- information is inconsistent/inaccurate, which could have FOI implications;
- poor decision-making capability;
- high agency and government costs;
- slower or incomplete responses to requests for information; and
- a poor image of the agency.

8.2.4 Characteristics and attributes of DOF's records

As the evidence shows, most of the records in CPIS about the case were not created contemporaneously with the events they record but were created weeks and in some cases months later. In fact, the majority of the records were created after baby Kate died. FSO One acknowledged that baby Kate's death was the catalyst for her creating records in CPIS on 11 and 12 September 2001. When interviewed, FSO One said:

> When Kate died I was informed quite late at night by the Acting Manager. **The next day, of course, the priority then is everything must be up (to date). Your name was going to be in the internal review.** Rather than digging through thousands of files I was asked to put the case notes etc on the system as soon as possible.

The accuracy of records created in these circumstances was open to challenge because:

(a) FSO One created the CPIS records long after the events to which they related; and

(b) At the time she completed them, she believed her management of the case would be the subject of internal review, thus giving rise to the perception that she may have recorded versions of the events that showed her management of the case in a favourable light.

The need for a reasonable degree of contemporaneity in record making is obvious. The greater the time between an event and the creation of a record of the event, 'the greater is the likelihood of memory loss or distortion of recall, so that the resulting record can become neither complete nor accurate'.[218]

My officers asked FSO One what contemporaneous written records, if any, she relied upon when inputting the data in CPIS. She explained that the material was, more than likely, derived from her handwritten notes contained in her notebook or written on loose pieces of paper (which would be located on the hard copy file, unless she had inputted the data in CPIS, in which case she would have destroyed them). FSO One also said **'I acknowledge that sometimes you're really that snowed under that you don't write anything down, it's in your head.'**

A comparison of some of the CPIS entries (made by FSO One after baby Kate died) with the source documents on which they were purportedly based is shown in Table 5. To some extent, the comparison supports the point I make in paragraph (b) above.

218 P. Swain, In the Shadow of the Law: The Legal Context of Social Work Practice, The Federation Press, New South Wales, 1995, p.247.

Table 5

Comparison of handwritten notes and CPIS data

Handwritten note	CPIS entry	Location of note
Example 1		
Phone call to foster mother Willing to collect Lisa and Kate and keep them **until Riverton available.** Will care for them again in the interim between Riverton and whatever is next e.g. Fatima. [emphasis added]	**Case Note – Lisa and baby Kate to Brisbane 26 July 2001** Spoke to foster mother re: Lisa and Kate coming down to Brisbane tomorrow. She stated that was fine and she would keep them **until an appropriate alternative** could be located. [emphasis added]	Loose piece of paper on DOF hard copy file
Example 2		
3:45 All okay	**Case Note – Phone call to group home 24 July 2001** House mother reports that all is going well. Lisa is in good spirits and has demonstrated that she is capable of caring for Kate. The only problem seems to be that Lisa is reluctant to get up to Kate in the night for feeding. House mother has informed Lisa that she is reporting back to the department and this could be a concern if it continues. House mother also stated that sometimes in the morning Lisa needs a bit of a 'shove' to fix Kate if Lisa is playing on the Nintendo, **but there are no significant concerns regarding Lisa's care of Kate.** [emphasis added]	FSO One's note book
Example 3		
Fernbrook 24/7 staff 80 Mum 10 bub 20-week security refunded at end of stay. Foster mother taking Lisa and baby to Fernbrook today. Will remain in touch with Lisa and Department. Yahoo.	**Case Note – Phone call Fernbrook 12 August 2001** The Intake Officer informed me that they are an organisation who has dealt with a number of young mothers who have disabilities. She stated that Fernbrook provides supported live in accommodation for mothers and babies with living and parenting skills programs included.… Part of their role is to assist with independent accommodation when the time comes and this could also be supported through other agencies. The Intake Officer stated that they have a number of workers on site during the day and a worker was there overnight on call for mothers who had concerns. She stated that they would be able to have Lisa and they were made aware that she has an intellectual impairment and a medical condition which requires medication.	FSO One's note book

I make the following observations about the information contained in this table.

- **Example One:** The handwritten note states the foster mother was willing for Lisa and baby Kate to stay with her 'until Riverton is available'. However, the case note in CPIS created after baby Kate's death does not mention Riverton but states that they would stay with Lisa's foster mother until 'an appropriate alternative could be located'.
- **Example Two:** The CPIS entry was made 49 days after the telephone conversation to which it refers. When my officers asked FSO One to explain the detailed entry in CPIS, she responded as follows:

  The confusion is coming in because often times I work out of two books. One is like a daily log which is everything that I do. There's another one that is just case notes. So this one here [referring to the note 'all okay'] for instance is a daily log book which is obviously what this has come out of. So it wouldn't have the full case note in there. **The case note itself would be located in whatever case note book I was using at the time...It could be on a piece of paper or could've been on a desk pad.**
- **Example Three:** As I have already mentioned,[219] the Fernbrook intake officer claims that she was never informed at intake that Lisa has an intellectual impairment and a certain medical condition. The accuracy of the entry in CPIS is open to challenge because it was made 30 days after the telephone conversation occurred, and after baby Kate had died, and is not consistent with the entry in the notebook.

In her response to my provisional report, FSO One made the following submissions:

> …I do not disagree that the manual notes were transferred to CPIS on the dates stated above, however, I maintain that they were made contemporaneously in handwritten form prior to this.
>
> …your insinuation that I attempted to sanitise my recollections, the department's records or any other documents by making false or misleading entries anywhere or at any time is a blatant insult to my integrity, my work ethic and to myself as a person.
>
> I would like to point out that it would be almost humanly impossible to take notes 'word-for-word under any circumstances and that normal practice is for FSOs (including myself) to record the relevant points of a conversation/discussion and expand on this in the final document.
>
> According to DOF Code of Conduct and professional practice, FSOs are expected to document truthful accounts and I maintain that this is exactly what I did in all instances pertaining to my case notes both manual and those on CPIS.

8.2.4.1 Reasons for the delay

At interview, FSO One offered 'work load pressures' as the primary reason for not inputting the data into CPIS in a timely manner.

A delay in recording important information about the management of a case almost inevitably means the record eventually created is neither accurate nor comprehensive. This was the case here.

A review of the case material reveals that it did not constitute a complete and accurate record of the various case management decisions and actions taken. Therefore, it would have been impossible for another DOF officer, including a Manager or Team Leader, by reviewing CPIS and the hard copy file, to identify what decisions and actions had been taken, the reasons for them and the status of the matter.

Good record keeping is an essential feature of good administrative practice generally and is the responsibility of both the case officer and the supervisor. Timely record making is essential to good record making. As one author in this field has pointed out, contemporaneous record keeping 'is a practice skill which necessitates support from agency management to ensure that time is available for (officers) to maintain their recording.' [220]

219 See section 7.5.1.
220 P. Swain, In the Shadow of the Law: The Legal Context of Social Work Practice, The Federation Press, New South Wales, 1995, p.246

My officers explored this issue when they interviewed FSO Five who was the Acting Team Leader at the relevant time:

AO: Were you aware that the case notes in relation to this matter were not up to date on the child protection information system at the time Kate died?

FSO Five: Not up to date on the electronic system. Generally, yes, I would have been because on that morning I had accessed the system to commence the transfer and was aware of what documents were recorded on the system.

AO: Is that a usual phenomenon in Area Office Green – that the child protection information system is not current, is not currently up to date with all of the records that need to be put on?

FSO Five: That's correct. That's a resource issue – people don't have time – they are busy doing it, not recording it.

AO: Do you know how far people are behind?

FSO Five: I think some people have got books and books of case notes that go back years.

In this regard, I should point out that in her response to my provisional report, FSO Two said:

> My experience, since the introduction of computers and the electronic case system, is that this has created extra volumes or work, i.e. everything should be entered on the case system. The expectation in an Area Office is that the FSO types all their work into the system. As caseloads have also increased so has the workload of officers. At the same time there has developed volumes of work to be placed on the computer system by FSOs. The practice in Area Office Green has been to deal with the human need and place the typing of information in a priority. Notifications, intakes, and the Case Management documents of Family Meetings and Placement meetings are the priorities. Case Notes continue to be an issue.

8.2.5 Audit of Area Office Green

As a result of this information, my officers made inquiries within Area Office Green to determine how widespread the problem was within that office. DOF was asked to provide a list of all current files from which my officers randomly selected 38 for the purpose of the audit.

Of those 38 files:

- 15 appeared complete and up to date on CPIS.
- 7 were one week behind with the officers stating that they expected to have the files up to date within one week.
- 4 were one month behind with the officers stating that they expected that it would be at least another month before the files were up to date on CPIS.
- 3 were two months behind with the officers stating that they expected it would be at least two months before they could have the files up to date on CPIS.
- 2 were three months behind with the officers also stating that they expected it would be at least two months before they could have the files up to date on CPIS.
- 7 were more than three months behind with officers stating that they expected it would take longer than three months before they could have the files up to date on CPIS.

To summarise, 23 of the 38 files were not up to date on CPIS. Of significant concern is the fact that 16 of the 38 files (or 42%) were at least one month behind on CPIS and nine of those files (or 23%) were at least three months behind.

These statistics paint an unsatisfactory picture of the record keeping practices in Area Office Green. However, it is unlikely that this problem is peculiar to Area Office Green. Indeed, the DOF officers interviewed, some of whom had worked in other area offices, suggested that poor record keeping is a chronic and systemic problem, to varying degrees, throughout all DOF offices in Queensland.

What these statistics do highlight is that FSO One was not the only officer in Area Office Green with poor recording keeping practices.

However, in my view, workload pressures were not the only cause of the unsatisfactory state of the records in baby Kate's case. The making of records and how they were made were haphazard and inconsistent. My officers observed that:

- Each of the officers interviewed in relation to this case had their own filing system. Some used a combination of systems. It was not uncommon for notes to be recorded on loose pieces of paper, on desk pads, on the cardboard cover of files, in day books, personal diaries and the like. Quite often, there was no record of significant events. In most cases, the notes did not find their way to the hard copy file maintained by DOF, which was just a correspondence file. As a result, DOF was unable to supply my Office with a complete copy of its records for the case. Even during interview, DOF officers produced original case records to my officers, copies of which had not been provided by DOF.
- In some cases, there were no file notes about important case management planning decisions or actions and the reason for those decisions or actions.
- In most cases, there were no file notes of meetings, discussions and telephone conversations relevant to case management and planning issues, making it difficult for officers to recall with any accuracy whom they spoke to, what they spoke about and when.

Officers said they did not have access to electronic recording equipment, such as digital recorders, for use in making contemporaneous file notes while engaged in field work. Digital recorders are readily available with the capacity to download stored information in the form of sound files into a computer. Field notes recorded and stored in this medium would only be transcribed if the need arose.

DOF officers also complained that there was little administrative support available to assist with general administrative work including the typing of notes and court documents. They said that they had to do most of this work themselves.

Several DOF officers told my officers that record keeping standards are not being monitored by management. All described work practices that relied heavily on verbal communication. Some officers made the point that they were 'verbal people', because their background and training was in social work not administration.

The Manager, Acting Manager and Acting Team Leader all conceded that from a supervisory perspective, their only means of effectively reviewing an officer's work in relation to a particular matter was to personally interview that officer. These work practices must lead to significant case management difficulties when FSOs become ill, take leave, resign or retire on short notice or are transferred. In such circumstances, DOF is exposed to considerable risk, potential embarrassment and perhaps legal liability if something goes wrong.

QPS also relies upon the accuracy of CPIS when investigating the sudden unexplained death of a child.

In its response to my provisional report DOF advised me that:

> The Department has targeted the development of a new Integrated Client Management System (ICMS) for child protection and youth justice.
>
> In particular, **the ICMS has been targeted to respond to the gross inadequacies of the existing Child Protection Information System (CPIS)** in terms of recording and accessing relevant data to support client decision-making. [emphasis added] The ICMS will mean that client data will be entered at the closest source once only and that authorised officers can access this data from any location across the state. Current practices of storing data in local systems will cease and the emphasis on hardcopy files as being the main source of information to support decision-making will be replaced. The ICMS will provide automatic alerts and prompts, supported by appropriate business rules, to escalate issues for resolution by relevant decision-makers.

8.3 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

8.3.1 The record keeping by DOF in relation to baby Kate's case was not of a satisfactory standard for the following reasons:

8.3.1.1 CPIS records relating to the notification and the initial assessment were not created immediately after relevant information was received (as required by the Manual).

8.3.1.2 Other significant information relevant to case management was not recorded in CPIS in a reasonably contemporaneous manner.

8.3.1.3 CPIS records were not comprehensive and some significant telephone conversations, meetings, decisions and actions were not recorded at all.

8.3.1.4 No uniform system was used for making case notes.

8.3.1.5 Case-work files were incomplete and contained some records that were inaccurate.

8.3.1.6 Some documents were filed out of chronological order.

8.3.1.7 Some documents were maintained externally to the DOF file.

8.3.1.8 FSO One's supervisors did not effectively supervise her record keeping practices.

8.3.2 The results of the audit of case records in Area Office Green undertaken by my officers indicate that the record keeping deficiencies identified in baby Kate's case may be a systemic problem within that office.

8.4 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

8.4.1 DOF undertake a statewide audit of record keeping practices in its offices to determine whether the record keeping deficiencies identified in Area Office Green also exist in those offices.

8.4.2 DOF review whether present resourcing is sufficient to enable officers to maintain appropriate records and if not, provide administrative or other support to assist officers in the performance of this obligation.

8.4.3 DOF develop and implement consistent procedures for record keeping in order to eliminate the multiple systems presently used by officers.

8.4.4 DOF provide training on proper record keeping procedures to officers in Area Office Green and officers in other offices identified in the audit as having inadequate record keeping practices.

8.4.5 DOF investigate the use of digital recording devices to assist officers to record contemporaneous file notes while engaged in fieldwork.

8.5 DOF's response to recommendations and Ombudsman's comments

8.5.1 DOF's response

DOF advised that it had 'noted' recommendations 8.4.1 and 8.4.2 and had 'endorsed' recommendations 8.4.3 to 8.4.5.

DOF's response to recommendations 8.4.1 and 8.4.2 together with my comments appear in section 8.5.2.

DOF's responses to recommendations 8.4.3 to 8.4.5 are set out in full at Appendix N. However, relevant extracts follow:

The Department recognises that there is a legacy of poor information management as highlighted by this case.

The Child Protection Information System is often described as being 'user vicious' and does not have credibility with many staff. As a result, a number of alternative systems have been developed to overcome this legacy.

This is highly problematic and means that information may be recorded in a variety of places. Further, the implication is that the Department of Families cannot assess accurate or historical data quickly.

The Department was allocated funds of $12M over four years in the 2002-03 Budget for better tools and practices. In delivering better tools and practices, a number of strategies are currently being progressed including:

- **Integrated Client Management System**

  The Department has targeted the renewal of its current information technology systems and infrastructure to respond to the demand to provide accurate and current integrated information for decision-making, reporting, performance measurement, and analysis and monitoring purposes. In particular, the Department has targeted the development of a new Integrated Client Management System (ICMS) for child protection and youth justice.

  The planning and development for the new ICMS commenced at the beginning of the 2002-03 financial year. This has included business process mapping, the development of the business information architecture and the design of business and system specifications, all of which have formed the basis of a tender document for the new ICMS for release to the information industry.

  Mapping the current baseline processes for child protection and youth justice has meant that the Department can look for ways to improve work practices that are supported by responsive and flexible business information systems.

  The ICMS specifications were released as a Request for Information (RFI) to the information industry on 6 June 2003. The Department is currently evaluating the responses and plans to shortlist successful suppliers who will then be invited to respond to a Request for Offer, planned for release in early October 2003.

- **Regional Systems Support Officers**

  The Department also appointed 15 Regional Systems Support Officers (RSSO) who are attached to the 11 Regional Offices in 2002. These officers work with Family Services Officers to assist in the recording of case notes and to improve data entry quality. The RSSOs will play a pivotal role in the release of the new ICMS including change management and training.

- **Better tools trials**

  Trialling of voice to text translation technologies using a remote device (PCEphone) and the PC desktop has been undertaken to assess business benefits and systems design features.

  These technologies have been targeted specifically to assess the benefits in terms of reducing data entry as well as providing remote access to client information.

  A number of area offices have taken part in the trialling of voice to text translation on the desktop, whilst targeted area offices have provided feedback on the demonstration of the remote advice, which accessed an external service provider for voice to text translation services.

  The learning from these trials have been integrated into the business specification for the ICMS and it is expected that the Department will be well positioned to evaluate and integrate new technology solutions, as part of the new ICMS, to support Family Services Officers in their tasks and activities.

- **Information Gathering Record**

  In April 2003, the Department of Families introduced the 'Information Gathering Record' to streamline recording on a statewide basis. This document is used to contemporaneously record observations and responses to allegations of harm when undertaking an initial assessment. Following the interviews this document is referred to when the initial assessment report is recorded on the Child Protection Information System (CPIS). The document is then retained on the child's file.

- **Child Protection Throughput Measures**

  The Department has recently commenced a specially designed performance-reporting framework for area offices. Each area office will report against ten measures and be able to view their performance against the performance of other area offices and the State average. The identified performance measures will drive change particularly in relation to record keeping. These measures include:

  - monthly finalisation rate by area office, for initial assessments (cases not being finalised until they are entered onto CPIS);
  - proportion of children in care whose case plans have been reviewed within six months;
  - distinct children re-substantiated within 3, 6 and 12 months;
  - placement stability;
  - open child protection follow-up cases by area office; and
  - indigenous children placed in accordance with the Aboriginal Child Placement Principle.

- **Records Management**

  A further requirement for the Department is to develop and implement an Operational Record Keeping Implementation Plan (ORIP). Completion of the ORIP is planned for August 2003.

  Following the endorsement of this Plan, records keeping best practice procedures will be developed for implementation by all staff (December 2003). A training program will be launched to assist staff to implement these procedures and a monitoring program developed. This will target the multiplicity of systems used to manage records.

8.5.2 Ombudsman comment

In its response to my recommendation at 8.4.1 that DOF undertake a statewide audit of record keeping practices in its offices, DOF said that 'a State-wide audit of record keeping practices would only flag what is already known to the Department of Families – that there are record keeping deficiencies across the State'. Therefore, DOF advised that it 'will implement the learnings from the current review undertaken by the Queensland Ombudsman' and the current audit of foster carers and the Collaborative Area Office Reviews.

While I acknowledge the impact that the Collaborative Area Office Reviews will have in the long-term, it will be a considerable amount of time before the problems in individual DOF Area Offices are identified. The audit undertaken by my officers in this case was limited to one particular DOF Area Office, that is Area Office Green. In my view, in order to identify all of the deficiencies in current record keeping systems and practices within DOF Area Offices, a wider and thorough audit is necessary.

Therefore, I do not accept DOF's response that an audit will only flag what is already known about its record keeping practices.

In relation to my recommendation at 8.4.2 that DOF review whether present resourcing is sufficient to enable officers to maintain appropriate records, DOF advised that 'the issue of the adequacy of resources is a matter for Government'. However, the point I was making was that DOF needed to consider whether present resources were being effectively utilised. For example, the DOF officers interviewed advised that they received limited support from administrative staff with the preparation of documents such as affidavits or with general filing.

9 The child death review

***'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.'*[221]**

As part of my preliminary inquiries, I asked DOF to provide me with a copy of the Child Death Review undertaken in relation to its management of baby Kate's case. The review was undertaken in accordance with the 'Child Death Review Policy' (the Policy) which came into effect on 19 September 2001, nine days after baby Kate's death, and replaced the procedures contained in PM05/17 – 'Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons'.

9.1 The level of review

As I have already explained,[222] the policy provides for two levels of review depending on the circumstances in which a child dies. A Level 1 review is completed by a Child Death Review Team lead by an appropriately qualified person external to DOF and a Level 2 review is completed as an internal review by an officer from within DOF.

I asked DOF to explain how the decision was made to complete a Level 2 review in this case. In response, DOF said:[223]

> The Deputy Director-General made the decision to conduct a Level 2 child death review on 14 September 2001 under the policy criteria 'other circumstances as determined by the Director-General or Deputy Director-General'. In making the decision, **the Deputy Director-General took into account the particular circumstances of the case including the fact that the mother was living with the baby in a supported environment.** [emphasis added]

The provision of the policy relied on by the Deputy Director-General in exercising the discretion to order that a Level 2 child death review be conducted reads as follows:

> A Level 2 Child Death Review will be applicable in the following circumstance:
>
> - accidental death.
>
> A Level 2 Review may also be conducted in the following circumstances:
>
> - Category 1 incidents[224] that do not involve deaths;
> - Category 2 incidents; and
> - **other circumstances, as determined by the Director-General or Deputy Director-General.** [emphasis added]

In a briefing note dated 12 September 2001, prepared by the Acting Manager at Area Office Green, the Deputy Director-General was given the following information concerning the circumstances of the case.

- Baby Kate was born in Hospital Green on 1 July 2001. The mother, Lisa and the baby were then transferred to the hospital in her home town. Lisa was the subject to a child protection order as a child and has a mild intellectual disability.
- A child protection notification was received on 10 July 2001 after Lisa was observed to shake her baby. There were also concerns that the baby was vulnerable due to Lisa's limited learning abilities and that the father of the baby, John was unable to support Lisa due to issues of alcohol abuse. Baby Kate and Lisa moved to the children's ward of Hospital Green for observation. John joined them for the weekend. The reports of their care of the baby were positive. The outcome of the initial assessment was substantiated risk of neglect and physical harm and a child protection follow up case was opened.

221 Victorian Child Death Review Committee, Department of Human Services, Annual Report of Inquiries into Child Deaths: Child Protection, Victoria, 2002, p. ii.
222 See section 3.1.3.
223 Letter dated 6 February 2003.
224 Incidents are defined as either category 1 or category 2 incident in accordance with the 'Reporting of Deaths, Serious Incidents and Missing Persons. Policy and Procedures'. The death of a DOF client is a category 1 incident.

- The family returned to their home on 16 July 2001 with a support plan involving home visits by the Family Services Officer and Child Health. Lisa was also supported by her previous foster carer by telephone.
- On 20 July 2001, Lisa contacted Area Office Green requesting assistance as John was abusing alcohol and not offering support in her care of the baby. Lisa indicated that she wished to learn to parent the baby by herself.
- On 25 July 2001 Lisa and baby Kate travelled by train to reside with the foster carer until an alternative placement could be arranged. Lisa indicated her ongoing commitment to learn to care for her baby. The foster mother reported positively about Lisa's care of baby Kate.
- On 13 August 2001 Lisa and baby Kate moved to Fernbrook which is a supervised residential facility for young mothers to learn parenting skills with daytime programs and overnight supervision. Positive reports of her care of Kate were received although there were concerns about Lisa's ability to care for Kate in the long term. Whilst at Fernbrook, Lisa appropriately utilised Fernbrook staff if she was experiencing any difficulties with the baby or was feeling stressed.
- The case was discussed at SCAN on 12 and 26 July 2001. FSO One established a close supportive relationship with Lisa and maintained regular contact after her move to Brisbane.
- Transfer had been negotiated with Area Office White.
- **An autopsy on 11 September 2001 confirmed Sudden Infant Death Syndrome (SIDS) as the cause of death.** [emphasis added]

At this point, I should mention that I have ascertained that DOF was not aware of the information in Lisa's statement to the QPS, including her statement that she had placed baby Kate to sleep on her stomach and covered her head with a blanket and two jumpers.

The Incident Report Form, which was also provided to the Deputy Director-General and which had been completed by DOF's Crisis Care on the evening of baby Kate's death, stated:

> 'Police advised Crisis Care that at the time of the child's death she had 3–4 blankets on her'.

The incident report did not state whether or not the blankets were covering baby Kate's head.

In my view, the briefing note is misleading in two respects. Firstly, it stated that 'an autopsy on 11 September 2001 confirmed SIDS as the cause of death'. This was not correct. The death certificate issued on 11 September 2001 showed the cause of death as 'not yet determined pending test results'. The final autopsy finding of SIDS was recorded in an amendment to the death certificate made on 24 October 2001 (nine days after the child death review had been completed).

DOF did not obtain a copy of baby Kate's death certificate for the purpose of its internal review. The review had already been completed when I first wrote to DOF making preliminary inquiries under section 22 of the *Ombudsman Act*. DOF advised that it was unable to confirm how the cause of death had been recorded. In my view, the death certificate should have been obtained as soon as possible during the internal review.

Secondly, the statement in the briefing note that Fernbrook is a 'supervised residential facility for young mothers to learn parenting skills with daytime programs and overnight supervision' was misleading. This conveyed the impression it was a suitable facility for Lisa's needs. It was not suitable because of the limited nature of the supervision provided. The Manager of Fernbrook agrees. The use of the term 'overnight supervision' implies that Lisa was being directly supervised in her care of baby Kate. This was not the case. As I have already pointed out,[225] Fernbrook is essentially a hostel for homeless women and their children. Lisa had her own private room and was not supervised to the extent her parenting ability warranted.

In response to my provisional report, the Acting Manager advised that the (former) Manager was actually in Area Office Green on the morning after baby Kate died, in her capacity as a Senior Practitioner, and that she compiled the briefing note with assistance from FSO One. She said the information that SIDS was the cause of death was given to FSO One by an officer from the QPS and subsequently communicated by FSO One to her and the Manager. FSO One also provided them with the information about Fernbrook. It is likely that the

225 See section 7.3.

Manager may have taken the information about Fernbrook directly from the case note in CPIS, which FSO One had created on the morning of 11 September 2001, the day after baby Kate died.[226] In her submissions in response to my provisional report, the Acting Manager stated that she checked the briefing note and 'accepts responsibility for it leaving the office' but said 'the information [in the briefing note] was the information that the Area Office had at the time and was not meant to be misleading'.

In any event, at the time of making her decision, the Deputy Director-General had been advised that baby Kate had died from SIDS. Given this advice, the policy suggests that a Level 1 review, by a Child Death Review Team lead by person external to DOF was warranted.

The Policy states:

> A Level 1 Child Death Review is indicated when a child client's death relates to one or more of the following circumstances:
>
> **...SIDS deaths where there have been previous contacts with the department relating to the neglect or physical abuse of a child.**

I raised this issue in my letter to DOF dated 7 January 2003, as follows:

> On 24 October 2001, an amended post-mortem certificate was issued for baby Kate with the cause of death being recorded as Sudden Infant Death Syndrome (SIDS). The policy (Child Death Review Policy) provides for a Level 1 Child Death Review to be undertaken in the circumstances of a SIDS death where there has been previous contact with the DOF relating to the neglect or physical abuse of a child. 'Neglect' is the recorded category of harm in relation to baby Kate. **In accordance with the policy, should a Level 1 Child Death Review have been undertaken in this case? If not, please explain why?**

In response, DOF said:[227]

> The policy is worded that a Level 1 Child Death Review is indicated when a child client's death relates to a SIDS death where there has been previous contact with the Departing relating to the neglect and physical abuse of a child. **The policy wording is 'indicated' rather than required.**
>
> The decision made by the Deputy Director-General, in the context of the operationalisation of the new 'Child Death Policy and Procedures', was that a Level 2 review would occur. **The policy allows for a Level 2 review in other circumstances and the Deputy Director-General determined that this was required, given the particular circumstances of this case.** [emphasis added]

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. In such cases, the review process has greater credibility if conducted by a suitably qualified independent practitioner.

In the 'Introduction' section of her review report, the review officer noted that, as at the date of the review, a final autopsy report had not been completed and she had been advised that the initial finding was 'unexplained death'.

The policy does not provide what level of review should be undertaken by DOF in circumstances where a child's death is *unexplained*. Therefore, I asked DOF to explain how it determined the level of the review to be carried out if the cause of death is *unexplained* or *indeterminate*.

By letter dated 6 February 2003, DOF advised:

> The Child Death Review Policy sets out the criteria for the decision regarding the level of review. The purpose of a review is to examine the practice and system issues that may have impacted on the situation

226 See Part 8 of this report – Record keeping.
227 Letter dated 6 February 2003.

related to the child who has subsequently died. The review is not focused specifically on the circumstances of the death of the child.

Where the cause of death is not known or indeterminate immediately following the death, the decision regarding review will still occur. The decision will take into account:

- the factors related to the death and known at the time;
- other factors, such as current departmental involvement, previous history with the child or the child's family and the level or extent of departmental involvement.

9.1.1 Baby Kate's child death review

In baby Kate's case, a Level 2 review was completed by a senior practitioner (the internal review officer) from within DOF but external to Area Office Green. The Acting Regional Director emailed the internal review officer on 13 September 2001 and requested that she undertake the review. Apart from this email, the internal review officer was given no further direction or instructions regarding the review. According to the internal review officer's records, she commenced the review on or about 24 September 2001. She advised my officers that she carried out the review in addition to her normal duties. The review was completed on 15 October 2001.

The terms of reference for the review were as defined in the policy:[228]

1. Determine whether current departmental procedures were adhered to and whether the current procedures were adequate in the situation.
2. Determine if there were factors that may have contributed to the child death related to individual judgment or decision-making.
3. Investigate whether systemic issues have impacted upon the nature of services to the child and/or family.
4. Investigate other case specific issues as directed by the Director-General.
5. Make recommendations in relation to departmental practice and procedures, any further actions required in relation to departmental services and any issues that need to be brought to the attention of other agencies.

The internal review officer provided the following information to my officers:

- She has a Bachelor of Arts with a major in welfare.
- She is currently a DOF Senior Practitioner.
- She has worked for DOF since 1992 in various positions from FSO to Acting Regional Director.
- She had only conducted one other child death review.
- She had received no specific training from DOF in relation to conducting child death reviews.
- Baby Kate's review was completed in accordance with the terms of reference prescribed in the policy.
- The review report was written in accordance with the 'Guidelines for Child Death Reports' prescribed in the policy.[229]

While the internal review officer was relatively inexperienced in terms of conducting child death reviews, she was otherwise appropriately qualified to conduct baby Kate's review from a child protection perspective.

The internal review officer also provided my officers with a copy of a document entitled 'Child Death & Category 1 & 2 Reviews – Level 2 Response Framework and Procedures' and indicated that she had referred to this document for guidance when conducting baby Kate's review.

A copy of this document had not previously been given to my Office when I asked DOF to provide a copy of all of its child death review policies and procedures. My officers subsequently queried DOF about the status of the document. In a letter dated 31 March 2003, DOF advised that the document was a 'draft document prepared in mid 2001 to facilitate discussions regarding the response framework. The draft document was never progressed and was subsequently superseded by the child death review policy implemented on 19 September 2001'.

228 See Appendix B for a copy of the Child Death Review Policy and Procedures.
229 See Appendix B for a copy of the Child Death Review Policy and Procedures.

9.1.1.1 Findings and recommendations of the child death review

A full copy of the review report is attached at Appendix M.

The internal review officer identified seven key issues in her review report. They were:

- The *Child Protection Act* requires that departmental staff engage with families on the **least intrusive level** possible while maintaining the safety of the child. Area Office Green staff have demonstrated commitment to this principle by providing an opportunity for Lisa to demonstrate her ability to parent baby Kate in supportive environments. [emphasis added]
- The initial concerns raised by hospital staff that baby Kate had been shaken were investigated thoroughly and resulted in Lisa identifying that she became stressed when baby Kate was unsettled and also that Lisa would require assistance, particularly while baby Kate required night feeds. There were no subsequent reports of any physical harm occurring to baby Kate.
- The opening of a Child Protection Follow Up case in response to the identified risk of harm reflected Lisa's willingness to work with the department. She had developed a positive relationship with the case-worker and demonstrated her ability to recognise when she was becoming stressed and to seek assistance.
- While scarcity of resources is an ongoing issue for departmental Area Offices, it appears that in this case, sufficient time was allowed for the case-worker to build and maintain a positive working relationship with Lisa. This initially occurred via home visits to Lisa's and John's house and subsequently via maintaining contact with those providing support and care for Lisa and baby Kate.
- Consideration was given to placement at Riverton and Fatima. A key issue with Riverton was that the program offered a five-day[230] stay for observation and assessment with no follow-up accommodation. Fatima had a 22-week waiting period. Lisa's foster parents had advised that her foster father had a heart condition and requested that alternative placement options be explored as a matter of urgency. Discussion with various Brisbane based agencies resulted in a verbal referral to Fernbrook. Lisa and her foster mother visited the facility and agreed on the placement.[231]
- A key issue in assessing safety for baby Kate was the extent to which Lisa's disability would inhibit her ability to parent her child. At various stages, this risk assessment was made in conjunction with SCAN, Child Health, and staff from the local residential home and Fernbrook. All feedback indicated that Lisa was able to care for baby Kate with heavy supervision and any risk to baby Kate appeared to be of a long-term nature. It was envisaged that placement in Fernbrook would determine the extent to which Lisa would be able to learn parenting skills to match baby Kate's developments.
- Transfer of this case had not occurred at the time of baby Kate's death.

The internal review officer made five recommendations. DOF has advised that it considered these recommendations and developed an Action Plan to give effect to them. On 12 May 2003, my officers asked DOF to advise what action had been taken to implement the recommendations. The recommendations and DOF's response of 2 June 2003 (in full) follows:

> **Recommendation 1: When referrals are made to SCAN which involve clients with a disability, a representative from Disability Services Queensland be co-opted to the SCAN Team. This would increase the team's capacity to make informed decisions about the likelihood of future harm.**
>
> **This recommendation was referred to the Coordinating Committee on Child Abuse (CCOCA) Child Deaths sub-committee on 20 May 2003 for consideration.** [emphasis added] CCOCA is to write to all relevant SCAN Team members to reiterate that SCAN Team members already have the capacity to co-opt relevant persons from other agencies to participate in SCAN Team meetings and discussions about a particular case or number of cases. The circumstances to co-opt members are:

230 The IPEP at Riverton is a 12 day program – see section 3.2.2 of this report.
231 The foster mother inspected Fernbrook with Lisa on 12 August 2001. On 19 August 2001, she sent an email to FSO One expressing concerns about the 'benefit of the placement at Fernbrook' and said 'we fail to understand the purpose of her being there'. She asked FSO One to make 'inquiries' with Fernbrook and find out what it provided.

- To enhance assessment of a particular case through a person's direct knowledge of a specific child or family
- When particular expertise is required to supplement the expertise of core members and
- When a child is an Aboriginal or Torres Strait Islander.

The internal review officer formulated the above recommendation on 15 October 2001. The Action Plan to give effect to the recommendations was developed on 19 November 2002. However, the recommendation was **not referred** to CCOCA in accordance with the Action Plan until 20 May 2003, 19 months after the recommendation was made, six months after the Action Plan was approved and eight days **after** my officers asked DOF to advise what action had been taken to implement the recommendation. It is apparent that DOF did not accord the recommendation any priority.

Recommendation 2: Area Office Green develop strategies for enhancing their knowledge about disability issues and incorporate Disability Services Queensland in case discussions and case planning. Given the level of diagnosed disability for departmental clients, an increased knowledge of disability issues is essential for all Area Offices. A professional development workshop, which explored the issues of Baby Kate's case, could provide an initial forum for this to occur.

On 24 July 2002, an initial workshop was conducted by Disability Services Queensland for staff in Area Office Green. A further workshop is to occur on 24 July 2003 to train new staff and upgrade training for existing staff. These workshops are to be conducted annually.

The Department of Families and Disability Services Queensland in Area Office Green have formed a local Child Protection and Disability Planning Group and developed a referral process that includes a Foundation Agreement covering:

- Children with disability in care program
- Transition funding
- Case collaboration
- Professional development and information sharing and
- Service development

This group meets on a bi-monthly basis. To date there have been no referrals via this process. To address this, the local area office is to initiate contact with Disability Services Queensland to confirm the referral process through the Child Protection and Disability Planning Group.

I am unclear why this recommendation and subsequent Action Plan were limited to Area Office Green. The recommendation was clearly relevant to all DOF offices and was capable of a general application.

Recommendation 3: Departmental policy and procedure regarding the management of Child Protection Follow Up cases is addressed in the current review.

The Child Protection Branch is currently in the process of developing a policy in relation to Child Protection Follow Up cases. On 5 November 2001 a copy of this child death review was forwarded by the region to the Child Protection Branch to be considered as part of the policy development process. This policy will be completed and implemented by 1 July 2003.

Recommendation 4: Departmental Area Office rely heavily on community agencies to provide direct service to departmental clients. It is recommended that consideration be given to the development of a standardised referral process including documentation which outlines an agreed case plan, identifies roles and responsibilities and communications processes.

A review of triennial service agreements will take place in September/October 2003. The learning from this review will assist in identifying whether standardised referral forms are required and clarity around the roles and responsibilities of funded services and departmental staff in referring to these services.

The local area office referral form and procedure is considered adequate. The referral procedure is to be reviewed on an ongoing basis. The current review of the procedure form is to be completed on 31 July 2003.

Recommendation 5: When community capacity building issues are being considered, it is recommended that specific needs of 'at risk' parents are taken into account. The lack of residential facilities, particularly in regional areas, results in parents such as Lisa and John having very limited opportunity to demonstrate their ability to acquire skills to safely parent their children.

On 5 November 2001 a copy of this recommendation was forwarded by the regional office to their regional social planner, and the Executive Director, Policy Directorate, for consideration and inclusion in future planning and funding of services and facilities in regional and remote locations.

An across Queensland Government Strategic Framework for Child Protection is currently being developed. The Framework will be accompanied by an Action Plan that sets out the specific initiatives that government agencies will commit to implementing over the next four years.

The Framework for the Action Plan has been developed by the Department of Families in collaboration with 14 Queensland Government agencies in recognition that holistic responses to the complex needs of clients can best be achieved through cross government collaboration and co-operation. The Framework's aim is to achieve better outcomes for children and young people who have been significantly harmed or at risk of harm.

One of the strategic directions in the framework relates to increasing the focus on prevention and early intervention, which includes increasing the knowledge, skills resources and support to parents and communities to ensure the safety and well being of their children and young people. Initiatives are currently being considered.

9.1.1.2 Adequacy of the child death review

The Director-General of DOF advised me in a letter dated 14 March 2002 that the child death review conducted in baby Kate's case found that 'No negligence had occurred in relation to the management of the case by departmental staff'. This conclusion is essentially an interpretation of the review report because this statement does not actually appear within the report itself.

However, my investigation has identified significant maladministration by DOF, most of which was not referred to by the internal review officer.

In my opinion, the internal review that was conducted in baby Kate's case was inadequate as it failed to critically examine the basis on which decisions were made about her care and well being. I have formed this opinion for the following reasons.

Terms of reference

The internal review officer failed to adequately address the terms of reference. In particular, she failed to thoroughly investigate and evaluate the following individual case management decisions:

- the adequacy of the risk assessment that was conducted;
- the decision to refer Lisa and baby Kate to Fernbrook and not Riverton, in accordance with the case plan agreed to by SCAN;
- the failure to refer the case to a Brisbane based SCAN Team; and
- the timeliness of the transfer of case management or case-work responsibility to Area Office White.

Interviews undertaken

The internal review officer failed to interview witnesses relevant to the review of DOF's case management decisions and actions. In particular, she did not interview:

- any QH staff including staff at Hospital Green and at Riverton;
- FSOs Two, Three, Four and Five;
- any Fernbrook staff; and
- the foster mother.

Documents obtained

The internal review officer failed to obtain access to all relevant documents, in particular:

- Lisa's files held by DOF concerning her history with DOF;
- medical records;
- diaries and/or field notes maintained externally to the DOF file by FSOs One, Two and Three;
- the Manager's and Acting Team Leader's supervision notes concerning baby Kate's case; and
- baby Kate's death certificate.

Record keeping

The internal review officer failed to identify the significant deficiencies I have noted earlier in relation to the record keeping in baby Kate's case. [232]

9.2 Analysis of the child death review system in Queensland

9.2.1 The statistics

The evidence that I have gathered in this case has caused me to consider the appropriateness of the present Queensland model for conducting child death reviews. The policy itself appears capable of multiple interpretations.

The December 2002 'Interim Report from the Child Protection Think Tank to the Director-General of DOF' said that:[233]

> There is also growing concern about the number of child deaths where there has been prior departmental involvement with the child, young person or their family and the need to analyse the circumstances surrounding departmental involvement. For the period 1 January 1999 to 29 July 2002, 75 children and young people between the ages of 0-17 were recorded as having died where either they or their family were recorded as having prior contact with the Department. Of these deaths, 27 occurred in the 12-month period 1 July 2001 to 30 June 2002.

The Interim Report provides the following analysis of the causes of death of those 75 children:

- 17 from an accident
- 14 from non-accidental injury
- 10 from suicide
- 15 from SIDS
- 7 from natural causes
- 12 from causes that had not been determined.

DOF has advised that, since the policy was implemented on 19 September 2001, 16 Level 1 and Level 2 reviews have been completed into the deaths of children the subject of intervention by DOF. Table 6 shows the cause of death identified in those 16 cases.

Table 6

Child death review statistics

Category	Level 1	Level 2
Suicide	2	0
Non-accidental	2	1
Sudden unexplained death[234]	0	2
Accidental death	2	2
Natural causes	0	2
Not yet determined	2	1

232 See Part 8 – Record keeping.
233 DOF 'Interim Report of the Child Protection Think Tank to the Director-General' 2002, pp. 2-3 <www.families.qld.gov.au>.
234 DOF advised that baby Kate's death was included in the category of 'sudden unexplained death'.

9.2.2 The Coroners Act 2003

The *Coroners Act 2003* was assented to on 9 April 2003. It provides the legislative framework for the modernisation and co-ordination of the Queensland coronial system and establishes the position of a State Coroner. Not all provisions have yet commenced.[235] Deaths that must be reported to the State Coroner are defined as 'reportable deaths'.[236] A 'death in care' is an example of a reportable death. The Act further provides that a person's death is a 'death in care' if, 'when the person died, the person was a child placed in the care of a licensed care service, approved foster carer, or other person under section 82 of the *Child Protection Act*'.

Baby Kate's death was not a death in care as defined.

Similarly, DOF has advised that of the 15 child deaths that have occurred since the policy was implemented, none of those children had been placed in the care of a licensed care service, approved foster carer or other person under section 82 of the *Child Protection Act*.

The *Coroners Act 2003* provides that the following other categories of death must be reported:

- deaths where it is not known who the person is;
- violent or otherwise unnatural deaths. Examples include deaths as a consequence of trauma, drowning, poisoning, asphyxia, or electrocution;
- deaths that happen in suspicious circumstances;
- deaths that were not reasonably expected to be the outcome of a health procedure;
- deaths in custody;
- deaths where a cause of death certificate has not been issued and is unlikely to be issued; and
- deaths of people not been seen by a doctor in the previous three months (the three month rule).

The Attorney-General will also be able to direct that any death, whether or not reportable under the Act, should be investigated by a Coroner.

It would therefore seem that whether or not a death will be captured as a reportable death will depend upon, in the majority of cases involving children known to DOF, whether the circumstances of those deaths could be described as either violent, unnatural or suspicious. In baby Kate's case it should be remembered that the QPS categorised baby Kate's death in the Form 4 as 'non-suspicious'. However, even if a death is reported, it does not mean that an inquest will be held into that death.[237]

9.2.3 The need for a consistent and transparent process

It is vital that the public has confidence in the child protection system and, in particular, the child death review process. In my view, only a consistent and transparent process for conducting child death reviews will achieve this. To this end, I have considered the following questions in relation to the deaths of children known to DOF:

- Should a body external to DOF investigate, or review the investigation of, such deaths?
- Should such investigations and reviews have a legislative basis?
- Should the body responsible for investigating or reviewing those deaths report annually to Parliament on its work?

In considering these questions I have examined two interstate models for child death reviews. One of those is statutorily based, the other operates within a policy framework. Both models have considerable merit.

9.2.4 Coordinating Committee on Child Abuse (CCOCA)

CCOCA was established by the Queensland government in 1978 to co-ordinate the activities of government departments and agencies in relation to child abuse and neglect.

The SCAN Team concept was initiated by CCOCA in 1980. It has an ongoing role in the review and supervision of the SCAN Team system.

CCOCA comprises representatives from QPS, QH, DOF, Education Queensland and the Department of Justice and Attorney-General.

235 The amendment of the District Court of Queensland Act 1967 as specified in schedule 1 of the Coroners Act 2003 commenced on 1 May 2003. The remaining provisions will commence on a day to be fixed by proclamation.
236 Section 8 of the Coroner's Act 2003.
237 Section 28 of the Coroner's Act 2003.

Its functions include:

- providing advice to the Minister for Families on matters relating to child abuse and neglect and on SCAN Team operations;
- other functions relating to SCAN Teams;
- providing a forum for the relevant government agencies to discuss and develop policy to ensure co-ordination of the child protection responses of the agencies involved in the investigation and management of child protection cases;
- to monitor statistics provided by SCAN Teams and CPIS on cases referred to SCAN Teams and to identify trends; and
- to encourage appropriate child protection notifications by publishing and disseminating relevant material.

As mentioned earlier,[238] child death reviews are undertaken as internal or external reviews by DOF. DOF's Child Death Review Policy and Procedures[239] states:

> A non-identifying copy of the child death review report will be submitted to the Chair of the CCOCA sub-committee on child deaths to enable them to provide trend data to the Department and other relevant agencies in relation to child deaths.

The Child Death Review sub-committee was established by CCOCA in March 1992. However, I understand that the terms of reference for the sub-committee are presently under review.

9.2.5 Commission for Children and Young People (CCYP)

The CCYP is established under the *Commission for Children and Young People Act 2000* which commenced on 2 February 2001. It was originally established in 1996 by the *Children's Commissioner and Children Services Appeals Tribunal Act 1996*.

The CCYP is an independent statutory authority. Administrative responsibility for the CCYP now lies with the Department of the Premier and Cabinet.

The CCYP has both complaints investigation and advocacy functions. Its key functions include:[240]

- receiving and investigating complaints about services provided to children by government and non-government service providers;
- advocating for the rights, interests and well being of children and young people;
- undertaking a statewide community visitor program for children and young people in out-of-home care including those in detention centres, mental health facilities and out-of-home residential care;
- monitoring and reviewing laws, policies and practices relating to children and young people;
- employment screening of persons in specific categories of child-related employment;
- establishing youth and other expert advisory committees for advice about specific issues relating to children and young people; and
- conducting research into issues impacting upon children and young people.

Considering the primary role of the CCYP in promoting the rights, interests and well being of children, it is surprising the Commissioner of the CCYP is not a member of CCOCA.

DOF's Child Death Review Policy states:

> A non-identifying summary of all child deaths will be provided to the Commission for Children and Young People on a regular basis.

238 See section 3.1.3.
239 This policy operated until the commencement on 21 August 2003 of the 'Review Policy and Procedure following the Death of a Child or Young Person'.
240 Section 15 of the Commission for Children and Young People Act.

9.3 Models for child death reviews

Victoria and New South Wales are the only two States in Australia that have adopted child death review or inquiry processes involving an external review committee.

9.3.1 Victorian Child Death Review Committee

In 1985, the Victorian Department of Human Services (DHS) introduced a process for reviewing deaths of children and young persons who had been the subject of child protection interventions. In 1995, the Victorian government established the Victorian Child Death Review Committee (VCDRC) to externally review child death inquiry reports prepared by DHS and provide advice to the Minister regarding common themes and patterns that may require departmental attention.

The VCDRC reviews the investigative reports (called 'case practice reviews') for all deaths of children who were current or recent (within three months of case closure) clients of child protection services. The case practice review is conducted within 45 days of a client death to establish the facts of the case and determine whether departmental standards, guidelines and protocols were followed in the management of the case. An officer of the department who is not associated with the region where the death occurred undertakes the review. The VCDRC considers all case practice reviews, and reports to the Minister in accordance with its terms of reference.

The VCDRC is a multi-disciplinary committee comprised of members from health, welfare, police, legal and academic fields and appointed by the Minister for a period of three years. The inquiry process relies on the voluntary participation of workers, community agencies and families of the deceased child, and participation in this process is reportedly high.

9.3.2The New South Wales Child Death Review Team and New South Wales Ombudsman

In 1990, the Physical Abuse and Neglect of Children (PANOC) Committee identified the 'lack of a central review mechanism in situations where a child suffers physical injury or dies'. The PANOC Committee recommended that the New South Wales (NSW) government establish an 'independent review mechanism' to examine cases where a child has been injured, or has died and to recommend changes to policies, procedures, services and training accordingly.[241]

In 1993, the Child Death Review Committee (the Committee) of the NSW Child Protection Council was established. The Committee reviewed a sample of child deaths that had occurred in NSW between 1989 and 1991 and been identified as due to abuse or neglect. The Committee's objective was to 'determine the characteristics, causes and contributing factors' of the deaths in order to 'assess the effectiveness of existing policies and practices in dealing with them'.

In its report, Preventing Child Homicide, the Committee recommended that the NSW government establish a Child Death Review Committee to learn from the facts surrounding the deaths of children and use the findings to educate workers and inform policy and procedures across all areas of work to prevent future child deaths. The NSW Child Death Review Team (CDRT) was subsequently established and the Children (Care and Protection) Act 1995 (NSW) was amended to establish the role of the CDRT.

Until recently, the CDRT was responsible for monitoring trends in child deaths in NSW and making recommendations to promote children's safety and welfare. The CDRT maintained a register of all child deaths in NSW and reviewed deaths from child abuse, neglect or suspicious circumstances in detail. The CDRT made recommendations to Parliament about policies and practices to be implemented by government, private agencies and the community to help prevent child deaths. Each year the CDRT reported on deaths of children in the reporting year and provided a detailed report on certain categories of deaths. For example, in 1999-2000 the Annual Report included in-depth reviews of 22 child deaths due to abuse or neglect or that occurred in suspicious circumstances.

The CDRT is a multi-disciplinary team comprising individuals who have expertise in paediatrics and child health, forensic pathology, mental health and child protection. The CDRT also has nominees of state

241 NSW Child Death Review Team, New South Wales Commission for Children and Young People, 2001-2002 Report, 2001, Sydney, p. 2-3.

government agencies concerned with the safety and well being of children including the Department of Community Services (DOCS), the Police Service, Department of Health, Department of Education and Training, Attorney-General's Department and the Office of State Coroner. The NSW Commission for Children and Young People (CCYP) (established in June 1999) provides research, policy, secretariat and administrative support for the CDRT. The CCYP Commissioner is the team's Convenor.

In December 2002, the NSW Community Services Commission **(and its staff of approximately 40 officers)** was amalgamated with the NSW Ombudsman. The Community Services Commission was established in April 1994 as a complaints handling body for the community services sector in NSW. It also reviewed the situation of children, young people and people with disabilities in residential care and the death of people with disabilities in residential care.

As a result of the amalgamation, a new statutory division known as the Community Services Division has been established to carry out these functions in the Office of the NSW Ombudsman. The Division is headed by the Community and Disability Services Commissioner as Deputy Ombudsman. The Ombudsman now reviews the causes and patterns of the deaths of children in certain circumstances, including the death of children in care and children who had been notified to the Department of Community Services within three years of their death. The Ombudsman is also responsible for:[242]

- making recommendations about policies and practices that could prevent or reduce deaths;
- maintaining a register of reviewable deaths in NSW;
- conducting research focusing on strategies to reduce or remove risk factors associated with reviewable deaths that were preventable; and
- preparing an annual report to Parliament relating to reviewable deaths.

The CDRT no longer reviews the deaths of children and young people that are subject to review by the Ombudsman. The CDRT continues to maintain the Child Death Register and examine child deaths in NSW from all causes. The CDRT also conducts broader research in relation to child deaths.

9.3.3 Previous Queensland proposal for review

In 2001, the Queensland Commission for Children and Young People (CCYP) convened a series of meetings attended by representatives of various agencies with child protection responsibilities and appropriately qualified experts. These meetings resulted in a proposal that a Child Death and Serious Injury Prevention Team (the team) be established to make recommendations in relation to law, policies and practices to be implemented by government and non-government service providers and the community for the prevention and reduction of deaths and serious injuries of children under 18 years of age.

It was envisaged that the team be chaired by the Commissioner for Children and Young People and comprise representatives from Queensland government and non-government agencies.

The guiding principles underpinning the proposal were:

- The safety and well being of children in Queensland is the team's paramount concern and will be reflected in all decisions made by the team.
- The responsibility for responding to and preventing child deaths and serious injuries lies with the whole community and not any single agency.
- Co-ordination, co-operation and communication by agencies involved in any aspect of child protection and injury prevention is an imperative aspect of child death and serious injury prevention.
- Timely, accurate, comprehensive and standardised data are essential to develop effective research and policy development as well as community education and other preventative strategies.
- Government agencies providing services to children should continue to investigate their responses to the circumstances surrounding the death of a child for whom they are responsible.

It was suggested that the team would carry out the following functions:

- collate and analyse data of existing child death and serious injury review, investigation and research bodies to identify the underlying systemic issues that contribute to preventable child deaths and serious injuries;

242 NSW Ombudsman, Community Services Division, Fact Sheet no 3, 2002, <www.nswombo.nsw.gov.au>.

- use the information of the team to educate the community and inform laws, policies and practices; and
- liaise with, and work in collaboration with, existing child death and serious injury review, investigation and research bodies to inform its agenda and focus areas.

As with the NSW CDRT and the VCDRC, it was proposed that the team prepare an annual report containing recommendations.

The proposal was submitted to the Premier for approval, but in July 2001 the Director-General of the Department of the Premier and Cabinet advised that the Premier 'did not wish to proceed with a Child Death and Serious Injury Prevention Team at this time'.

9.4 Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act*, are as follows:

9.4.1 The briefing note prepared by the Acting Manager for the information of the Deputy Director-General was misleading because it incorrectly stated that:

9.4.1.1 a post-mortem on 11 September 2001 had confirmed SIDS as the cause of baby Kate's death.

9.4.1.2 Fernbrook provided 'overnight supervision'.

9.4.2 DOF's Child Death Review Policy is unclear because key terms are not defined and no guidance is given to exercising the discretion given in the policy under the heading 'Level 2 Child Death Reviews'. This creates the potential for inconsistency in decision-making on issues such as the level of review appropriate in SIDS deaths.

9.4.3 In all the circumstances of the case, a Level 1 review of baby Kate's death was called for.

9.4.4 The Deputy Director-General did not record the reasons for her decision that a Level 2 review be conducted.

9.4.5 The Level 2 child death review that was conducted was inadequate because, as particularised at 9.1.1.2, the internal review officer failed to:

9.4.5.1 adequately address the terms of reference;

9.4.5.2 interview all relevant witnesses;

9.4.5.3 obtain access to all relevant documents; and

9.4.5.4 identify significant deficiencies in DOF record keeping.

9.5 Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act*, that:

9.5.1 A body external to DOF monitor and review the investigation of the deaths of all children known to DOF and, unless another body is established for that purpose, the Child Death Review sub-committee of CCOCA carry out this role.

9.5.2 The Commissioner for Children and Young People be a full member of CCOCA and be the Chair of the Child Death Review sub-committee.

9.5.3 If another body is established to carry out the role specified in 9.5.1, the Commissioner for Children and Young People be the Chair of that body.

9.5.4 The State Coroner be a member of the Child Death Review sub-committee or other body established to carry out the role specified in 9.5.1.

9.5.5 The body that carries out the role specified in 9.5.1 be empowered to:

9.5.5.1 give directions to DOF that a child death review be conducted and about the type of review (internal or external) to be conducted;

9.5.5.2 approve persons as child death external reviewers and maintain a register of such persons;

9.5.5.3 appoint persons from the register to supervise the conduct of external reviews; and

9.5.5.4 make recommendations to the agencies with child protection responsibilities about policies and procedures that could prevent or reduce child deaths.

9.5.6 The Office of the Commissioner for Children and Young People provide administrative support to the body that carries out the role specified in 9.5.1.

9.5.7 The body that carries out the role specified in 9.5.1 report annually to Parliament in relation to child deaths that have been the subject of review.

9.5.8 That, pending the implementation of recommendation 9.5.1, DOF amend its new 'Review Policy Procedure following the Death of a Child or Young Person' to require that:

9.5.8.1 a copy of the report of each child death review be forwarded immediately upon completion to the Commissioner for Children and Young People and that such copies not be de-identified; and

9.5.8.2 the reasons for decisions about the type of review to be conducted be appropriately recorded in the official file.

9.6 DOF's response to recommendations and Ombudsman's comments

9.6.1 DOF's response

In response to my provisional report, DOF advised that it had 'noted' my provisional recommendations 9.5.1 to 9.5.5 that read:

9.5.1 A body external to DOF investigate, or review the investigation of, the deaths of all children known to DOF.

9.5.2 A committee be established comprising representatives from the Office of the Commissioner for Children and Young People, DOF, QH, QPS, the State Coroner and other appropriate experts to evaluate and make recommendations about the most suitable model for this body.

9.5.3 The Commissioner for Children and Young People be the chairperson of the committee and the Commissioner's Office provide administrative support to the committee.

9.5.4 DOF immediately review its policy entitled 'Child Death Review Policy and Procedures' to address the deficiencies identified in this report.

9.5.5 The reasons for the decisions about the level of review to be conducted be appropriately recorded in the official file.

DOF advised that provisional recommendations 9.5.1 to 9.5.3 were matters for Cabinet and therefore it would progress a submission to Cabinet to consider whether or not the recommendations should be accepted.

In relation to provisional recommendations 9.5.4 and 9.5.5, DOF 'noted' the recommendations and advised that it had commenced a review of the policy in late 2002 but 'decided not to progress it any further until the findings' from my report could be reviewed. Accordingly, DOF said it was now in a position to review its policy in light of my findings.

9.6.2 Ombudsman comment

Some time after my provisional report was sent to DOF, I received a copy of DOF's new policy titled 'Review Policy Procedure following the Death of a Child or Young Person' (316-2). Had this policy applied at the relevant time, an external review of baby Kate's death would have been conducted (clause 2.1 of policy) unless the Director-General had exercised his discretion[243] to decide that no review be conducted.

I note that the policy requires that any review be forwarded to the Director-General of DOF and then to the RSIC. The composition of the RSIC has not changed.[244] There is only one external representative on this committee, currently an officer from the Department of Corrective Services.

In relation to liaison with the Commissioner for Children and Young People, the policy states:[245]

> The department actively encourages collaboration and consultation with the Commission for Children and Young People.
>
> Non-identifying copies of child death case review reports will be forwarded to the Commission for Children and Young People on a regular basis.

As mentioned, the Commissioner's functions include the investigation of complaints and services provided to children by service providers.[246] The Commissioner may also commence investigations on her initiative in certain circumstances.[247]

Having regard to the Commissioner's statutory independence and primary role to take action to promote the rights, interests and well being of children, it is my view that she should be the Chair of any body established to monitor and review the investigation of deaths of children known to DOF. I have therefore amended my provisional recommendations accordingly.

243 Section 1 of the policy.
244 See section 3.1.3 of this report.
245 Section 8 of the policy.
246 Section 15(a) of the Commission for Children and Young People Act.
247 Section 37 of the Commission for Children and Young People Act.

10 Official misconduct and disciplinary action

10.1 Official misconduct

Under section 38 of the *Crime and Misconduct Act* I have a duty to notify the Crime and Misconduct Commission (CMC) if I suspect that a complaint, or information or matter, involves, or may involve, official misconduct.

Official misconduct is defined in section 15 of the *Crime and Misconduct Act* to mean work related conduct that could, if proved, be a criminal offence or a disciplinary breach providing reasonable grounds for termination of a person's services. The term 'conduct' is defined in section 14.

The evidence does not, in my opinion, give rise to any suspicion of official misconduct by a person involved in this case.

10.2 Disciplinary action

The grounds for disciplinary action against an officer are set out in section 87 of the *Public Service Act 1996*.

Section 87(1)(a) provides that an agency may discipline an officer if the agency is satisfied that the officer has performed duties carelessly, incompetently or inefficiently.

In disciplining an officer, an agency may take action that it considers reasonable in the circumstances ranging from reprimand at the lowest end of the scale to termination at the highest end.

As Ombudsman, I do not have the authority to discipline an officer. Only an employing agency is able to initiate such an action. However, I am able to provide a report to the principal officer of an agency, if I consider there is evidence of a breach of duty or misconduct on the part of an officer of the agency. [248]

I note that the internal review officer made no recommendation that disciplinary action be considered against any DOF officer. The Director-General agreed with this assessment.[249]

As indicated, my opinion is that several decisions made by FSO One, her supervisors and other officers in Area Office Green about the management of this case were wrong and/or unreasonable within the meaning of section 49(2) of the *Ombudsman Act*. In my opinion, these decisions were influenced, at least to some extent, by the officers' shared belief about how they should apply the so-called minimal intervention policy and their reluctance to separate Lisa and baby Kate. Their approach was endorsed by the internal review officer.

As I have explained, I believe too much emphasis was given to these considerations and insufficient emphasis to baby Kate's safety and well being. However, the correct application of the various principles contained in the *Child Protection Act* is a complex issue involving philosophical considerations in relation to which minds can differ. That is why I have referred the issue to CCOCA.

For these reasons, I am not in a position to form an opinion about whether or not the evidence could establish a breach of duty by any officer. However, I am aware that the Director-General's view (referred to above) was based substantially on the report of the internal review officer. I have formed the opinion that her investigation and report had serious deficiencies.

The Director-General did not have the benefit of the evidence summarised in my report. In these circumstances, it is a matter for him to assess whether the evidence now available to him warrants consideration of disciplinary action against any officer.

248 Section 50(2) of the Ombudsman Act.
249 Letter to me dated 14 March 2002.

11 Responses to the recommendations

11.1 Department of Families

DOF's response to my provisional report is set out in Appendix N.

11.2 Queensland Health

No maladministration was identified in relation to QH. However, a number of the recommendations I have made require consultation with QH. QH has agreed to co-operate with the relevant agencies to give effect to the relevant recommendations. QH's response to my provisional report is set out in Appendix O.

11.3 Queensland Police Service

The QPS response to my provisional report is set out in Appendix P.

12 Responses to adverse comments

The responses of the individual officers have been incorporated into the report at various points and have otherwise been summarised in Appendices Q, R, S and T.

13 Summary of opinions and recommendations

Observations on the role of the Queensland Police Service

4.3.1 The statement contained in the Form 4 that baby Kate's death was 'non suspicious' was both premature and unjustifiable and had the potential to mislead the Pathologist in circumstances where there was no clear explanation for the death.

4.3.2 The female Constable in making this statement in the form complied with the instructions in the footnote to the form.

4.3.3 The current form has the potential to mislead Pathologists and other persons / entities who investigate the sudden unexplained deaths of children.

4.3.4 The QPS did not advise the Pathologist of the results of the CPIS search before baby Kate's post-mortem examination commenced in accordance with section 7.14 of the QPS OPM.

4.3.5 The QPS should have provided the Pathologist with information obtained in the investigation potentially relevant to establishing the cause of death, including Lisa's statement, before the post-mortem was completed and the death certificate issued.

4.3.6 It is likely that the pathologist wrongly recorded SIDS as the cause of baby Kate's death instead of recording 'undetermined'.

4.3.7 There is presently no standardised QPS report that is used for notifying a pathologist of the findings of an investigation of the sudden unexplained death of a child.

Suggestions for improving administrative practice

4.4.1 In consultation with the Department of Justice and Attorney-General, take steps to ensure that sudden unexplained deaths of children are not described as 'non suspicious' in a Form 4 prior to the completion of the investigation.

4.4.2 Investigate if there are any systemic issues adversely impacting upon lines of communication between the QPS and pathologists as suggested by the communication failures in this instance.

4.4.3 In consultation with QH, develop and implement a standardised death scene investigation checklist (similar to the SUIDIRF[250] or the NSW Police checklist[251]) for the sudden unexplained deaths of children aged under two years and amend section 7.14 of the OPM as necessary. A copy of the checklist should be provided to the pathologist tasked with making a finding as to the cause of death.

4.4.4 QPS amend its OPM to require officers investigating the sudden unexplained death of children to advise the pathologist of any information obtained that may be relevant to the pathologist's finding as to the cause of death.

4.4.5 Review the current level of training provided to QPS officers concerning the procedures contained in section 7.14 of the OPM and, if necessary, take steps to ensure that all relevant QPS officers are aware of the nature of SIDS and the circumstances in which pathologists who conduct post-mortem examinations of children who have died from unknown causes may make such a finding.

250 See Appendix F
251 See Appendix I

Department of Families – Opinions

PART 6 – DECISIONS ABOUT INTERVENTION

Pre-birth intervention

6.3.1 FSO Five should have documented the telephone call that she claims to have made to the QH Social Worker asking to be notified when Lisa gave birth.

6.3.2 DOF failed to intervene and work with Lisa before baby Kate was born to resolve concerns about her ability and willingness to properly care for her baby or to follow up on the intake when Kate was born.

6.3.3 DOF's existing procedures for recording and managing child protection notifications received before a child is born are inadequate because:

6.3.3.1 there is no written policy to guide DOF's officers.

6.3.3.2 there is no process in place for ensuring that intakes received before a child's birth are followed up when the child is born.

The initial assessment

6.7.1 FSO One failed to obtain and evaluate significant and relevant information that was available to DOF concerning Lisa's ability to parent baby Kate, including information that FSO Four could have provided.

6.7.2 DOF failed to clarify and document QH's role in the initial assessment of Lisa's and John's suitability as parents as a result of which not all relevant QH staff understood their role.

6.7.3 FSOs One, Two and Three, in failing to obtain available information about Lisa's parenting ability, did not fully comply with procedural and practice guidelines and good practice generally for the assessment of the risk of harm to children.

6.7.4 FSOs Two and Three should have reviewed relevant medical records and sought the views of relevant medical and nursing staff about Lisa's ability and willingness to parent baby Kate.

6.7.5 The decision to release baby Kate from Hospital Green into Lisa's and John's care was based on an inadequate assessment of the risk of harm to baby Kate.

Decision-making and case planning

6.11.1 The DOF officers in making various decisions about the level of intervention in baby Kate's case:

6.11.1.1 gave too much weight to the principle that their approach at all times had to be the least intrusive one.

6.11.1.2 did not give sufficient weight to the principles that 'if a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care' and the 'welfare and best interests of the child are paramount'.

PART 7 – CASE MANAGEMENT DECISIONS

Riverton

7.2.1 DOF officers at Area Office Green did not implement the SCAN Team's recommendation that Lisa and baby Kate be placed at Riverton followed by a placement at either Sisters of Mercy or Fatima. This decision was based wholly or partly upon a misunderstanding of the services provided by Riverton and a misunderstanding of Riverton's approach, namely, that it would have 'set Lisa up to fail'.

7.2.2 The DOF officers did not comply with the SCAN Team Manual and DOF Manual that required either the implementation of the SCAN Team recommendation or the referral of the matter to a SCAN Team for further review.

7.2.3 Placement of Lisa and baby Kate at Riverton would have:

7.2.3.1 provided a more appropriate level of support for them.

7.2.3.2 led to a comprehensive professional assessment of Lisa's ability and willingness to care for her baby, that could have informed future decision-making by DOF in respect of baby Kate's safety and well being.

7.2.4 FSO One failed to record in CPIS, or elsewhere, the reasons for the decision not to refer Lisa and baby Kate to Riverton. The lack of any such record makes it difficult to identify the reasons for that decision and who approved the decision.

Fernbrook

7.6.1 The referral information provided by DOF to Fernbrook should have been confirmed in writing.

7.6.2 DOF's decision to refer Lisa and baby Kate to Fernbrook was inappropriate because:

7.6.2.1 it was not based on a comprehensive assessment of Lisa's ability to care for baby Kate. Lisa required direct supervision and assistance to meet baby Kate's basic care needs and Fernbrook did not provide that level of supervision and support.

7.6.2.2 it did not adequately take into account the significant information provided by Lisa's foster mother concerning Lisa's willingness and ability to care for baby Kate.

7.6.2.3 it was based on FSO One's opinion that Lisa's parenting ability had improved to the extent that she would be able to properly care for her baby at Fernbrook.

7.6.3 The ongoing contact by FSO One with Fernbrook staff about Lisa's parenting was inadequate.

7.6.4 FSO Five's responsibility as Acting Team Leader was to evaluate the suitability of FSO One's verbal recommendation that Fernbrook was a suitable placement for Lisa and baby Kate. She did not effectively discharge this responsibility in approving FSO One's recommendation because she did not have a clear understanding of the level of supervision that Lisa required or the type of supervision available at Fernbrook.

7.6.5 The Manual gives insufficient guidance to Team Leaders and Managers about their role in case management and decision-making.

The transfer

7.10.1 The failure of Area Office Green to transfer case management or case-work responsibility to Area Office White meant that Lisa had no face to face contact with an FSO while she was at Fernbrook and no FSO directly observed how Lisa was coping in her care of baby Kate.

7.10.2 FSO One's assessment of Lisa's progress in learning to care for baby Kate while at Fernbrook was based on inadequate feedback, namely her telephone calls to Lisa and two calls to the Fernbrook Intake Officer.

7.10.3 In the circumstances of the case, and its categorisation as a priority one matter, case management or case-work responsibility should have been transferred earlier.

7.10.4 DOF's existing policies and procedures for transferring child protection matters are inadequate because they do not clearly outline:

7.10.4.1 the process for transferring a child protection matter between area offices;

7.10.4.2 the forms required to effect a transfer;

7.10.4.3 the time frame for effecting a transfer; and

7.10.4.4 the responsibilities of the original case-worker and of the sending and receiving managers and/or team leaders.

7.10.5 DOF officers interviewed had a mistaken belief that the existing policy provided that case-workers had a period of up to three months to transfer a case even if a family had 'settled' in a new area much earlier.

7.10.6 DOF failed to provide FSO Five with any training that would have assisted her to make decisions, as an Acting Team Leader, about how the transfer of baby Kate's case should have been approached.

PART 8 – RECORD KEEPING

8.3.1 The record keeping by DOF in relation to baby Kate's case was not of a satisfactory standard for the following reasons:

8.3.1.1 CPIS records relating to the notification and the initial assessment were not created immediately after relevant information was received (as required by the Manual).

8.3.1.2 Other significant information relevant to case management was not recorded in CPIS in a reasonably contemporaneous manner.

8.3.1.3 CPIS records were not comprehensive and some significant telephone conversations, meetings, decisions and actions were not recorded at all.

8.3.1.4 No uniform system was used for making case notes.

8.3.1.5 Case-work files were incomplete and contained some records that were inaccurate.

8.3.1.6 Some documents were filed out of chronological order.

8.3.1.7 Some documents were maintained externally to the DOF file.

8.3.1.8 FSO One's supervisors did not effectively supervise her record keeping practices.

8.3.2 The results of the audit of case records in Area Office Green undertaken by my officers indicate that the record keeping deficiencies identified in baby Kate's case may be a systemic problem within that office.

PART 9 – THE CHILD DEATH REVIEW

9.4.1 The briefing note prepared by the Acting Manager for the information of the Deputy Director-General was misleading because it incorrectly stated that:

9.4.1.1 a post-mortem on 11 September 2001 had confirmed SIDS as the cause of baby Kate's death.

9.4.1.2 Fernbrook provided 'overnight supervision'.

9.4.2 DOF's Child Death Review Policy is unclear because key terms are not defined and no guidance is given to exercising the discretion given in the policy under the heading 'Level 2 Child Death Reviews'. This creates the potential for inconsistency in decision-making on issues such as the level of review appropriate in SIDS deaths.

9.4.3 In all the circumstances of the case, a Level 1 review of baby Kate's death was called for.

9.4.4 The Deputy Director-General did not record the reasons for her decision that a Level 2 review be conducted.

9.4.5 The Level 2 child death review that was conducted was inadequate because, as particularised at 9.1.1.2, the internal review officer failed to:

9.4.5.1 adequately address the terms of reference;

9.4.5.2 interview all relevant witnesses;

9.4.5.3 obtain access to all relevant documents; and

9.4.5.4 identify significant deficiencies in DOF record keeping.

Department of Families – Recommendations

PART 6 – DECISIONS ABOUT INTERVENTION

Pre-birth intervention

6.4.1 DOF develop written policies and procedures for recording notifications in relation to unborn children, for working with the parents before the birth and for ensuring that such notifications are followed up when the child is born.

6.4.2 In consultation with QH, DOF develop a memorandum of understanding that outlines the process for DOF to notify QH that it has concerns about the safety and well being of an unborn child due to be delivered in a QH hospital and for QH to notify DOF when that child has been born.

6.4.3 The *Child Protection Act* be amended to enable DOF to intervene where it is suspected before the birth of a child that the child may be at risk of harm after birth.

The initial assessment

6.8.1 DOF evaluate the training that is presently provided to DOF officers responsible for undertaking child protection assessments with a view to identifying whether increased emphasis should be given to conducting risk assessments and considering all relevant information for that purpose.

6.8.2 DOF develop and implement procedures and processes to be observed when involving other agencies in a child protection matter to ensure that the officers of the agencies involved understand their responsibilities.

6.8.3 DOF immediately issue a written memorandum to all relevant officers advising them of the authority under section 194 of the *Child Protection Act* for authorised officers to obtain access to information that is subject to confidentiality under section 63 of the *Health Services Act* where that information is relevant to the protection and welfare of a child.

Decision-making and case planning

6.12.1 DOF refer the comments that I have made in this report about the application of the principles in section 5 of the *Child Protection Act* and the 'minimal intervention' or 'least intrusive approach' principle to the Coordinating Committee on Child Abuse (as reconstituted in accordance with my recommendations at 9.5) with a view to that body or an appropriately constituted sub-committee providing guidance on the weight officers should give to such principles when conducting child protection assessments.

6.12.2 If a sub-committee is constituted to carry out the role specified in recommendation 6.12.1 the Commissioner for Children and Young People be the Chair.

PART 7 – CASE MANAGEMENT DECISIONS

Riverton

7.3.1 In consultation with QH, DOF provide information to its officers about the services provided by Riverton and the criteria for admission there.

7.3.2 To ensure appropriate ongoing involvement by a SCAN Team, DOF review its procedures for transferring to a local SCAN Team cases that have been closed to SCAN in another area because the family or child has left that area.

7.3.3 DOF develop and maintain a comprehensive resource database that contains information about the emergency, support and residential services available in Queensland to assist officers with decisions about the placement and referral of families in need.

Fernbrook

7.7.1 The recommendation made by the internal review officer in her review that DOF consider developing a standardised referral process, including documentation outlining an agreed case plan and identifying roles, responsibilities and communication process, be implemented as a matter of urgency.

The transfer

7.11.1 DOF review its existing policies and procedures in relation to the transfer of case-work and case management responsibility with a view to developing a comprehensive policy that addresses the deficiencies I have identified.

7.11.2 The policy should include a standardised transfer summary for officers to complete to ensure that the receiving office has accurate and timely information concerning the family that it will be working with.

7.11.3 DOF provide appropriate training to all relevant staff once the policy has been developed.

7.11.4 DOF investigate the claim that transfers are generally not accorded appropriate priority and, in some cases, refused or deliberately delayed by the receiving office, by:

7.11.4.1 auditing a sample of transferred cases; and

7.11.4.2 consulting with Managers and/or Team Leaders.

PART 8 – RECORD KEEPING

8.4.1 DOF undertake a statewide audit of record keeping practices in its offices to determine whether the record keeping deficiencies identified in Area Office Green also exist in those offices.

8.4.2 DOF review whether present resourcing is sufficient to enable officers to maintain appropriate records and if not, provide administrative or other support to assist officers in the performance of this obligation.

8.4.3 DOF develop and implement consistent procedures for record keeping in order to eliminate the multiple systems presently used by officers.

8.4.4 DOF provide training on proper record keeping procedures to officers in Area Office Green and officers in other offices identified in the audit as having inadequate record keeping practices.

8.4.5 DOF investigate the use of digital recording devices to assist officers to record contemporaneous file notes while engaged in fieldwork.

PART 9 – THE CHILD DEATH REVIEW

9.5.1 A body external to DOF monitor and review the investigation of the deaths of all children known to DOF and, unless another body is established for that purpose, the Child Death Review sub-committee of CCOCA carry out this role.

9.5.2 The Commissioner for Children and Young People be a full member of CCOCA and be the Chair of the Child Death Review sub-committee.

9.5.3 If another body is established to carry out the role specified in 9.5.1, the Commissioner for Children and Young People be the Chair of that body.

9.5.4 The State Coroner be a member of the Child Death Review sub-committee or other body established to carry out the role specified in 9.5.1.

9.5.5 The body that carries out the role specified in 9.5.1 be empowered to:

9.5.5.1 give directions to DOF that a child death review be conducted and about the type of review (internal or external) to be conducted;

9.5.5.2 approve persons as child death external reviewers and maintain a register of such persons;

9.5.5.3 appoint persons from the register to supervise the conduct of external reviews; and

9.5.5.4 make recommendations to the agencies with child protection responsibilities about policies and procedures that could prevent or reduce child deaths.

9.5.6 The Office of the Commissioner for Children and Young People provide administrative support to the body that carries out the role specified in 9.5.1.

9.5.7 The body that carries out the role specified in 9.5.1 report annually to Parliament in relation to child deaths that have been the subject of review.

9.5.8 That, pending the implementation of recommendation 9.5.1, DOF amend its new 'Review Policy Procedure following the Death of a Child or Young Person' to require that:

9.5.8.1 a copy of the report of each child death review be forwarded immediately upon completion to the Commissioner for Children and Young People and that such copies not be de-identified; and

9.5.8.2 the reasons for decisions about the type of review to be conducted be appropriately recorded in the official file.

Queensland Health – Opinions

I did not identify any maladministration by QH.

Queensland Health – Recommendations

Several recommendations concern QH, namely 4.4.3, 6.4.2 and 7.3.1 as set out above.

APPENDICES

Appendix A – Documents obtained during the course of the investigation

The following documents were provided or obtained during the course of this investigation:

1 Department of Families

1. Baby Kate's file.
2. Lisa's files for the period that she was in care.
3. CPIS records from Area Office Green for baby Kate.
4 Case note from Area Office White dated 3 September 2001.
5. The Child Death Review dated 15 October 2001 in relation to baby Kate's death.
6. Copies of the Manager's and FSO Five's supervision notes for the relevant period.
7. Copies of FSO One, Two and Three's diary/field notes for the relevant period.
8. Copies of the internal review officer's notes.
9. The Action Plan developed by the RSIC in relation to baby Kate's child death review recommendations.
10. Child Protection Procedures Manual.
11. A Practice Guide for the Assessment of Harm and Likely Harm.
12. Initial Assessment – Outcomes and Recording – Families Practice Paper, August 1999.
13. Reporting of Deaths, Serious Incidents and Missing Persons Policies and Procedures.
14. Child Death Review Policies and Procedures.
15. Review of Significant Incidents Committee Policy.
16. Interim Report of the Child Protection Think Tank to the Director-General, December 2002.
17. Queensland Government SCAN Team Manual.
18. Initial letter to this Office from DOF dated 14 March 2002.
19. Letter to Ombudsman dated 4 December 2002.
20. Letter to Ombudsman dated 6 February 2003.
21. Letter to Ombudsman dated 4 March 2003.
22. Letter to Ombudsman dated 15 March 2003.
23. Letter to Ombudsman dated 31 March 2003.
24. Letter to Ombudsman dated 2 June 2003.
25. Email from FSO Five dated 6 February 2003.
26. Email from FSO One dated 10 February 2003.
27. Email from Director, Child Protection dated 31 March 2003.

2 Queensland Health

1. Baby Kate's medical records held by Hospitals Green and White.
2. Lisa's medical records held by Hospitals Green and White.
3. Post-Mortem Examination Report.
4. Form titled Infant Event Scene Investigation.
5. Fact sheet – Riverton State-wide program.
6. Riverton Early Parenting Centre – Information Booklet.
7. Riverton Early Parenting Centre – Family Information Booklet.
8. Report titled Review of the Intensive Parenting Education Program – Riverton Early Parenting Centre Community Child Health Service, December 2000.
9. Discharge summary from the Riverton Early Parenting Centre.
10. Letter to Ombudsman dated 27 January 2003.
11. Letter to Ombudsman from the Paediatrician dated 24 February 2003.
12. Email from the Manager, Parliamentary and Ministerial Services Unit dated 7 March 2003.
13. Email to this Office from the Manager, Parliamentary and Ministerial Services Unit dated 6 March 2003.

3 Other sources

1. Submissions and documents from the complainant.
2. Letter to Ombudsman from the QPS dated 13 February 2003.
3. Letter to Ombudsman from the QPS dated 29 April 2003.
4. Document titled 'Sudden Infant Death – Death Scene Investigation Checklist', provided by the New South Police Service.
5. QPS Operations Procedures Manual.
6. QPS document titled 'Form 4 – Reporting of death by member of the police service'.
7. QPS report to the Coroner dated 17 October 2002.
8. Letter to Ombudsman from the Coroner dated 8 January 2003.
9. Letter to Ombudsman from the Coroner dated 20 January 2003.

Appendix B – Department of Families – Child Death Reviews Policy and Procedures

Department of Families Policy and Procedures

Title: Child Death Reviews Policy and Procedures **Reference No.:**

Version: 1

Date of Approval by EMC: 23 May 2001 **Date of Review:**

Date of Implementation: 19 September 2001

Directorate: Children, Families and Young People

Authority: Child Protection Act 1999

Policy: Child Death Reviews will comprise two different levels of review categorised by the circumstances of the child's death. Child Death Reviews will be conducted in accordance with prescribed terms of reference and will examine the circumstances leading to the death of the child, focusing on departmental systems, practices and procedures, as they applied to the child.

Level 1 Child Death Reviews will be initiated by the Director-General following the death of a child who has been subject to interventions by the Department of Families, with the Child Death Review Team Leader to be an experienced officer external to the Department.

Level 2 Child Death Reviews will be initiated by the Regional Director/Executive Director, Youth Justice following the accidental death of a child, without the inclusion of an officer external to the Department or the formation of a Child Death Review Team.

Procedures: **Principles**

1. The Department of families has a responsibility to review the circumstances leading to the death of a child who has been subject to departmental interventions, and to examine the departmental systems, practice and procedures as they applied to the child.
2. To ensure impartiality, Level 1 Child Death Reviews will be lead by an experienced officer external to the Department of Families.
3. Non-identifying data relating to child deaths will be provided to the Coordinating Committee on Child Abuse (CCOCA) Subcommittee on Child Deaths and the Commission for Children and Young People to enable a systemic whole-of-government consideration of appropriate responses to identified systems deficits.

1

Purpose

To establish procedures for reviewing the death of a child who has been subject of interventions by the Department of Families.

Process

Level 1 Child Death Reviews

The decision to initiate a Level 1 Child Death Review of a child client's death will be made by the Director-General following consultation with the Deputy Director-General and where required, the respective Executive Director or Regional Director.

A Level 1 Child Death Review is indicated when a child client's death relates to one or more of the following circumstances:

- suspected non-accidental death or illness;
- suicidal or self-injurious behaviours;
- a death that is associated with a child protection matter where there has been pattern of contact with the Department based on similar concerns;
- SIDS deaths where there have been previous contacts with the Department relating to the neglect or physical abuse of the child;
- a young person who has died within a Youth Detention Centre; and
- where there are contentious circumstances or significant external criticism in relation to the prior management of the case.

Activation of Child Death Reviews

As required by the *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures*, an Incident Report is prepared for all serious matters. In the case of a death, immediate verbal advice is to be provided to the Deputy Director-General, or after hours to the Duty Executive Officer, followed by an emailed Incident Report. A subsequent Background Brief will be provided to the Deputy Director-General by the relevant Region or Youth Detention Centre within 48 hours.

Terms of Reference for Child Death Reviews

1. Determine whether current departmental procedures were adhered to and whether the current procedures were adequate in this situation.

2. Determine if there were factors that may have contributed to the child death related to individual judgment or decision making.

3. Investigate whether systemic issues have impacted upon the nature of services to the child and/or family.

4. Investigate other case specific issues as instructed by the Director-General.

5. Make recommendations in relation to departmental practice and procedures, any further actions required in relation to departmental

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services, and any issues that may need to be brought to the attention of other agencies.

Level 1 Child Death Reviews

- A Level 1 Child Death Review should be commenced without delay and be completed within two months of receipt of the Incident Report.
- The Director-General will select the Child Death Review Team, with the Child Death Review Team Leader being an experienced officer external to the Department.
- In cases where a Child Death Review involves the death of an Indigenous child, at least one Child Death Review Team member will be an Indigenous person.
- The Child Death Review will have clear terms of reference, with a formal Child Death Review Report to be prepared for the consideration of the Director-General within two months.
- In cases where a Level 1 Child Death Review leads the Child Death Review Team to suspect activities of a criminal nature or official misconduct, advice should be sought from the Misconduct Prevention Branch. This is to ensure the proper coordination of these activities, to minimise duplication of effort, and to ensure that the departmental Child Death Review does not interfere with any Police investigations, CJC Inquiries and/or Coronial Inquiry.
- The final Child Death Review Report will be submitted by the Regional Director/ Executive Director Youth Justice, to the Director-General through the Deputy Director-General.
- The Regional Director/Executive Director, Youth Justice is responsible for the implementation of approved recommendations from the Child Death Review.
- The relevant Director will provide progress reports in relation to implementation of the required actions to the Director-General and the Chair of the CCOCA Subcommittee on Child Deaths.
- The CCOCA Subcommittee on Child Deaths will review recommendations from Child Death Review Reports with a view to identifying systemic issues.
- The relevant Executive Director will be responsible for acting upon recommendations that impact upon policy provisions.
- A procedure for writing Child Death Review Reports is detailed in Attachment 1, *Guidelines for Child Death Review Reports*.

Reporting Procedures for Level 1 Child Death Reviews

- Following approval, a copy of the Child Death Review Report will be provided by the Director-General to the relevant Executive Director and Regional Director.
- The Executive Director, Children, Families and Young People will forward the report to the Director, Child Protection Branch for provision to the Manager, Child Protection Information System (CPIS) for coding.
- A non-identifying copy of the Child Death Review Report will also be submitted to the Chair of the CCOCA Subcommittee on Child Deaths to enable them to provide trend data to the Department and other relevant agencies in relation to child deaths.
- A non-identifying summary of all child deaths will be provided to the Commission for Children and Young People on a regular basis.

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- In relation to the death of a child in a Youth Detention Centre, a non-identifying copy of the Child Death Review Report may be provided to other relevant agencies at the discretion of the Executive Director, Youth Justice.
- The Child Death Review Report should be written in a non-identifying manner through utilisation of a detachable face sheet, to allow provision of the Child Death Review Report to the Chair of the CCOCA Subcommittee on Child Deaths, or for other review and research purposes.
- The Manager, CPIS will ensure information is recorded in relation to each child death and that Level 1 Child Death Review Reports are coded prior to submission to the Chair of the CCOCA Subcommittee on Child Deaths.

Level 2 Child Death Reviews

A Level 2 Child Death Review will be applicable in the following circumstances:

- accidental death

A Level 2 Review may also be conducted in the following circumstances:

- Category 1 incidents that do not involve child deaths;
- Category 2 incidents; and
- other circumstances, as determined by the Director-General or Deputy Director-General.

Level 2 Child Death Reviews

- The instigation, implementation and operation of a Level 2 Child Death Review will be the responsibility of the Regional Director/Executive Director, Youth Justice.
- The Child Death Review will be conducted without the inclusion of an officer external to the Department and may be undertaken without the formation of a Child Death Review Team.
- As a Level 2 child death may also include involvement of the Police or Coroner, advice should be sought from the Misconduct Prevention Branch to ensure coordination of activities if required.
- A copy of the Level 2 Child Death Review Report will be submitted by the Regional Director/Executive Director, Youth Justice to the Executive Director, Children, Families and Young People who will forward the report to the Director, Child Protection Branch for provision to the Manager, CPIS for coding.
- A non-identifying copy of the Child Death Review Report will be submitted to the Chair of the CCOCA Subcommittee on Child Deaths to enable them to provide trend data to the Department and other relevant agencies in relation to child deaths.
- A non-identifying summary of all child deaths will be provided to the Commission for Children and Young People on a regular basis.
- The Child Death Review Report and any resultant recommendations are to be implemented by the Regional Director/Executive Director, Youth Justice and staff.
- If during the course of the Child Death Review, new information indicates that the incident constitutes a Level 1 Child Death

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Review, the matter should be referred immediately to the Deputy Director-General.

Links

- Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures
- Child Protection Act 1999

Availability: Public

Delegations: Nil

Signatures: **F J Peach**
Director-General
Department of Families
13/9/01

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Attachment 1

Guidelines for Child Death Review Reports

Child Death Review Reports will be prepared in accordance with the following headings and numbering conventions.

1. **Introduction** – Include brief details of the child's history/status with the Department, and the date and circumstances of the death.

2. **Terms of Reference** – Outline

3. **Process of Review** – Detail actions taken as part of the review, such as examination of departmental records, discussions with staff/workers, who must be identified by their position and/or agency only.

4. **Family Composition** – Include all members of the immediate family, whether or not they resided with the child, and any other significant family or non-family members. They must be identified only by their gender, age and relationship to the deceased child.

5. **History of Department of Families Involvement** – Include a description of departmental involvement with the family, not just the child.

6. **Key Issues Identified** – Detail the practice and systems issues identified.

7. **Discussion** – Include assessment of all information and issues, addressing any practice and/or systems dilemmas as appropriate.

8. **Summary** – Detail the review findings.

9. **Recommendations** – Avoid making recommendations that are impractical or unlikely to be acted upon. Consult as necessary with Area and/or Regional Office, Directorate or Branch staff to ensure recommendations are appropriate.

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Appendix C – Riverton Early Parenting Centre – Discharge Summary

DISCHARGE SUMMARY

UNIT: Riverton Early Parenting Centre Community Child Health Service Royal Children's Hospital and Health Service District		
CAREGIVER:	D.O.B.:	UR NO:
CHILD:	D.O.B.:	UR NO:
ADDRESS:		
TELEPHONE:		
DATE OF ADMISSION:	DATE OF DISCHARGE:	
ADMISSION WEIGHT:	DISCHARGE WEIGHT:	
PSYCHIATRY STAFF:	SOCIAL WORKER:	
PAEDIATRIC CONSULTANT:	NURSING STAFF:	

Referring Agent:

Other Agents/Services Providing Care/Support on Admission:

Client Goals:

Presenting Problem:

Initial Presentation:

NAME DISCHARGE SUMMARY Page 2

Nursing Intervention ***(Include Health Promotion Activities; Education; Demonstrations and Supports):***

Please delete any of the following headings that are not appropriate for your discharge summary:

Safety:

*

Hygiene:

*

Nutrition:

*

Interaction:

*

Managing Each Day:

*

Life Style Change:

*

G:\cslsl\Discharge Summary\DISCHARGE SUMMARY FOR IPEP FAMILIES.doc Riverton Early Parenting Centre

Care of sick child:

-

Management of Stressors and Stress:

-

NURSING OUTCOME:

SOCIAL WORKER AND OR PSYCHIATRIST INTERVENTION:

PAEDIATRIC MEDICAL INTERVENTION:

Medication:

Admission medication:

Discharge medication:

Case conference:

This family's management was presented for case conference at the Riverton Early Parenting Centre on ……/……/…… & ……/……/……

Staff present at case conference include *Riverton Early Parenting Centre multiprofessional team:*
Specify others:

Discharge concerns:

Team recommendations:

NAME DISCHARGE SUMMARY Page 5

Was discharge planned?

❑ Yes
- ❑ Summary of discharge plan communicated to patient/carer as appropriate

❑ No
- ❑ Stated they did not wish to continue with Residential Stay
- ❑ Was admitted to hospital
- ❑ Discharge from Residential Centre against advice
- ❑ Other: ____________________

Follow up required:

		Copy of summary Yes	Copy of summary No
❑	Community Child Health- specify...................	❑	❑
❑	Mental Health - specify	❑	❑
❑	Medical – specify	❑	❑
❑	Department of Family Services specify-................................	❑	❑
❑	Support Services – specify	❑	❑
❑	Housing – specify	❑	❑
❑	Other – specify	❑	❑

OUTCOME:

SIGNATURE: ____________________________

NAME: ____________________________

DESIGNATION: ____________________________

DATE: ....../....../2003

Copies to:

O:\achs\Discharge Summary\DISCHARGE SUMMARY FOR EPEP FAMILIES.doc Riverton Early Parenting Centre

Appendix D – Extract from the Queensland SCAN Team Manual

Suspected Child Abuse and Neglect (SCAN) Team Manual *Part 5*

Chapter 16 Guidelines for referral of cases to SCAN teams

Each of the core departments have separate referral guidelines. It is important that each core member give careful consideration to the referral guidelines as prescribed by their department. These guidelines are to be used by officers to assist them in deciding what matters should be referred to their SCAN team.

Referrals should be made to the coordinatorof the SCAN team in a timely way. If an urgent matter arises which requires SCAN team consideration, the coordinatorshould be contacted to arrange an emergency meeting. This may be particularly necessary for SCAN teams that do not meet frequently.

Some cases referred to the SCAN team will not have the direct involvement of the three core departments. However, core members will still be expected to contribute their expertise to the general case discussion regarding team recommendations for case management.

Which cases to refer?

Queensland Police Service should refer:

- all suspected child abuse and neglect matters

Department of Families, Youth and Community Care should refer matters where:

- the initial assessment is being conducted jointly with police
- the use of health services or health workers is required as part of the initial assessment process
- the alleged abuse or neglect has caused severe physical, psychological or emotional harm to the child
- sexual abuse is alleged
- a child has been taken into temporary custody
- an application for a protective order is being considered
- the suspected or alleged significant harm concerns a child under the age of three years
- a number of agencies are involved in the initial assessment and initial management of complex cases.

Health Department should refer:

- all suspected child abuse and neglect matters, including every mandatory notification made in accordance with the Health Act to an authorised medical person.

Section 76K of the Health Act requires medical practitioners to notify an authorised person of suspected child abuse and neglect. The Health Regulation establishes the positions which are authorised to receive these notifications throughout the State. Authorised persons are specified medical practitioners, police officers and officers of the Department of Families, Youth and Community Care.

Timing of SCAN team referral

All core members must refer all appropriate cases to the SCAN team as soon as it is clear that the case meets their referral criteria.

For Department of Families, Youth and Community Care officers, SCAN team referrals can be made:

- before the initial assessment, to plan and co-ordinate the assessment process
- during the initial assessment, as part of the information-gathering process
- after a completed initial assessment
- when a notification is anticipated, for example when concerns exist prior to a child's birth
- at any other point during intervention, when consultation with the SCAN team will assist planning.

For police officers, some SCAN team referrals may be made prior to the recording of a notification by the Department of Families, Youth and Community Care.

A case which has been closed to the SCAN team may be referred again at a later date for further consideration.

Appendix E – Queensland Police Service – Form 4

Form 4
Queensland
CORONERS ACT 1958
(Sections 12, 50, 60)

REPORT CONCERNING DEATH BY MEMBER OF THE POLICE SERVICE

Name of deceased

Date of Place of Birth

Occupation :

Place of Residence

Date, time and place of death

When, and where found (date, time and place)

By whom identified (name, address, relationship to deceased, and for how long known) :

To whom identified (Police Officer) :

Time death reported-
To Coroner :

To member of the Police Service :

Medical practitioner, if any, attending last illness and when last attended :

#Medical practitioner certifying life extinct :

*Brief circumstances of death so far as ascertained :

+Remarks (including as to any Medical Certificate)

Next of Kin (Name and Address) :

....

Member of the Police Service

Date : Station :

* Where no suspicious circumstances exist, state this fact.

\+ When any witness is permanently resident in another State but is temporarily in Queensland insert full name, address in that other State, temporary address in Queensland and date intending to leave Queensland, and bring this feature to the notice of the Coroner.

\# When a prescribed organ has been removed, TWO MEDICAL PRACTITIONERS, other than the one concerned with the removal in question of the prescribed organ or organs are required to certify life extinct.

ver. 1 – 28/5/96

Appendix F – Sudden Unexplained Infant Death Investigation Report Form (SUIDIRF)

16 MMWR June 21, 1996

SUDDEN UNEXPLAINED INFANT DEATH
INVESTIGATION REPORT FORM (SUIDIRF) 3/96

Case number ____________

Infant's full name ____________ Age ____ DOB ____
Home address ____________ Race ____ Sex ____
City, state, zip ____________ Ethnicity ____________
County ____________ SS# ____________
Police complaint number ____________ Police department ____________

I. CIRCUMSTANCES OF DEATH

Action	Date	Time	By whom (person or agency)	Remarks
ME/C notified				Received by:
NOK notified				Person:
Scene visit				__ ME/C staff __ Other agency __ Not done
Scene address				
Condition of infant when found			__ Dead (D) __ Unresponsive (U) __ In distress (I) __ NA (N)	
Sequence of events before death:				

Event	Date	Time	Location (street, city, state, county, zip code)
Injury			
Discovery			
Arrival			Hospital: Transport by:
Actual death			__ On scene (S) __ Emergency room (E) __ Inpatient (I) __ En route or DOA (D) __ During surgery (O)
Pronounced dead			By whom: License #: Where:

Event	Date	Time	By whom (person)	Remarks
Infant placed				Place:
Known alive				Place:
Infant found				Place:
First response				Type:
EMS called				From where:
EMS response			Agency:	
Police response			Agency:	

Place of fatal event	Describe type of place:
__ Witness in room or area (W) or __ Unwitnessed (U) __ At own home (H) or __ Away from home (A) __ Indoors (I) or __ Outdoors (O) __ In vehicle (V) or __ Not in vehicle (N)	

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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96 Case number ________

II. BASIC MEDICAL INFORMATION

Health care provider for infant: Phone:

Medical history: ___ Not investigated (X) ___ Unk (U) ___ No past problems (N) ___ Medical problems (P)

Medical source: ___ Physician (P) ___ Medical records (M) ___ Other health care provider (H) ___ Family (F) ___ Other (O) ___ None (N)

Specific infant medical history	Yes	No	Unk	Remarks
A. Problems during labor or delivery Birth hospital: Birth city and state:				
B. Maternal illness or complications during pregnancy Number of prenatal visits:				
C. Major birth defects				
D. Infant was one of multiple births (e.g., a twin) Birth weight: Gestational age at birth (weeks):				
E. Hospitalization of infant after initial discharge				
F. Emergency room visits in past 2 weeks				
G. Known allergies				
H. Growth and weight gain considered normal				
I. Exposure to contagious disease in past 2 weeks				
J. Illness in past 2 weeks				
K. Lethargy, crankiness, or excessive crying in past 48 hours				
L. Appetite changes in past 48 hours				
M. Vomiting or choking in past 48 hours				
N. Fever or excessive sweating in past 48 hours				
O. Diarrhea or stool changes in past 48 hours				
P. Infant has ever stopped breathing or turned blue				
Q. Infant was ever breast-fed				
R. Vaccinations in past 72 hours				
S. Infant injury or other condition not mentioned above				
T. Deceased siblings				

Diet in past 2 weeks included: ___ Breast milk ___ Formula ___ Cow's milk ___ Solids
Date and time of last meal:
Content of last meal:

Medication history: ___ Not investigated (X) ___ Unk (U) ___ Rx (P) ___ OTC (O) ___ Home remedies (H) ___ None (N)

Emergency medical treatment: ___ None (N) ___ CPR (R) ___ Transfusion (T) ___ IV fluids (F) ___ Surgery (S)

Medicine names and doses (if prescription, include Rx number, Rx date, and name of pharmacy):	Describe nature and duration of resuscitation and treatments used to revive infant:	Describe any known injuries or marks on infant created or observed during resuscitation or treatment:

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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number ______________

III. HOUSEHOLD ENVIRONMENT

Action	Yes	No	Unk	Remarks
A. House was visited				
B. Evidence of alcohol abuse				
C. Evidence of drug abuse				
D. Serious physical or mental illness in household				
E. Police have been called to home in past				
F. Prior contact with social services				
G. Documented history of child abuse				
H. Odors, fumes, or peeling paint in household				
I. Dampness, visible standing water, or mold growth				
J. Pets in household				

Type of dwelling: | Water source: | Number of bedrooms:

Main language in home: | Estimated annual income: | On public assistance ___ Yes ___ No

Number of adults (>18 years of age) ___ and children (<18 years of age) ___ living in household. Total = ___ people

Number of smokers in household: | Does usual caregiver smoke? ___ Yes ___ No ___ Unk | If yes, ___ cigarettes/day

Maternal information: | Age: | ___ Married (M) ___ Single (S) ___ Divorced (D) ___ Widowed (W) | Cohabiting w/partner ___ Yes ___ No | Education (years): | ___ Employed (E) ___ Not employed (N)

IV. INFANT AND ENVIRONMENT

___ In crib (C) ___ In bed (B) ___ Other (O) | ___ Sleeping alone (A) ___ Sleeping with others (O) ___ NA (N) | Temperature of area:

Body position when placed	___ Unk ___ Back ___ Stomach ___ Side ___ Other
Body position when found	___ Unk ___ Back ___ Stomach ___ Side ___ Other
Face position when found	___ Unk ___ To left ___ To right ___ Facedown ___ Face up ___ To side
Nose or mouth was covered or obstructed	___ Unk ___ No ___ Yes
Postmortem changes when found	___ Unk ___ None ___ Rigor ___ Lividity ___ Other

Number of cover or blanket layers on infant: ___ Covers on infant (C) ___ Wrapped (W) ___ No covers (N)

Sleeping or supporting surface: | Clothing:

Other items in contact with infant: | Items in crib or immediate environment:

Devices operating in room: | Cooking source in room: ___ On (+) ___ Off (-) ___ Central (C) ___ Space (S) ___ None (N) | Heat source in room: ___ On (+) ___ Off (-) ___ Central (C) ___ Space (S) ___ None (N)

Item collected	Yes	No	Item collected	Yes	No	Number of scene photos taken:
Baby bottle			Apnea monitor			Other items collected:
Formula			Medicines			
Diaper			Pacifier			
Clothing			Bedding			

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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number ___________

V. INTERVIEW AND PROCEDURAL TRACKING

Contact	Name	Date	Time	Phone	Relationship to infant
Mother					
Father					
Usual caregiver					
Last caregiver					
Placer					
Last witness					
Finder					
First responder					
EMS caller					
EMS responder					
Police					

Alternate contact person: Phone:

Action	Date	Time	Action
Medical record review for infant			Doll reenactment performed ___ Yes ___ No
Medical record review for mother			Scene diagram completed ___ Yes ___ No
Physician or provider interview			Body diagram completed ___ Yes ___ No
Referral to social or SIDS services			Detailed protocol completed ___ Yes ___ No ___ NA
Cause of death discussed with family			Other:

VI. OVERALL PRELIMINARY SUMMARY

Notes to pathologist performing autopsy:

Indications that an environmental hazard, drug, poison, or consumer product contributed to death ___ Yes ___ No	Organ or tissue donation requested by family or agency ___ Yes ___ No ___ Unk

Cause of death: ___ **Presumed SIDS** ___ **Suspect trauma or injury** ___ **Other**

VII. CASE DISPOSITION

Case disposition	___ Case declined (D) due to: ___ Topic (T) ___ Locale (L)	___ Case accepted (J) for: ___ Autopsy (A) ___ Inspection (I) ___ Certification (C)
Body disposition	___ Brought in for exam (E) ___ Brought in for holding or claim (C) ___ Released from site (R)	
Who will sign DC?		

Transport agent:	Funeral home:

Investigator and affiliation:	Date: Number of supplement pages attached:

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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3,96

Case number ______________

SCENE DIAGRAM

Instructions

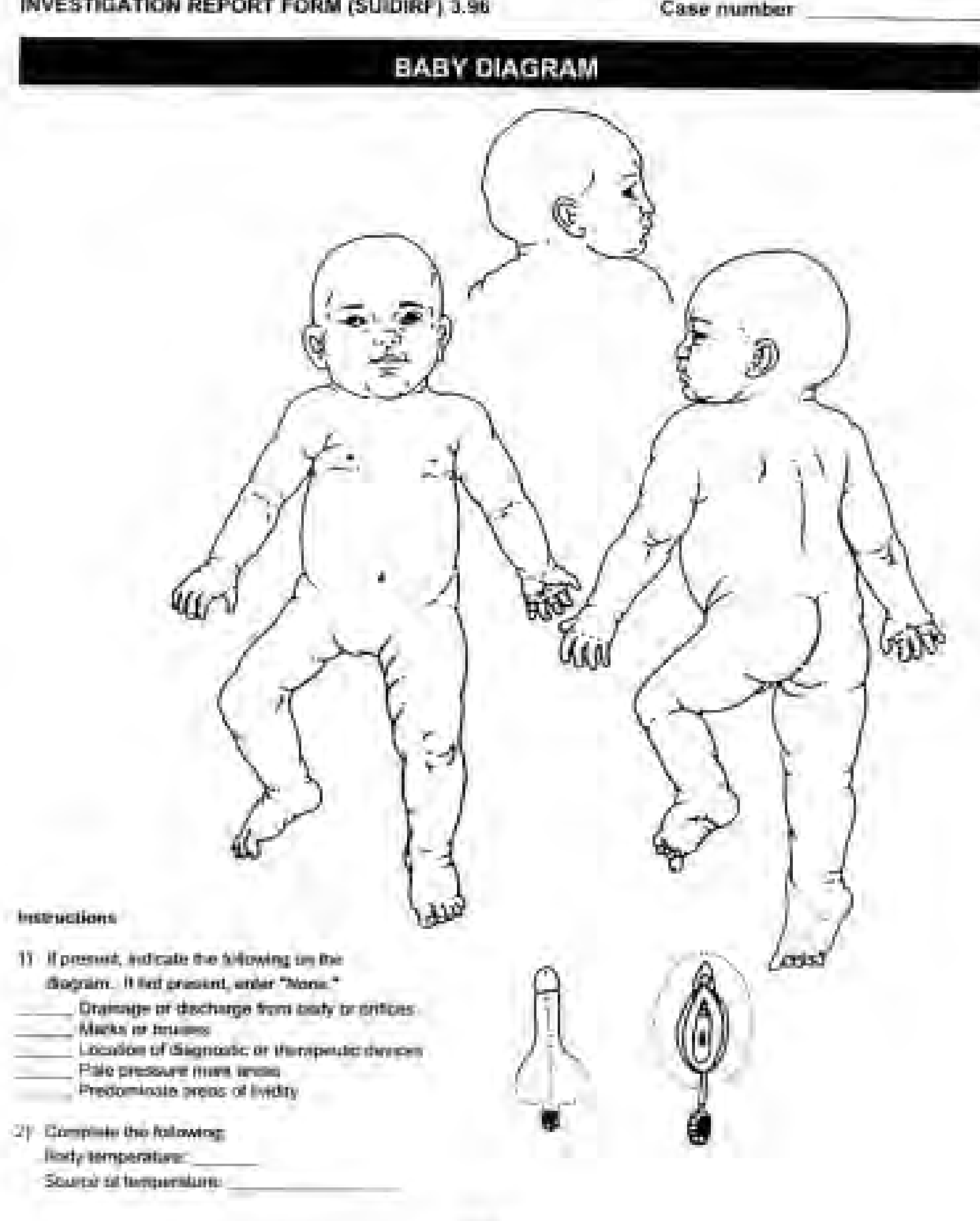
1) Use figure at right for a rectangular room, and use figure below right for a square room. Use a supplementary page to draw an unusually shaped room.

2) Indicate the following on the diagram (check when done):
___ North direction
___ Windows and doors
___ Wall lengths
Ceiling height: __________
___ Location of furniture
___ Location of crib or bed
___ Body location when found
___ Location of other objects in room
___ Location of heating and cooling supplies and returns

3) Make additional notes or drawings in available spaces as needed.

4) Check all that apply about heat source:
___ Gas furnace or boiler
___ Electric furnace or boiler
___ Forced air
___ Steam or hot water
___ Electric baseboard
Other: ____________________________
___ None

5) Complete the following:
Thermostat setting: ________
Thermostat reading: ________
Actual room temperature: ________
Outside temperature: ________



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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number ______________

BABY DIAGRAM

Instructions

1) If present, indicate the following on the diagram. If not present, enter "None."

_____ Drainage or discharge from body or orifices
_____ Marks or bruises
_____ Location of diagnostic or therapeutic devices
_____ Pale pressure mark areas
_____ Predominate areas of lividity

2) Complete the following:

Body temperature: _______

Source of temperature: ______________

SUDDEN UNEXPLAINED INFANT DEATH
INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number ______________

SUIDIRF SUPPLEMENT

Appendix G – Document provided by QH – Infant Event Scene Investigation

INFANT EVENT SCENE INVESTIGATION

Biological Details

Case No:________ Name First:________ Last:________
Street Address:________ Suburb:________ State:____ Postcode:____
D.O.B.:________ Age (days):______ Religion:________ Ethnicity:________ Sex:____

Mother Circle if: Biological / Adoptive / Step / Foster mother / Defacto
Name First:________ Last:________
Street Address:________ Suburb:________ State:____ Postcode:____
D.O.B.:________ Home Phone:________ Work Phone:________
Living with child at time of death: Y / N / U Occupation:________

Father Circle if: Biological / Adoptive / Step / Foster mother / Defacto
Name First:________ Last:________
Street Address:________ Suburb:________ State:____ Postcode:____
D.O.B.:________ Home Phone:________ Work Phone:________
Living with child at time of death: Y / N / U Occupation:________
Siblings (age / sex / biological / step):________

Emergency Contact Person (different from above)
Name First:________ Last:________ Contact Phone Number:________

Event Information

Date found unresponsive:________ Time:________ Ambulance called: Y / N / U
Time ambulance called:______ Time ambulance arrived:______ Date of certification:______ Time:______
Name of caregiver who found child unresponsive:________
Caregivers relationship to deceased:________
Last seen alive – Date:______ Time:______ By whom:______
Reported to the coroner – Date:______ Time:______ Notified investigator – Date:______ Time:______
Name of investigator:________ Phone No:________
Investigator attended scene – Date:______ Time:______ Investigator left scene – Time:______

CASE HISTORY

Medical Information

Did the child have any of the following during the past two weeks prior to the event?

- Unknown ☐
- Cold ☐
- Sniffles ☐
- Cough ☐
- Fever ☐
- Wheezing ☐
- Vomiting ☐
- Recent injury or other illness ☐
- Diarrhea ☐
- Recent inoculation ☐

Was the child known to have:

- Unknown ☐
- Recent hospital visits ☐
- Abnormal development ☐
- Medical equipment in use ☐
- Exposure to contagious decease ☐
- Any known medical problems ☐
- Known allergies ☐

Explain:________ P.T.O.
Explain (cont'):________

Did the child have;
Any changes in behavior over the last 48 – 72 hours prior to the event: Y / N / U
Explain:________
Did the child receive, in the past 24 hours, any prescription or over the counter medications: Y / N / U
Describe:________
Child's Pediatrician / Maternal child health nurse / Health care provider:
Name:________ Phone number:________
Name:________ Phone number:________
Child's health book present: Y / N / U Taken by investigator: Y / N / U

HISTORY OF ANY FAMILY ILLNESS

Mother, father and siblings: ____________________

Has there been any other children die in the immediate family: Y / N / U

Cause(s) of death: ____________________

BIRTH INFORMATION

Place of birth: ____________________

Birth weight: ________ kg   Gestational age: ________ weeks   Number of pregnancies: ________

Premature birth: Y / N / U   Method of delivery: Unknown ☐

Birth abnormalities: Y / N / U   Vaginal ☐

Multiple births: Y / N / U   C-section ☐

CHILD LAST FED – Date: ________ Time: ________ Last fed by whom: ________

Breast fed: unknown ☐ present ☐ past ☐   Formula fed: unknown ☐ present ☐ past ☐

Formula brand: ____________________

Solid food: Y / N / U   Describe: ____________________

After eating does the child: unknown / vomit / gag / turn blue / none

LOCATION OF EVENT

Normal place of residence: Y / N / U   Explain: ____________________

Address: ____________________   Postcode: ________

		Condition: (outside)		Type:		Condition: (inside)	
Unknown	☐	Unknown	☐	Unknown	☐	Unknown	☐
House	☐	In need of repair	☐	Weatherboard	☐	Clean	☐
Flat / Unit	☐	Well maintained	☐	Tin	☐	Dirty	☐
Housing commission	☐			Concrete	☐	Tidy	☐
Caravan / Mobile home	☐			Brick	☐	Untidy	☐
Other: ________							

Number of rooms: ________   Estimated number of residents: ________

Signs of habitual smoking: Y / N / U   Explain: ________

Any evidence of alcohol or drug use around the child: Y / N / U   Explain: ________

Any history of family violence: Y / N / U   Explain: ________

ROOM WHERE INFANT WAS FOUND

ENVIRONMENT

Type of weather: unknown / hot / cold / rainy / other   Daily temperature (from newspaper) – Min ________ Max: ________

Deceased's bedroom: ☐   Parents bedroom: ☐   Other: ________

Temperature in room where deceased was found: ____________________

Humidity in room where deceased was found: ____________________

Room ventilation		Heating (on in room where deceased was found)	
Unknown	☐	Unknown	☐
Window open	☐	Electric	☐
Fan on	☐	Fireplace	☐
Door ajar	☐	Central heating	☐
Air vents on wall	☐	Natural gas	☐
Airconditioning	☐	Other (specify): ________	
Other (specify): ________			

Bedside humidifier / vapouriser: Y / N / U

TYPE OF SURFACE CHILD WAS FOUND ON

Unknown ☐
Bassinet ☐
Adult bed ☐
Cot ☐
Couch ☐
Cradle* ☐
Water bed ☐
Other (specify): ____

* What is the maximum angle of tilt and the position of the security pin? ____

TYPE OF MATTRESS

Unknown ☐
Foam ☐
Fabric covered foam ☐
Innerspring ☐
Water ☐
Other (specify): ____

Brand ____
Hardness: H / M / S
Thickness: ____ cm
Stains present: Y / N / U

BEDDING

Bedding over child:
No. of adult blankets: ____
No. of child blankets: ____
No. of sheets: ____
No. of adult doonas: ____
No. of child doonas: ____
Other: ____

Bedding under child:
No. of adult blankets: ____
No. of child blankets: ____
No. of sheets: ____
Sleepskin: ____
Item directly under child: ____
Other: ____

Cot protector present: Y / N / U
Was bedding soiled: Y / N / U Describe: ____
Was infant swaddled: Y / N / U
Were any items covering the head: Y / N / U List the items: ____
Was the bedding tucked in at the sides: Y / N / U ____

CLOTHING ON CHILD

Singlet ☐
Jump-suit ☐
Pyjamas ☐
Tracksuit pants ☐
Other:

T-shirt ☐
Cardigan ☐
Jumper ☐
Socks ☐

Nappy:
Unknown ☐
Cloth ☐
Disposable ☐
Was it soiled?: Y / N / U
Describe:

CIRCUMSTANCES OF THE EVENT

Was the child moved from the time found to the time of the first responders arrival: Y / N / U
Was resuscitation attempted by the first responder: Y / N / U
Characteristics of the child when found:

Unknown ☐
Cold ☐ Blue ☐
Mottled ☐ Sweaty ☐

Explain: ____

Was resuscitation attempted by the ambulance officer: Y / N / U Duration: ____
When child was found was there discharge around the mouth (blood / froth): Y / N / U
Was there items / object in the mouth: Y / N / U Describe: ____

POSITION OF CHILD

POSITION OF CHILD WHEN PUT DOWN		POSITION OF CHILD WHEN FOUND	
Unknown	❑	Unknown	❑
Supine / on back	❑	Supine / on back	❑
Prone / stomach	❑	Prone / stomach	❑
Side	❑	Side	❑
Head to left side	❑	Head to left side	❑
Head to right side	❑	Head to right side	❑
		Head face down	❑

DRAW POSITION OF CHILD IN COT

When put down — When found

Top

Bottom

Was child sleeping alone: Y / N / U	With whom:
POSITION OF CHILD DURING COSLEEPING:	Frequency of cosleeping (nights per week):
Unknown ❑	Normal duration of cosleeping per night (hours):
On top of adult ❑	Was the child found in an unusual position?: Y / N / U
Lying facing adult ❑	Any other features:
Lying with back to adult ❑	
Was the child in contact with adult: Y / N / U	
Was the child between adults: Y / N / U	

Duration of normal sleeping pattern (hours):

Normal sleeping arrangements:

Recent changes in sleeping pattern:

Circumstances of the event and additional comments

Name of person completing forms ____________________

Institution ____________________ Phone no ____________________

Signature ____________________ Date ____________ Time ________

Appendix H – Gold Coast JAB – SIDS Investigation Sheet

APPENDIX 3 – SIDS Investigation Sheet

SUDDEN INFANT DEATH INVESTIGATION

Childs Name:		Dob:	
Hospital Born at:		Health Care Nurse:	
Family Doctor:		Last seen by Doctor:	
Current Medication:		Last Injection:	

Breast Feed/ Bottle (Including Type and amount of formula):

Last Feed (Time/Amount):	
Time discovered deceased:	
Type of bedding (Including material and make):	
Deceased clothing been worn:	

Room where deceased discovered (Include hand diagram of room and dwelling).

SOP'S Child Abuse 20 Gold Coast J.A.B.

Dwelling checked internally/ externally (For signs of forced entry, include details of windows/doors unlocked or open):

Additional Information (Including: Is house air conditioned/ room temperature/ Observations regarding childs body position/ clothing/ notable marks)

Parents/ Care Providers Details:

Fathers Name:		Dob:	
Address:			
Occupation:		Place of Employment:	
Home Ph:		Work Ph:	

Mothers Name:		Dob:	
Address:			
Occupation:		Place of Employment:	
Home Ph:		Work Ph:	

Maiden Name:	

Details of Other Care Providers:

Sibling Details (Name/ Dob):

Witness Details:

Neighbours (Details/ Comment):

QAS:

Officers Name:	
Station:	
Contact Details:	
Call Time to QAS:	
Time on scene:	

Treatment (including details of resuscitation/ drugs administered/ needle sites):

Comment:

Hospital:

Time of arrival:	
Attending Doctor:	

Treatment details (including details of resuscitation/ drugs administered/ needle sites):

Comment:

Parents Version of events as stated to Doctor:

SOP'S Child Abuse 23 Gold Coast J.A.B.

Department of Families/ Crisis Care (after hour):

Office:	
Contact Person:	
Registrar check details:	

QPS computer message (HJAB01) No:

SIGEV message No:

Occurrence Sheet reference:

INVESTIGATORS COMMENTS:

....	....	....
Signature **Investigating Officer**	**Rank**	**Reg. No.**

Appendix I – NSW Police Sudden Infant Death – Death Scene Investigation Checklist

SUDDEN INFANT DEATH

Death Scene Investigation Checklist

(Sudden deaths of children up to two years of age are notifiable)

1. When inquiring into the circumstances of the death of a child two years and younger, this form is to be completed and forwarded to the Coroner with completed form P.79A.
2. Contact the Duty Forensic Pathologist immediately on: Glebe 9660 0977 or Westmead 9845 6244

Carefully explain to the parents, family or carer the need to fully explore the circumstances in an attempt to establish the cause of death. Do not hurry the interview.

TELEPHONE INTERPRETER SERVICE: 131 450 (24 hrs)

INFANT'S DETAILS

Surname: .... Place of Birth: .... (Hospital/Town)

First name/s: .... Date of Birth: .... (D/M/Y)

Male ☐ **Female** ☐ **Usual Address:** No. and Street ....

Suburb: .... State: .... Postcode: ....

Place of death: No. and Street ....

Suburb: .... State: .... Postcode: ....

MOTHER'S DETAILS

Surname: ....

First name/s: .... Date of Birth: .... (D/M/Y)

Residential address at time of birth of infant: No. and Street ....

Suburb: .... State: .... Postcode: ....

MEDICAL INFORMATION

- Weight at birth: .... g/lbs Premature birth? Yes ☐ No ☐
- Does the infant have brothers/sisters: Yes ☐ No ☐ Has he/she been immunised? Yes ☐ No ☐
- Normal birth? Yes ☐ No ☐ Eg. Triple Antigen (or DPT), Polio (Sabin)
- Comments: ....
- Is there a past history of unexpected Infant Death in the family?
  If yes, names: ....

- Was the infant previously healthy? Yes ☐ No ☐ Comments: ....
- Did the infant have any illnesses or changes in behaviour in the past two weeks especially in the last 24 hours?
  Colds ☐ Cough ☐ Fever ☐ Diarrhoea ☐ Other ☐ (specify) ....
- Had the infant received any prescription or over-the-counter medication? Yes ☐ No ☐
- Did the infant have any falls or sustain any injury recently? Yes ☐ No ☐
  Comments: ....
- How was the infant being fed? Breastmilk/formula: brand .... / solids / Other: ....
- Were there any feeding problems? Yes ☐ No ☐ Describe: ....
- When was the infant last feed? .... am / .... pm
- Name and address of local doctor: ....
- Location of Early Childhood Centre attended: ....

Continued overleaf

Request the "Personal Health Record" (blue book) of the infant. Explain to the parents that it is required by the medical officer to assist with regard to the cause of death and will be returned once the Coroner has had the opportunity to consider the matter fully.

- Are there any illnesses in the family? Yes ☐ No ☐ Describe: ....
- Is any family member taking medication? Yes ☐ No ☐ Comment: ....
- Does anyone in the household smoke? Yes ☐ No ☐
- How many people live with the infant? ....
- Who found the infant? .... Time: ....am / ....pm
- How did the infant come to be found?
  Random check ☐ noise ☐ specify: ....
- Was any resuscitation attempted?
  Parent ☐ ambulance officer ☐ Other ☐ (specify): ....
- **Where was the infant when found?**
  Adult Bed ☐ cot ☐ cradle* ☐ unknown ☐ Other ☐ (specify): ....
  *was locking pin in place?
- **Type of mattress:** Foam ☐ fabric covered foam ☐ innerspring ☐ water ☐ unknown ☐
  Other ☐ (specify): ....
- **Type of Bedding:** Sheet ☐ Blanket ☐ Doona ☐ Other ☐ (specify): ....
- Were there items covering the infant's head? Yes ☐ No ☐ List the item/s: ....
- Was the infant sleeping alone? Yes ☐ No ☐ With whom: ....
- **Position of infant when put down:** On back ☐ on stomach ☐ side ☐ head to left side ☐
  head to right side ☐ head face down ☐ unknown ☐
- Were there any recent changes in sleeping pattern? Yes ☐ No ☐
  Describe: ....
- Was the infant found in an unusual sleeping position? Yes ☐ No ☐
  Describe: ....
- What clothing was the infant wearing at the time?
  Describe: ....

SUPPORT ORGANISATIONS

The Grief Counseling Service available through the NSW Institute of Forensic Medicine, Glebe (02) 9660 5977 **(24 hours)**, including the Counselling Service, Westmead Coroners Office and the Sudden Infant Death Association SIDA **1 800 186 (24 hours)** are available to assist parents and families in the event of sudden infant death. Refer next of kin to these organisations or contact them on the family's behalf.

Name of Officer: ☐ Rank: ☐
Location: ☐ Phone: ☐ Date: ☐

Investigating Officer to complete this section with own observations:

Is there any evidence of drug/alcohol abuse? Comment: ....
What is the general condition of the premises? Describe: ....
Specify which room the infant was found: ....
Room temperature: Comfortable/Other: .... Ventilation: Comfortable/Other: ....
General Comments: ....

Appendix J – Section 5 of the Child Protection Act

5 Principles for administration of Act

This Act is to be administered under the following principles –

(a) every child has a right to protection from harm;

(b) the welfare and best interests of a child are paramount;

(c) families have the primary responsibility for the upbringing, protection and development of their children;

(d) the preferred way of ensuring a child's wellbeing is through the support of the child's family;

(e) powers conferred under this Act should be exercised in a way that is open, fair and respects the rights of people affected by their exercise, and, in particular, in a way that ensures –
- (i) actions taken, while in the best interests of the child, maintain family relationships and are supportive of individual rights and ethnic, religious and cultural identity or values; and
- (ii) the views of the child and the child's family are considered; and
- (iii) the child and the child's parents have the opportunity to take part in making decisions affecting their lives;

(f) if a child does not have a parent able and willing to protect the child, the State has a responsibility to protect the child, but in protecting the child the State must not take action that is unwarranted in the circumstances;

(g) if a child is removed from the child's family –
- (i) the aim of the authorised officers' working with the child and the child's family is to safely return the child to the family if possible; and
- (ii) the child's needs to maintain family and social contacts, and ethnic and cultural identity, must be taken into account;

(h) if a child is able to form and express views about his or her care, the views must be given consideration, taking into account the child's age or ability to understand;

(i) if a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care.

Appendix K – Department of Families Practice Guide – Part 3 – Risk Factors

RISK FACTORS

Assessing the likelihood of future harm is an integral part of every child protection assessment. Every time you make a child protection assessment including an:

- intake assessment
- initial assessment
- assessment of protective needs

you need to assess the likely harm to the child or young person.

Risk, or the likelihood of future harm, is after all, the reason that workers take actions to protect a child or young person. For example when a child suffers a fractured leg due to the actions of a parent/caregiver, it is not the fracture alone which prompts intervention - rather we take action to protect the child on the basis of what harm is likely to occur in the future to the child.

When making a judgement about the likelihood of future harm to a child or young person and the degree of that harm, three key factors need to be estimated:

- probability - estimating the likelihood that harm will occur ie how likely is harm to occur in the future?
- vulnerability - estimating the vulnerability of a child ie how vulnerable is this child to harm?
- severity - estimating the probable severity of a future incident of harm ie if harm occurs in the future, what type of harm is likely to occur, and to what degree?

The following risk factors need to be considered in relation to the circumstances of the particular child and family being assessed. These factors relate to what workers know about the child and family and aim to support judgements about future harm.

Descriptions of the identified risk indicators are provided in order to assist workers to identify how the particular risk factor may apply to the family with whom they are working.

THE HARM/LIKELY FUTURE HARM

Harm is the impact for the child or young person - what is actually experienced or likely to be experienced by the child/young person. Harm can result from any of the commonly recognised abuse types: physical, sexual, emotional and neglect.

The current injury/harm/condition is severe
The more severe an injury, the greater the impairment for the child/young person and the greater the likelihood of re-occurrence (Sigurdson and Reid 1990). The location of certain injuries can increase the **severity** of the injuries, increasing the degree of impairment for the child/young person. As an example, head/face injuries are more serious because of the potential for permanent brain, eye and ear damage.

The pattern of harm is escalating
If harm has been escalating over time, ie increasing in severity and frequency, it is more likely that without effective intervention, the child/young person will be significantly harmed.

The pattern of harm is continuing
The more often harm has occurred in the past the more likely it is to occur in the future (Sigurdson and Reid 1990).

The parent or caregiver has made a threat to cause serious harm to the child/young person
A threat to harm a child or young person may cause significant emotional harm. A threat to harm a child or young person may also reflect parental non-coping and stress. The greater the stress for a careprovider the greater the likelihood of future physical and emotional harm to the child or young person (Sigurdson and Reid 1990).

Sexual abuse is alleged with the perpetrator still having access to the child/young person
If the alleged perpetrator has unlimited access to the child or young person there is an increased likelihood of further harm. Research suggests that sexual abuse is a compulsive or addictive behaviour and that people with a history of sexually offending against children have a high rate of recidivism, even if they participate in a treatment program (Marshall and Barbaree 1988).

Chronic neglect is identified
In QLD the most frequently recorded 'behaviour responsible for harm/likely harm' is categorised as neglect (DFYCC data, 1996-1997). However the serious effects of neglect on children and young people are often not recognised. Children and young people can be seriously harmed through neglect such as inadequate supervision, failure to

meet medical needs and failure to nurture. Inadequate supervision can result in death or injury, untreated medical ailments can result in lifelong medical conditions, inadequate nurturing may psychologically damage a child or young person.

There is previous history on the Child Protection Information System (CPIS)
If a parent/caregiver has previously harmed a child or young person, there is a greater likelihood of re-occurrence. Previous notifications may indicate that harm is continuing or escalating and that effective intervention is necessary. Notifications with a protective advice response, and unsubstantiated initial assessments should be considered when reviewing previous.

THE CHILD

Physical harm to a child under 12 months
Children under the age of 12 months are more vulnerable due to their age and dependency. Given this, any physical harm to a child of this age should be considered serious. Here the risk of future harm focuses not just on the action or any resultant harm, but rather the fact that a parent has **actually used** a physical action on a child under 12 months.

If a parent/caregiver has used physical means with a child under 12 months ie a slap, hit, pinch or shake, this may be a reflection of parenting skill deficits or severe stress. Parents with limited parenting skills or who are highly stressed are more likely to harm their children.

The child/young person is unprotected by self and others (age may be a critical indicator)
Due to age and vulnerability, children and young people need to be supported by parents or caregivers who are **willing and able** to protect them from harm. Both ability and willingness need to be assessed ie if the parent or caregiver is able to protect, are they willing to protect? If the parent or caregiver is willing to protect are they able to protect? Where these supports are missing, children and young people are left at greater risk of all forms of harm. Research suggests that children aged 0-5 are unable to protect themselves (Sigurdson and Reid 1990).

The child/young person has special needs which increases their vulnerability
Age alone should not be the basis for a child or young person's perceived vulnerability. Some older children who are intellectually or physically impaired may be as vulnerable as an infant, due to their inability to communicate, move around or access basic needs or supports. Children and young people who have emotional or behavioural problems may have a higher likelihood of being harmed due to the increased stress their behaviour places on their parents or caregivers.

Ammerman and Hersen (1990) have found that abused and neglected children disproportionately experience prematurity, low birth weight, mental disability, physical and/or sensory handicaps and display difficult behaviour (eg ADD). It is theorised that disruptions in mother-infant attachment, increased stress from difficult behaviours and heightened vulnerability, increase the likelihood of future harm.

The child presents as fearful of the parent or caregiver or other household members.
A child/young person's disclosure or behaviour may indicate that they are being harmed at home. If a child or young person presents as fearful, withdrawn or distressed, this presentation should be considered in a context of possible harm. A disclosure by a child or young person suggests that there is high probability of harm occurring. A child/young person's fearful presentation and disclosure can indicate harm or likely harm.

The child/young person is engaging in self-harm/substance abuse/dangerous sexual behaviour or other 'at risk' behaviours.
Substance abuse, involvement in sex for money or favours, or threats to suicide/self harm can all be indicators of past or current abuse and harm. If a child or young person is engaged in such at-risk behaviours it continues to be highly likely that they will experience physical, emotional or psychological harm.

THE PARENTS OR CAREGIVERS
– including patterns of behaviour

The parent or caregiver has caused serious harm to any child/young person in the past through physical or sexual assault/abuse
Once a person has been a perpetrator of an incident of maltreatment there is an increased likelihood that this behaviour will re-occur (Sigurdson and Reid 1990). Resesarch regarding sexual offending suggests high recidivism rates ie approx 30% of perpetrators who participate in treatment re-offend (Marshall and Barbaree 1988).

The parent's or caregiver's explanation for the current injury is inconsistent or the harm is minimised
An inconsistent explanation may suggest a non-accidental injury. Where a child or young person has been injured, and the parent's or caregiver's explanation for how this occurred is inconsistent with the injury, this may indicate denial of non-accidental causes. Where a child or young person has experienced harm through neglectful parenting behaviour eg an untreated medical condition, and this is not acknowledged by the parent or caregiver, this may indicate denial or minimisation.

Inconsistent explanations, denial and minimisation can increase the likelihood of future harm

Some research states that parents or caregivers who abuse and neglect their children will systematically lie and conceal their behaviour so as to improve their position. When a parent or caregiver fails to recognise their own contributions to the problem this is considered to create higher risk (Sigurdson and Reid 1990). In summary, if a parent or caregiver is not recognising how their behaviour has contributed to their child being harmed there is a higher likelihood of future harm.

The parent's or caregiver's behaviour is presently violent or out of control
If a child or young person is in the care of a parent or caregiver who is currently out of control and/or violent, there is a greater likelihood that the child/young person will be physically harmed either deliberately or accidentally, as the parent or caregiver cannot contain their actions. There is a general understanding that violent behaviour is likely to lead to physical and emotional harm of a child or young person. People who resort to violence in any context are more likely to use violent means with a child or young person (Sigurdson and Reid 1990).

A parent or caregiver is unable to meet their child's protective needs because of mental illness, intellectual/physical disability or because they are the victim of domestic violence or are attached/dependent upon another person who has harmed their child
A parent's or caregiver's ability to meet a child or young person's protective needs can be significantly influenced by mental illness or physical/intellectual disability. Parents or caregivers who are intellectually disabled or mentally ill (eg psychosis), may not be able to respond to their child in an emotionally appropriate manner and/or may not adequately meet their child's physical needs.

The ability to meet a child or young person's protective needs can be influenced by domestic violence and a parent's attachment to or dependence upon another. Parents or caregivers involved in a domestic violence (DV) situation may be unable to protect their child from emotional or physical harm from witnessing or becoming caught in the conflict, whether this is deliberate or accidental. Parents or caregivers who are emotionally attached to or dependent upon (eg financial or psychological dependence) the person who has harmed their child may be unable to act protectively.

The parent/caregiver is experiencing a high degree of stress
Research indicates that the greater the stress for a parent/caregiver the greater the likelihood of future harm for a child or young person (Sigurdson and Reid, 1990). Stressors may include financial issues, physical or emotional isolation, health issues, disability, poverty, the child/young person's behaviour, death of a child/other family member, divorce/separation, large numbers of children and so on.

The parent/caregiver has unrealistic expectations of their child or describes or acts towards their child in a negative way - this includes parent/adolescent conflict
If a parent has unrealistic expectations about the child or young person (often linked to a lack of understanding of developmental levels and poor parenting skills) there is a greater likelihood that the parent will harm the child/young person. This could occur through the parent not appreciating potential harms or physically harming the child or young person by responding to developmentally appropriate behaviour with frustration and anger.

Research linked to this subject has found that adolescents and toddlers are subjected to the most serious acts of parental violence, as parents

may not understand normal developmental milestones and tend to make demands which don't match the child/young person's cognitive, developmental or physical ability (Sigurdson and Reid 1990).

The parent/caregiver has poor attachment to the child/young person
If the parent or caregiver is poorly attached to their child they are likely to demonstrate little interest in their child's well-being and may not meet their emotional needs. When there is no or little attachment, there is a higher risk of the child/young person being rejected which causes significant emotional and sometimes physical harm. An indicator of poor attachment may be repeated requests for alternative care for the child/young person. Multiple placements with a variety of carers, which involve separation and loss for children can have serious emotional and psychological effects upon young children.

Research suggests a number of behavioural and long-term effects for children and young people who have developed attachment disorders such as anxious attachment and detachment.

Anxious attachment, which implies an inability to trust in the presence of the principal attachment figure, may involve behaviour directed at keeping the attachment figure (usually the parent) in close proximity. Anxious attachment is a chronic condition, which may become incorporated in the personality and may result in phobic behaviours, school refusal, sleeping problems and poor peer relations. Anxious attachment may develop as a result of the parent figure being unresponsive, rejecting or inconsistent, threatening to abandon their child, threatening to commit suicide or kill the other parent or their child, or blaming their child for parental illness or impending death. It may also be as a result of multiple loss or separation from parents in infancy or childhood.

Detachment which is an inability to form attachments with others usually arises out of multiple losses or separations during the first few years. With each loss the quality of the child's attachment deteriorates. Some of the clinical features found in detached children and young people include: inability to discriminate in relationships resulting in overfamiliar behaviour with strangers and adults, little reaction to loss or separation, preoccupation with food or material possessions and insensitivity to the needs of others (Drury-Hudson 1994).

The parent/caregiver has a substance abuse problem
Parental substance abuse can result in a number of consequences for children eg

- poor supervision;
- inability to provide basic needs due to lack of money;
- harmful responses to the child or young person due to the parent or caregiver's altered state of consciousness; and
- risk of harm by others as a result of parents being unable to protect their child.

If there is clear evidence that parents have used money, which was needed for food, shelter, clothing or any other essential item, on alcohol or drugs, this should be considered an indicator of the inability to care adequately for the child or young person. A pattern of this sort would indicate that the parent's ability to act in the interests of the child or young person is seriously impaired as obtaining the substance is consistently prioritised over the child/young person's welfare (Sigurdson and Reid 1990).

The parent/caregiver is refusing access to the child/young person, there is reason to believe that the family is about to flee or the family is highly mobile
If parents or caregivers are refusing access to a child or young person, it is possible that the parents wish to avoid further assessment of notified conditions/injuries. A highly mobile family decreases the opportunity for effective intervention and may thus increase the likelihood of future harm to the child/young person.

Other harms from high mobility may include disruption to education and disruption to peer and family relationships.

The parent/caregiver is young - generally under the age of 21
It is generally accepted that youth increases the likelihood of future harm for a child. This is because immaturity, lack of parenting knowledge, poor judgement and the inability to tolerate stress may correlate to youth. While these factors are more likely to be displayed by young parents, they also occur with parents who are older. Consequently increased age does not always decrease the likelihood of future harm.

The parent or caregiver has themself experienced childhood abuse
As parenting skills are frequently learned/modelled from our own childhood experiences, parents or caregivers who have been physically, emotionally or psychologically harmed as children

may also display the harmful parenting behaviours to which they were subjected. However later positive experiences may influence the parent or caregiver's ability to minimise the significance of the childhood harm.

Environment

The physical and social environment is chaotic, hazardous and non- child- safe
A chaotic, unhygienic, non-child-safe physical environment can pose a risk to a child's health through exposure to bacteria/disease or through exposure to hazards such as hot water, stairs, swimming pools and heights eg open windows, balconies etc. The behaviour and ability of the parent within the environment should be assessed, for example what is it about the parent's functioning which contributes to the environment being unsafe, unhygienic or chaotic? What safety strategies have been provided to protect the child in this environment?

In relation to the social environment- children may be at risk of harm through exposure to multiple unknown adults if there is inadequate parental supervision.

Ammerman, R. and Hersen, M. (1988) Children at Risk- An Evaluation of Factors Contributing to Child Abuse and Neglect, Plenum Press, New York.

Drury-Hudson, J. (1994) *'Some effects of attachment disturbance on child behaviour'*, Children Australia, Vol 19, No 1.

Marshall,W.L. and Barbaree, H.E. (1988) *'The long-term evaluation of a behavioural treatement program for child molesters'*, Behaviour Research and Therapy, Vol 26 pp 499-511.

Sigurdson, E. & Reid, G. (1990) The Manitoba Risk Estimation System, Canada

The South Australian Child Protection Manual of Practice 1998.

Appendix L – Extract from the Department of Families Child Protection Procedures Manual – Chapter 27

(ii) Case Management

The term Case Management refers to the responsibility to ensure than an effective case plan is prepared, managed and co-ordinated for a subject child. Case management responsibility is held by one Area Office only for each subject child, regardless of how many Area Offices are involved with the family.

The general guideline is that case management responsibility for a subject child is held by the Area Office responsible for the geographic area where the child resides.

If the child is in care this will be the location of their placement.

The following are exceptions to the general guideline.

When a child's placement is:

• emergency or short-term care; or

• short-term licensed residential care

case management responsibility will rest with the Area Office which referred the child for placement. This will usually be the area in which the main parent is residing.

When a child's placement is:

• long-term residential care, or

• it is not possible to determine a 'usual address' for the child (ie the child is highly mobile)

case management responsibility will rest with the area office for the location in which the main parent or family is residing.

(iii) Decision-making

For cases which fall outside the general guidelines, the decision about which Area Office has case management responsibility for a subject child/children requires negotiation between offices. In such cases, Area Offices should determine case management responsibility based on their professional judgement about how best to meet the needs of a particular child.

Factors to be considered when making decisions about which office should have case management responsibility for a case which falls outside the above guidelines include:

• where is the main family-based casework occurring? If a number of children reside within a boundary of one Area Office, case management may best be facilitated by that office.

• what decision will best facilitate planning to maintain contact between the child and their family?

• what decision will best facilitate planning towards resolution of the child protection concerns and reuniting the child with their family or community?

• has there been a resolution of child protection planning? If a decision has been made about the long-term needs of the children eg to remain in alternative care long-term or to return home, this impacts upon the decision as to which office is best to hold case management

• what is most accessible for the family and will best facilitate the case planning and intervention process?

• children and families have a right to a planned and consistent service. Which decision will promote consistency of service?

• in all circumstances, the best interests of the child or young person is of paramount importance.

(iv) Case co-ordination

This means case management responsibility for siblings may be held by different Area Offices where appropriate. This may occur for example, when siblings are placed in long-term shared family care placements, in different geographical areas.

In such cases, where case management responsibility for subject children within the one family is held by different Area Offices, the offices involved must ensure co-ordinated and integrated case planning. This includes co-operation about the use of client records and the provision of information by Area Offices.

(v) Case Management record

The Case Management record is designed to record:

- Case Membership – built around the subject children whose cases are managed jointly by the one Area Office because they are part of the same family grouping, and any primary clients related to those cases.
- the Area Office with case management responsibility for the subject children.

Case Management records are to be approved by Managers or Team Leaders

(vi) Case work responsibility

The term case work responsibility refers to the responsibility to provide services to the child and family in accordance with an identified case plan.

Case work responsibility will usually coincide with case management responsibility. Case work responsibility can be temporarily given to an office which does not have case management responsibility if the child is residing temporarily in another area. Where there are a number of children residing in different areas, casework responsibility for each child will usually be held by different offices.

Managers or Team Leaders are to negotiate any disputes arising over which offices hold casework responsibility. If the dispute cannot be resolved, line managers area to be consulted

(vii) Case work record

An individual case work record will be established for each case (child). The case work record documents:

- the current status of the case
- the Area Office with case work responsibility.

Case work records are to be approved by Managers or Team Leaders.

(viii) How to 'open' and 'close' a case:

When a decision is made to open a case, the case is officially commenced by creation of:

- a client profile (See 27.3 What is a Client Profile?)
- the Case Management Record (See 27.4 iii)
- the Case Work Record (see 27.4 v)

When an assessment is made that departmental intervention is no longer required and a case is to be closed, this occurs by completion of the Case Work Record (see 27.4 v)

Managers and Team Leaders are to approve the opening and closure of a case.

(ix) Transfer of case management responsibility

Decisions about transfer of case management should take place as part of an overall case plan, which takes account of the family as a whole and does not cause undue disruption to the family.

Case management transfer usually occurs when a child and/or family moves to another area, on a permanent or long-term basis. Stability in the child's living situation should be established before transfer takes place. Generally this is established at some point between eight and twelve weeks.

Managers and Team Leaders are to negotiate and approve the transfer of case management. The principles to be considered in deciding case management responsibility should be used when negotiating transfer of either case management or case work responsibility, or both. (See 27.4 ii) Case Management) .

Appendix M – The child death review in relation to baby Kate

CASE REVIEW FOLLOWING THE DEATH OF BABY KATE

1 INTRODUCTION

Baby Kate was the subject of a Child Protection Follow-Up case opened by Area Green Office of Department of Families Office on 16 July 2001. Baby Kate was found dead in her mother's accommodation unit at Fernbrook residential facility on 10 September 2001. While a final autopsy report will not be provided until completion of a toxicology report, an initial finding of Unexplained Death has been advised.

2 TERMS OF REFERENCE

This Level 2 Child Death Report has been completed at the request of Department of Families Regional Director in accordance with Child Death Reviews policy and procedure dated 16 July2001.

3 PROCESS OF REVIEW

- review of departmental files
- discussion with relevant departmental staff

4 FAMILY COMPOSITION

Subject Child Baby Kate born 01.07.01 aged 3mths

Mother Lisa

Father John

5 HISTORY OF DEPARTMENT OF FAMILIES INVOLVEMENT

5.1 Lisa was subject to a Care and Protection application in 1981 as result of her mother's lack of parenting skills, low levels of intellect and an inability to provide a basic level of care for her baby. Lisa was diagnosed as having [certain medical conditions] and some developmental delays — a family history of delayed intellect and cerebral palsy was identified.

5.2 Lisa turned 18 in July 1998 but casework with Lisa continued after the expiration of the Care and Protection order due to Lisa's intellectual disability. Lisa remained with departmental foster carers for a period of time after her release from care. Minutes of a placement meeting held at Area Office Blue in June 1999 documents concerns regarding Lisa's lack of motivation in doing any household chores and Lisa's inability to 'follow through' on any tasks.

5.3 Area Office Blue received information regarding Lisa on 6 February 2001. Concerns expressed included Lisa's pregnancy, her possible inability to provide adequate care for her child due to Lisa's low intellect and allegations of a domestic violent relationship with the child's father. This information as recorded as an intake and forwarded to Area Green Office as it was an alleged that Lisa was living in the vicinity of that area.

5.4 Area Office Green received a mandatory notification on 10 July 2001. Baby Kate had been born on 1 July 2001 and hospital staff had concerns regarding Lisa's lack of parenting skills and her ability to acquire those skills. Lisa had been observed to shake Baby Kate and verbal abuse had been observed between Lisa and John. This notification was recorded on Priority I (High) and responded to on the day of receipt.

5.5 On initial contact with departmental workers both parents responded negatively to departmental intervention. Lisa indicated awareness that she would have difficulty caring for Baby Kate but felt she would receive support from John and did not want Departmental involvement. John stated that he was embarrassed about the current situation, as he was 'the talk of the town' because Lisa was too stupid to care for the baby.

5.6 Following this initial contact departmental workers again met with Lisa and John and were able to engage well. Both parents acknowledged their need for support in caring for Baby Kate and a plan was developed for support to be provided by departmental staff and community agencies. Lisa acknowledged shaking Baby Kate, was able to identify safety strategies and was able to her stress. An outcome of Substantiated risk was recorded.

5.7 The case was taken to Area Green SCAN on 12 July 2001 where a case plan which allowed Baby Kate to go home with her parents with intensive support and monitoring was developed. At this time it was stated that 'Lisa's skills have improved 200% in the last 4-5 days and Lisa is now asking appropriate questions'. Lisa and Baby Kate were discharged from hospital on 16 July 2001. A Child Protection Follow-up Case was opened with a plan 'to monitor Lisa and John's ability and willingness to provide for Baby Kate on a long-term basis'.

5.8 A home visit on the day after discharge from hospital, 17 July 2001, found a positive situation with appropriate care being given to Baby Kate. Both parents were observed bathing Baby Kate, formula was prepared and sleeping area clean was noted. Again parents were receptive to both departmental and community help.

5.9 During the night of 19 July 2001 Lisa contacted her foster mother. John had been drinking at the local hotel for an extended period and Lisa had been left to care for Baby Kate through the night. Lisa had requested assistance to leave John as she realised she could not adequately care for Baby Kate without support, particularly during the night. Lisa was seen to be acting protectively f Baby Kate.

5.10 Lisa and Baby Kate were placed at a local residential home, a departmental residential facility as an interim measure prior to residing with Lisa's former foster parents in Brisbane. Staff reported no concerns of possible harm for Baby Kate but did observe Lisa to be lazy and unable to prioritise between recreational activities and feeding Baby Kate.

5.11 Lisa and Baby Kate travelled to Brisbane by train on 25 July 2001. A diary kept by Lisa's foster mother indicates similar concerns to those raised by staff both Hospital Green and the local residential home. 'Still going well, but also loses confidence as soon as baby is unsettled. She (Lisa) is becoming more responsible with her baby chores although without constant reminders her willingness deteriorates.' This placement was to provide support and monitoring while a suitable residential facility could be located.

5.12 On July 2001 the case was again discussed at Area Green SCAN with recommendations reached that residential accommodation be found for Lisa and Baby Kate and that the case be transferred when such a placement was finalised. The options of Riverton and Fatima were considered. Staff advise that there was a 22 week waiting period for admission to Fatima. Riverton offers a five-day program but no placement options following the assessment. The case was closed to SCAN.

5.13 On August 13th 2001, following inquiries by the case worker and consultation with both Lisa and her foster mother, Lisa and Baby Kate moved to Fernbrook, a supervised residential for young mothers to learn parenting skills with daytime and overnight supervision. This placement was to provide support and assessment with a possible move to independent accommodation and community supports.

5.14 Baby Kate was examined at Royal Children's Hospital on 14 August 2001 regarding an apparent hernia and a tendency to arch her back. The hospital report identified no major concerns regarding either issue.

5.15 Phone contact between Fernbrook and the case worker on 20th August 2001 indicated similar concerns regarding Lisa's personal hygiene and general tidiness but reported by Lisa was 'maintaining excellent levels of cleanliness with Baby Kate'.

5.16 Contact on 28 August 2001 identified difficulty engaging with Lisa regarding future accommodation. Staff reported concerns regarding Lisa's level of hygiene but stated 'There are no concerns about Lisa's ability to care for Baby Kate who was gaining weight, healthy and very bonded to Lisa.'

5.17 At this time the Department stated its intention to transfer the case to Area Office White. Consideration was initially given to transferring the case to Area Office Blue as Lisa had previously received after-care casework services from that office. It was established that her former caseworker had left so negotiations occurred to transfer the case to Area Office White. Contact with Lisa, her foster parents and Fernbrook continued to be maintained by the Area Green caseworker.

5.18 On 10 September 2001 Lisa put Baby Kate to sleep after a 5pm feed, reporting that Baby Kate was unsettled. Lisa ate her evening meal and completed her communal chores at 7pm. Lisa checked on Baby Kate at 8pm and found her not breathing. Lisa found a staff member who gave CPR to Baby Kate. Ambulance workers were called and they pronounced Baby Kate dead.

5.19 On the night of Baby Kate's death Fernbrook staff advised Crisis Care that 'while there were some long-term concerns for Lisa's ability to parent Baby Kate, on immediate concerns had been present. Lisa had showed no hesitation in contacting Fernbrook staff if she was experiencing any difficulties with Baby Kate or feeling stressed'.

6 KEY ISSUES IDENTIFIED

6.1 The Child Protection Act 1999 requires that Departmental staff engage with families on the least intrusive level possible while maintaining the safety of child. Area Green office staff have demonstrated commitment to this by providing an opportunity for Lisa to demonstrate her ability to principle parent Baby Kate in supportive environments.

6.2 The initial concerns raised by hospital staff that Baby Kate had been shaken were investigated thoroughly and resulted in Lisa identifying that she became stressed when Baby Kate was unsettled and also that Lisa would require assistance, particularly while Baby Kate required night feeds. There were no subsequent reports of any physical harm occurring to Baby Kate.

6.3 The opening of a Child Protection Follow Up Case in response to the identified risk of harm reflected Lisa's willingness to work with the department. She had developed a positive relationship with her case worker an had demonstrated her ability to recognise when she was becoming stressed and to seek assistance.

6.4 While scarcity of resources is an ongoing issue for Departmental Area Offices, it appears that in this case, sufficient time was allowed for the caseworker to build and maintain a positive working relationship with Lisa. This initially occurred via home-visits to Lisa and John at Area White and subsequently via maintaining contact with those providing support and care for Lisa and Baby Kate.

6.5 Consideration was given to placement at Riverton and Fatima. A key issue with Riverton was that the program offered a five-day stay for observation and assessment with no follow-up accommodation. Fatima had a 22-week waiting period. Lisa's foster parents had advised that her foster father had a heart condition and requested that alternative placement options be explored as a matter of urgency. Discussion with various Brisbane based agencies resulted a verbal referral being made to Fernbrook. Lisa and her foster mother visited the facility and agreed on the placement.

6.6 A key issue in assessing safety for Baby Kate was the extent to which Lisa's disability would inhibit her ability to parent her child. At various stages this risk assessment was made in conjunction with SCAN, Child Health, and staff from both the local residential home and Fernbrook. All feedback indicated that Lisa was able to care for Baby Kate with heavy supervision and any risk to Baby Kate appeared to be of a long-term nature. It was envisaged that placement in Fernbrook would determine the extent to which Lisa would be able to learn parenting skills and to match Baby Kate's development.

6.7 Transfer of this case had not occurred at the time of Baby Kate's death.

7 DISCUSSION

7.1 Baby Kate was born to parents Lisa and John. Lisa had a diagnosed disability and had spent a significant period of her life in care of the Department. John was several years older than Lisa and had previously parented a child with another partner.

7.2 The key risk factors identified were Baby Kate's age, the risk of further physical harm following an incident where Lisa had shaken Baby Kate in Hospital, Lisa's disability, the abusive nature of the relationship between Lisa and John and the lack of an informal support network. This combination put by Kate in a high-risk category.

7.3 The initial case plan was to support and monitor Lisa and John's care of Baby Kate. The breakdown of this relationship heightened the need to assess the level of need required by Lisa to safely parent her child. Lisa's actions at this willingness.

7.4 Carers who supported Lisa in three different settings all stated that, mother and child were very well bonded, Lisa required heavy supervision to ensure she attended to Baby Kate's needs in a timely manner but that no immediate risk of harm was present.

7.5 The transfer of the Child protection Follow-up Case to Area Office White had not occurred at the time of Baby Kate's death. Contact was being maintained by Area Green and initial discussion regarding transfer had occurred.

8 SUMMARY

8.1 The death of Baby Kate occurred at a time when she was residing with her mother Lisa at Fernbrook, a residential facility. Her death occurred at a time when assessment was continuing to ascertain the level of support Lisa required to safely parent her child on an ongoing basis. Throughout their involvement with Lisa, Area Green Office staff had consulted appropriately with SCAN and maintained ongoing contact with Lisa and her carers.

8.2 Critical analysis of this cases raises the question of whether the additional consultation with Disability Services Queensland (DSQ) may have assisted in assessing the extent to which Lisa's disability would inhibit her ability to provide long-term care for her child. Such consultation is unlikely however to have altered the availability of support services as direct service delivery from DSQ is focused on clients with severe or profound disabilities.

8.3 Analysis also raises the issue of whether the referral to Fernbrook was the most appropriate in the circumstances. Case notes state that, on referral, a Fernbrook worker advised 'they are an organisation who has dealt with a number of young mothers who have disabilities.. .they have a number of workers on site through the day and a worker was there overnight on call for others who had concerns or emergencies'. While this verbal referral gave a general indication of suitability a more thorough, documented referral which included an indication of Departmental assessment of risk and documented a jointly negotiated case plan outlining roles and responsibilities fall parties would have provided a sound basis for ongoing assessment.

8.4 The transfer of the case was in the process of being undertaken at the time of Baby Kate's death. There is nothing to indicate that this delay had any impact on subsequent events and there remained ongoing involvement by the caseworker with most knowledge of the case, however, a more timely transfer may have facilitated more interaction between Fernbrook and the Department.

9 RECOMMENDATIONS

9.1 It is recommended that when referrals are made to SCAN which involve clients with a disability, a representative from Disability Services Queensland be co-opted to the SCAN team. This would increase the team's capacity to make informed decisions about likelihood of future harm.

9.2 It is recommended that Area Green office develop strategies for enhancing their knowledge about disability issues and incorporate DSQ in case discussions and case planning. Given the level of diagnosed disability for Departmental clients, an increased knowledge of disability issues is essential for all Area Offices. A professional development workshop, which explored the issues of Baby Kate's case, could provide an initial forum for this to occur.

9.3 It is recommended that Departmental policy and procedure regarding the management of Child Protection Follow-Up Cases is addressed in the current review.

9.4 Departmental Area Offices rely heavily on community agencies to provide direct services to departmental clients. It is recommended that consideration e given to the development of a standardised referral process including documentation which outlines an agreed case plan, identifies roles and responsibilities and communication processes.

9.5 When community capacity building issues are being considered, it is recommended that the specific needs of 'at risk parents' are taken into account. The lack of residential facilities, particularly in regional areas, results in parents such as Lisa having very limited opportunity to be demonstrate their ability to acquire skills required to safely parent their children.

15 October 2001

Appendix N – Department of Families response to provisional report and Ombudsman comments

The Queensland Government launched its policy document Queensland Families: Future Directions in June 2002. This document has had a major impact on the Department of Families and the way in which we provide services to the people of Queensland. Supported by national and international research, Queensland Families: Future Directions has provided the Department with a significant new agenda and a range of challenges.

At the outset, it is important to note that virtually all of the issues identified in the provisional report are known to the Department of Families. The Department's reform agenda acknowledges these issues and is progressing them through a series of strategic interlinked projects.

The focus of the Department's response is ensuring a quality child protection system for the future so that the impacts of these past legacies are unlikely to re-occur. In summary, the reform processes are beginning to have a real impact. Reforms to longstanding issues are complex and will take time – but, based on evidence of what has worked elsewhere, these reforms will achieve the Government's objectives over the coming two to four years.

This agenda includes the following:

- **Strategic focus upon prevention and early intervention – June 2002**

In June 2002, the Government announced a significant strategic change by the Government and the Department of Families in emphasising prevention and early intervention. This resulted in $14.9M being allocated to prevention and early intervention initiatives and some $7.24M being allocated to alternative care initiatives.

- **Establishment of the Review and Evaluation Branch – July 2002**

In July 2002, the Review and Evaluation Branch was established and purposefully located in the Office of the Director-General. The primary mandate of this Branch is to assist the Department's Executive Management Committee to review, evaluate and monitor the implementation and impact of strategic policy, strategies, programs and legislation.

On establishment, it comprised two units – a Review Unit and an Evaluation Unit. Of particular note, the Review Unit provides executive and research support to the Review of Significant Incidents Committee (RSIC). This committee (described in more detail below) was established to provide quality and timely oversight of reviews into significant incidents relating to the Department's operation and in particular, the deaths of children and young people with whom the Department has had some involvement.

- **Establishment of the Child Protection Think Tank – August 2002**

The Child Protection Think Tank was established in August 2002 to progress the Department's reform agenda around aspects of the child protection system.

The Think Tank was charged with identifying innovative strategies to deal with urgent and compelling matters, in particular, on how to respond to increasing levels of child protection notifications, and provide advice about the strategic directions and priorities for child protection over the next decade.

The interim report has been completed and is available on the Department's web site. Following receipt of the interim report, the Department prepared an action plan outlining strategies and initiatives identified by the Think Tank. This included:

- trialling a range of differential responses for dealing with all child protection notifications;
- developing a broader range of tools for assessing and responding to the needs of at risk children and young people;
- making changes to policies and procedures to streamline processes and increase effectiveness in working with families; and
- developing throughput and performance benchmarks to enable targets to be set for area offices.

The Department's Executive Management Committee will consider the final report and departmental response in August 2003.

- **Establishment of the Review of Significant Incidents Committee – September 2002**

The Review of Significant Incidents Committee (RSIC) was established in September 2002 to provide quality and timely oversight of reviews into significant incidents in relation to the Department's operation.

A substantial proportion of the Committee's time has been spent on assisting the Review Unit to improve the quality of child death reviews conducted as well as to design and implement a process for monitoring implementation of action plans developed around recommendations from those reviews.

The operation of RSIC ensures that the Department's role in causing any significant incidents will be identified, actions necessary to improve the Department's performance will be taken and the quality of those actions monitored over time.

- **Ceasing of Workload Management – April 2003**

Workload management of child protection notifications by departmental officers ceased on 28 April 2003. 'Workload management' was a strategy used to administratively close initial assessments due to workload reasons.

To ensure that all notifications of allegations of abuse and neglect of children are dealt with, the Department has replaced its workload management policy with a suite of new initiatives that increase the range of responses to children and families.

- **Trialling of Differential Responses – April 2003**

The Department no longer responds to notifications with a 'one size fits all' approach. A range of differential responses commenced being trialled by 25 Area Offices across the State on 28 April 2003 and will conclude on 31 October 2003. The objective of the trials is to increase responsiveness to notifications.

The range of responses includes:

- In-home assessments – conducted by departmental officers when an assessment of the child's environment is central to the assessment of the child's protective needs;
- In-office assessment – families are invited by phone or letter to attend a meeting at a departmental office to discuss the protective needs of their child;
- Planned joint assessments – conducted with specialist workers to assist in the assessment process, i.e. mental health or child health workers;
- Protective advice – provided to the notifier including details of suitable services;
- Assisted referrals – departmental workers actively facilitate contact between a family and an agency to ensure follow-up occurs; and
- Letter and information package – provided to parents advising them of services that are available in their area and other information to assist them.

The anticipated outcomes of the differential response trials are to:

- allow staff greater flexibility so that responses and services can be tailored to the needs of the child and family;
- facilitate better outcomes for children and families including early assistance and intervention; and
- promote collaboration with other government and community agencies and access their expertise to inform assessment and intervention activities.

- **Long Term Stable and Secure Caring Environments – May 2003**

A discussion paper, 'Stopping the drift: Improving the lives of Queensland children and young people in long term care', was released for consultation on 1 May 2003. This paper focuses on the child's right to long term stable and secure care, recognising that the most difficult decisions relate to the most appropriate circumstances for placing a child or young person in the long term care of someone other than his or her parents.

The discussion paper was made available to members of the public as well as key stakeholders including Aboriginal and Torres Strait Islander communities and those in rural and remote areas. Community meetings were held in numerous locations throughout the State to allow feedback from community groups, individuals and peak organisations.

Upon completion of the consultation process, a White Paper will be produced summarising the outcomes of the consultation process, identifying the major issues and formulating recommendations.

- **Whole of Government Strategic Framework for Child Protection – June 2003**

The Department of Families co-ordinated the development of a whole-of-government strategic framework for child protection in collaboration with fifteen other government agencies.

The Framework identifies three strategic directions to guide Queensland Government responses to child protection over the next four years. The strategic directions are consistent with the key themes of Future Directions and are as follows:

- increasing the focus on prevention and early intervention;
- meeting the safety, well being and developmental needs of children and young people who have been significantly harmed; and
- promoting across government partnerships.

The Strategic Framework is accompanied by an Action Plan that sets out the undertakings of each government agency to deliver on the Framework including the implementation of information sharing protocols by Queensland Health, Education Queensland, Queensland Police Service and the Department of Families.

The Framework and Action Plan were endorsed by Cabinet in June 2003.

- **Integrated Client Management System – June 2003**

The Department has targeted the development of a new Integrated Client Management System (ICMS) for child protection and youth justice.

In particular, the ICMS has been targeted to respond to the gross inadequacies of the existing Child Protection Information System (CPIS) in terms of recording and accessing relevant data to support client decision-making. The ICMS will mean that client data will be entered at the closest source once only and that authorised officers can access this data from any location across the state. Current practices of storing data in local systems will cease and the emphasis on hardcopy files as being the main source of information to support decision-making will be replaced. The ICMS will provide automatic alerts and prompts, supported by appropriate business rules, to escalate issues for resolution by relevant decision-makers.

The Department has targeted a two stage tender process for the procurement of the new ICMS. The first of these, the Request for Information was released to the industry on 4 June 2003 along with an Industry Briefing, conducted on Friday 6 June 2003.

- **Establishment of the Quality Assurance Unit – July 2003**

On 1 July 2003, the Quality Assurance Unit was also established within the Review and Evaluation Branch.

The primary purpose of this Unit is to assist work units within the Department to better understand, analyse and report on their performance. The staff of this Unit will be responsible for conducting collaborative reviews of all Area Offices during the next 12 months.

- **Development of the Quality Performance Framework and the introduction of Collaborative Area Office Reviews – August 2003**

The Collaborative Area Office reviews will commence in August 2003.

The Collaborative Area Office review process is a mechanism that will ensure a much better quality of decision-making than has been the case in the past. In particular, the reviews will monitor, validate and evaluate professional decision-making. The Collaborative Area Office Reviews involve a number of phases including:

- The area office will undertake a process of self-assessment.
- An external review team from the Quality Assurance Unit will visit area offices for approximately five days to seek additional information to expand on that obtained from the self-assessment and also to quality assure work practices.
- The Quality Assurance unit will write a 'Collaborative Area Office Review Report' about the Office's performance.
- The Area Office Manager will prepare an improvement plan for the Office based on key themes highlighted in the 'Collaborative Area Office Review Report'.
- This will form the basis for the subsequent Collaborative Area Office Reviews.

Finally, the provisional report makes reference to a range of matters that have ceased to impact on Area Office functioning. In particular, the following should be noted:

- The Child Protection Procedures Manual has been replaced by various Policies and Procedures accessible through the Infonet.
- The Workload Management Policy ceased in April 2003 and additional resources have been applied to ensure that all notifications are dealt with.

- The Think Tank was established for a time-limited period to provide advice to the Director-General. It has now completed its brief with the final report to be considered by the Department's Executive Management Committee in August 2003.

The proposed recommendations to the Department of Families are organised under specific categories to ensure the issues are effectively highlighted and responded to.

Policies and Procedures – Development and Revision

6.4.1 DOF develop written policies and procedures for recording notifications in relation to unborn children and for ensuring that such notifications are followed up when the child is born.

RECOMMENDATION: NOTED

Response/Action to date

In Australia it is not usual practice to record a notification in relation to an unborn child. Currently, NSW is the only Australian jurisdiction that enables a person to report suspected risk of harm in relation to an unborn child and the recording of a pre-natal report.

The Children and Young Persons (Care and Protection) Act 1998 (NSW), Section 25, provides the following:

A person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm after his or her birth may make a report to the Director-General.

Note: The intention of this section is to provide assistance and support to the pregnant woman to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

Section 28 of this legislation outlines details about recording and subsequent action in relation to the report as follows:

The Director-General must keep a record of:

(d) all reports made to or by the Director-General, and

(e) any action taken as a consequence of a report, and

(f) any subsequent disposition of and dealings with children and young persons to whom such reports or actions relate, subject to the regulations.

Currently, there is no legislative basis in the Child Protection Act 1999 (Qld) to intervene with the parents of an unborn child about the safety and well being of their child other than in a voluntary way.

In these circumstances, intervention is directed at risk assessment and planning for the baby's safety needs upon arrival and thereafter.

In the first instance, any policy and procedure would need to articulate a clear framework for working with parents prior to the birth of the child. The scope of the policy and procedure would need to be clarified. That is, which unborn children would this apply to and what type of intervention can/could be undertaken with this group of parents. If policy and procedure were developed it would require additional resourcing to meet community expectation, workload demand and practice development.

Given that this recommendation is not only about having policies and procedures in place, but is a matter for broader community consultation about the rights of the unborn child, this matter will be progressed to Cabinet for consideration in due course.

6.4.2 In consultation with QH, DOF develop a memorandum of understanding that outlines the process for DOF to notify QH that it has concerns about the safety and well being of an unborn child due to be delivered in a QH hospital and for QH to notify DOF when that child has been born.

RECOMMENDATION: NOTED

Response/Action to date

A memorandum of understanding (MOU) is currently being developed by Queensland Health, Queensland Police Service, Department of Families and Education Queensland in relation to respective roles, responsibilities and referrals to Suspected Child Abuse and Neglect (SCAN) Teams. Completion of the MOU is expected in November 2003.

Pending the outcome of consideration by Cabinet as outlined in 6.4.1, the MOU could be expanded to incorporate referral to a SCAN team of an unborn child who is assessed as being at risk of significant danger or harm following birth due to parental factors.

6.8.2 DOF develop and implement procedures and processes to be observed when involving other agencies in a child protection matter to ensure that the officers of the agencies involved understand their responsibilities.

RECOMMENDATION: ENDORSED

Response/Action to date

On 10 June 2003, Cabinet approved the 'Queensland Government Strategic Framework for Child Protection (2003–2006)', which provides the overarching policy framework for child protection and recognises that this issue impacts on the work of a range of government agencies. The development of the policy and accompanying action plan involved 15 state government agencies and focuses on the roles and responsibilities of these respective departments.

A project, Enhanced Collaboration in the Management and Accessibility of Client Information, is currently being co-ordinated by the Department of Families and involves Queensland Police Service, Queensland Health and Education Queensland in further development of co-ordinated record keeping and information sharing across these government agencies in child protection matters. The significant output of this project is the draft interagency protocol entitled 'Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm'. This draft protocol was signed off by the Human Services Chief Executive Officers' Committee on 6 June 2003 and is being trialled from October 2003 to March 2004 in the Sunshine Coast and Brisbane City (North) Regions.

The policy and procedure 'Information sharing: pre-notification' (policy no: 330-1), implemented statewide on 28 April 2003, involves other agencies in providing information to the Department of Families to enable decision-making about whether allegations constitute a child protection notification and what level of action is warranted regarding the allegations. This policy clearly outlines the responsibilities of other agencies in providing this information.

Finally, the Differential Response Trials policies and procedures acknowledge the importance of input from other agencies in child protection investigations and assessments. These policies, implemented on 28 April 2003 highlight the roles and responsibilities of other agencies and DOF when involved in joint assessments of child protection issues.

7.3.2 To ensure appropriate ongoing involvement by a SCAN Team, DOF review its procedures for transferring to a local SCAN Team cases that have been closed to SCAN in another area because the family has left that area.

RECOMMENDATION: ENDORSED

Response/Action to date

The Department of Families chairs the Coordinating Committee on Child Abuse (CCOCA), which is responsible for oversighting SCAN Team functioning and business practices across the State.

The SCAN Team manual currently provides guidelines for the transfer of cases between SCAN Teams for open matters only.

Following the finalisation of the SCAN Team MOU, the SCAN Team Manual will be updated as a matter of priority. This will include reviewing the procedures for the transfer of all cases between SCAN Teams.

Finally, the Integrated Client Management System (ICMS) will allow greater sharing of information and an enhanced capacity to track matters referred to SCAN teams across the State.

7.7.1 The recommendation in the Child Death Review that DOF consider developing a standardised referral process, including documentation outlining an agreed case plan and identifying roles, responsibilities and communication process, be implemented as a matter of urgency.

RECOMMENDATION: ENDORSED

Response/Action to date

A standardised referral process was developed specifically for the Future Directions trials that commenced in November 2002. The documentation that is completed as part of the referral process includes the reason for referral, identified needs of the family, goals for intervention, and area office contact.

It is anticipated that this referral process and accompanying documentation will be evaluated, amended if necessary and implemented more fully during the pilot phase of the Prevention and Early Intervention services.

In addition, the Differential Response Trials that commenced in April 2003 have also incorporated this process and documentation in the provision of the assisted referral response and will be evaluated at the completion of the trials in November 2003.

7.11.1 DOF review its existing policies and procedures in relation to the transfer of case work and case management responsibility with a view to developing a comprehensive policy that addresses the deficiencies I have identified.

RECOMMENDATION: ENDORSED

Response/Action to date

The Department's Executive Management Committee approved the policy and procedure on 'Transfer of case management and casework responsibility' in June 2003 for immediate implementation.

The new policy and procedure is a comprehensive document that clearly describes processes of case management, case co-ordination, case work responsibility, negotiation of case transfer and transfer of case management including interstate transfers of Child Protection Orders and proceedings.

The policy provides for casework responsibility to be temporarily given to another office without the transfer of case management responsibility. There is a range of circumstances outlined in the policy when this action is justified.

This policy will be reviewed in December 2003.

7.11.2 The policy should include a standardised transfer summary for officers to complete to ensure that the receiving office has accurate and timely information concerning the family that they will be working with.

RECOMMENDATION: ENDORSED

Response/Action to date

The policy and procedure on 'Transfer of case management and casework responsibility' approved in June 2003 outlines a range of requirements for the transfer of case management responsibility to proceed. These requirements include both practice responses and various types of case recording, including a case transfer summary, if requested by the receiving office.

The policy outlines a range of documents to be completed before case management transfer can occur. The purpose of this is to ensure that the receiving office has full and current information on the family.

The adequacy of this documentation will be included with the policy review in December 2003.

8.4.3 DOF develop and implement consistent procedures for record keeping in order to eliminate the multiple systems presently used by officers.

RECOMMENDATION: ENDORSED

Responses/Action to date

The Department recognises that there is a legacy of poor information management as highlighted by this case.

The Child Protection Information System is often described as being 'user vicious' and does not have credibility with many staff. As a result, a number of alternative systems have been developed to overcome this legacy.

This is highly problematic and means that information may be recorded in a variety of places. Further, the implication is that the Department of Families cannot assess accurate or historical data quickly.

The Department was allocated funds of $12M over four years in the 2002-03 Budget for better tools and practices. In delivering better tools and practices, a number of strategies are currently being progressed including:

• Integrated Client Management System

The Department has targeted the renewal of its current information technology systems and infrastructure to respond to the demand to provide accurate and current integrated information for decision-making, reporting, performance measurement, and analysis and monitoring purposes. In particular, the Department has targeted the development of a new Integrated Client Management System (ICMS) for child protection and youth justice.

The planning and development for the new ICMS commenced at the beginning of the 2002-03 financial year. This has included business process mapping, the development of the business information architecture and the design of business and system specifications, all of which have formed the basis of a tender document for the new ICMS for release to the information industry.

Mapping the current baseline processes for child protection and youth justice has meant that the Department can look for ways to improve work practices that are supported by responsive and flexible business information systems.

The ICMS specifications were released as a Request for Information (RFI) to the information industry on 6 June 2003. The Department is currently evaluating the responses and plans to shortlist successful suppliers who will then be invited to respond to a Request for Offer, planned for release in early October 2003.

• Regional Systems Support Officers

The Department also appointed 15 Regional Systems Support Officers (RSSO) who are attached to the 11 Regional Offices in 2002. These officers work with Family Services Officers to assist in the recording of case notes and to improve data entry quality. The RSSO will play a pivotal role in the release of the new ICMS including change management and training.

• Better tools trials

Trialling of voice to text translation technologies using a remote device (PCEphone) and the PC desktop has been undertaken to assess business benefits and systems design features.

These technologies have been targeted specifically to assess the benefits in terms of reducing data entry as well as providing remote access to client information.

A number of area offices have taken part in the trialling of voice to text translation on the desktop, whilst targeted area offices have provided feedback on the demonstration of the remote advice, which accessed an external service provider for voice to text translation services.

The learning from these trials have been integrated into the business specification for the ICMS and it is expected that the Department will be well positioned to evaluate and integrate new technology solutions, as part of the new ICMS, to support Family Services Officers in their tasks and activities.

• Information Gathering Record

In April 2003, the Department of Families introduced the 'Information Gathering Record' to streamline recording on a statewide basis. This document is used to contemporaneously record observations and responses to allegations of harm when undertaking an initial assessment. Following the interviews this document is referred to when the initial assessment report is recorded on the Child Protection Information System (CPIS). The document is then retained on the child's file.

• Child protection throughput measures

The Department has recently commenced a specially designed performance-reporting framework for area offices. Each area office will report against ten measures and be able to view their performance against the performance of other area offices and the State average. The identified performance measures will drive change particularly in relation to record keeping. These measures include:

- monthly finalisation rate by area office, for initial assessments (cases not being finalised until they are entered onto CPIS);
- proportion of children in care whose case plans have been reviewed within six months;
- distinct children re-substantiated within 3, 6 and 12 months;
- placement stability;
- open child protection follow-up cases by area office; and
- indigenous children placed in accordance with the Aboriginal Child Placement Principle.

• Records management

A further requirement for the Department is to develop and implement an Operational Record Keeping Implementation Plan (ORIP). Completion of the ORIP is planned for August 2003.

Following the endorsement of this Plan, records keeping best practice procedures will be developed for implementation by all staff (December 2003). A training program will be launched to assist staff to implement these procedures and a monitoring program developed. This will target the multiplicity of systems used to manage records.

9.5.4 DOF immediately review its policy entitled 'Child Death Review Policy and Procedures' to address the deficiencies identified in this report.

9.5.5 The reasons for the decisions about the level of review to be conducted be appropriately recorded in the official file.

RECOMMENDATION: NOTED

Responses/Action to date

As previously advised, the Department of Families commenced a review of this policy in late 2002 with the review being completed in January 2003. However, the Department decided not to progress this further until the findings from the Ombudsman's report could be reviewed.

The Department of Families is now in the position to review the draft policy in light of the Ombudsman's findings.

Legislative Considerations

6.4.3 DOF assess whether the definition of 'child' in the Child Protection Act should be amended to include an unborn child.

RECOMMENDATION: NOTED

Response/Action to date

In addition to previous advice given by the Department of Families on this matter on 29 April 2003, child protection legislation in other Australian jurisdictions does not include an unborn child in the definition of 'child'.

All jurisdictions, apart from the Australian Capital Territory, New South Wales and Victoria define a child to be a person under 18 years of age:

- The ACT Children and Young People Act 1999 defines 'child' to be a person who is under 12 years old and defines a 'young person' as a person who is 12 years old or older, but not yet an adult.
- The Victorian Children and Young People Act 1989 defines a 'child' to be a person who is under the age of 17 or, if there is an order in place for the child, a person who is under 18.
- The NSW Children and Young Persons (Care and Protection) Act 1998 defines a 'child' to be a person who is under 16 years of age.

To alter the definition of 'child' in the Child Protection Act 1999 to include an unborn child is an issue for broader community consultation and this matter will be progressed to Cabinet for consideration in due course.

Learning and Development

6.8.1 DOF evaluate the training that is presently provides to DOF officers responsible for undertaking child protection assessments with a view to identifying whether increased emphasis should be given to conducting risk assessments and considering all relevant information for that purpose.

RECOMMENDATION: ENDORSED

Response/Action to date

Since June 2002, the Department has allocated and spent well over $2.6M on learning and development for employees, almost twice the size of expenditure in previous years. The budget allocation for 2003-04 is even larger, with $3.8M set aside for learning and development for departmental employees. The real investment is even higher when you take into account internally delivered 'on the job' learning and development activities and travel and accommodation for officers attending training.

This allocation has funded specific learning and development strategies including an improved Induction and Learning Program for Family Services Officers, a Leadership and Management Development Program for service delivery managers and team leaders, Lighthouse Projects for service delivery staff to apply learning to improve current work practice and an on-line induction program for all new employees.

The Family Services Officer Induction and Learning Program that is provided to new Family Services Officers contains a module that is devoted to 'Connecting with your clients and community: Assessing, deciding and planning'. The module comprises 143 pages of information, instructions and activities for Family Services Officers to learn from and practice.

This module and other modules within the program refer Family Services Officers to the Department's 'Practice Guide for the Assessment of Harm and Likely Harm'. The emphasis on conducting risk assessments and considering all relevant information for that purpose has increased over recent years and with each review of the program.

The Department already has plans to further increase the emphasis on risk assessment and the use of evidence in practice and decision-making. This is intended to be achieved by delivering the face to face training workshops for new Family Services Officers with a stronger emphasis on problem based learning and practical application of the risk assessment and information gathering frameworks.

As part of an ongoing approach to continuously improve learning and development of our employees, the Department is currently preparing a proposal seeking additional resources for a comprehensive professional practice and learning and development infrastructure for service delivery staff. This proposal will be informed by recommendations arising from internal and external reviews.

Finally, it must be noted that the importance of developing more effective risk assessment models remains firmly on the departmental agenda.

In October 2001, the trial of the Assessment of Risk, Safety and Harm (ARHS) tools was undertaken by staff in three locations following research into safety/danger assessment and risk assessment tools from five US jurisdictions and other Australian states.

Professor Jim Barber subsequently evaluated these tools in August 2002. In summary, Phase One of the audit showed that the ARHS tool improved consistency in priority ratings but Phase Two of the audit, and placement data, indicated that the ratings were inflated. The outcomes and learning from this trial are currently informing the development of an enhanced risk assessment tool.

6.12.1 DOF refer the comments that I have made in this report about the application of the principles in Section 5 of the Child Protection Act and the minimal intervention or least intrusive approach principle to the Child Protection Think Tank for consideration, with a view to that body providing guidance on the weight officers should give to such principles when conducting child protection assessments.

RECOMMENDATION: NOTED

Response/Action to date

As noted in the provisional report, the Child Protection Think Tank considered the concept of 'least intrusive' in 2002 and their interim report (December 2002) acknowledges that the term is not used in the Child Protection Act 1999 and is commonly used/misused in practice.

The Think Tank recommended that the Department of Families develop definitions for the meaning of key terms including the phrase 'least intrusive'. Significant work has been undertaken in this area and the Department of Families will be finalising this work in the near future. To this end, a group will be established to:

- finalise the definitive descriptions for a number of key terms;
- draft a Practice Direction for all staff in relation to the application of the principles in Section 5; and
- develop training for Family Services Officers, Team Leaders and Area Managers throughout the State in 2004.

7.11.3 DOF provide appropriate training to all relevant staff once the policy has been developed. (in relation to 7.11.1)

RECOMMENDATION: ENDORSED

Response/Action to date

The policy and procedure on 'Transfer of case management and casework responsibility' provides key principles, procedural guidance and a framework for professional decision-making to manage the transfer process effectively.

Comprehensive risk assessment and the application of Section 5 of the Child Protection Act 1999 are the critical aspects that underpin effective transfer processes.

As outlined in the response to 6.8.1, the Department of Families acknowledges the need for training regarding risk assessment and decision-making and is currently preparing a proposal seeking additional resources for a comprehensive professional practice and learning and development infrastructure for service delivery staff. This proposal will be informed by recommendations arising from internal and external reviews.

8.4.4 DOF provide training on proper record keeping procedures to officers in Area Office Green and officers in other offices identified in the audit as having inadequate record keeping practices. (refer 8.4.1)

RECOMMENDATION: ENDORSED

Response/Action to date

Records Management Services, Information Services Branch will continue to provide records best practice training to all Area Offices.

This training will be supported by a number of key initiatives including:

- Regional Systems Support Officers (refer to response to 8.4.3);
- Collaborative Area Office Reviews (refer to response to 7.11.4);
- Family Services Officer Learning and Development Programs; and
- Interviewing Children and Recording Evidence (ICARE) training.

The Department of Families and the Queensland Police Service are currently reviewing the training to ensure it remains contemporary and reflects learning from the Ombudsman's review.

Information Resources to Area/Regional Office Staff

6.8.3 DOF immediately issue a written memo to all relevant officers advising them of the authority under section 194 of the Child Protection Act for authorised officers to obtain access to information that is subject to confidentiality under section 63 of the Health Services Act where that information is relevant to the protection and welfare of a child.

RECOMMENDATION: ENDORSED

Response/Action to date

A memo has been developed regarding authority under section 194 of the Child Protection Act 1999. This memo was distributed to staff on 18 July 2003.

7.3.1 In consultation with QH, DOF provide information to its officers about the services provided by Riverton and the criteria for admission there.

RECOMMENDATION: ENDORSED

Response/Action to date

An information paper has been developed regarding the services provided by Riverton and the criteria for admission. This paper was distributed to staff on 1 August 2003.

7.3.3 DOF develop and maintain a comprehensive resource database that contains information about the emergency, support and residential services available in Queensland to assist officers with decisions about the placement and referral of families in need.

RECOMMENDATION: NOTED

Response/Action to date

Specific functionality for a statewide Service Directory has been included in the Department's new Integrated Client Management System (ICMS). This has been targeted for inclusion as stage 1 of this project. Refer to response to 8.4.3. Service Directory functionality will mean that the myriad of local systems that store details about support services can be replaced by one that is up-to-date and centrally maintained.

8.4.5 DOF investigate the use of digital recording devices to assist officers to record contemporaneous file notes while engaged in fieldwork.

RECOMMENDATION: ENDORSED

Response/Action to date

Refer to response to 8.4.3

6.12.2 DOF advise me of the final recommendations of the Child Protection Think Tank and the actions taken, to give effect to any recommendations made (in relation to 6.12.1)

RECOMMENDATION: ENDORSED

Response/Action to date

The Department's Executive Management Committee will consider the final report of the Child Protection Think Tank and the departmental response in August 2003.

The Department of Families will provide a copy of this report to the Ombudsman as soon as it becomes available.

Issue Analysis, Review and Evaluation

7.11.4 DOF investigate the claim that transfers are generally not accorded appropriate priority and, in some cases, refused or deliberately delayed by the receiving office, by: auditing a sample of transferred cases; and consulting with Managers and/or Team Leaders.

RECOMMENDATION: ENDORSED

Response/Action to date

The Collaborative Area Office reviews will commence in August 2003 and information about delays in case transfers will be targeted for specific review.

The Collaborative Area Office process is a mechanism that will ensure a much better quality of decision-making than has been the case in the past. The reviews will monitor, validate and evaluate professional decision-making. The Collaborative Area Office Reviews involves a number of phases including:

- The area office will undertake a process of self-assessment.
- An external review team from the Quality Assurance Unit will visit area offices for approximately five days to seek additional information to expand on that obtained from the self-assessment and also to quality assure work practices.
- The Quality Assurance unit will write a 'Collaborative Area Office Review Report' about the Office's performance.
- The Area Office Manager will write an improvement plan for the Office based on key themes highlighted in the 'Collaborative Area Office Review Report'.
- This will form the basis for the subsequent Collaborative Area Office Reviews.

In addition, the case transfer policy will be reviewed in December 2003 where information regarding priority or delaying of transfers will be examined.

The new ICMS will also provide the opportunity to electronically record the details of a client at the closest source, once only. It will also mean that any officer who deals with the same client will have the full profile of details about that client to support decision-making. The ICMS will be accessible from all work locations by all FSOs, and client records will be automatically available should a client transfer from one Area Office to another.

8.4.1 DOF undertake a statewide audit of record keeping practices in its offices to determine whether the record keeping deficiencies identified in Area Office Green also exist in those offices.

RECOMMENDATION: NOTED

Response/Action to date

A statewide audit of record keeping practices in its offices would only flag what is already known to the Department of Families – that there are record keeping deficiencies across the State.

Rather, the Department will implement the learnings from the current review undertaken by the Queensland Ombudsman, the current Audit of foster carers and the Collaborative Area Office Reviews.

8.4.2 DOF review whether present resourcing is sufficient to enable officers to maintain appropriate records and if not, provide administratve or other support to assist officers in the performance of this obligation.

RECOMMENDATION: NOTED

Response/Action to date

The issue of the adequacy of resources is a matter for Government.

However, the Department is currently undertaking the development of a resource allocation model that will inform the allocation of staff across regions. This model will be implemented in late 2003.

In addition, the Department will continue advocating for additional funding though the Cabinet Budget Review Committee.

Management of Child Death Reviews

9.5.1 A body external to DOF investigate, or review the investigation of the deaths of all children known to DOF.

9.5.2 A committee be established comprising representatives from the Office of the Commissioner for Children and Young People, DOF, QH, QPS and other appropriate experts to evaluate and make recommendations about the most suitable model for this body.

9.5.3 The Commissioner for Children and Young People be the Chairperson of the committee and the Commissioner's Office provided administrative support to the committee.

RECOMMENDATION: NOTED

Response/Action to date

Consideration of whether or not to establish a body as described in these recommendations is a major public policy issue. As such the decision on whether or not to accept this recommendation sits with Cabinet.

The Department of Families will progress a submission to Cabinet in due course.

As the Ombudsman's Investigation Team (Peter Cantwell and Angela Ritchie) were briefed earlier this year, the Review of Significant Incidents Committee (established in September 2002) comprises representatives of key directorates within the Department as well as having one member external to the Department (currently from Queensland Corrective Services). During the past 11 months, RSIC has developed and implemented a process to:

- monitor all reviews of child deaths requested by the Director-General;
- consider review reports and recommendations when they are finalised;
- assign responsibility for taking actions in relation to review recommendations as appropriate;
- monitor the quality and timeliness of actions taken; and
- manage the action plan until it is considered to have been fully addressed.

At monthly RSIC meetings, the progress of reviews into child deaths and current action plans following a child death review are reported to the Committee. The quality of reviews conducted and action plans developed have significantly improved since the establishment of the committee. With the assistance of staff from the Review Unit within the Review and Evaluation Branch, RSIC is commencing an analysis of whether there are patterns and trends in the deaths of children or young people with whom the Department has had some involvement.

Disciplinary Action

10.2 Contents of this report be drawn to the attention of the Director-General for consideration of matters in relation to disciplinary action.

Response/Action to date

The Director-General has carefully considered the contents of the provisional report and will give full consideration to the matters in relation to disciplinary action as soon as the final report of the Ombudsman is issued.

Steve Armitage
Acting Director-General
Department of Families
4 August 2003

Appendix O – Queensland Health response to provisional report

Thank you for your correspondence dated 3 July 2003 inviting Queensland Health to comment on the opinions and proposed recommendations contained in the Provisional Report and Proposed Recommendations – The Baby Kate Report. I am grateful for this opportunity to provide comments prior to this provisional report being finalised and forwarded to the Speaker of the Queensland Parliament.

I note that at this stage, the report does not contain any proposed adverse comment about any Queensland Health officer.

There are however, provisional recommendations that require co-operative action between Queensland Health and the Department of Families (DOF), the Queensland Police Service (QPS) and the Commission for Children and Young People (CCYP) – specifically recommendations relating to improved administrative practice (4.4.2 & 4.4.3); decisions about intervention (6.4.2); case management decisions (7.3.1); and child death review (9.6.2).[252]

Officers of my department have reviewed this provisional report and inform me that no significant issues of fact have been identified.

I would advise that inclusion of the newly appointed Queensland Coroner to the child death review committee (recommendation 9.6.2) be given active consideration in your final report. The State Coroner is an active member of the Inter-Departmental Steering Committee (IDSC) – Forensic Sciences which is tasked with addressing communication and service delivery issues between departments.

Queensland Health will act co-operatively with the relevant departments to action the report recommendations as they are finalised.

Dr R Stable
Director-General
Queensland Health

252 In my provisional report I recommended at 9.6.1 'A body external to DOF be established to investigate, or review the investigation of, the deaths of all children known to DOF' and at 9.6.2 that 'A committee be established comprising representatives from the Office of the Commission for Children and Young People, DOF, QH, QPS and other appropriate experts to evaluate and make recommendations about the most suitable model for this body'. I have since amended my recommendations which now appear at 9.5.

Appendix P – Queensland Police Service response to provisional report

Re: Provisional Report Of Queensland Ombudsman – Investigation Into The Adequacy Of The Actions Of Certain Government Agencies In Relation To The Safety, Well Being And Care Of The Late Baby Kate, Who Died Aged 10 Weeks.

I refer to your correspondence dated 3 July 2003 attaching a copy of the provisional report, which you have compiled in relation to the abovementioned matter and provide the following response.

JURISDICTION

I note that s.14 of the Ombudsman Act 2001 ('OA') specifies that you 'may investigate administrative actions of agencies'. The term 'administrative action' is defined in s.7 OA and specifically excludes an 'operational action of a police officer'. (s.7(2) OA).

The term 'operational action' is defined in schedule 3 of the OA as follows:

'Operational Action', for a police officer, a criminal justice commission officer or a crime commission officer, means any action taken in or for performing functions the officer has under powers conferred on the officer by any Act or law, including, for example –

(a) enforcement powers;

(b) investigation, information gathering, search and questioning powers;

(c) arrest and custody powers;

(d) powers for preserving public order and safety;

(e) for a police officer, powers of a public official.

'example – powers a police officer or criminal justice commission officer has under the Police Powers and Responsibilities Act 2000'.

It is my view that all actions of police officers involved in the investigation of Baby Kate's death were undertaken in the exercise of the police officers powers under the Police Powers and Responsibilities Act 2000 or in assisting the Coroner under the provisions of the Coroners Act 1958. As such, I believe that the actions of any police officer taken in relation to this matter fall within the definition of 'operational action' in the OA and therefore fall outside your investigative jurisdiction.

In addition, if a police officer fails to comply with a provision of the Operational Procedures Manual ('OPM'), the officer is liable to disciplinary action under Part 7 of the Police Service Administration Act 1990. In these circumstances, it would appear that even if the actions of the relevant police officers involved were to be considered 'administrative' actions, (which is not conceded), s.16(2)(d) of the OA would appear to exclude your jurisdiction to investigate the actions of the police officers involved in this matter.

Notwithstanding my concerns regarding the possibility that some of the content of your provisional report has been included in excess of your investigative jurisdiction, I provide the following comments in relation to the issues raised insofar as they address the actions of the relevant police officers and the Queensland Police Service.

POLICY AND PROCEDURES OF THE QUEENSLAND POLICE SERVICE

Form 4 'Report Concerning Death by Member of the Police Service'

The Form 4 in this instance was completed by the first response officer whilst in attendance at the John Tonge Centre, and was done so in accordance with Service policy. The Service policy regarding procedures for the completion of a Form 4 and the lodgement of a deceased person at the John Tonge Centre are contained in sections 8.4.8, 8.4.13 and 8.4.15 of the Operational Procedures Manual (OPM). The Service policy as it was in September 2001 stated:

8.4.8 Completion of Form 4

PROCEDURE

The purpose of the Form 4 is to assist the Coroner in deciding whether a post-mortem should be ordered, and to assist the pathologist performing the post-mortem to establish the cause of death. Therefore the investigating officer should complete the form as soon as possible. In some cases, the form may be completed and post mortem examination procedures carried out before the deceased is positively identified. Generally, the post mortem examination will be carried out on the next working day of the Government Pathologist, Government Medical Officer or other medical practitioner, as applicable. The Form 4 should be completed and an order for post mortem obtained before that time (emphasis added).

8.4.13 Special arrangements John Tonge Centre

The John Tonge Centre, Nathan, is the morgue which serves the metropolitan and near metropolitan areas. Due to the volume of deceased persons processed, procedures for that centre differ from other morgues throughout the State. The procedures outlined above differ in respect of:

(i) placing a body in the morgue;

(ii) obtaining an order for post-mortem;

(iii) attending the post-mortem; and

(iv) registering the death.

ORDER

Officers attached to the John Tonge Centre are to ensure compliance with the provisions of this chapter, except where those provisions are inconsistent with the special arrangements provided for the John Tonge Centre.

8.4.15 Obtaining order for post-mortem at John Tonge Centre

POLICY

In the case of bodies placed in the John Tonge Centre, there is no necessity to deliver the original and copy of the Form 4 to the Coroner immediately. Where facsimile facilities exist, the investigating officer may forward a copy of the Form 4 by facsimile to the office of the Brisbane Coroner, and a second facsimile copy to the John Tonge Centre police office. The Coroner will then provide an order for post mortem direct to the John Tonge Centre.

When transmitting forms by facsimile, it is not necessary to send a covering sheet.

After transmitting a Form 4 by facsimile, the investigating officer should then forward the original and two copies of the Form 4 to the office of the Brisbane Coroner by Service despatch or by mail.

In instances where the deceased is transported from an area outside the jurisdiction of the Brisbane Coroner, it will still be necessary to obtain an order for post mortem from the local Coroner. In these cases, the order should be transmitted by facsimile message to the John Tonge Centre, and the original later sent by Service despatch or by mail.

The above-mentioned policies were in effect at the time of the incident in September 2001 and remain the current policies of the Service in relation to the completion of a Form 4 and obtaining an order for a post mortem examination from the Coroner when a deceased person is lodged at the John Tonge Centre. From the information provided, it would appear the first response officer responsible for the lodgement of the deceased child at the John Tonge Centre on 10 September 2001 complied with all relevant Service policies and procedures.

The current Form 4 'Report Concerning Death by Member of the Police Service' was developed by the Department of Justice and Attorney-General in accordance with section 6 of The Coroners Rules 1959. The Form 4 was approved in the Government Gazette on 11 October 1996 and has not been amended to date.

Instructions for the completion of the Form 4 require officers to state the brief circumstances of death so far as ascertained and is based on the information known at the time. These instructions clearly do not contemplate the completion of the Form 4 after all investigations have been undertaken. This process is affirmed when regard is had to the fact that post mortem examinations are generally conducted on the first working day following the lodgement of the deceased persons body to ensure the accuracy of results and the release of the deceased person to the family as soon as possible.

Section 12 of the *Coroners Act 1958* requires every person who finds a dead body, or has knowledge of the finding of a dead body or of the death of any person to report such information to a police officer who is then required to report the matter to the Coroner. Section 6 of The Coroners Rules 1959 requires a member of the Police Service to report a death to the Coroner in the approved form, which is currently the Form 4.

As the current Form 4 was developed and is administered by the Department of Justice and Attorney-General, the Service is unable to deviate from the information to be recorded on the form.

Section 50 of the *Coroners Act 1958* places a duty on a police officer to assist a Coroner in their inquiries and in the exercise and performance of their powers and duties under the *Coroners Act 1958*. Such assistance includes the completion of a Form 4, which is forwarded to the Coroner to assist the Coroner in determining whether or not to order a post-mortem examination under section 18 of the *Coroners Act 195*8.

The information recorded on a Form 4 is obtained from initial investigations at the scene of the incident. In the present case, officers spoke with the deceased child's mother who provided police with a version of events and it was this information that was recorded on the Form 4 as indicated on page 26 of your report.

You have indicated in your report at page 26 that 'This was the only information ever provided by the Service to the Pathologist.' In relation to this comment I am informed that this was in fact the only information available at the time the Form 4 was completed and was conveyed to the Pathologist by police who were acting as assistants to the Coroner under the provisions of the *Coroners Act 1958*.

On page 27 of your report you have commented that, 'it is apparent that the Form 4 does not state that baby Kate's head was covered with any blankets or jumpers.' In response to this comment, I am informed that the information the blankets were placed over the head of the deceased child when she was in her cot was not obtained until the following day. This information was provided in a statement by the child's mother and was forwarded to the Coroner as part of the coronial brief of evidence for his consideration in determining whether or not to hold an inquest. The information that was contained on the Form 4 consisted of what was available at the time and clearly stated that:

the mother has placed the baby on her stomach and covered her with a blanket and two jumpers.

You have indicated at page 29 of your report that the requirement for officers to provide 'brief circumstances of the death so far as ascertained' is indicative of a requirement to provide further details ascertained during any subsequent investigation. As the Form 4 is completed and forwarded to the Coroner to assist him in determining whether an order for a post mortem examination should be made, it would appear that the form's purpose is not to contemplate the provision of information gleaned from subsequent investigations as this material would form part of the coronial brief of evidence.

The Form 4 used by members of the Service in accordance with the provisions of the Coroners Act 1958 places a requirement on officers in the footnote to the form to clearly state whether there exists any suspicious circumstances or not. The officer completing the Form 4 on this occasion complied with these instructions.

You have expressed concern that what was recorded on the Form 4 in accordance with the instructions in the footnote may have inappropriately influenced any subsequent investigation and findings by the Coroner. At the time the Coroner made his ruling in relation to the holding of an inquest into the sudden death of baby Kate, he was in possession of the full brief of evidence that contained the statement of the child's mother, Department of Families records relating to the deceased child and relevant hospital records relating to both the deceased child and her mother. The Coroner was therefore appraised of all information relating to this matter and his decision not to hold an inquest resulted from an independent and unbiased assessment of the evidence.

New *Coroners Act 2003*

Section 7 'Duty to report deaths' of the Coroners Act 2003 places a requirement under subsection (3) on a police officer to whom a death is reported to report the death to the Coroner in writing. Presently, the Department of Justice and Attorney-General who administer the Coroners Act 2003 have not developed any forms in relation to the new Act. It may be beneficial for you to forward your suggestions regarding the deficiencies with the current Form 4 to the Department of Justice and Attorney-General for consideration when developing the new forms.

Child Protection Information System (CPIS)

The Service policy relating to conducting a check of the Child Protection Information System in the instance of a sudden unexplained infant death is contained in section 8.5.10 of the Operational Procedures Manual, which provides:

8.5.10 Sudden Infant Death Syndrome (SIDS)

POLICY

Sudden Infant Death Syndrome (SIDS) or 'cot death' can be responsible for the deaths of otherwise healthy children between two weeks and two years of age. The specific cause of this type of death is unknown. Officers should be aware that SIDS deaths are invariably extremely traumatic for parents of the child and any investigation should be conducted in as tactful and unobtrusive manner as possible.

Where an officer attends a suspected SIDS death, an attempt should be made to interview the parents and arrange identification of the infant before the body is removed to the morgue. Attempts should be made to avoid the trauma of having a parent attend at the morgue to identify the infant. The parents should be reassured that either they or their relatives may arrange with the funeral director to view the body again if they so desire.

ORDER

In the case of any death suspected of being the result of sudden infant death syndrome, the investigating officer is to:

(i) in areas where the post-mortem examination will be performed at the John Tonge Centre, Brisbane, ensure that the counsellor at that centre is advised of the incident;

(ii in all other areas, contact the nearest Department of Health Community Health Centre and advise of the incident;

(iii) notify the Officer in Charge, Sexual Crimes Investigation Unit and arrange to have a search made of the Child Protection Register for any previous child abuse history of the deceased;

(iv) note on the Form 4 that the above action in part (ii) has been completed; and

(v) provide a copy of the booklet 'Facts about Sudden Infant Death Syndrome (Cot Death)' to the parents where one is available.

PROCEDURE

Officers should see s. 7.14: 'Sudden deaths of children' of this Manual for procedures relating to the investigation of sudden unexplained deaths of children.

It has been identified that an anomaly existed in the above-mentioned policy at the time of this incident. This error has been rectified to ensure the inclusion of information relating to a CPIS check is contained on the Form 4.

Section 7.14 of the Operational Procedures Manual

Service policy relating to the investigation of sudden deaths of children is contained in section 7.14 of the Operational Procedures Manual. In relation to conducting a check of the CPIS, the policy provides in part:

ORDER

When the Officer in Charge, Sexual Crimes Investigation Unit, or other officer authorised to access the Child Protection Information System, receives notification of the sudden unexplained death of a child, that officer in charge or other officer is to initiate a search of the Child Protection Information System and forward the results of the search to the officer investigating the sudden unexplained death of the child.

When the results of the Child Protection Information System are received by the officer investigating the sudden unexplained death of a child, that officer is to bring the results of the system search to the attention of the medical practitioner conducting the post-mortem examination before that examination commences (emphasis added).

I have been informed that the investigating officer in this matter sent a computer message at 10:15pm on 10 September 2001 to the Officer in Charge of the Sexual Crime Investigation Unit to request a check of the Child Protection Information System.

The post-mortem was conducted on the deceased child at 8:30am on 11 September 2001 and the investigating officers received the results of the CPIS check by facsimile at 2:36pm on 11 September 2001. Therefore, the requirement contained in section 7.14 of the Operational Procedures Manual that such information be conveyed to the medical practitioner conducting the post mortem before that examination commenced was not met.

Consideration will be given to reviewing the current Service policies and procedures in relation to conducting CPIS checks when investigating a sudden unexplained death of a child.

Training

Training in relation to the investigation of sudden unexplained child deaths is a component of the Juvenile Aid Bureau course that is conducted internally by the Sexual Crimes Investigation Unit, State Crime Operations Command.

In response to the recommendations from the Crime and Misconduct Commission paper 'Seeking Justice – Investigation into sexual offences by the Criminal Justice System' the Service will be undertaking a review of all training conducted by the Sexual Crimes Investigation Unit, encompassing the Juvenile Aid Bureau course.

The Queensland Police Service Competency Acquisition Program (CAP) is a program designed to meet the National Training Board guidelines in relation to competency-based training. It ensures that participants develop competencies specific to policing while acquiring generic key competencies. The Service currently distributes a participant work and reference book entitled 'Child Abuse Investigations' of which a component of this workbook provides the participants with an understanding of the processes and guidelines for the investigation of sudden infant deaths. This particular component makes specific reference to section 7.14 of the Operational Procedures Manual.

The 'Child Abuse Investigations' workbook is currently being reviewed to ensure the currency of information and will be available for release in late August 2003.

I am informed that recruits undertaking pre-service training as part of the Police Recruit Operational Vocational Education (PROVE) program that is conducted at the Queensland Police Service Academy receive specific training relating to the investigation and handling of sudden unexplained infant deaths.

All officers are provided with a 'first response handbook' that has been prepared to assist operational police in first response situations where decisions must often be made and appropriate and timely action taken. Specific reference is made within the handbook to the relevant sections of the Operational Procedures Manual that relate to the investigation of sudden unexplained child deaths.

Death Scene Investigation Checklist

I have perused Appendices 'F' and 'G' in your report and concur with your recommendation that there is scope for the development of a standardised death scene investigation report for the investigation of not only the sudden unexplained death of a child but also in relation to all sudden deaths where a medical certificate is not forthcoming. The development of appropriate forms would appear to be an effective tool for enhancing communication between the Service and pathologists, subject to the direction of a Coroner whom the police are assisting.

It is noted that several units within the Service have developed such checklists similar in principle to the Appendices, and have done so as part of a localised standard operating procedure.

I am informed that the Coordinating Committee on Child Abuse, Child Death Sub-Committee are presently considering the issue of the development of an appropriate form to be used during the investigation of a sudden unexplained child death.

Consideration will be given to your recommendation in relation to the development of an appropriate form having regard to any statutory restrictions placed on the Service in relation to the release of information.

I trust that you will find the abovementioned comments of assistance in the preparation of your final report.

R. ATKINSON
COMMISSIONER

Appendix Q – Response to notice of proposed adverse comment FSO One

FSO One provided me with a lengthy submission of 41 typed pages in response to my provisional report. Some material in her reply was repetitious or could not be considered a submission about proposed adverse comment. I have summarised FSO One's submissions in this appendix. Where appropriate, a significant number of submissions made by FSO One have also been incorporated into my report at various points.

FSO One did not accept or agree with the majority of the adverse comment, which I had indicated to her I would be making in my report. She said in her reply that 'Nowhere in your report do you provide any substantive evidence to indicate that any administrative action (as defined in section 7 of the Ombudsman Act) performed (or not) by myself, to be either *unreasonable* or *wrong*'. She also claimed that my report unfairly singled out particular persons, principally herself, and was not confined to an examination of the adequacy of 'the actions of certain agencies' as the title of my report suggested. She felt that my report implied a 'bottom up approach' to decision-making within DOF when a 'top down approach' was applicable and that the roles and responsibilities of Team Leaders and Managers in relation to decisions/actions she may have made were not appropriately considered.[253]

FSO One also submitted that although I had acknowledged FSO Four's 'concerns and subsequent efforts to ensure that these were understood by workers in Area Office Green' her own levels of 'distress and frustration in relation to the delay' in having either case-work or case management transferred from Area Office Green to Area Office White were not acknowledged and that this was a significant oversight.[254]

FSO One agreed with a number of my comments in the provisional report in relation to the failure to transfer baby Kate's case between the two Area Offices and record keeping. Those comments related to:

- that there was an unacceptable delay in transferring the case to Area Office White;[255]
- the desirability of a detailed transfer summary;
- that she had conducted herself professionally despite her strained relationship with FSO Five;
- the need to create contemporaneous and reasonably comprehensive records; and
- the notification was dated the day after it was received.

FSO One's response contained the following summary of her key submissions:

"The Initial Assessment

- I believe that I made every reasonable effort to gather and collate all information relevant to this Initial Assessment, and that all of my actions and decisions were discussed with, and authorised by, a supervisor.
- I believe that this Initial Assessment was conducted in accordance with the Procedures Manual and that every consideration, decision and action was not only conducted in accordance with the provisions of the *Child Protection Act 1999* (Qld), but sanctioned by the appropriate authority. I further believe that I conducted this Initial Assessment to the best of my then professional knowledge and experience, with the then available resources.
- I feel that the opinions stated in your report are based on incorrect interpretations of particular actions and decisions, and that your report fails to provide comprehensive factual information, such as those relating to the assessment of the father and the placement of the mother and child at the Group Home.
- I feel that your report does not adequately reflect the situation in Area Office Green in terms of lack of appropriate supervision (Team Leader) for 9 weeks for all FSOs in the Initial Assessment Team, the high case loads, and the extreme time constraints on workers in relation to prioritising tasks according to their statutory roles, and the inappropriate responsibilities placed on FSOs during this time.
- I believe that your report also fails to acknowledge or delineate the roles and responsibilities of FSOs, Team Leaders and Managers, and does not take into consideration the relevance of a PO3 level worker in terms of expected knowledge and skills.

253 Section 10 of the Ombudsman Act provides that an 'administrative action of an agency' includes administrative action taken by an officer.

254 A comprehensive extract of FSO One's interview with my officers in relation to this issue appeared in the provisional report as it does in this report in section 7.9.3.

255 See section 7.9.3 of this report.

Case Management Decisions

- I do not agree with the intended meaning of your opinions relating to my knowledge of services within the metropolitan area and believe that this statement is an assumption of my abilities and is therefore invalid and irrelevant in terms of an adverse comment.
- I do not agree that DOF involvement with this family was based on the rights or interests of the parent, and maintain that at all times the welfare of the child was the primary consideration in terms of my actions/decisions, and that these were at all times authorised by my supervisor.
- I do not agree that my actions in relation to contact with Fernbrook were 'less than adequate' and maintain that I made every effort under the circumstances to continue to gather and assess information relevant to the safety of the child.
- I believe that I made every attempt and effort within my power as an FSO to facilitate the transfer of this case to ensure ongoing support and assessment.
- I feel that your report does not adequately reflect my level of concerns and frustration in relation to what I considered a delay or failure on FSO Five's part to initiate and complete the transfer according to the avenues open to her as a Team Leader.
- I feel that your report reflects a 'bias' in that it clearly acknowledges FSO Four's concerns and her efforts to be 'heard', yet it fails to acknowledge my own frustration and concern in terms of the transfer yet it is clear that this (the transfer) was a priority for me as an FSO.

Record Keeping

- I do not agree that my case notes were not contemporaneous, factual and accurate reflections of events, decisions and observations.
- I do agree that there was a delay in inputting information onto CPIS.
- I believe that my administrative practices were conducted according to time constraints, my knowledge and understanding at the time, and that at no time did I 'sanitise' my or DOF's records to enhance or 'favourably' reflect my case work for any purpose.
- I believe that your opinions concerning delays relating to the CPIS records are incorrect on a number of points including the time frame for the Initial Assessment 'write up', and the processes relating to the creation of documents, authorised access according to worker position, and time constraints as detailed in my responses."

OTHER SUBMISSIONS

FSO One made other submissions not contained in her 'conclusion'. Whilst the majority of these have been incorporated in my report at various points, I have summarised her submissions as follows:

- The report misrepresented the actions that FSO One took during the initial assessment.
- That she gathered information from appropriate sources including:
  - QH
  - SCAN Team Paediatrician
  - CPIS (Intake and the April case Note)
  - Lisa's foster mother.
- She formulated an 'action strategy' that was endorsed by the SCAN Team.
- That the initial assessment was conducted in accordance with the guidelines.
- Both parents 'acknowledged and demonstrated' a willingness to care for baby Kate.
- John clearly identified his commitment to baby Kate's safety and well being.
- John's 'reactions and responses' were 'consistent and appropriate' in terms of prioritising baby Kate's needs.
- John articulated his intention 'to establish and maintain a solid support network for Lisa should he not be available at any given time'.
- John demonstrated his 'parenting ability' and his awareness of baby Kate's needs during his 'rooming in' at Hospital Green.
- Both parents identified family supports.

- DOF acted appropriately in not taking statutory action and by releasing baby Kate from the hospital and initiating a CPFU.
- Of the 13 risks identified in DOF's Practice Guide, only one was identified for John – this related to the nature of the relationship between himself and Lisa.
- The provisional report failed to include a risk assessment of John and should have.
- The initial assessment document correctly shows that risks to baby Kate were identified and acknowledged and recorded in the outcome section as 'substantiated risk of neglect and substantiated risk of physical harm'.
- Baby Kate had one parent (Lisa) who was 'willing' however her ability was 'doubtful' and one parent John who was 'both willing (and assessed by QH staff and FSOs Two and Three) and able…'
- She conducted a home visit to assess the situation once both Lisa and John had had an opportunity to parent overnight without supervision.
- Decisions were both discussed with and approved by her supervisor.
- The SCAN Team Paediatrician at Hospital Green supported her decisions.
- There are extremely limited opportunities to complete, or in most cases commence, administrative tasks in Area Office Green.
- She had an extensive workload at the relevant time as follows:
  "At the time of this particular Initial Assessment, I had case responsibility for 14 families consisting of 7 ongoing Initial Assessments (including this one), 5 CPFU's of which there were 1 pending application for a Child Protection Order, and 2 families on Child Protection Orders, as well as being 'rostered on' for Intake duties for one and a half days per week. In total my case load consisted of 20 children of which 11 were vulnerable (under 5).

  From the date of this Notification to the 10th September 01, I was allocated a further 11 Initial Assessments of which 5 were priority 1's and 6 were priority 2's, as well as acting as 'second' on approximately 14 Initial Assessments allocated to other worker. It is important to note here that Initial Assessments often require a number of interviews, meetings etc to finalise and at one stage I was actively assessing and/or involved in at least 9 assessments at a time. In terms of note taking, it would be impossible to maintain administrative (full comprehensive case notes etc) in the time available. It is also important to note that due to the Intake duties expected of all workers, I personally was effectively left with three and a half days per week for all other assessments, case work on CPFUs and the preparation of Court related documents for the pending CPOs."
- The Intake and Assessment Team did not have a Team Leader at the relevant time which placed all FSOs in an extremely vulnerable position in terms of 'accountability for decisions and actions, a responsibility and burden that is not theirs to carry according to DOF roles, responsibilities and delegations'.
- A 'back-log of paperwork' was preferable to a back-log of notifications where children have been harmed or are at significant risk of harm.
- Any inadequacies in the initial assessment document that she prepared should have been 'picked up', noted and acted upon by her supervisor.
- Any information FSO Four wanted to convey should have been included in the intake and the case note, both of which were not prepared by her.
- Hospital White's decision to merely 'note' the incident of Lisa shaking baby Kate on the baby's chart was inadequate and should have been reported to DOF thus allowing an earlier opportunity for DOF intervention.[256]
- The comment that DOF officers should have re-assessed Lisa's ability and willingness to care for baby Kate once the relationship between Lisa and John had ended is 'totally unfounded and conflicting in relation to the events of the day' – her assessment was 'ongoing and this new situation required immediate action and response', which was provided.
- She re-assessed the risks to baby Kate and acted appropriately in an effort to minimise them.
- Her comments about the least intrusive approach have been taken out of context and been misconstrued.
- She does not agree that DOF placed too much emphasis on the least intrusive approach.

256 This issue is discussed at section 5.1.3 of this report.

- She believes an application by DOF for a child protection order would not have been successful given that the requirements of section 159 of the *Child Protection Act* could not have been met.
- She said:

  … your statement suggests that up till this time in the assessment process, there was no or little information gathered about Lisa's ability to parent. I would argue that this was not the case and in fact it was this information that provided the basis for the decision not to proceed with the referral. On this ground, I would argue that my comment that 'Riverton would be setting her up to fail' was based on my expectation that the report from this agency would merely confirm this. This being so, I can only assume that your opinion is based on your interpretation of my meaning only and is therefore neither valid nor relevant.
- At the time this case was closed to the SCAN Team, she was not present and therefore this decision was not hers.
- She maintains that the decision to place Lisa and baby Kate at Fernbrook was appropriate under the circumstances.
- That she maintained contact with Fernbrook staff, Lisa and the foster mother to the best of her ability with consideration of distance, workloads and priorities of other cases at the time.
- She had recognised the difficulties in managing a case over a considerable distance and felt very strongly about this unsuitable situation.
- There are 14 instances where information 'was passed on, obtained and/or sought'.
- The information provided by her during this investigation was 'authentic, truthful and therefore valid'.
- She maintained that she made contemporaneous handwritten notes, but agreed that the manual notes were then 'transferred to CPIS' on the dates that were recorded.
- She believes that the making of contemporaneous case notes is vital and said that she makes the effort within workload and time constraints to do so.

At FSO One's request, I have not set out some information that she provided in her response in relation to the initial assessment.

FSO One also made further submissions about the administrative conduct of FSO Five in relation to the transfer of baby Kate's child protection matter between Area Offices Green and White. I did not believe that the submissions added anything further to the claims that she had already made.

Appendix R – Response to notice of proposed adverse comment FSO Two

FSO Two provided a typed submission of 11 pages in length. She offered her own 'summation' of her response as follows:

"Summation

- I do not agree that the principle of 'least intrusive' was given too much weight in assessing the parent's abilities and willingness to care for their child. The father was assessed as willing and able after joint assessment by QH staff and DOF officers.
- I had no specific information in respect to Riverton, and have never referred a family to their service.
- I have experienced different time frames in respect to the transferring of cases to other area offices. I believe this is strongly related to the risk factors for the children of each individual case, and should therefore be managed according to each individual child's priority.
- My experience, since the introduction of computers and the electronic case system, is that this has created extra volumes or work, i.e. everything should be entered on the case system. The expectation in an Area Office is that the FSO types all their work into the system. As caseloads have also increased so has the workload of officers. At the same time there has developed volumes of work to be placed on the computer system by FSOs. The practice in Area Office Green has been to deal with the human need and place the typing of information in a priority. Notifications, intakes, and the Case Management documents of Family Meetings and Placement meetings are the priorities. Case Notes continue to be an issue.
- As the seconder on the Initial Assessment (IA), I was responsible for taking notes, however the situation at the hospital was such that to start writing down the emotions and feelings that were being expressed at the time was deemed as not appropriate. The parents were so stressed by our involvement that they both wanted to speak over the top of each other. The most practical response to their needs was to separate the parents, so that each felt they were being heard. I dealt with the father, John. At the time I was engaging him, and trying to gain his trust and confidence. I stand fast on my stance that it was not appropriate to start taking notes.
- I stand by my belief that on the day in question a shared decision was made that was not strongly influenced by minimal intervention. We had a parent willing and able – the father. The parents had also agreed to voluntarily work with departmental officers and others as requested."

OTHER SUBMISSIONS

FSO Two also made other submissions that were not included in her summation. I have summarised those comments as follows:

- As a secondary FSO, she was not in a situation to directly input information into the initial assessment document.
- The outcome of this notification was substantiated risk of neglect and substantiated risk of physical harm – as documented in the initial assessment.
- It was assessed that Lisa was willing but her abilities to be able to care for and protect her baby were in serious question.
- A multi-disciplinary assessment of John was undertaken by DOF and QH to assess if he was a parent both willing and able to protect Kate.
- The risks of harm to baby Kate had been identified.
- John was able to recognise, accept and articulate what DOF's concerns were for the care of baby Kate and was able to articulate his commitment to Lisa and baby Kate.
- John stayed at Hospital Green for three consecutive nights in order 'to demonstrate his commitment' and to allow QH to assess 'his abilities to care for and protect baby Kate' and 'his desire to support Lisa'.
- John was assessed as 'both willing and able'.
- John had identified other avenues of assistance he could access for help.
- Lisa and John had agreed to 'voluntarily work with the department and other agencies' as requested.
- A decision was made that the case would become a CPFU in light of the fact there were SCAN recommendations.
- She was not aware that FSO Four's information and the April case note existed until the Ombudsman's officers

interviewed her.

- She was 'not briefed' about the observations made by medical/nursing staff at Hospital White.
- She was unaware that baby Kate had been at Hospital White.
- There was no Client Search request for her to access prior to leaving the office to attend Hospital Green.
- There was no notification in CPIS for her to access.
- FSOs were not supervised at the time and 'for a period of nine weeks, they had no Team Leader'.
- Her contemporaneous case note shows that on 16 July 2001, she had a telephone conversation with the Paediatrician at Hospital Green 'inquiring how [John's] stay at the hospital had progressed'. Her memory is that the overall message was 'positive' and therefore 'affirmed that baby [Kate] could leave the hospital in the care of her parents'.
- She was aware of some SCAN Team recommendations and a statement that 'mother had improved 200% in her skills'.
- John demonstrated to Hospital Green staff over the period that he stayed there that he could 'care for [baby Kate's] needs' and 'support Lisa with the day to day care' of baby Kate.
- She personally observed John on two occasions.
- She did not consider the need to look at the medical files held by Hospital Green because she had information from:

  - the SCAN Team
  - the Paediatrician and
  - Hospital Green staff

- Verbal information from medical staff is 'the most appropriate form' to receive this type of information.
- The Ombudsman did not sufficiently address the absence of risk factors in relation to John – a relevant consideration in the assessment of John.
- The Ombudsman 'refers primarily to the mother's willingness and ability'.
- Section 194 of the Child Protection Act provides that information 'may' be released. It does not say 'shall' be released.
- The absence of a Team Leader, staff issues, time constraints and case loads impacted on best practice.
- If a briefing procedure had taken place, which it did not, she believes that she would have been aware of all available information in a collated and structured way – she was briefed 'just prior to and in the car travelling to Hospital Green…'
- The Ombudsman's report misrepresents how decisions are made by departmental officers – 'It presents as if ONE individual makes these all of life case decisions. This is NOT the case …'.
- At the time of Office Green receiving this notification, she was accountable for an estimated caseload of fourteen individual families:

  "Seven of these cases were in the process of Children's Court matters. Three of these cases had suicidal teenagers, three had children under two years of age, two were involved in criminal court proceedings, six were substantiated sexual abuse cases, and one family unit was a sibling group of five. I was also averaging one to one and half days of intake per week. This left me with three and half, to four days to focus on IA's and casework. Area Office Green had received forty-two (42) notifications for May 2001, twenty-four (24) in June and twenty-three (23) for all of July. I had approximately thirty (30) Notifications allocated for assessment during that period. The Team I was in at that time had no Team Leader for a period of approximately nine (9) weeks until 30 July 2001. The Intake officer had not returned to work after their leave had concluded, so we were effectively minus a Supervisor and an FSO. FSO Three was new to the Team and the type of work we addressed in this team."

- She did not have concerns for her safety in dealing with John.
- She complied with practice guidelines.
- She gave appropriate weight to child protection principles.
- Resourcing continues to be an issue for Area Office Green.
- The Paediatrician sent a letter to the Manager of Area Office Green which said that:

While in hospital Lisa received intensive help with developing appropriate parenting skills to meet Kate's needs. It was noted by the staff that she enhanced her skills significantly while under supervision and tutelage. Kate was not discharged however until it was felt that Lisa could meet her needs without extra support or direction from the nursing staff.

Appendix S – Response to notice of proposed adverse comment The Manager of Area Office Green

Outline

1. Background Context of Area Office Green in 2001
2. Section 194 of *Child Protection Act 1999*
3. Issue of 'least intrusive' practice

1. Background Context of Area Office Green during 2001

The following information is to assist the reader to understand the context in which DOF Area Offices continually attempt to implement our statutory expectations. It is not a case of any justification but to present an understanding of the pressures of DOF staff, particularly those in the Intake and Initial Assessment Team in Area Office Green during the months of July to September 2001.

The Intake and Initial Assessment team was made up of a Team Leader position and five Family Service Officer positions. The team was made up of :

FSO 1	19 months DOF experience
FSO 2	12 years DOF experience
FSO 3	15 months DOF experience
4th FSO	5 years DOF experience
FSO 5	2 years DOF experience (on part-time basis)
6th FSO	9 years (6 on part-time basis) DOF experience

FSO 5 and 6th FSO shared the role of Intake, working 3 and 2 days a week respectively. The 6th FSO left in March 2001 and FSO 5 increased to 4 days a week on 28 May 2001.

A chronology of changes in the Management Team and workload during 2001 follows:

Jan 2001	Appointed Team Leader in position	
	Team Leader position advertised on 30 January due to transfer	
	Notifications received	33
	Initial Assessments approved	26
Feb 2001	Appointed Team Leader leaves on 9 February	
	Manager undertakes dual role	
	Notifications received	34
	Initial Assessments approved	14
March 2001	Acting Team Leader (3 1/2 months experience) commences on 5 March	
	6th FSO leaves	
	Notifications received	46
	Initial Assessments approved	9
April 2001	Acting Team Leader continues	
	Notifications received	30
	Initial Assessments approved	9
May 2001	Acting Team Leader leaves on 25 May	
	Interviews for both Team Leader positions in Area Office Green held on 25 May	
	Manager undertakes dual role	
	Notifications received	38
	Initial Assessments approved	1
June 2001	Manager undertakes dual role	
	Selected Team Leader requests delay in date of commencement	
	Notifications received	24

	Initial Assessments approved	57
July 2001	Manager undertakes dual role until 27 July and leaves to commence Regional Office position	
	Selected Team leader requests further delay in commencement until end of August on 19 July	
	FSO 5 agrees to act as Team Leader and commences on 30 July	
	Acting Manager commences on 30 July	
	Notifications received	20
	Initial Assessments received	57
Aug 2001	Acting Manager and Team Leaders (no previous experience)	
	Notifications received	28
	Initial Assessments approved	41
Sept 2001	Acting Manager and Team Leaders	
	Acting Regional Director commences	
	Notifications received	33
	Initial Assessments approved	22
Oct 2001	Acting Manager and Team Leaders	
	Notifications received	20
	Initial Assessments approved	1
Nov 2001	Acting Manager and Team Leaders	
	Notifications received	28
	Initial Assessments approved	10
Dec 2001	Manager with no DOF experience commences	
	Team Leader with 5 years DOF experience commences	
	Notifications received	15
	Initial Assessments approved	0

The Family Service officers in the Intake and Initial Assessment team remained relatively stable, with the resignation of one part-time Officer. They experienced four (4) Team Leaders with differing levels of experience, both in DOF and as a supervisor, and with different expectations of work practice and standards. The Area Office also experienced significant changes within the Management team and periods of uncertainty about appointments.

While the Manager undertook the dual role for approximately three (3) months during 2001, the team used regular team meetings, peer supervision and individual supervision sessions for work allocation and case supervision.

Support for FSO 5 in the role as Team Leader was limited to a handover of cases in July 2001 and supervision by the Acting Manager and the Acting Regional Director.

The figures of notifications received and Initial Assessments approved demonstrates the workload and demands of undertaking incoming assessments and delays in completing the written documentation. The number of outstanding Initial Assessments for the Area Office increased by 50 per cent during 2001. The team was also working with 20 to 30 families as Child Protection Follow Up cases during May to July 2001.

2. Section 194, *Child Protection Act 1999*

6.6.8 Access to medical records

Staff in Area Office Green are aware of Section 194 of the Child Protection Act 1999. Past and current personal and anecdotal experience of DOF staff requesting information relevant to the protection and welfare of a child under this Section of the Act is that, outside SCAN, Queensland Health staff either refuse or are extremely reluctant to provide it. Written requests including reference to or accompanied by copies of Section 194 can result in exchange of information.

The draft 'Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland In regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk' provides clear guidelines for all staff.

3. Issue of 'least intrusive' practice

6.10 Decision-making and case planning

The case plan for Baby Kate was based on the following factors :

- the risk assessment that her mother, Lisa, was not able to care for baby Kate without ongoing support and monitoring of her ability to parent a child;
- the mother's involvement in and consent to case plans;
- the support of family and significant others;
- consideration of bonding and attachment between baby Kate and her mother;
- application of 'least intrusive' practice frameworks.

'Least intrusive' practice is the way the Department culturally applies the Principles of the Child Protection Act 1999 and a response to community perception and criticism of intrusive statutory intervention with families. It is a framework that is congruent with the legislative Principles.

In 1996, the Child Protection Concepts Training presented an assessment framework with a shift from investigation to assessment and the new electronic Child Protection Information System. The training was developed with the following:

- Five Broad Themes from Research
  1. sensitive and informed professional/client relationships
  2. an appropriate balance of power between key parties
  3. a wide perspective on child abuse
  4. effective supervision and training
  5. enhancing children's quality of life

- Seven Critical Elements of Good Practice
  1. Assessment
  2. Planning
  3. Client participation
  4. Accurate recording
  5. Culturally appropriate interventions
  6. Focus on the needs of child and family
  7. Effective supervision and training

In 1998 Policy and Practice Workshops for Child Protection Workers were held. The core principles were :

1. the welfare and best interests of the child protection notification are paramount
2. the preferred way of ensuring a child's welfare is through support of the child's family
3. intervention is not to exceed a level necessary to protect the child
4. family participation in planning and decision-making for children
5. consultation with Aboriginal and Torres Strait Islander agencies in decision-making
6. children and families have a right to information
7. services are to be culturally appropriate
8. co-ordination, consultation and collaboration with families, other professionals and agencies and the community
9. accountability

In 1999 and 2000, workshops were held in Core Procedures Training for the Child Protection Act 1999. The workshop handout for 'Ongoing Intervention' includes :

- occurs when a decision has been made that a child protection notification is in need of protection
- 2 types – child protection follow-up and child protection orders
- principles in Section 5 critical to determining use of these orders

My handwritten notes beside the last point are 'least intrusive'.

The workshop handout for considerations in 'decision-making for type of CPO' were :

- what the child needs to be safe
- what the strengths and weaknesses of the family are
- what level of intervention is needed to meet the child's needs.

Similarly, 'A Practice Guide for the Assessment of Harm and Likely Harm' printed in 1999 states 'Intervention occurs to the extent necessary to ensure what the child or young person needs to be safe.'

The Child Protection Procedures Manual in Section 21.2 'Have the child's protective needs been met?' states:

'Once you have considered all of the factors listed above, use your professional judgment to decide :

- whether the child/young person has continuing protective needs. If so –
- whether departmental intervention is still required to meet these needs. If so –
- what is the least intrusive level of departmental intervention which would meet these needs.'

Workbook One of the FSO Induction and Learning Program (2002), Module One, Part 4 'Overview of the Principles of The Child Protection Act 1999' states :

'The principles also place limits on the degree of statutory intervention in the lives of children, young people and families by telling you what level of intervention is warranted by the circumstances.'

Appendix T – Response to notice of proposed adverse comment The Acting Manager of Area Office Green

ADVERSE COMMENT ONE

'DOF' officers had a mistaken belief that the existing policy provided that case-workers had a period of up to three months to transfer a case even if a family had 'settled' in a new area much earlier.

I am unable to comment directly on the transfer of 'baby Kate' as my role was Acting Manager with no involvement on the decision-making. The Manager does hold the delegation to transfer cases, however generally Managers do not transfer cases to Area offices this is usually done between Team Leaders and Family Service Officers. Managers will send to the Area office computer case screens, which have been sent to the Area Manager by the Team Leader.

ADVERSE COMMENT TWO AND THREE

In my view, the briefing note is misleading in two respects, First it stated that an autopsy on 11 September 2001 confirmed SIDS as the cause of death. This was not correct. The death certificate issued on the 11th of September 2001 showed the cause of death as 'not yet determined pending test results'. The final autopsy finding of SIDS was recorded in an amendment to the death certificate made on 24 October 2001 (nine days after the child death review had been completed).

In my view, the briefing note that Fernbrook is a 'supervised residential facility for young mothers to learn parenting skills with daytime programs and overnight supervision' was misleading. This conveyed the impression it was a suitable facility for Lisa's needs. It was not because of the limited nature of the supervision provided. The use of the term 'overnight supervision' implies that Lisa was being directly supervised in her care of baby Kate. This was not the case. As I have already pointed out, Fernbrook is essentially a hostel for homeless women and their children. Lisa had her own private room and was not supervised to the extent her parenting ability warranted. The Acting Manager, who compiled the briefing note, may have taken this information directly from the case note in CPIS which FSO One had created on the morning of 11 September 2001, the day after baby Kate died.

In response, the briefing note was compiled by Manager at the time whose role was Senior Practitioner, this was checked and sent by Acting Manager to Regional Office as per protocol. As Acting Manager at the time I take responsibility for the brief leaving the office. The information in the brief was written in good faith based on information given to Manager and Acting Manager by FSO One. This process would be in keeping with normal practice for writing briefs on any matter. Briefs of this nature 'Child Death' need to be completed immediately with information at hand. Briefs are then updated as needed or when new information is given to the Department or further correspondence is warranted.

FSO One who was advised verbally by the Police gave the specific information of 'SIDS AS THE CAUSE OF DEATH' to the Manager and Acting Manager.

The specific information of Fernbrook is a 'supervised residential facility for young mothers to learn parenting skills with daytime programs and overnight supervision' was given to the Manager and Acting Manager by FSO One who was the case worker for the case.

The above information was the information the Area Office had at the time and was not meant to be misleading by the Manager and Acting Manager compiling the brief.

ADVERSE COMMENT FOUR

In response to the following adverse comment please see response to adverse comment two and three.

'the briefing note prepared by the Acting Manager for the information of the Deputy Director-General was misleading because it incorrectly stated that:

- a post mortem on 11 September 2001 had confirmed SIDS as the cause of baby Kate's death.
- Fernbrook provided 'overnight supervision.'

ADVERSE COMMENT FIVE

'As indicated, my preliminary opinion is that several decisions made by FSO One, her supervisors and other officers in Area Office Green about the management of this case were wrong and/or unreasonable within the meaning of section 49(2) of the Ombudsman Act. In my opinion, these decisions were influenced, at least to some extent, by the officers' shared belief about how they should apply the so called minimal intervention policy and their reluctance to separate Lisa and baby Kate. Their approach was endorsed by the internal review officer.

As I have explained, I believe too much emphasis was given to these considerations and insufficient emphasis to baby Kate's safety and well being.'

In my role as Acting Manager or my previous role as Team Leader for Long Term team of Office Green I was not involved in any decision-making around 'Baby Kate's' case or supervision of FSO One.

I do recall at the time of my interview I was asked to comment in relation to the placement of baby Kate with her mother, based on the information given to me by the Ombudsman interviewers 'that Fernbrook was not a supervised facility for mothers with intellectual disabilities'. I recall that I indicated that I would have removed baby Kate from her mother.

I feel that I am unable to comment on whether decisions were influenced by shared belief of minimal intrusion as I have not interviewed the staff involved and was not involved in the decision-making whilst baby Kate was subject to Departmental involvement.

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