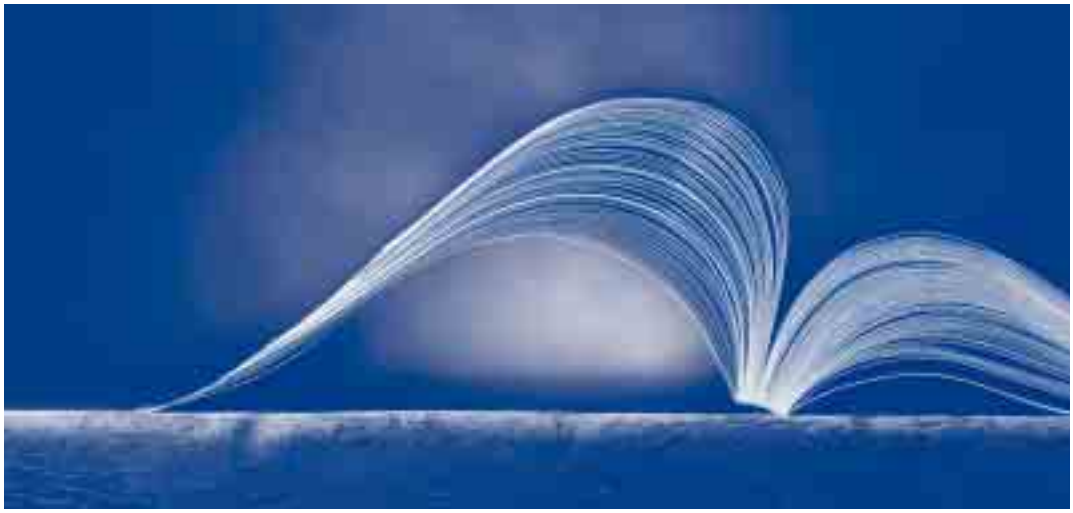
Report of the

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

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Queensland
OMBUDSMAN
Parliamentary Commissioner for
Administrative Investigations

31 May 2002

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 of the late Brooke Brennan, aged three.* The investigation considers the administrative conduct of the Department of Families, the Department of Health and the Queensland Police Service.

Yours faithfully

D J Bevan
Ombudsman

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Foreword

The Queensland Ombudsman has an important role in investigating administrative actions and decisions of public sector agencies. Since the *Ombudsman Act* commenced in December 2001, the Ombudsman also has a statutory responsibility to make recommendations to agencies and provide them with other help to improve their administrative practices.

This report presents the findings of an investigation conducted by my Office into complaints about the administrative actions of the Department of Health, the Department of Families and the Queensland Police Service in relation to three year old Brooke Brennan.

Brooke was murdered at the Gold Coast in July 1999 by Troy Self, her mother's then partner. Self was convicted of her murder in the Queensland Supreme Court and sentenced to life imprisonment.

My investigation examined the appropriateness of actions taken and decisions made by the three agencies in their dealings with Brooke and her mother some days before Brooke's murder, in particular, their responses to issues relating to her safety.

The report also makes recommendations for improvements to the administrative practices of the agencies concerned to reduce the chance of similar tragedies occurring.

Because the issues dealt with in the report are of significant public interest, I have decided to present the report to the Speaker for tabling in the Legislative Assembly as provided for in section 52 of the *Ombudsman Act*.

I would like to thank Assistant Ombudsman Peter Cantwell and Investigating Officer Megan Jarvis for their hard work and professionalism in conducting the investigation and preparing the report.

D J Bevan
Queensland Ombudsman

Contents

Abbreviations and dictionary

Brooke	Brooke Leyana Brennan, the child of Ms A
Child Protection Act	*Child Protection Act 1999 (Qld)*
Children's Services Act	*Children's Services Act 1965 (Qld)*
Commissions of Inquiry Act	*Commissions of Inquiry Act 1950 (Qld)*
Complainants	The persons who made a complaint to this Office concerning the administrative actions taken by DOF, QH and QPS in relation to Brooke
CPSSIP	Child Protection Service System Improvement Project
DOF	Department of Families
DPP	The Director of Public Prosecutions
Former Ombudsman	Mr Fred Albietz, LL.B, Solicitor
FSO X, FSO Y	Family Services Officers of the DOF who carried out DOF's initial assessment in relation to Brooke, collectively called the FSOs in this report
Ms A	Brooke's mother
The Health Act	*Health Act 1937 (Qld)*
The Health Regulation	*Health Regulation 1996 (Qld)*
The hospital	Gold Coast Hospital
The internal review officer	The senior officer from DOF who conducted an internal review of Brooke's case subsequent to her death in accordance with DOF policy PM95/17
JAB	Gold Coast Juvenile Aid Bureau located at Surfers Paradise
The Manual	DOF's *Child Protection Procedures Manual*
My Officers	Ms Megan Jarvis, LL.B, Investigating Officer and Mr Peter Cantwell, LL.B (Hons), Solicitor, Assistant Ombudsman
Ombudsman Act	*Ombudsman Act 2001 (Qld)*
PC Act	*Parliamentary Commissioner Act 1974 (Qld)*, now repealed
QH	Queensland Health or the Department of Health
QPS	Queensland Police Service
QPSU	Queensland Public Sector Union
SCAN team	Gold Coast Suspected Child Abuse and Neglect Team
Mr Self	Troy Self, former de-facto partner of Ms A and the person convicted of Brooke's murder

Executive Summary

Investigative context

This report presents the results of an investigation by the Queensland Ombudsman concerning the administrative actions of Queensland Health (QH), the Department of Families (DOF) and the Queensland Police Service (QPS) in relation to Brooke Brennan, aged three years, in July 1999. Brooke was murdered by Troy Self, her mother's then partner, and died on 25 July 1999.

The investigation was initiated after a written complaint was made to the Queensland Ombudsman on 21 March 2001.

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:

- unlawful, unreasonable or unjust;
- taken for an improper purpose, 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.

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 Queensland Police officers and officers from the two departments, the investigation has necessarily considered the actions of police officers involved for the purpose of assessing the administrative actions of QH and DOF officers.

The circumstances

At the time of Brooke's death, she was living with her mother (Ms A) and Mr Self in a unit at Back Street, Biggera Waters, on the Gold Coast. The three had lived together in the unit since the previous month.

On the morning of 12 July 1999, Ms A took Brooke to see a Gold Coast general practitioner about a sore finger, episodes of vomiting and hair loss. The doctor also noticed bruises on Brooke's body and he referred her to the Emergency Department of the Gold Coast Hospital for further investigations. He advised the hospital that some of Brooke's problems could be related to 'non-accidental' injuries.

Brooke was reviewed in the Emergency Department by the Emergency and Paediatric Registrars, both of whom noted multiple bruising to her body as well as a swollen and bruised little finger which was later confirmed through X-ray as fractured. The records reflect that both doctors discussed the likely cause of Brooke's injuries with Ms A.

Brooke was admitted to the Paediatric Ward of the hospital overnight and a doctor specialising in child abuse, who was a member of the Gold Coast Suspected Child Abuse and Neglect (SCAN) team, was contacted and arrangements made for him to review Brooke the following morning. Ms A remained with Brooke at the hospital that afternoon and evening, leaving around 7.30pm after Brooke had settled for the night.

Ms A returned to the ward the following morning at about 7.15am. After a matter of only some minutes, she led Brooke out of the ward, allegedly explaining to a nurse that she was taking Brooke for breakfast at the hospital canteen. The nurse claims that she objected to this course of action and asked Ms A not to remove Brooke from the ward, but Ms A ignored her request. The nurse notified hospital security and some searches were carried out, but Ms A and Brooke could not be found.

The hospital contacted the SCAN doctor who was to review Brooke that morning and advised him of what had occurred. The SCAN doctor said he immediately attempted to contact the Gold Coast Juvenile Aid Bureau (JAB) of QPS and DOF, but was unable to contact either agency for some hours. The SCAN doctor and several doctors employed at the hospital had the ability to issue an order pursuant to the *Health Act 1937 (Qld)* to have Brooke taken into custody and returned to the hospital to be detained for up to 96 hours (a '96-hour order' under Section 76L of the *Health Act).* However, this course of action was not taken.

The SCAN doctor claims to have spoken to an officer at the JAB in the early afternoon and requested assistance to locate Brooke, but his request was refused. The SCAN doctor spoke to DOF later that afternoon and made a child protection notification in relation to Brooke.

After receiving the notification – and in order to assess Brooke's situation – DOF immediately sent two Family Services Officers (FSOs) to the Back Street address given to the hospital by Ms A. They arrived at the address, a unit in a two-story block, at about 4pm that afternoon. According to the FSOs, they knocked on the front door and called out for any occupants, but no one answered. They then spoke to a neighbour, who directed them to the back of the units. They found the back door to the unit open and could hear a radio playing. One officer entered the unit to see if Brooke or Ms A was inside, but found no one there.

The FSO found a note that appeared to be written by Ms A to her partner, Mr Self, indicating she had left him because of her belief that he had injured Brooke.

The FSOs left after searching in the vicinity of the units for a period of time in case Ms A or Brooke remained in the area. They made some efforts to find an alternative address for Ms A or Brooke, but with no success.

The matter was then referred to the Gold Coast SCAN team for discussion at a meeting on 22 July 1999, nine days after Brooke's disappearance. At this meeting, the SCAN team recommended that no further action be taken by any of the SCAN participating agencies. DOF did not make any further efforts to locate Brooke.

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

It was later revealed that Ms A and Brooke had in fact continued to live in the Back Street unit with Mr Self from the day Brooke was removed from the hospital until the day of her death. At the time the FSOs visited the unit on 13 July 1999, Ms A and Brooke were actually hiding in a downstairs laundry. Ms A advised that she had wanted to avoid speaking to the officers because she thought they were police officers.

The Ombudsman has no jurisdiction to express opinions about Ms A's conduct except to the extent that it is relevant to the assessment of the actions of QH and DOF officers. On that basis, the evidence suggests that her conduct is relevant in the following ways:

- her removal of Brooke from the Gold Coast Hospital without informing hospital staff of her intention prevented QH staff from further caring for Brooke;

- it also resulted in a situation where the making of a 96-hour order could have been considered by any prescribed medical officer at the Gold Coast Hospital;

- her action in hiding herself and Brooke from DOF officers visiting the unit prevented those officers from properly assessing Brooke's situation and taking action to ensure her safety;

- because she hid from the officers and wrote the note found at the unit, the FSOs were led to believe it was likely she had removed Brooke from the suspected cause of abuse; and

- this belief, together with a lack of resources, resulted in DOF's procedures in relation to initial assessments that are unable to be completed for 'client reasons' being applied and a decision being made to take no further action in the case.

Although Brooke was removed from the hospital by her mother, QH retained a responsibility to ensure that appropriate action was taken for her safety. DOF also took on responsibility once it received notification. Assuming that the SCAN doctor did request assistance from the Gold Coast JAB, the QPS also had a responsibility to provide an appropriate response.

Because of a combination of factors, the responses of these agencies and the involvement of the SCAN team were insufficient to prevent Brooke from being further harmed.

Particulars of Maladministration

Pursuant to section 49(2) of the *Ombudsman Act*, the Ombudsman considers that the administrative actions of QH and the DOF were, at various times:

- unreasonable (section 49(2)(b)),
- based wholly or partly upon a mistake of fact (section 49(2)(f)); and
- wrong (section 49(2)(g)).

1. Queensland Health

The particulars of maladministration by QH are that:

1.1 There are no written policies or procedures to address when, and in what circumstances, prescribed medical officers of QH should make a 96-hour order in relation to a child, which resulted in inconsistent application of section 76L of the *Health Act* by QH officers.

1.2 A 96-hour order should have been issued by the SCAN doctor, or another prescribed medical officer, given the circumstances of Brooke's presentation and subsequent removal from the Gold Coast Hospital. As a result, the SCAN doctor failed to fulfil his obligation as an authorised person pursuant to section 76K of the *Health Act* to act in such manner as would best ensure Brooke's safety and well-being.

1.3 There are no written policies or procedures requiring the documenting of verbal child protection referrals/requests made by QH officers to other agencies that have a concurrent child protection role. This encourages the making of verbal referrals or requests that:

- lead to uncertainty as to the nature and priority of the referrals/requests; and
- cannot be effectively audited.

The present case highlights these problems.

1.4 The SCAN doctor's verbal referral/request was ineffective. Despite the absence of any written policies or procedures, the SCAN doctor, in view of his concerns, should have

documented the child protection referral/request that he made to QPS on 13 July 1999 following Brooke's removal from the Gold Coast Hospital.

1.5 Despite having an opportunity to do so, QH failed to formally refer Brooke's case to the first available SCAN team meeting held on 15 July 1999, some two days after Brooke had been removed by her mother from the Gold Coast Hospital.

1.6 Lines of communication between QH and QPS and between QH and DOF were inadequate – the SCAN doctor says he was unable to contact QPS until after 1.00pm and unable to contact DOF until after 3.00pm.

2. Department of Families

The particulars of maladministration by DOF are that:

2.1 No remedial action was taken in response to a memo dated 2 March 1998, some 16 months before Brooke's death, prepared by the Gold Coast Area Office Intake Team concerning resourcing constraints that were impacting upon the team's ability to effectively perform child protection work.

2.2 Brooke's case was not referred to the first available SCAN meeting held on 15 July 1999, two days after Brooke had been removed by her mother from the Gold Coast Hospital, despite DOF's assessment that her case 'required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable'.

2.3 The decision-making process the Gold Coast Area Manager was required to follow in Brooke's case, in accordance with DOF procedures, was inadequate. The procedures did not require consideration to be given to whether Brooke was truly 'safe' from future physical abuse before the case was closed.

2.4 Given the circumstances of Brooke's case, the decision not to take any further action in relation to Brooke's case was unreasonable. DOF should have taken further action to ensure Brooke was safe.

2.5 Inadequate resources were allocated to the Gold Coast Area Office at the time of Brooke's notification to meet its statutory child protection obligations pursuant to the provisions of the *Children's Services Act*.

2.6 Policy PM95/17 - *Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons,* was not complied with.

2.7 No immediate action was taken to implement the recommendation contained in the internal reviewer's report or to otherwise make any changes to DOF procedures in respect of child protection.

2.8 Lines of communication between DOF and QH and between DOF and QPS were inadequate.

2.9 There is no requirement for recording of requests by DOF officers for JAB or other QPS assistance. This encourages the making of verbal referrals or requests that:

- lead to uncertainty as to the nature and priority of the referrals/requests; and
- cannot be effectively audited.

The present case highlights these problems.

3. Suspected Child Abuse and Neglect Team

The particulars of maladministration by the SCAN team are that:

3.1 The minutes of the SCAN team meeting of 22 July 1999 did not record the reasons for the recommendation made that the matter be deleted to SCAN, that is, not considered further by SCAN, and why other courses of action were not recommended, such as referring the matter to QPS for further action.

3.2 The recommendation made 'to delete the case to SCAN' was unreasonable given the circumstances of Brooke's case. The SCAN team should have recommended that further action be taken to ensure her safety.

Recommendations

The Queensland Ombudsman makes the following recommendations pursuant to section 50(1) of the *Ombudsman Act*:

1. Queensland Health

It is recommended that QH:

1.1 Develop written policies and procedures to address when and in what circumstances prescribed medical officers of QH should make a 96-hour order in relation to a child. The policies and procedures must provide that 96-hour orders are to be issued in any circumstances (within the terms of section 76L of the *Health Act*) where it will best ensure the safety of a child who is likely to be subject to unnecessary injury, suffering or danger.

1.2 Develop written policies and procedures that require the documentation of verbal child protection referrals/requests made by its officers to other agencies with a concurrent child protection role.

1.3 Review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that all suspected child abuse and neglect matters are referred to the SCAN team for discussion in a timely and appropriate manner, and in accordance with its child protection obligations.

1.4 Review its lines of communication with QPS and DOH to ensure a rapid response in priority child protection cases.

2. Department of Families

It is recommended that DOF:

2.1 Review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that such matters are treated with an appropriate level of priority and, specifically, that urgent matters are referred to the first available SCAN team meeting, irrespective of when notifications are received.

2.2 As part of the Child Protection Service System Improvement Project (CPSSIP), replace the policy contained in chapter 6, point 6.2(iv) of its *Child Protection Procedures Manual* (in relation to notifications for which initial assessments are unable to be commenced or completed because of 'client reasons') with a policy that addresses the deficiencies identified by this report.

2.3 Engage a suitably qualified independent expert to review whether the Gold Coast Area Office of DOF is currently adequately resourced to meet its statutory child protection obligations under the *Child Protection Act.* The independent expert should report to the Minister and the Director-General of DOF and provide a copy of the report to this Office.

2.4 Implement procedures to ensure that feedback and support are provided to DOF officers whose administrative actions are the subject of a review pursuant to DOF's recently developed policies entitled *Child Death Reviews Policy and Procedures* and *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures*.

2.5 Review its lines of communication with QH and QPS to ensure a rapid response in priority child protection cases.

3. Suspected Child Abuse and Neglect Team

It is recommended that:

3.1 QH, DOF and QPS develop a Memorandum of Understanding in relation to the referral of child protection matters to SCAN teams to ensure that:

- each core agency appreciates its role and obligations for referring matters to SCAN teams;
- formal procedures for referral of child protection matters are followed consistently; and
- referrals are made in a timely fashion, having regard to the level of priority of the particular matter.

3.2 QH, DOF and QPS develop a proforma for minutes taken at SCAN team meetings to ensure that the basis upon which recommendations are made is recorded; specifically, the reasons for selecting a particular course of action over other possibilities should be documented.

Matters for the Queensland Police Service

The *Ombudsman Act* effectively prohibits the Queensland Ombudsman's consideration of operational police matters. However, the circumstances of this particular matter required the investigation to take account of the interaction of other departmental officers (within jurisdiction) with members of the Gold Coast JAB.

Therefore, this report contains references to and comments about actions taken or failed to be taken by police officers that, in the opinion of the Ombudsman, affect or concern the QPS. It was for this reason that the Commissioner for Police was provided with a notice that adverse comment about QPS would be included in this report.

With a view to improving the quality of QPS decision-making and administrative practice where officers interact with other agencies having a child protection responsibility, the following observations and suggestions for improvement are offered for consideration by the QPS in any review of how it responded in this case.

Observations on the role of the Queensland Police Service

Observations on the role of QPS in relation to this matter are that:

1.1 QPS did not have in place adequate policies and procedures for recording all incoming telephone calls received in relation to child protection referrals or requests. Therefore, there was no method for recording or assessing the decisions made by JAB officers as to the type of response to be given to each call.

1.2 The JAB officer failed to record any details of the telephone call made by the SCAN doctor on 13 July 1999 in which he requested police assistance. The lack of any such record:

- led to uncertainty as to the nature and urgency of the request; and
- means that the reasonableness of the decision refusing assistance cannot be audited.

1.3 There were no procedures in place between QPS and QH for making or following up child protection referrals or requests to QPS in writing (e.g. by facsimile or email).

Suggestions for improving administrative practice

Suggestions for improving administrative practice for the QPS are:

2.1 Appropriate policies and procedures be implemented to record all incoming telephone calls received in relation to child protection referrals or requests and QPS's responses;

2.2 In consultation with QH, appropriate policies and procedures be implemented to ensure that any child protection referrals or requests made by QH to QPS are confirmed in writing (e.g. by facsimile or email) as soon as possible after any referrals or requests are made.

Response to the recommendations

QH and DOF have endorsed all of my recommendations and have taken steps to implement them.

QPS’s response to my suggestions for improving administrative practice was qualified in relation to my suggestion that appropriate policies and procedures be implemented to record all incoming telephone calls received in relation to child protection referrals or requests and QPS’s responses. An analysis of the response is set out in Chapter 11

1 Background

1.1 Introduction

I have completed my statutory investigation of a complaint made to the Queensland Ombudsman on 21 March 2001 by persons[1] who, in my opinion, have a sufficient direct interest in certain administrative actions taken by Queensland Health (QH) and the Department of Families (DOF) in relation to the late Brooke Brennan, who died from internal injuries on 25 July 1999 at the age of three years.

Mr Troy Self, Brooke's mother's de facto partner at the time, was later convicted of Brooke's murder and sentenced to life imprisonment.

At the time of her death, Brooke was living with her mother, Ms A, and Mr Self in a unit at 7/24 Back Street, Biggera Waters on the Gold Coast. The three had resided together in the Back Street unit since sometime in June 1999.

On the morning of 12 July 1999, Ms A took Brooke to see a Gold Coast general practitioner (GP) about a sore finger and episodes of vomiting and hair loss. In addition to these complaints, the GP noticed that Brooke had bruises on her body. He referred her to the Emergency Department of the Gold Coast Hospital for further investigations. He advised the hospital that some of Brooke's problems could be related to 'non-accidental' injuries.

Brooke was reviewed in the Emergency Department by the Emergency and Paediatric Registrars, both of whom noted multiple bruising to her body as well as a swollen, bruised left little finger (later confirmed by X-ray as fractured). The records reflect that both doctors spoke to Ms A and discussed with her the likely cause of Brooke's injuries. Brooke was admitted to the Paediatric Ward of the hospital overnight, a doctor specialising in child abuse who was a member of the Gold Coast Suspected Child Abuse and Neglect (SCAN) team[2] was contacted and arrangements were made for him to review Brooke the next morning.

Ms A remained with Brooke at the hospital that afternoon and evening, leaving around 7.30pm after Brooke had settled for the night.

Ms A returned to the ward the next morning, 13 July 1999, at about 7.15am. After a matter of only some minutes, Ms A led Brooke out of the ward, allegedly explaining to a nurse that she was taking Brooke for breakfast at the hospital canteen. The nurse claims she objected to this course of action and asked Ms A not to remove Brooke from the ward but that Ms A ignored this request. The nurse notified hospital security and some searches were carried out, but Ms A and Brooke could not be found.

The hospital contacted the SCAN doctor who had been arranged to review Brooke that morning and advised him what had occurred. The SCAN doctor said he immediately attempted to contact the Queensland Police Service's (QPS) Gold Coast Juvenile Aid Bureau (JAB) and DOF but was unable to contact either agency for some hours. The SCAN doctor claimed to have finally spoken to the JAB in the early afternoon and requested its assistance to locate Brooke, but his request was refused. The SCAN doctor then spoke to DOF later that afternoon and made a child protection notification in relation to Brooke.

After receiving the notification, and in order to assess Brooke's situation, DOF immediately sent two Family Services Officers (FSOs) to the Back Street address given to the hospital by Ms A.

1 'the complainants'

2 See Part 3.3 for explanation of SCAN teams.

They arrived at the address, which was a unit in a two-story block of units, at about 4.00pm. According to the FSOs, they knocked on the front door and called out for any occupants, but no one answered. They then spoke to a neighbour, who directed them to the back of the units where they found the back door to the unit open and could hear a radio playing. One FSO entered the unit to see if Brooke or Ms A were inside but found no one. However, the FSO found a note that appeared to be written by Ms A to her partner, Mr Self. The note indicated that Ms A had left Mr Self because of her belief that he had injured Brooke.

The FSOs left after searching in the vicinity of the units for a period of time in case Ms A or Brooke had remained in the area. They made some efforts to find an alternative address for Ms A or Brooke, but again with no success.

The matter was then referred to the Gold Coast SCAN team, that met some days later. The SCAN team recommended that no further action be taken. DOF did not make any further attempts to locate Brooke. The FSOs never returned to the Back Street unit.

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

It was later revealed that Ms A and Brooke had in fact continued to live in the Back Street unit with Mr Self from the day Brooke was removed from the hospital until the day of her death. At the time of the FSOs' visit to the unit on 13 July 1999, Ms A and Brooke were actually at home. Ms A advised she and Brooke had hidden in a downstairs laundry to avoid speaking to the FSOs, whom Ms A thought were police officers.

Mr Self was charged with and later convicted of Brooke's murder. The court heard evidence that Mr Self had assaulted Brooke some time during the evening of 24 July 1999, causing her death.

This report reflects my final opinion of the matters complained about and contains recommendations made pursuant to section 50 of the *Ombudsman Act 2001 (Qld)*.

This report is provided to the Speaker of the Queensland Legislative Assembly pursuant to section 52 of the *Ombudsman Act*[3] for tabling in the Assembly.

1.2 The complaint

The complainants raised a number of concerns in relation to the administrative actions of both QH and DOF:

Principal allegations in relation to Queensland Health:

- That QH failed to alert DOF and QPS immediately upon Brooke's admission to hospital.
- That QH failed to fully convey the gravity of Brooke's situation to Ms A.
- That QH failed to advise Ms A of the options available to ensure Brooke's welfare.
- That QH failed to keep Brooke in hospital for the prescribed period for children showing signs of abuse.

3 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 the Department of Families:

- That DOF officers did not make reasonable attempts to establish Brooke's whereabouts or follow up on their concerns for her welfare.

- That DOF officers did not properly investigate the factual situation in relation to Brooke's welfare and made incorrect assumptions based on insufficient evidence.

- That DOF officers failed to leave information for Ms A notifying her of their concerns and the options available for Brooke.

- That the subsequent internal review and report in relation to Brooke's case conducted by DOF was inadequate, in that it failed to address the shortcomings that should have been evident in the way the initial assessment and investigation of Brooke's circumstances were handled.

The complainants also raised a number of concerns in relation to actions of officers of QPS, and in relation to the prosecution of Mr Troy Self by the Director of Public Prosecutions (DPP).

1.3 Investigative role and reporting

This Office's charter, as provided in the *Ombudsman Act*, is to investigate complaints or grievances involving the administrative decisions and procedures of public sector agencies and to recommend remedial action where appropriate.

The Office also seeks to provide complainants with explanations of government decisions affecting them and to make recommendations to improve the quality of public sector behaviour based on an examination of particular practices and procedures in agencies that have been the subject of a complaint.

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[4].

Recommendations are made to the principal officer of a relevant agency[5], who is required to notify me of the steps proposed to be taken to give effect to my recommendations[6]. If the recommended steps are not taken by the agency, I can report the matter to the Premier and ultimately cause the matter to be laid before Parliament[7].

Further, section 52 of the *Ombudsman Act* provides that the Ombudsman 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.

On 26 and 27 March 2001, the former Ombudsman[8] respectively advised the Directors-General of DOF and QH of his intention to conduct a formal statutory investigation of the complainants' allegations, pursuant to the provisions of the now repealed *Parliamentary Commissioner Act 1974 (Qld)*[9] (PC Act).

4 Part 6 of the *Ombudsman Act.*

5 Section 50 of the *Ombudsman Act*.

6 Section 51(2) of the *Ombudsman Act*.

7 Section 51(3) and (4) of the *Ombudsman Act.*

8 Mr Fred Albietz, LL.B, Solicitor.

9 *Parliamentary Commissioner Act 1974 (Qld).* The *Ombudsman Act* was proclaimed on 3 December 2001. The majority of this investigation was conducted under the provisions of the PC Act.

Once the investigation commenced, section 19(1) of the PC Act conferred upon the Ombudsman all of the rights, powers and privileges of a Royal Commission, as contained in the *Commissions of Inquiry Act 1950*.

In particular, under the powers contained in the *Commissions of Inquiry Act*, persons can be required to attend to give information and answer questions. By exercising this power, formal interviews were conducted by officers as part of the investigative process. I have similar powers under the *Ombudsman Act*.

1.4 Jurisdictional Limitations

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

Firstly, the combined effect of sections 7(2) and 16(2)(c) and (d) of the *Ombudsman Act* is that I am unable to investigate alleged acts or omissions that relate to police operational matters.

I was therefore unable to take up the complainants' concerns in relation to the alleged actions taken or not taken by individual QPS members. The complainants were directed to the Commissioner of Police and the then Criminal Justice Commission[10] in relation to these concerns. However, it was necessary to involve QPS in this investigation because of the interaction of QPS, QH and DOF in this matter.

Secondly, section 16(2)(b) of the *Ombudsman Act* provides that I am not authorised to investigate any administrative action taken by a person acting as Counsel for the State in any legal proceedings.

Accordingly, I was also unable to take up the complainants' concerns in relation to the prosecution of Mr Self in the Supreme Court of Queensland. Again, the complainants were offered other avenues of review in relation to these issues. For the record, the DPP's prosecution of Mr Self appears to have been successful, given the conviction that resulted.

1.5 Procedure for gathering evidence

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.

10 Now the Crime and Misconduct Commission.

The *Ombudsman Act* is silent as to what standard of proof is required to be met before an opinion pursuant to section 49(2) is formed. The question therefore arises as to what standard of proof should be applied when forming an opinion, particularly one which might be considered adverse to any person.

1.6 Sufficiency of evidence

The question of the sufficiency of evidence requires some assessment of its weight and reliability. In making that assessment, it is essential that the applicable standard of proof appropriate to the opinions that are required to be formed be considered.

There are two standards of proof known to the common law: 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 in order to be proved, it must be more probable than not that the allegations are made out.

The civil standard of proof applies in administrative investigations.

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.

Investigators must be careful to ensure they do not reduce the standard of proof dictated by the test in *Briginshaw* by erroneously taking into account extraneous considerations. For example, the fact that an agency has a statutory responsibility to protect children does not reduce the standard of proof required to establish that the agency has failed to discharge that responsibility.

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 put to me for assessment must be robustly tested.

1.7 Procedural Fairness

Certain sections of the *Ombudsman Act* require that various persons be provided with an opportunity of being heard in relation to a matter before I form my final opinion. These sections essentially comprise the ‘natural justice’ provisions of the Act.

Section 26(3) 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 must be offered an opportunity to comment on the subject matter of the investigation before the report is published.

Section 55 of the 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 the person's defence is fairly stated in the final report.

In order to satisfy the statutory obligation pursuant to section 26(3) of the *Ombudsman Act*, this report was issued in provisional form to the Directors-General of both QH and DOF on 14 December 2001. On that same day, I also advised the responsible Ministers, the Honourable

Wendy Edmond MP, Minister for Health, and the Honourable Judy Spence MP, Minister for Families, that I had taken this step. I invited the Directors-General to comment on the matters under investigation.

In order to satisfy my statutory obligation pursuant to section 55 of the *Ombudsman Act*, I also provided Ms A, the SCAN doctor and the Commissioner of Police, Mr R Atkinson APM, with a notice 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 Directors-General of QH and DOF, Ms A and the Commissioner of Police. The SCAN doctor did not separately reply, advising instead that he would rely upon the reply from QH to address the issues that had been raised.

The agencies responses are set out in full (with identifying information deleted) in Appendices A to C. Ms A's response has been incorporated into the report at various points.

This report contains recommendations made pursuant to section 50 of the *Ombudsman Act*. Section 51 of the 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, the Directors-General of QH and DOF were asked to advise the above. Their responses are set out in full in Appendices P and Q respectively. The Commissioner of Police was also asked to respond to observations and suggestions for improvement in relation to QPS. The Commissioner's response is contained in Appendix R.

2 The Investigation

2.1 Initiation

In letters to DOF and QH dated 26 and 27 March 2001 respectively, the former Ombudsman presented the complainants' allegations and outlined the issues arising from the complaint that would constitute the terms of reference for the investigation. A written report in response to these matters was requested, as well as copies of all documents held by the agencies relevant to the matters raised.

This Office received QH's initial report on 10 May 2001 and DOF's initial report on 31 May 2001. DOF provided a copy of its file on 6 June 2001.

2.2 Process – Queensland Health

My officers[11] took the following actions in relation to QH:

- obtained and examined a complete copy of QH's medical records in relation to Brooke;
- examined and compared with other evidence written statements provided to this Office by QH staff involved in the events surrounding Brooke's admission to the Gold Coast Hospital[12];
- attended the Gold Coast Hospital and inspected the Paediatric Ward where Brooke had stayed, as well as other relevant areas of the building (canteen) and grounds (entrance and pool area). Copies of hospital floor plans were subsequently obtained and examined;
- exchanged various formal correspondence between this Office and QH for the purpose of clarifying the evidence gathered and attempting to resolve inconsistencies that had arisen.

2.3 Process – Department of Families

My officers took the following actions in relation to DOF:

- conducted formal interviews in person with the two FSOs who carried out DOF's initial assessment in relation to Brooke. The interviews were conducted separately and consecutively and recorded on audio tape;
- conducted a formal interview in person with the officer who conducted DOF's internal review in relation to Brooke's case subsequent to her death. This interview was also recorded on audio tape;
- attended and inspected the Gold Coast Area Office of DOF and had discussions with the Gold Coast Area Manager, the internal review officer and the current Intake Team Leaders of the Gold Coast Area Office;
- requested the Gold Coast Area Manager to respond to written questions. His answers were assessed and compared with other evidence gathered;
- examined and compared documents and other information provided by the Gold Coast Area Manager, the internal review officer and the two FSOs with other evidence gathered; and
- exchanged various formal correspondence between this Office and DOF for the purpose of clarifying the evidence gathered and attempting to resolve inconsistencies that had arisen.

11 Ms Megan Jarvis, LL.B, Investigating Officer, and Mr Peter Cantwell, LL.B(Hons) Solicitor, Assistant Ombudsman.

12 Initially, my officers requested that QH staff attend this Office to be interviewed in person. However, at QH's request, my officers agreed to first assess detailed written statements from the staff. This request was made on the basis that a number of QH staff were considerably distressed by the events that had occurred, and an examination of the written statements might forgo the need for the staff to be interviewed. After examining the statements, it was determined that interviews were not necessary in all cases.

2.4 Other investigations

My officers also took the following actions in relation to this investigation:

- obtained from the DPP and examined the transcript of the Supreme Court Trial of Mr Self and attended the DPP's office and examined other relevant documents, including the transcript of Mr Self's committal hearing and various documentation from the DPP's file in relation to the prosecution of Mr Self;
- made a formal request to the CJC for information in relation to aspects of this matter concerning QPS;
- exchanged formal correspondence between this Office and the QPS in relation to its involvement in the matter (QPS provided a number of reports and other documents, which were examined and compared with other evidence gathered);
- attended the address at Back Street, Biggera Waters, where Brooke and Ms A had resided at the relevant time (an inspection of the units was not possible because they had been demolished);
- attended the offices of the Queensland Public Sector Union and had informal discussions concerning resourcing levels within DOF (various documents and other information were provided by the QPSU and examined);
- obtained, with his approval, certain telephone records pertaining to calls made by the Gold Coast SCAN doctor from Telstra Corporation Limited and compared them with other evidence gathered; and
- obtained and assessed various media articles relating to Brooke's death and the subsequent prosecution and conviction of Mr Self.

2.5 Ms A

Ms A, Brooke's mother, resides outside Queensland. She generally communicated with this Office through a third party, although my officers did speak with her on one occasion. Unfortunately, Ms A declined to attend my Office to be interviewed in person, and also declined to participate in a tape-recorded interview by telephone.

However, Ms A did eventually agree to provide answers to written questions that were sent to her. She also responded to the section 55 notice of proposed adverse comment[13]. The information provided was assessed and compared with the evidence provided by the agencies. Ms A's version of events is set out in this report.

In addition, my officers spent a significant amount of time gathering evidence from other sources[14] about what had occurred from Ms A's perspective, in order to supplement and balance the information that had been provided by the agencies.

2.6 Documentation obtained

During the course of this investigation, various documents were obtained from QH, DOF, QPS and other sources. A list of these documents is contained in Appendix D.

13 See Part 1.7.

14 Statements given by Ms A to QPS, information obtained from DPP files, and evidence given by Ms A during the committal proceeding and the Supreme Court trial in relation to Mr Self.

3 Relevant Law

Legislation, policy and procedures

3.1 Queensland Health

The legislative obligations imposed on hospitals in relation to the admission of children exhibiting signs of suspected abuse are contained in the *Health Act*[15].

Section 76K of the 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. In accordance with regulation 63 and schedule 1 of the Health Regulation[16], an *authorised person* for the Gold Coast area is one of the following:

- the medical superintendent of the Gold Coast Hospital;
- the visiting paediatrician of the Gold Coast Hospital;
- the superintendent of police assigned to the South-Eastern Police Region, Surfers Paradise;
- the superintendent of police assigned to the Gold Coast Police District;
- DOF's regional director for the South Coast;
- DOF's area manager for the Southport or Burleigh Heads area offices.

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…'.

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'.

QH has advised that, at the time of Brooke's admission, the medical practitioners at the Gold Coast Hospital who were prescribed medical officers in accordance with section 76L were the medical superintendent, the Gold Coast SCAN team doctor, who was also the hospital's visiting paediatrician, and three other medical practitioners[17].

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 no more than 96 hours. Before issuing this order, the prescribed medical officer must suspect upon

15 *Health Act 1937 (Qld)* - see Appendix E for a full extract of the relevant sections.

16 *Health Regulation 1996 (Qld*).

17 These other medical practitioners have been identified to this Office by name. They do not include the Emergency Registrar or the Paediatric Registrar who examined Brooke when she was brought to the hospital by Ms A.

reasonable grounds 'the maltreatment or neglect of the child in such a manner as to subject or be likely to subject it (the child) to unnecessary injury, suffering or danger'[18].

Where the prescribed medical officer who makes a 96-hour order is of the opinion that the assistance of a police officer is necessary for the purpose of enforcing the order, the prescribed medical officer may certify as to this opinion by 'endorsement' upon the order[19]. A police officer who is notified of this endorsement then has a duty to assist the prescribed medical officer as required[20]. The police officer so assisting is authorised to take or convey the child the subject of the order to such hospital as the prescribed medical officer directs[21]. Further, a warrant may be obtained authorising police officers to search for the child and, for that purpose, to enter any place or premises, take the child into custody and convey the child to the hospital, using such force as is necessary[22].

At the time of Brooke's admission to the Gold Coast Hospital, QH's procedure in relation to suspected child abuse was for a medical practitioner at the hospital who suspects abuse to contact the Gold Coast SCAN team doctor by telephone as soon as practicable after the admission of the child or after the development of the suspicion of abuse. As the SCAN doctor is the Gold Coast Hospital's visiting paediatrician, he is one of the *authorised persons* for the Gold Coast in relation to the mandatory notice requirements of section 76K of the *Health Act*. The SCAN doctor is also a *prescribed medical officer* for the purposes of section 76L of the *Health Act*.

QH staff are also referred to the guidelines set out in the Queensland 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.

When notified of a case of suspected abuse, the SCAN team doctor makes arrangements to attend the hospital to examine the child as soon as possible. The doctor also notifies other government departments as that becomes necessary and is responsible for raising the case at the next SCAN team meeting.

At the time of Brooke's admission, QH did not have any written policies or procedures in place in relation to 96-hour orders. QH have advised[23] that they hold a view in relation to 96-hour orders, which was stated to be as follows:

> The question of whether to make a "96-hour order" is routinely considered as part of every case assessment where a child is suspected of being the subject of abuse or neglect. However, the powers under section 76L of the Health Act 1937 are broad, and importantly, are not subject to judicial review. There is always a risk that a "96 hour order" could wrongly interfere with the civil liabilities (sic) of individuals. For this reason, QH holds the view that the issue of a "96-hour order" should only be made in certain circumstances. For example, where a child is threatened to be removed or is removed from hospital and when that child is in urgent need of medical or surgical treatment or where there are strong grounds to believe the child is at immediate risk of serious injury.
>
> QH's preferred option in other circumstances is for the medical officer who has the conduct of the case to contact the Police Department and the Department of Family Services so that those Departments can take the steps they consider appropriate in all the circumstances of the particular case.

18 Section 76L(3) of the *Health Act.*

19 Section 76L(4) of the *Health Act*.

20 Section 76L(5) of the *Health Act.*

21 Section 76L(5) of the *Health Act.*

22 Section 76L(7) and (8) of the *Health Act*.

23 QH's further report to this Office dated 10 August 2001.

3.2 Department of Families

As at 13 July 1999 — the day Brooke was removed from the Gold Coast Hospital — DOF's statutory responsibilities in relation to child protection were contained in the *Children's Services Act 1965 (Qld)*. This Act did not specifically codify the actions that DOF was required to take upon receiving a notification alleging harm to a child.

Since that time, a new Act has been implemented in relation to child protection: namely, the *Child Protection Act*[24]. This Act provides that if the Chief Executive of the DOF becomes aware, whether because of notification given to the Chief Executive or otherwise, of alleged harm or alleged 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 the Chief Executive considers appropriate[25]. A *child in need of protection* is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm, and does not have a parent able and willing to protect the child from the harm[26].

DOF's procedural requirements and practice standards in relation to child protection are contained in its *Child Protection Procedures Manual* (the Manual). I have been advised that, although the Manual is in the process of being updated in response to the implementation of the *Child Protection Act*, the current procedures contained in the Manual have not significantly altered since the time of Brooke's notification in July 1999. However, the Manual is used in conjunction with relevant policy memoranda, which are issued to implement new policies and procedures within DOF. Some of DOF's policies have altered significantly since the date of Brooke's notification.

When DOF receives information which leads it to reasonably believe that a child has suffered harm or is at risk of suffering harm due to the action or inaction of a parent, careprovider 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.

An initial assessment is carried out by two FSOs, who will visit the child and family to discuss the concerns and assess the child's protective needs. 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.

As resourcing impediments do not allow DOF to carry out an initial assessment of every notification immediately, notifications are assessed to determine which particular notifications should receive priority. At the time of Brooke's notification in July 1999, the only written policy in relation to prioritising notifications was contained in chapter 5 point 5.5 (ii) of the Manual. It stated that the level of current risk to the child would determine the timeframe in which an initial assessment should be carried out. When a child was considered to be in imminent danger, immediate action must be taken to ensure that child's safety.

Since that time, a comprehensive written policy for prioritising notifications has been implemented within DOF. This policy is contained in DOF's Policy Memorandum PM00/03, entitled *Child Protection Notification (Initial Assessment) Response and Specific Workload Management Strategy*. PM00/03 is dated 28 February 2000 and took effect from 6 March 2000.

The first part of PM00/03 outlines DOF's strategy for prioritising responses to child protection notifications requiring initial assessments. Essentially, notifications are prioritised according to an assessment of the level of likely significant harm, and the urgency/immediate danger associated

24 *Child Protection Act 1999 (Qld*) - commenced on 23 March 2000.

25 Section 14(1) of the *Child Protection Act*.

26 Section 10 of the *Child Protection Act.*

with that significant harm. Notifications with a high risk of immediate danger and a high or low risk of future significant harm are classified as a 'priority one' notification. Notifications with a low risk of immediate danger and a high risk of future significant harm are classified as 'priority two' notifications. Notifications with a low risk of immediate danger and a low risk of future significant harm are classified as 'priority three'. Specific criteria for determining the level of harm are outlined in a document titled *Practice Guide for Assessing High/Low Level of Risk - Notifications Requiring Initial Assessment*[27].

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

The second part of PM00/03 outlines DOF's procedure for managing and processing notifications that cannot be responded to within an appropriate time period because of resourcing limitations. This procedure is called the 'Specific Workload Management Strategy'. This Strategy was not utilised in Brooke's case, however it is examined in more detail later in this report[28].

DOF also has a written policy in relation to notifications for which initial assessments are unable to be commenced or completed because of 'client reasons'. An inability to locate a family is an example of a 'client reason'. This policy is contained in chapter 6, point 6.2 (iv) of the Manual, and was therefore applicable at the time that Brooke's notification was received[29].

The policy provides that if the Area Manager is satisfied that all reasonable steps have been taken to commence or complete an assessment, no further action is required to be taken to assess the notification. In determining what is reasonable, the Area Manager must take into account the general circumstances, the level of alleged harm, and any factors making the assessment difficult to commence or complete. Where an assessment could only be partially completed, the outcome to be recorded is 'Partial Assessment (Client Reasons)'. Where an assessment could not be commenced, for example where the family could not be located, the outcome to be recorded is 'No Assessment Possible (Client Reasons)'.

Persons wanting to notify DOF of concerns about a child are able to do so by telephone or in person at one of DOF's Area Offices. Outside of normal working hours (9am to 5pm Monday to Friday), persons may contact Crisis Care, which is DOF's 24-hour emergency telephone service. Crisis Care is staffed by FSOs and a Team Leader, who are available to respond to all urgent requests for assistance. If callers telephone an Area Office outside working hours, they receive a recorded message advising of Area Office working hours and requesting they contact Crisis Care in case of emergency.

At the time of Brooke's notification in July 1999, five telephone lines in the Gold Coast Area Office were dedicated to incoming calls and there were two administration officers whose duty it was to answer all incoming calls. If a call was not answered immediately, it was diverted to a message advising that operators were busy and requesting callers to hold until their call could be answered by the next available operator.

The Gold Coast Area Office had an Intake Team, which was responsible for receiving and assessing information from the community about any child-related matter in the Gold Coast Area. The Intake Team consisted of five FSOs and a Team Leader. Each day, one FSO was allocated the task of answering calls from the community in relation to concerns about children. This FSO was said to be on 'intake'. Callers with new information in relation to a child were transferred to the intake officer by the two administration officers who answered all incoming calls.

27 See Appendix F.

28 See Part 5.4.6.

29 A copy of this policy is contained in Appendix G.

All information received on intake was assessed by the Team Leader to determine whether it constituted a notification requiring an initial assessment, and if so, what priority the notification should be given. Once a notification had been assessed, the Team Leader allocated the matter to one of the FSOs in the Intake Team. The FSO was then responsible for carrying out the initial assessment within the appropriate time period.

Once the initial assessment had been completed — or attempts had been made to complete it — the FSO reported the findings to the Team Leader. The Team Leader then determined what further action, if any, DOF would take in relation to the matter. If further action was recommended, the matter was reallocated to another FSO outside the Intake Team for follow up.

Currently, the Gold Coast Area Office operates under the same organisational structure and follows the same basic procedures in relation to intake as it did at the time of Brooke's death. However, it now has two Intake Teams, each with its own Team Leader.

When a child who has been the subject of DOF's intervention dies or suffers serious injury, DOF staff are required to follow the procedures set out in PM95/17 – *Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons*[30]. In cases where the death or serious injury was or could have been non-accidental, a review of the matter must be carried out by a review team consisting of a minimum of two DOF officers external to the region, both of whom have relevant experience and expertise.

The review team must establish the facts, formulate findings and make recommendations. The focus of the review is on DOF's systems, practices and procedures. Individual staff members must not be named in the report. Once the review is completed, staff members who were interviewed as part of the review must be invited to comment on and/or discuss the draft report. Alterations to the report as a result of this consultation can be made in relation to matters of fact or, at the discretion of the reviewing officers, in relation to other aspects of the report. The final report is provided to the Divisional Head with copies to both the Regional and Area Managers. The individual staff members who were involved in the matter must be provided with appropriate and timely support and debriefing services, and it is the responsibility of the Regional Manager to ensure that this occurs.

3.3 Suspected Child Abuse and Neglect (SCAN) Teams

SCAN teams are committees of persons from QH, DOF and QPS. They were developed in 1980 as a means of providing a coordinated response by these agencies to cases of suspected child abuse and neglect. SCAN teams do not have a legislative basis. There is therefore no specific legislation that confers any powers, procedures or formal status to these teams.

The role of SCAN teams is explained in the Queensland 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…

30 This DOF policy has recently been replaced by two new policies, copies of which were provided by DOF to this Office on 24 September 2001. The documents are entitled *Child Death Reviews Policy and Procedures* and *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures*. It was not necessary for me to consider these documents as part of my report.

> The team has a core membership of representatives of DOF, QPS and an authorised medical practitioner as defined in the Health Act...
>
> 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 coordinated
> - formulate recommendations for action incorporating the statutory responsibilities of the core departments represented in the multi-disciplinary team
> - 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 coordinating initial child protection responses.

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.

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. 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 medical person. DOF is directed to refer matters only in certain circumstances[31].

As to the timing of SCAN team referrals, the Queensland SCAN Team Manual states:

> Referrals should be made to the coordinator of the SCAN team in a timely way. If an urgent matter arises which requires SCAN team consideration, the coordinator should be contacted to arrange an emergency meeting…
>
> 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.

Core members contact the SCAN team coordinator to advise of referrals. The SCAN team coordinator then ensures that the case is scheduled for discussion at the next available meeting. The coordinator may call an emergency SCAN team meeting 'if warranted'. The referring agency prepares a written referral for distribution to other SCAN team members prior to the meeting.

31 See referral guidelines in Appendix H (extracted from the Queensland SCAN Team Manual).

4 Analysis of Queensland Health's Actions

4.1 Evidence

During this investigation, QH provided written reports as well as the original hospital records and statements of hospital staff. The information contained in the reports was generally consistent with the information in the statements and the hospital records.

On the morning of Monday, 12 July 1999, Ms A took Brooke to see a Gold Coast general practitioner about a sore finger and episodes of vomiting and hair loss. The GP carried out a general examination of Brooke and noticed bruises that he considered to be quite severe on her forehead, abdomen and groin. He also noticed that the sore finger appeared to be broken or twisted. From these observations, the GP suspected that Brooke may have been abused. The GP then carried out urine tests, the results of which suggested Brooke was suffering from dehydration.

The GP decided to refer Brooke to the Emergency Department of the Gold Coast Hospital for further investigations. He told Ms A that Brooke would have to be admitted to the hospital due to dehydration and the injury to her finger. In private, the GP telephoned the hospital at approximately 8.15am and spoke to an emergency physician. The GP informed the physician that his concerns in relation to Brooke included unexplained bruises, bruises on her lower abdomen consistent with hand marks, a possible fractured little finger, hair loss and vomiting. The GP specifically mentioned his concern that some or all of these problems could be related to non-accidental injuries[32].

The GP also wrote a letter of referral, addressed to the emergency physician to whom he had spoken, stating as follows:

> Thank you for assessing the abovementioned child as per arrangement. Has been vomiting for the last 5 days. No diarrhoea. Urine = ketones ++. Also bruised oedematous L little finger - for X ray etc

The GP gave this letter of referral to Ms A to take with her to the hospital. The letter did not refer to the GP's suspicions in relation to abuse. The GP thought it possible that Ms A might read the referral letter and he did not want to alert Ms A to these concerns[33].

Ms A arrived at the emergency department with Brooke at approximately 9.20am. She was first examined by the Emergency Registrar, who documented the following numerous injuries:

- 1 x 2 cm bruise on the forehead, brown colour with palpable swelling (and tender at that time).
- 1 x 2 cm bruise under right and left angle of the jaw – red brown in colour.
- 0.5 cm red scratch on left side anterior neck.
- Swollen left little finger, purple and tender (fractured middle phalanx left little finger confirmed on xray).
- 2 x 1 cm bruise on right lower anterior chest, red/brown.
- 0.5 x 0.5 cm bruise to right costal margin anterior chest.
- 1 x 1 cm and 0.5 x 0.5 cm bruises to left costal margin anterior chest, both red/brown in colour.
- 1.5 x 1.5 cm bruise to the right and inferior of the umbilicus, red/brown in colour.
- 2 x 2 cm and 2 x 2 cm bruise to the left iliac region both red/brown.
- 3 x 2 cm bruise medially of the right anterior superior iliac spine, red/brown in colour.
- 1.3 x 1.5 cm bruise on right groin region, green in colour.
- 3 x 2.5 cm bruise to left anterior upper thigh, green in colour.

32 This evidence was obtained from the emergency physician's written record of the telephone call, a copy of which was provided to this Office by QH as part of its medical records.

33 This information is derived from the GP's statement to QPS dated 26 July 1999.

- Two x 1 x 1 cm bruises to left lower back, red/brown in colour.
- 1 x 1 cm bruise to right lower back, brown/purple in colour.
- 5 x 2 cm bruise to upper left buttock, green in colour.

After his examination, the Emergency Registrar interviewed Ms A about Brooke's injuries. According to the notes taken by the Emergency Registrar, which are consistent with Ms A's recollection of the conversation, Ms A told the Emergency Registrar the following:

- Brooke had suffered multiple injuries over the past month since Ms A commenced living with her new partner;
- She had never witnessed these injuries as they had occurred while Brooke was in her partner's care;
- Her partner had told her that the injuries were due to falls and that Brooke was clumsy;
- Brooke was not clumsy and had not been falling or bruising prior to living with her new partner;
- Brooke was anxious and stressed lately and not eating;
- Brooke's hair was falling out and she was losing weight; and
- She planned to move out rather than risk further injury to Brooke, but her partner was not yet aware of this decision.

While still in the Emergency Department, Brooke was examined by a second doctor, the Paediatric Registrar. The Paediatric Registrar's examination notes, which were included in the hospital records, documented that Ms A suggested the bruising could have been caused during a game with her partner, which involved him bouncing Brooke up and down on the bed with his hands on her abdomen. The notes also recorded that Ms A said her partner was 'quite rough' with Brooke but did not hit her. In a statement provided by the Paediatric Registrar, she said that she told Ms A: 'there was more to it than that and just rough play would not make those bruises'. The Paediatric Registrar stated that Ms A acknowledged her concerns and comments, and 'seemed to take them on board'.

However, in contrast, Ms A has since told my officers that the Paediatric Registrar did *not* suggest to her that Brooke's injuries could have been caused by abuse. She recalls that the Paediatric Registrar informed her that Brooke would have to be admitted to hospital overnight because she was dehydrated and required a drip. Ms A says she does not recall the Paediatric Registrar expressing any other concerns to her in relation to Brooke.

Brooke was then admitted to the Paediatric Ward of the hospital overnight. Ms A agreed to Brooke being admitted and, according to the Nurse in Charge[34], told hospital staff that she was 'happy' that Brooke was in hospital because she was in a 'safe place'. However, Ms A claims that she was not 'happy' about Brooke's admission, and does not agree that she made any statements to this effect to hospital staff.

Some time that afternoon, the Paediatric Registrar who had examined Brooke notified the Gold Coast SCAN doctor about Brooke's injuries. The SCAN doctor was informed that Brooke had been admitted to the hospital overnight and that Brooke's mother was happy about this arrangement. As he was scheduled to attend the hospital the following morning at 8.00am for rounds, the SCAN doctor arranged to examine Brooke just before this time.

Ms A remained with Brooke in the hospital that afternoon, helping to feed and shower her. The hospital's nursing staff stated that Ms A's behaviour towards Brooke appeared to be warm, caring and concerned. Ms A remained in the ward until approximately 7.30pm, leaving after Brooke had fallen asleep. Although there were facilities for Ms A to stay in the hospital overnight with Brooke, Ms A claims that she was not informed of this option.

34 In her statement dated 6 June 2001, provided to this Office by QH.

Ms A returned to the Paediatric Ward of the hospital at approximately 7.15am on Wednesday, 13 July 1999. According to the recollection of the nurse on duty[35], the following events occurred upon Ms A's arrival.

When Ms A entered the ward, the nurse on duty approached her and asked if she needed any help. Ms A told the nurse that she was Brooke's mother. The nurse asked Ms A a few questions to confirm that Ms A was in fact Brooke's mother (e.g. 'What is Brooke's date of birth?'). The nurse then asked Ms A why Brooke was in hospital. Ms A replied that Brooke was really clumsy and the doctors thought there might be something wrong with her. The nurse thought this statement was inconsistent with the reasons for Brooke's admission given in her hospital chart, but she did not challenge Ms A as she did not think it was appropriate at the time.

Ms A then went to Brooke, who was calling for her, and the two played together on the floor for about five minutes. The nurse was attending another patient during this time. The nurse heard the gate to the play area open where Brooke and Ms A had been, and approached Ms A to ask if she needed help. Ms A told the nurse that she wanted to take Brooke to the hospital canteen for breakfast. The nurse responded by saying that this was not normal practice, and that she would appreciate it if Brooke stayed in her room. The nurse told Ms A that she was welcome to continue playing with Brooke, and that she should discuss the matter with the doctor and the nursing staff who were about to commence the morning shift.

The nurse turned around to attend another infant patient who was crying. Ms A then took Brooke's hand and walked in front of the nurse down the corridor, towards the ward's exit. The nurse followed Ms A and called out to her: 'Please wait, I don't want you to go off the ward'. Ms A failed to stop.

The nurse immediately went to the staff room where the nursing staff were preparing for the morning shift and informed them that Ms A was in the hospital and was taking Brooke off the ward. The nurse heard the elevator bell ring and then the doors to the elevator open. The nurse in charge, who was inside the staff room, told the nurse on duty that the after hours supervisor, hospital security and the unit manager would be notified. The nurse on duty returned to the ward to see if Brooke and Ms A had returned, but could not find them. The nurse then ran down the hospital's stair well to the ground floor to look for Brooke in the canteen. She asked canteen staff if they had seen two people of Brooke and Ms A's description, and was told that no one of that description had been seen. The nurse then searched the parking area out the front of the hospital and the swimming pool area at the rear of the hospital, but saw no sign of Brooke or Ms A. The nurse returned to the ward and notified the staff on duty that she had not been able to find Brooke.

Ms A's account of events differs significantly from that of the nurse on duty. Ms A stated that when she arrived in the ward that morning, she was not approached or questioned by a nurse, and was able to go straight to Brooke's bed. Ms A stated that she immediately gathered Brooke and her belongings and went to leave the ward. At this time, Ms A recalls a nurse approaching her to ask where she was going. Ms A stated that the conversation was as follows:

> She approached me and asked where I was going. I said downstairs for a cigarette. She said it might be a bit cold downstairs and I said 'Yeah I've got her blankey'. I walked to the elevator and turned around worried she was following. She was gone.

Ms A claimed that the nurse did not follow her as she left the ward with Brooke, and did not call out to her or request her not to leave the ward. She said that she left the hospital by taking the lift to the ground floor and then walking quickly outside and across the road to the taxi stand, where she and Brooke caught a taxi home.

35 As contained in her statement dated 20 June 2001, provided to this Office by QH.

The nursing staff immediately notified the SCAN doctor about Brooke's removal. He has confirmed that he received the call either at home or on the way to the hospital. He said he advised the hospital that he would notify DOF and QPS. He waited until he arrived at the hospital to notify these agencies, as the relevant telephone numbers he needed were at the hospital. He arrived in the Paediatric Ward at approximately 8.00am and spoke to the nursing staff about the circumstances of Brooke's removal.

The SCAN doctor states that as soon as he had the necessary information, he telephoned the Gold Coast JAB of QPS. However, he said that he was unable to make contact with the JAB as their telephone rang out. He also claimed that he attempted to contact DOF, but his calls were repeatedly answered by a recorded message. He said that throughout the morning, he and his secretary continued to telephone both agencies. He recalled that around midday to 1.00pm, he managed to get through to the JAB and speak to a senior police officer. He said that he explained Brooke's situation and asked the officer to try to locate Brooke immediately. He said the police officer he spoke to informed him that the Gold Coast JAB was extremely short staffed and would not have an officer available until the afternoon shift came on duty. The SCAN doctor claimed it was suggested to him that he contact DOF as it may be able to respond more quickly.

The SCAN doctor claimed that he finally made contact with DOF at about 3.00pm that afternoon. He said he notified DOF of Brooke's situation and provided the relevant names and contact details, as provided by Ms A. He said he again stressed that Brooke should be located as a matter of urgency.

The SCAN doctor had no further involvement in the matter until 22 July 1999, when he attended a meeting of the Gold Coast SCAN team, of which he was a member. At this meeting, Brooke's case was discussed and he was then informed of the result of the investigations carried out by DOF.

Brooke died some three days later.

4.2 Inconsistencies

I have identified a significant inconsistency between the information provided to my officers by QH and the information provided by QPS. The inconsistency relates to the telephone call the SCAN doctor says he made to the Gold Coast JAB on 13 July 1999.

In a statement provided to this Office dated 6 June 2001, the SCAN doctor asserted that he spoke to a police officer from the JAB at about midday to 1.00pm that afternoon. The SCAN doctor recalled this conversation as follows:

> The officer told me he preferred to leave the search until the afternoon shift. I told him it was most important and could not be left any longer. I explained the situation and asked the officer to try to locate Brooke immediately. I gave the officer the mother's name, address and phone number as well as details recorded in the clinical records.

By letter of 17 July 2001, the former Ombudsman asked the Commissioner of Police to respond to various questions about the involvement of the Gold Coast JAB in this case. The Commissioner of Police advised that QPS had no record of contact between the SCAN doctor and the Gold Coast JAB in relation to Brooke. The QPS arranged for a search to be undertaken of the Gold Coast JAB's records covering the period 12 July 1999 to 16 July 1999. Specifically, those records consisted of daily occurrence sheets compiled by JAB staff that recorded work performed on each day. The sheets specifically make provision for entries relating to SCAN referrals, joint DOF child abuse investigations, child abuse inquiries and SCAN information. These documents, copies of which were provided to this Office, contain no record of any phone contact between the SCAN doctor and the JAB for the relevant period.

QPS also made specific inquiries with the officers working shifts with the JAB during the relevant period. All officers denied any recollection of phone contact with the SCAN doctor for the period 12 July 1999 to 15 July 1999. Consequently, QPS maintained that it was not alerted to Brooke's situation and therefore had no reason to investigate it.

The QPS asserts that if the SCAN doctor had made a 'SCAN referral' to the JAB in relation to Brooke, it would have been recorded and investigated either with or without DOF involvement. The QPS advised that investigations were prioritised according to the nature of the material provided to the JAB and competing operational requirements.

In an attempt to clarify what had occurred, my officers informed QH of QPS's position and asked QH to respond. QH raised the matter with the SCAN doctor once more, who asserted he did in fact call the Gold Coast JAB on 13 July 1999, as he previously advised. He gave the following recollection of his conversation with the police officer:

> Unfortunately, I can not remember with whom I spoke. We ring each other several times a week and the calls tend to merge in my memory. However, it was one of the senior officers whom I knew well. I was informed that they were extremely short staffed and would not have an officer available until the afternoon shift came on duty. This is a frequent occurrence in what I know to be a badly undermanned office.
>
> It was suggested that I contact DOF as they may have been able to respond sooner. So I did.

With the consent of the SCAN doctor, my officers subsequently obtained the service provider's records[36] of all telephone calls made from the SCAN doctor's rooms on 13 July 1999. These records confirm that a call was in fact made to the Gold Coast JAB at 1.02pm that day. The duration of the call was 186 seconds, or approximately three minutes. These details appear to corroborate the SCAN doctor's version of events that he had a significant conversation with a JAB officer and cast considerable doubt upon QPS's claim that there had been no phone contact on that day. As I have already reported, the Gold Coast JAB's Occurrence Sheets for 13 July 1999 do not show any record of a telephone call from the SCAN doctor.

Given this information, I was therefore concerned about the accuracy of the original report prepared by the Detective Senior Sergeant of the Gold Coast District Criminal Investigation Branch, which was provided to the Detective Inspector of that same branch. It stated:

> I have spoken with Juvenile Aid Bureau officers working on 13 July 1999, in relation to this alleged phone call from the SCAN doctor. No officer recalls the phone call **and in fact state they did not receive one** (emphasis added).
>
> Any notification received by the Queensland Police Service is **always** investigated. All SCAN referrals are investigated by police, either with or without the assistance of the Department of Family Services (emphasis added).

However, the evidence that had been gathered supported the SCAN doctor's account of events. If the call was in fact made, what remained unresolved was:

- the identity of the officer within the Gold Coast JAB to whom the SCAN doctor spoke;
- why no record of this conversation was made;
- why the officer did not recall or admit to the conversation; and
- why, if QPS asserts that every notification is investigated, no one from the Gold Coast JAB took any action to investigate the SCAN doctor's notification in relation to Brooke.

QPS was therefore invited to address the above issues as part of its response to relevant sections of my provisional report. I also asked QPS to provide details as to what procedures apply to the

36 Telstra Corporation Ltd

recording of details of telephone calls made to the Gold Coast JAB regarding child protection matters.

Following my request, QPS carried out further investigations and a Detective Inspector from the Gold Coast District CIB prepared a report which was provided with QPS's response to my provisional report. In relation to the alleged telephone call by the SCAN doctor, the Detective Inspector reported as follows:

> On 13 July 1999, although there was no receptionist available, there were two officers attending to office duties. Both these officers have been interviewed and do not recall receiving any telephone calls from the SCAN doctor. These officers were rostered 8.00 am to 4.00 pm.

The Detective Inspector's explanation as to the relevant telephone procedures within the Gold Coast JAB was as follows:

- There are ten telephone numbers allocated to the JAB. Telephone calls are answered by a receptionist on Mondays and Wednesday to Friday. On other days, calls are received by rostered JAB staff. A telephone message book is maintained to record any non-urgent matters, and is checked by all staff.

- There are no specific procedures in place in relation to recording all incoming telephone calls.

- Issues of significance are recorded on the JAB Occurrence Sheet and actioned.

- A CRISP report is generated for all Child Protection matters whether instigated by DOF or otherwise. This is either substantiated or non-substantiated after inquiries are made.

- All members of the staff in the JAB are fully aware of the need to action child protection matters promptly. Items of significance are recorded on daily occurrence sheets and actioned.

In its response, QPS offered the following further comments in relation to the Detective Inspector's report:

> The enclosed report reaffirms that, notwithstanding the results of further investigation by the Ombudsman, police personnel do not have a recollection of the conversation with the SCAN doctor referred to. Equally, upon further investigation, there appears no written recordings of such conversation. That said, the material merely shows that the doctor indicated that a child had been taken from the hospital by her mother…
>
> From a police perspective, it is clear that depending on the tone of the caller, and the nature of the information received, a determination must be made by the officer or administration officer as to whether the call is of significance and should operate as a notification. In the absence of any recording, in this case, it would seem to follow that the person involved with the phone conversation with the doctor did not consider the matter to be such to warrant a notification for recording in the necessary job sheets. This would seem to bear out the doctor's recollection that he was requested to contact DOF for assistance…
>
> With respect, it is not necessarily of suspicious note that an officer does not recall some two and a half years later the content of a call made to JAB with a doctor. The only conclusion that can be drawn is that the two persons, the parties to the conversation may not necessarily have treated the information with the same significance or priority as the other. However, it appears clear that the doctor concerned did not have such significant concerns as to warrant the making of a 96-hour order or take some other preventative step. This is further borne out by the absence in later SCAN documents as to concern by the response of QPS to the initial contact…
>
> It would seem to follow that the conversation with the doctor was not considered to be a notification based on its content and tenor.

Although the *Ombudsman Act* prevents me from investigating police operational matters, as explained earlier[46], I have had to consider the involvement of QPS in the matter to assess the administrative decisions made by DOF and QH. QPS's response speculates that the SCAN doctor's child protection referral/request to QPS in this case did not result in police action because it may have been dependent upon an individual officer's assessment of the SCAN doctor's tone of voice.

QPS's argument is based on the assertion that 'the material merely shows that the doctor indicated that a child had been taken from the hospital by her mother'. However, the SCAN doctor says that he told the JAB officer much more than this. The doctor says he 'explained the situation and asked the officer to try and locate Brooke immediately'. He says he also gave the officer Ms A's 'name, address and telephone number as well as details recorded in the clinical records'. His account is supported by the telephone records showing a call at the relevant time from the doctor's service to the JAB office that lasted for more than three minutes.

Given the SCAN doctor's experience in child protection matters as a core member of the Gold Coast SCAN team, I consider it highly unlikely that his tone of voice could have given the JAB officer the erroneous impression that the call was not 'of significance' and should not 'operate as a notification'.

For these reasons I do not believe that the explanation provided by QPS as to why no record of the call was made by a QPS officer is credible. Furthermore, I do not believe that QPS's submission on this point is strengthened by the fact that QH did not make a 96-hour order or that the minutes of the SCAN team meeting did not note any concern about QPS's response to the SCAN doctor's contact. The absence of procedures regulating the making of 96-hour orders and deficiencies in minutes of SCAN meetings are issues critically examined later in this report.

Finally, while I accept that the SCAN doctor had to act urgently, if he had been required by a QH policy to provide written confirmation to QPS of his referral/request, the JAB may have taken action and the evidentiary problems encountered by my officers in the investigation could have been avoided.

4.3 Queensland Health's Response to Complainants' Allegations

I have set out below QH's response to each of the complainant's allegations, as contained in QH's various reports to this Office. My analysis of each issue appears in Part 4.4 of this report.

4.3.1 That Queensland Health failed to alert the Department of Families and the Queensland Police Service immediately upon Brooke's admission

QH advised that there was no statutory or other obligation upon medical practitioners at the hospital to notify either DOF or QPS upon Brooke's first admission. The obligation under section 76K of the *Health Act* was to notify an 'authorised person' within 24 hours of the suspicion first arising. This obligation was fulfilled when the SCAN doctor was notified shortly after Brooke had arrived at the hospital.

QH stated that at the time of Brooke's admission, Ms A was co-operative with medical and nursing staff. She expressed appropriate levels of concern about Brooke's welfare and made it clear to nursing staff that she was happy for Brooke to be admitted because she was in a 'safe place'. In these circumstances, QH did not see the need for any further steps to be taken other than to contact the SCAN doctor and arrange for him to attend Brooke early the next morning.

46 See Part 1.4 of the report.

QH further highlighted that when Ms A left with Brooke, the SCAN doctor was immediately notified. He, in turn, claims that he notified DOF and QPS as soon as he was able to do so and impressed upon these agencies the urgency of locating Ms A and Brooke.

In order to clarify the obligations on staff at the Gold Coast Hospital under the *Health Act*, my investigation also addressed whether a notification was made in accordance with section 76K when Brooke was first referred to the hospital by the GP. Given that the GP had suspicions about the nature of Brooke's injuries, it would appear that he also had an obligation as a medical practitioner to notify an 'authorised person' in accordance with section 76K. QH was asked whether, in its opinion, a referral of a child with suspected non-accidental injuries to the hospital by a general practitioner effectively constitutes a notification to the hospital's medical superintendent, who is also an 'authorised person', in accordance with section 76K.

QH responded as follows:

> It is our opinion (based on legal advice) that referral of a child with suspected non-accidental injuries to a hospital by a general practitioner does not amount to notification of an authorised person within the meaning of section 76K of the *Health Act*.

4.3.2 That Queensland Health failed to fully convey the gravity of Brooke's situation to Ms A

In response to this allegation, QH stated that, in its opinion, Ms A was 'well aware of Brooke's predicament'. In support of this view, QH made the following points:

- (Brooke) was referred to hospital by a General Practitioner clearly on the suspicion that Brooke's injuries were not accidental. This is apparent from the referral letter which is contained in the hospital records[37].
- Ms A discussed Brooke's situation with both the Emergency Registrar and the Paediatric Registrar. Both those doctors made it clear to her that Brooke's injuries could not have been sustained in any other way than by abuse.
- Ms A was aware of the fact that Brooke was to be examined by a doctor specialising in child abuse.
- Ms A acknowledged the seriousness of the situation by telling medical practitioners that she intended to discontinue her relationship with Mr Self.
- In discussions with the nurses in the Paediatric Ward, Ms A repeatedly expressed her relief that Brooke was in hospital receiving care and in a 'safe place'.

4.3.3 That Queensland Health failed to advise Ms A of options available to ensure Brooke's welfare

QH relied on the following claims in defence of this allegation:

- Ms A was advised that Brooke's welfare was best served by her admission to hospital and her remaining in hospital until investigations were conducted.
- Further advice would have been provided to Ms A by the SCAN doctor had she not left with Brooke prior to her review by that doctor.
- Ms A had, herself, expressed her understanding of Brooke's needs and best interests by saying that she intended to discontinue her relationship with Mr Self.

37 QH's claim in this regard is incorrect. The GP's referral letter (a copy of which was provided to this Office by QH) did not mention his suspicions for the reasons mentioned at Part 4.1.

4.3.4 That Queensland Health failed to keep Brooke in hospital for the prescribed period for children showing signs of abuse

In response to this allegation, QH advised as follows:

> Under the legislation, there is no "prescribed period" for retention of a child in hospital where that child is suspected of having suffered abuse.
>
> A medical practitioner is empowered to make a 96-hour order but is not obliged to do so in every case. Indeed, it would be entirely inappropriate to do so. A 96-hour order involves significant deprivation of liberty for the child and should only be a step of last resort.

QH offered the opinion that, in this case, Ms A initially displayed appropriate behavior and concern for Brooke's welfare. She outlined an appropriate plan for dealing with the situation and was compliant with Brooke's admission to hospital. Indeed, she repeatedly stated that she was pleased about this development. QH stated that, in these circumstances, it did not consider that the making of a 96-hour order at the time of Brooke's admission was warranted.

However, QH's initial report did not address why the Department did not make a 96-hour order at the time of Brooke's *removal* from hospital or any time thereafter. My officers pursued this line of inquiry and QH was subsequently asked to provide a report addressing this specific issue. In its second report, QH outlined its 'view' in relation to 96-hour orders[38]. QH stated that it considered a 96-hour order should only be made in certain circumstances because 'the powers under section 76L of the *Health Act 1937* are broad, and importantly, are not subject to judicial review. There is always a risk that a 96-hour order could wrongly interfere with the civil liabilities (sic) of individuals'.

QH stated that a 96-hour order would be made, for example:

> …where a child is threatened to be removed or is removed from hospital and when that child is in urgent need of medical or surgical treatment or where there are strong grounds to believe the child is at immediate risk of serious injury.

QH stated that the preferred option in other circumstances is for the medical officer who has the conduct of the case to contact QPS and DOF. QH claimed that the actions taken by the SCAN doctor after Brooke was removed from the Gold Coast Hospital were in accordance with this policy.

QH was asked whether it considered the circumstances of Brooke's removal warranted the making of a 96-hour order. QH stated:

> Given the circumstances of Brooke's removal as they were known to QH staff at the time, QH does not consider that any further action on behalf of QH was warranted, other than those actions taken by the SCAN doctor.

The SCAN doctor provided a written statement to this Office, in which the availability of 96-hour orders was discussed. The doctor stated: 'An option exists for a 96-hour (admission) order under the *Health Act*. This is usually done if a child's parents are not cooperating or there is a risk that they will not cooperate.'

In a further report[39], QH made further comments about the operation of section 76L of the *Health Act*. It stated:

> In so far as you have expressed your views in relation to the provisions of sections 76K and 76L of the *Health Act*, we agree with your interpretation with one exception. That exception relates to the operation

38 See Part 3.1.

39 QH's further report to this Office dated 30 November 2001.

> of section 76L of the *Health Act*. You state in your letter that "if a 96 hour order is issued in these circumstances (a child removed from the hospital without permission) the child can be taken into custody and returned to the hospital to be detained for no more than 96 hours". It is our understanding (based on legal advice) that the 96 hour order, of itself, does not provide the police with any additional powers in terms of taking the child into custody and returning it to the hospital than those which they already have. The Act does, however, allow for a mechanism by which warrants can be more easily obtained if a 96 hour order exists. We point out, however, that even if a 96 hour order is issued the Hospital and the Health Department have no control over the manner in which it may be enforced.

4.3.5 Information from QPS

QPS was also asked about 96-hour orders. Specifically, QPS was asked:

> When QPS receives notice of an order made in accordance with section 76L(5) of *the Health Act 1937*, what actions are usually taken to enforce such an order? Within what timeframe are these actions taken?

Contrary to what I understand the effect of section 76L(5) to be, and to what QH has advised, QPS (in its letter of 3 August 2001) advised this Office as follows:

> As far as the Service is aware, *Health Act* orders contain provisions empowering police to make an application for an order to have a child deemed to be at risk removed from that situation for 96 hours and placed with DFYCC. The previous *Children's Services Act* also empowered police as well as DFYCC officers to make an application for a temporary care and protection order if circumstances warranted it. Under the current *Child Protection Act*, DFYCC officers are the only authorised applicant for such an order although police are empowered to act upon a notification.
>
> When the JAB are notified of the existence of such an order, it takes effect as a notification requiring investigation and location of the child the subject of the order. Usually JAB and DFYCC co-ordinate a response to assess risk to the child before any formal application is made.

This interpretation[40] appears to be based on the report of a Detective Senior Sergeant of the Gold Coast District Criminal Investigation Branch, who reported to the Detective Inspector of that Branch as follows:

> The *Health A*ct has now been superseded by the *Child Protection Act 1999*, however in July 1999, the *Health Act* Section 76L(5) would have contained the provision for Police in consultation with the Department of Family Services, to make application for an order to have a child deemed at risk, to be removed from the situation for a period of 96 hours (4 days). This period would allow initial assessment for medical examinations to be conducted and to allow for further permanent applications to be made if deemed necessary. During this period of time the child would be placed in the care of the Department of Family Services. Whilst QPS has the discretion to take an order out under that section, as in most child protection issues, unilateral decision making is encouraged. If it was deemed necessary to act under the then section 76L(5) of the *Health Act*, in most cases those applications would be made by a representative from the Department of Family Services.

It is appropriate that I now consider each of these responses.

40 In my view, this interpretation is incorrect - see Part 4.4.3.

4.4 Analysis of the evidence gathered

4.4.1 Brooke's admission

When Brooke was admitted to the Gold Coast Hospital on 12 July 1999, medical staff clearly suspected she was suffering from abuse. The medical practitioners who examined her had a legislative obligation to inform an authorised person of this suspicion within 24 hours, by the most expeditious means possible. The SCAN doctor, who is an 'authorised person', was telephoned within hours of Brooke's admission.

The complainants have suggested that QPS and DOF should have been immediately contacted upon Brooke's admission. QH's obligation was to notify an 'authorised person'. An authorised person in the Gold Coast area includes certain persons from QPS and DOF. However, it is QH's policy to notify the SCAN doctor as the authorised person, who attends as soon as possible to conduct a thorough clinical review. QH believes that it is then the SCAN doctor's responsibility to notify other government agencies (such as QPS and DOF) if that becomes necessary.

Given that Brooke was admitted to hospital because of a belief that she was being abused, QH — or, more accurately, a prescribed medical officer — did have the discretion to order Brooke's detention in hospital for 96 hours. A 96-hour order could have been made at any time after Brooke had arrived at the hospital with Ms A. However, according to QH officers, at the time of Brooke's admission Ms A was fully cooperative, pleased and even grateful for the treatment Brooke was receiving. There was no suggestion that Ms A was not willing to cooperate with hospital staff or receive their assistance in relation to Brooke's situation. In these circumstances, the medical staff did not consider a 96-hour order was warranted. Instead, normal procedure was followed and the SCAN doctor was contacted and was arranged to review Brooke the next morning. I have not seen any evidence to suggest that, at the time of Brooke's admission, QH acted unreasonably in applying its usual policy in this regard.

Upon receiving the notification from the hospital, the SCAN doctor was obliged to act in such manner as would best ensure Brooke's safety and well being. The SCAN doctor was informed by QH officers that Brooke had been admitted into hospital overnight, and that Brooke's mother was happy to have Brooke in hospital. Given these circumstances, the SCAN doctor did not consider it necessary to attend Brooke immediately. Instead, he arranged to review Brooke first thing the following morning, before his 8.00am rounds. The evidence supports the view that the SCAN doctor could have reasonably believed that while Brooke remained in the hospital, her safety and well being were ensured.

In my opinion, the actions taken by QH upon Brooke's admission and the actions of the SCAN doctor in scheduling his examination of Brooke for the following morning were reasonable and in accordance with their relevant legislative obligations. Further, QH's decision not to make a 96-hour order in relation to Brooke upon her admission appears justifiable in the circumstances.

One issue that remained for consideration was whether the GP's referral of Brooke to the hospital amounted to a notification to the hospital's medical superintendent in accordance with section 76K. It is QH's view that such a referral would not amount to a notification. QH did not initially give any explanation for its view in this regard, except to say that it was 'based on legal advice'.

I therefore asked QH to provide me with a better explanation for its view in relation to this point. I was concerned that it may be that some general practitioners mistakenly believe they are fulfilling their legislative obligations under section 76K of the *Health Act* by referring children with signs of abuse to hospitals for further investigation, without specifically notifying an 'authorised person'.

However, if a referral of a child to a hospital because of a suspicion of abuse did in fact amount to a notification to the medical superintendent of the hospital in accordance with section 76K, then

another point arises. It would appear that the medical superintendent as an authorised person could then have a personal obligation under section 76K to act in such manner as would best ensure the safety and well being of any such child. Given that the medical superintendent would not usually have personal contact with such children and would not be directly involved in their treatment, it might be difficult for the medical superintendent to discharge this obligation.

QH provided the following explanation as to why it considered that the GP's referral of Brooke to the Gold Coast Hospital did not amount to a notification in accordance with section 76K:

1. S.76K(1) and (2) of the *Health Act* requires the general practitioner, if he suspected abuse, to notify an authorised person of the suspected abuse by the most expeditious means available and to send a formal notification to (the director-general of QH) within 7 days.

2. The general practitioner was in breach of the requirements of s.76K in that the general practitioner did not notify the authorised person, this being the Medical Superintendent or the Visiting Paediatrician, Gold Coast Hospital. The general practitioner notified the Emergency Department (ED) consultant on duty and referred the patient to the ED Department. The ED consultant notified the "authorised person".[41]

3. The referral by the general practitioner also did not strictly comply with the requirements of s.76K(4) in that it did not state the observations and opinions upon which the suspicion of suspected abuse was based.

Having considered the point, I believe the above view is a sustainable one. However, QH was incorrect when it advised that the GP did not state the observations and opinions upon which his suspicion was based. Although the GP's subsequent letter of referral did not mention a suspicion of abuse, the GP informed the emergency physician of his suspicion in relation to Brooke's injuries and stated the observations and opinions upon which his suspicion was based when he spoke to him by telephone. Section 76K requires that a notification be made 'by the most expeditious means available'. It does not require a notification to be made in writing. A notification may therefore be made by telephone, which presumably would often be the 'most expeditious means' available to a general practitioner.

In any case, it is my opinion that any failure by the GP to comply with his statutory obligation was more one of form than substance. The GP took positive action to refer Brooke to the hospital and advised the emergency physician of his suspicions. Although the emergency physician was not an 'authorised person', the SCAN doctor who was an authorised person was notified by the hospital staff shortly after Brooke's admission.

However, I will pursue this matter further with QH. It may be that medical practitioners operating within Queensland would benefit from further education/direction from QH in relation to the statutory obligations imposed upon them by section 76K of the *Health Act*.

4.4.2 Information provided to Ms A

The complainants alleged that hospital staff failed to fully convey the gravity of Brooke's situation to Ms A. QH asserted that Ms A was 'well aware of Brooke's predicament'; that is, that she was being physically abused. According to QH, hospital staff had informed Ms A that there was no other possible cause for Brooke's injuries.

However, the evidence I have gathered during my investigation, including evidence directly from Ms A, does not corroborate all of the claims made by QH in support of this conclusion.

41 This last statement is not correct. It is clear from QH's medical records that the Paediatric Registrar notified the 'authorised person' (i.e. the SCAN doctor) following Brooke's admission to hospital.

Firstly, QH pointed to the circumstances of Brooke's referral to the hospital as some evidence that Ms A would have been aware of the concerns in relation to Brooke. It is clear that the GP referred Brooke to the hospital because of a suspicion that her injuries were non-accidental. However, the GP's evidence is that he deliberately did not inform Ms A of his concerns in this regard[42]. The GP told Ms A that Brooke was being referred to the hospital because of dehydration and the injury to her finger. Ms A has confirmed that this was her belief at the time.[43] Contrary to QH's claim, the GP ensured that the main reason for Brooke's referral (i.e. her suspicious injuries) was **not** apparent in his letter of referral.

Given the GP's statement, the physical evidence of the referral letter and Ms A's response, the circumstances of Brooke's referral to the hospital does not constitute evidence that Ms A was well aware of Brooke's predicament.

Secondly, QH asserted that the Emergency Registrar and the Paediatric Registrar both *made it clear* to Ms A that Brooke's injuries '**could not** have been sustained **in any other way** than by abuse' (emphasis added).

The Emergency Registrar and Ms A have both given evidence that Ms A informed the Emergency Registrar of the following:

- Brooke's injuries had occurred whilst in her partner's care;
- Ms A had some doubts about her partner's explanation for Brooke's injuries; and
- Ms A planned to leave her partner rather than risk further injury to Brooke.

It is therefore evident that, at the time of speaking to the Emergency Registrar, Ms A was at least aware of the possibility that Brooke's injuries had been caused by abuse, and that this possibility was discussed. Further, Ms A's statement about leaving her partner does indicate that Ms A believed the situation to be serious enough to warrant such action. At the very least, Ms A believed this proposed action to be an appropriate response to the concerns conveyed to her by the Emergency Registrar, even if she did not truly intend to leave her partner[44].

Ms A then spoke to the Paediatric Registrar. It is clear that Ms A did suggest to her that Brooke's injuries were caused by 'rough play' with her partner, as this is specifically recorded in the contemporaneous notes made by the Paediatric Registrar at the time of examination. However, I have been unable to substantiate that the Paediatric Registrar then went on to inform Ms A that Brooke's injuries *could not* have been caused by just 'rough play'. Although the Paediatric Registrar gave a statement to this effect, Ms A denies that any such concerns were discussed and the examination notes do not contain any record of this advice being given.

I specifically asked Ms A to clarify what she understood the situation to be in relation to Brooke's injuries after speaking with the Emergency Registrar and the Paediatric Registrar. My written questions and her written answers are as follows:

Q: From the conversations you had with both (the Emergency Registrar) and (the Paediatric Registrar), what was your understanding, at the time, as to the cause of Brooke's injuries?

A: I was unsure.

Q: Did the doctors make it clear to you that Brooke's injuries could <u>not</u> have been sustained <u>in any other way</u> than by abuse? Or was your impression that they <u>thought</u> it was abuse, but there was <u>still the possibility</u> that it could have been something else?

42 The GP's statement did not specifically explain his reasons for not wanting to inform Ms A of his concerns.

43 This was confirmed by Ms A in her response to the written questions posed by this Office.

44 Upon completion of my provisional report, I invited Ms A to comment upon my analysis of her statement about leaving her partner. In response, Ms A stated that at the time of speaking with the Emergency Registrar, she had intended to leave Mr Self if it were true that he was harming Brooke. Ms A explained that at the time, she was suspicious of Mr Self but had no proof that he had harmed Brooke. Ms A did not in fact leave Mr Self until after Brooke's death.

A: (The Emergency Registrar) had expressed his opinion, which was where I was heading in my thinking.

Q: After speaking to the doctors, did you consider in your own mind that Brooke's injuries must have been cause by abuse? Or was it still a possibility in your mind that it could be something else, such as "rough play" or clumsiness?

A: I was suspicious of Troy.

My officers also obtained a copy of a statement made by Ms A to QPS during the course of its investigation into Brooke's murder. In the statement, dated 1 February 2001, Ms A said:

> (On 13 July 1999,) I had just come back from the hospital with Brooke. Self was still asleep. The previous night I had made my mind up to leave him and when he was out I had packed up all my and Brooke's belongings and had put them in her room. I did this as **I was suspicious that Self had been violent with Brooke, due to what I had been told at the hospital** and the bruises I had seen on Brooke (emphasis added).

Further in her statement, Ms A discussed what occurred after she and Brooke visited the GP on 12 July 1999. She stated:

> I then drove to the Gold Coast Hospital and Brooke was admitted in the Children's Ward. It was during this process I was told that the Police were going to be called and would want to talk to us
>
> I stayed with Brooke for the day. I remember talking with one doctor who had an accent. I remember this doctor asking about the bruises and he asked me if I suspected anything and I told him that I was starting to wonder. We talked a while about the bruises and Brooke. I stayed with Brooke all day and up until she fell asleep at about 7.00pm.

Ms A's earlier statement to QPS is consistent with the evidence I have obtained from the doctors' statements and from Ms A directly. It demonstrates that, at the very least, doctors at the hospital held discussions with Ms A regarding the suspicious nature of Brooke's injuries.

However in my opinion, the evidence I have set out to this point does not substantiate QH's assertion that the Emergency and Paediatric Registrars 'made it clear' to Ms A that Brooke's injuries 'could not have been sustained in any other way than by abuse'.

There is other evidence, discussed later in this report[45], that is relevant to Ms A's state of awareness of Brooke's situation. The evidence relates to a note that was found by the two DOF officers inside Ms A's unit on the afternoon of the day Brooke was removed from the Gold Coast Hospital. The note was addressed to Mr Self from Ms A (using a different christian name that was not familiar to the FSOs at the time) for the purpose of telling Mr Self that she intended to leave him. One of the FSOs who read the note recalled[46] it stated something to this effect:

> …that Ms A had spoken to hospital staff; that they had told her that the injuries (to Brooke) were non-accidental (and) could not have been caused by an accident.

The same FSO provided a written statement to QPS during the course of its investigation into Brooke's death. In the FSOs' statement, which is dated 31 August 1999, he recalled the content of the note as follows:

> The letter stated that (Ms A) had spoken to the doctors at the hospital and they have said that the injuries to the child could only have been caused by someone hitting the child very hard.

If the FSOs' recollection of the contents of the note is accurate, this evidence does indicate that Ms A had been informed that Brooke's injuries *could only have been caused by abuse*. However, the

45 See Part 5.1.

46 During his formal interview with my officers.

evidence is not first hand; rather, it is a person's recollection of the contents of a document. Therefore, it is of limited weight and has to be weighed against the evidence obtained directly from Ms A, who has stated that after speaking to the doctors, she only had a 'suspicion' that Brooke was being abused.

QH also claimed that Ms A was aware arrangements had been made for Brooke to be seen by the SCAN doctor, a paediatrician whose role it is to attend and review children suspected to be suffering from abuse. Effectively, QH submitted that as Ms A was aware of these arrangements, this would have impressed upon her the seriousness of Brooke's situation. However, none of the medical practitioners or nurses who spoke to Ms A mentioned in their statements that Ms A was told of this fact, either by themselves or by someone else.

I specifically asked Ms A whether hospital staff had told her that a doctor specialising in child abuse had been arranged to examine Brooke the following morning. Ms A stated that she was not told of any such arrangements, and she was completely unaware that she and Brooke were to receive the SCAN doctor's assistance. However, she did recall being told that the police were going to attend the next morning. In fact, Ms A has consistently maintained that she removed Brooke from the hospital because she was told that the police were going to attend and she was afraid to speak to them[47]. Ms A explained that she had a number of unpaid fines at the time and feared that if the police became involved they might arrest her, leaving her unable to care for Brooke[48].

Again, it is difficult for me to determine what information was in fact conveyed to Ms A. Ms A's evidence in this regard has been consistent for a period of some years.

QH further argued that Ms A told nursing staff she was happy Brooke was in a 'safe place' and this also demonstrated, to some extent, her awareness of Brooke's situation. However, Ms A has denied ever expressing these feelings to hospital staff. I am therefore unable to draw any firm conclusions from this evidence.

The complainants also asserted that hospital staff failed to give Ms A advice in relation to Brooke's ongoing welfare. QH claimed Ms A was advised: 'Brooke's welfare was best served by her admission to hospital and her remaining in hospital until investigations were conducted'. I specifically asked Ms A if she was provided with this advice. In response, Ms A stated: 'No one said anything of the sort. (Brooke) was to stay (in hospital) due to dehydration'. In addition, none of the hospital staff who provided statements to this Office stated that Ms A was given this advice, either by themselves or by another member of staff. I have therefore been unable to substantiate QH's claims in this regard.

Further, QH pointed out that Ms A would have received further advice from the SCAN doctor after his review of Brooke the following morning. I am sure this is so, however as I have previously discussed, it cannot be concluded from the evidence that Ms A was informed that the SCAN doctor would be attending and that he would be able to provide her with advice in relation to Brooke's ongoing welfare.

QH also noted that Ms A had expressed an appropriate plan for ensuring Brooke's welfare, which was to leave her partner. Although this would seem to be the case, I do not believe this stated intention alleviated QH of its responsibility to ensure Ms A received appropriate advice and assistance about the gravity of Brooke's situation and about her ongoing welfare.

47 Ms A gave this evidence in her statement to QPS dated 1 February 2001, at the Supreme Court trial and in her response to the written questions posed by this Office.

48 This is discussed further at Part 5.1 of this report.

Overall, I am unable to establish from the available evidence whether or not QH officers informed Ms A that:

- Brooke's injuries could not have been caused by anything other than abuse; and
- the SCAN doctor had been arranged to review Brooke and he would speak to Ms A about Brooke's situation.

However, while Ms A may not have been given this actual advice, I am satisfied she was aware there was cause for real concern about:

- the origin of Brooke's injuries; and
- Brooke's ongoing safety.

This is clear from her conversation with the Emergency Registrar and the note she wrote to Mr Self saying she was leaving.

Furthermore, whether Ms A knew of the SCAN doctor's scheduled examination of Brooke or not, by removing Brooke from the hospital, she deprived herself of the benefit of further advice from him or any other QH officer.

Therefore, I am of the view that, even on Ms A's version, QH staff provided her with information about Brooke's situation that was reasonable in the circumstances.

4.4.3 Brooke's removal from the hospital

In my opinion, QH was not obliged to keep Brooke in hospital for a 'prescribed period', as the complainants have suggested. However, from the time of her admission, the medical superintendent or any prescribed medical officer at the hospital had the discretion to order her detention in hospital for 96 hours. I have already discussed whether such an order should have been made upon Brooke's admission to the hospital. The evidence supports the view that, given the circumstances of Brooke's admission, the making of a 96-hour order was not warranted *at that time*.

However, circumstances changed when Ms A removed Brooke from the hospital the following morning without the hospital's permission. Section 76L of the *Health Act* specifically authorises a prescribed medical officer to issue a 96-hour order in such a situation. If a 96-hour order had been issued at this time and police assistance requested, Brooke could have been taken into custody, returned to the hospital and detained for up to 96 hours.

To make a 96-hour order, the medical practitioner must suspect upon reasonable grounds the maltreatment or neglect of the child in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger.

Clearly, medical staff suspected that Brooke had been maltreated. This suspicion appeared to be based on reasonable grounds, given Brooke's physical condition and the statements made by Ms A upon Brooke's admission. Further, the manner in which Brooke was removed from hospital caused the medical staff serious concern about the child's continuing welfare. The SCAN doctor also demonstrated such concern by immediately attempting to notify QPS and DOF and, when he was eventually able to make contact, impressing upon them what he considered to be an urgency in locating Ms A and Brooke[49].

In my opinion, the evidence suggests that the circumstances gave rise to a reasonable suspicion that Brooke was likely to be exposed to 'unnecessary injury, suffering or danger' if she was not located.

49 According to SCAN doctor's statement to this Office dated 6 June 2001 and QH's initial report to this Office dated 8 May 2001.

Therefore, it appears that the statutory requirements for considering the making of a 96-hour order upon Brooke's removal did exist.

The SCAN doctor stated that a 96-hour order 'is usually done if a child's parents are not cooperating or there is a risk that they will not cooperate'. On this basis, it would seem that Ms A's removal of Brooke from the hospital constituted grounds for making such an order. In comparison, QH stated[50] that 96-hour orders are only made in circumstances where, for example, a child is threatened to be removed or is removed from hospital and when that child is in urgent need of medical or surgical treatment or where there are strong grounds to believe the child is at immediate risk of serious injury. In QH's opinion, Brooke's case did not meet these circumstances. It is QH's view that no further action was warranted other than those actions taken by the SCAN doctor, which were in accordance with QH's normal policy.

I was not persuaded that Brooke's case fell outside the circumstances described by QH for issuing 96-hour orders, as set out above. It is clear that Brooke was removed (as opposed to being discharged) from hospital. Perhaps it could not be said that Brooke was in 'urgent need of medical or surgical treatment'. However, the evidence suggests there were 'strong grounds to believe' that Brooke was at 'immediate risk of serious injury' in that:

- She was admitted with bruises that were described by the GP as 'severe', and was also suffering from a fractured finger and dehydration;
- Medical practitioners identified that Brooke was likely the victim of physical abuse, and informed Ms A of this fact;
- Ms A made reference to her de facto as the possible cause of the injuries;
- Ms A acted deceptively in removing Brooke from hospital without seeking the hospital's permission when, according to QH staff, she was aware Brooke was to be examined by a doctor specialising in child abuse (though Ms A denies she knew this); and
- Brooke was only three years of age, which made her extremely vulnerable to further abuse.

In these circumstances, my provisional view was that a 96-hour order was warranted. I considered that the circumstances of Brooke's removal from the hospital fell squarely within QH's policy as described above.

I therefore asked QH to provide a better explanation as to how it had reached its decision. QH replied as follows (in part)[51]:

> As I stated in (my response to your Office dated 10 August 2001), it is QH policy that a 96-hour order is only issued in those circumstances where without it, it is not possible to adequately assess and/or treat the child…
>
> The assessment of QH staff in Brooke's case was that Brooke was not at "immediate risk of serious injury" for the following reasons:
>
> 1. Although Ms A had acted inappropriately in removing Brooke from the hospital, she had, during the time of Brooke's admission, exhibited appropriate concern for Brooke's welfare, a caring attitude towards Brooke and had expressed a plan to protect Brooke by ending her relationship with Mr Self. QH staff had, at that time, no reason to doubt Ms A's expressed intentions. There was never any reason to believe that Ms A would harm Brooke
>
> 2. QPS and DOF had been notified of Brooke's removal from hospital and the importance of her being located. QH staff then believed that those departments would investigate the situation and take all necessary steps to protect Brooke. Indeed, you have concluded in your preliminary report that DOF officers' initial response to the notification of Brooke's disappearance was appropriate.

50 QH's further response to this Office dated 10 August 2001.

51 QH's response to provisional report dated 18 January 2002.

However, I should point out that evidence provided by DOF in response to my provisional report strongly conflicts with QH's assertion that Brooke was not at 'immediate risk of serious injury'. In commenting on its assessment of the notification received in relation to Brooke, DOF stated[52]:

> The Brennan case required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable. In these circumstances, the child's immediate safety would have been the primary consideration.

Furthermore, I do not understand how QH can rely on Ms A's behaviour during Brooke's *admission* to the Gold Coast hospital as support for its assertion that Brooke was not at immediate risk of serious injury upon her *removal* from the hospital. In my opinion, the fact that Ms A removed Brooke from the hospital in the manner that she did should have altered any perception that QH had that Ms A intended to act in Brooke's best interests.

Indeed, QH has previously stated as follows[53]:

> (There was) no prior indication that Ms A *would act so directly contrary to Brooke's interests as to leave the hospital with her…*
>
> Ms A's removal of Brooke from the care of the hospital was based on a *deceptive* pretext and could be viewed as *premeditated…*It is clear that Ms A was *deliberately avoiding the assistance that was made available to her at the hospital.* (emphasis added)

QH further claimed that QPS and DOF were appropriately notified, leading hospital staff to believe that Brooke's case was being appropriately attended to by these other agencies. Hence, she was not at any 'immediate risk of serious injury'. With respect, I disagree with QH's submission in this regard. In fact, the SCAN doctor states that after Brooke was removed from the hospital, he was unable to contact QPS until 1.00pm and did not speak to anyone from DOF until 3.00pm. Furthermore, the SCAN doctor asserts that QPS advised it was unable to assist in locating Brooke and suggested he contact DOF for assistance. Therefore, from the time of Brooke's removal at approximately 7.15am in the morning until 3.00pm that afternoon, the SCAN doctor was well aware that no one had taken any steps to locate Brooke and ensure that she was safe. Brooke would have been at immediate risk of further injury for at least that period of time.

I note QH's further advice that 'a 96-hour order is only issued in those circumstances where **without it, it is not possible to adequately assess and/or treat the child**'. Although QH claimed that this specific advice had previously been given to my Office, my comprehensive review of the material does not support this claim. Further, the circumstances described in this statement are very different from the circumstances given in QH's initial advice in relation to its policy for the issuing of 96-hour orders. QH has not made any further submissions regarding why it considered Brooke's case did not fall within these newly described circumstances.

However, QH went on to provide further reasons as to why it considered a 96-hour order was not appropriate in Brooke's case. QH stated[54]:

> In addition, an agreement has been reached with DOF about the circumstances in which QH will issue 96-hour orders. In 1999, the *Child Protection Act* was introduced to completely replace pre-existing, outdated legislation under which DOF functioned. The *Health Act* (in which Section 76L appears) is also a very old piece of legislation. The new *Child Protection Act* reflects current practice in child protection.
>
> During the drafting process for the *Child Protection Act*, discussions were held between officers of QH and DOF. At that time the issue of whether section 76L of the *Health Act* should be repealed was discussed. After internal discussions with senior child protection paediatricians, QH identified some

52 DOF's response to provisional report dated 11 January 2002.

53 QH's initial report to this Office dated 8 May 2001.

54 QH's response to provisional report dated 18 January 2002.

very specific circumstances when there would be a need for medical officers to order the detention of a child under those provisions. Also, QH was in the process of conducting a legislative review of the Health Act (which has not yet been completed). Therefore, it was agreed that section 76L should be retained in the *Health Act* for the time being.

It was clearly identified at that time by DOF that this provision in the *Health Act* was not intended to be used by medical officers to over-ride the decisions made by appropriately appointed statutory protection officers of DOF or QPS in the routine pursuit of their duties.

It was agreed that it would be appropriate for a medical officer to invoke the powers in section 76L (so as to over-ride the immediate child protection decision by officers of DOF or QPS not to detain a child under the *Child Protection Act*) if the child had an acute medical/surgical problem which required immediate return to the medical facility and the officer of DOF or QPS was not of the view that there was a medical/surgical imperative to do so. In that circumstance, it can be argued that the medical officer had specific expertise by nature of his/her professional credentials which justified activation of powers to return the child while further discussion occurred. That was not the case in this instance.

In this case, the officers of DOF and QPS were fully informed (in a timely manner) of all the allegations of abuse/neglect that had been passed to the medical service and the circumstances in which the child presented, was admitted, and subsequently left the health facility. It was not appropriate in that circumstance for a medical officer to activate section 76L, and in effect, to become a 'de-facto' statutory child protection officer and legally coerce the formally appointed child protection officers of DOF or QPS in the performance of their duties.

It could perhaps be argued that in a case of 'extremus' - i.e. if the medical officer had certain knowledge that the child was at imminent risk of death or serious injury (i.e. the mother told him/her of an intention to leave the hospital and kill the child), and was aware that statutory officers of DOF or QPS were unable to activate their powers under the *Child Protection Act* - activation of section 76L might be a reasonable, if extreme, utilisation of medical powers in response to an extreme situation. Again, that was not the scenario in this case.

I make the following points in relation to this further submission:

- Neither DOF nor QPS has provided any information regarding an 'agreement' reached with QH for the issuing of 96-hour orders.

- It is unclear whether this agreement between QH, DOF and QPS was reached *prior* to the time of Brooke's case.

- Although the *Health Act* is an 'old piece of legislation', section 76L was not in fact inserted into the Act until 1978[55]. Furthermore, the provision has not been repealed and remains in force as at the date of this report.

- The 'agreement' relates to circumstances where a 96-hour order might be issued 'to **over-ride the immediate child protection decision** by officers of DOF or QPS not to detain a child under *the Child Protection Act*'. In Brooke's case, from the time of her removal from the hospital until the time that DOF was finally notified of her case, DOF and QPS had not made any 'child protection decision' in accordance with the Child Protection Act. Therefore, the 'agreement' was not applicable and QH was not limited to issuing a 96-hour order in relation to Brooke only if it could be said that she 'had an acute medical/surgical problem which required immediate return to the medical facility'.

- QPS and DOF were not informed of Brooke's case in 'a timely manner', having regard to the immediate risk of serious injury that Brooke faced upon her removal from the hospital.

55 Inserted 1978 No. 65 s 9 (never proclaimed into force and omitted 1980 No. 26 s 3), ins 1980 No. 26 s 4, amended 1981 No. 77 s 2, 1991 No. 24 s 7.3 sch 3, 1995 No. 58 s 4 sch 2.

- QH's claim that it was not appropriate in the circumstances of Brooke's case for a medical officer to activate section 76L 'and in effect, to become a 'de-facto' statutory child protection officer and legally coerce the formally appointed child protection officers of DOF or QPS in the performance of their duties' is, in my view, a curious interpretation of this section. Section 76L of the *Health Act* confers upon QH statutory child protection powers. In my view, QH officers should exercise this power in any circumstances, within the terms of the section, where it will best ensure the safety of a child who is likely to be subject to unnecessary injury, suffering or danger.

  This is especially the case where the medical officer has received a notification about a child in accordance with section 76K of the *Health Act* that gives rise to a statutory obligation to act in such manner as will best ensure the safety and well being of that child. Safety of children should be paramount to all other considerations and child protection powers should be exercised if they are the most effective means of securing that end. It is not appropriate for QH to fail to discharge its child protection responsibilities simply because DOF and QPS have a concurrent jurisdiction. QH had the earliest and best opportunity to address Brooke's situation from a child protection perspective.

As part of its response provided above, QH was also asked to provide details of other circumstances in which 96-hour orders had been issued at the Gold Coast Hospital in the previous five years. In response, QH stated as follows[56]:

> The prescribed medical officers have issued two 96-hour orders in the past five years, on 20 August 2000 and on 5 February 2000. **They were issued in similar circumstances to those described (above)**. (emphasis added)

I arranged for my officers to inspect QH's files relevant to the two cases referred to. While these arrangements were being made, QH identified two more cases where 96-hour orders had been issued at the Gold Coast Hospital in the previous five years. My officers therefore inspected four files to ascertain in what circumstances such orders had been made. The following is a summary of the facts of each case, as gleaned from my officers' perusal of these four files (names and other details have been changed in order to protect the identity of the parties):

56 QH's response to provisional report dated 18 January 2002.

Case Example One:

An eight-month-old child, 'Lisa', was brought to the Gold Coast Hospital one evening by police officers who had attended her parents' home after a reported noise disturbance. The parents were found to be intoxicated, and an altercation between the parents and the police officers ensued. The parents were charged with assault and taken into custody.

The medical practitioner (a paediatrician) who examined Lisa was informed by the police officers that she had fallen off a couch during the altercation. The medical practitioner observed two bruises on the child: one on each side of her forehead, and both roughly 1cm by 1cm in size. The medical practitioner also noted a scratch to Lisa's right knee, and a mild nappy rash on her vagina.

According to a police statement contained on QH's file, the medical practitioner's opinion regarding Lisa's injuries was as follows:

…the physical signs on the child were consistent with a normal level of care…the bruises and scratch were consistent with normal day-to-day trauma which a child may inflict upon themselves with falls.

The medical practitioner issued a 96-hour order in relation to Lisa and referred her case to the SCAN team. In the police statement, the medical practitioner explained his reason for issuing the order as follows:

The reason for placement of this order was because of concerns about the child's well being because of the events that had been reported to me prior to presentation. I needed the SCAN Unit Services to have adequate time to investigate the case and the safety of the home environment. With the aggression that had been shown during the interaction with the police I decided to be protective of the child and the staff and to restrict the ability of the parents to remove the child from the hospital until some of these investigations had been carried forth.

Skeletal surveys of Lisa were subsequently carried out and no fractures were found. QH staff liaised with DOF, and arrangements were made to have Lisa discharged to her grandparents. DOF undertook to follow-up concerns about Lisa's safety with her parents. The parents were released from custody two days after Lisa's admission and were allowed to visit her at the hospital. Lisa was discharged as arranged three days after her admission.

Analysis:

In my opinion, case example one does not assist QH's submission that a 96-hour order was inappropriate in Brooke's case. To the contrary, I believe that the circumstances of example one were significantly less serious than those pertaining to Brooke. The child in this example had two small bruises, a scratch on her knee and a mild nappy rash, which the doctor described as 'consistent with a normal level of care'. When Brooke was first examined, she had a broken finger and exhibited multiple bruising (at least 15 separate injuries of various sizes and age) over her entire body, which the GP described as '*severe*'.

In the example, the doctor said that it was necessary 'to have adequate time to investigate the case and **the safety of the house environment**'. While I appreciate that, in the example, both parents had temporarily displayed aggression towards QPS (presumably because of intoxication), the safety of Brooke's home environment should also have been an issue for QH immediately she had been removed from hospital, given that QH categorised such removal as 'deceptive', 'premeditated' and 'directly contrary to Brooke's interest'.

Case Example Two:

A child, 'Michael', was born in the Gold Coast Hospital to a mother who was identified as being an intravenous drug user and Hepatitis C positive. The mother had admitted to using speed on at least one occasion during the pregnancy.

According to the file notes, the parents had a history of a volatile relationship with frequent arguments and verbal abuse occurring. The mother had two other children: a five-year-old who lived with her and her partner and another child who lived with her ex-partner.

The day following Michael's birth, hospital staff spoke with the mother about keeping the baby in hospital for four to five days for observation and to deal with any drug withdrawal symptoms. According to the hospital's notes the mother agreed with this course of action.

The following day, a medical practitioner issued a 96-hour order in relation to Michael. The specific reasons for issuing the order were not stated on the file. It is noted that the hospital progress notes do not record any significant events as having occurred between the time of Michael's birth and the time of the issuing of the order.

The day following the issue of the 96-hour order, a hospital social worker spoke with the mother and noted that the mother was upset about the 96-hour order and about possible DOF involvement. The social worker recorded that the mother appeared keen to take Michael home. The social worker ascertained that Michael's parents were financially able to support Michael and would receive support from Michael's maternal grandmother, who lived nearby.

The social worker then contacted DOF. The file notes record that DOF advised it would not become involved in the matter unless further concerns arose.

The next day, the social worker referred the family to 'Community Child Health' (a QH service) and Michael was discharged from hospital into the care of his parents.

Analysis:

Similarly, I can not see how case example two supports QH's submission that Brooke's case fell outside its policy for 96-hour orders.

In this example, a newborn child was required to be kept in hospital for observation in order to assess whether he had any drug withdrawal symptoms. His mother was known to be an intravenous drug user and Hepatitis C positive. According to the hospital's records, the mother was agreeable to the child being kept in hospital. Although DOF was contacted, it did not consider the facts of the case significant enough to warrant DOF intervention.

The circumstances of this example (although serious) have little in common with the gravity of Brooke's situation at the time of her removal from the Gold Coast Hospital.

Case Example Three:

Two children, siblings aged 16 months and 7 months, were brought into the Gold Coast Hospital emergency department by ambulance and police officers. They had been found in a parked car along with their father, who was found unconscious and slumped over the steering wheel with a syringe in his hand. The eldest child was described as being found 'wedged under the seat'. The mother of the children was reported to be in jail.

Hospital notes record the children as appearing 'unkempt' but otherwise well. A medical practitioner, who conferred with another medical practitioner prior to the decision, decided to issue a 96-hour order in relation to the children. Brief notes in the hospital's progress notes state as follows:

> 'Child at risk due to current social circumstances - 96hr order for care and protection'

QPS contacted DOF and arrangements were made for the children to be placed in immediate foster care. DOF intended to apply for temporary assessment orders over the children.

The father of the children, who had been revived at the scene, attended the hospital with the children. There is no notation or record to suggest that the father was uncooperative with hospital staff regarding the children's admission. The father was informed of the 96-hour order, DOF's involvement and the foster care arrangements. He reacted by going home to collect clothing for the children.

The children were discharged later that day into the care of foster carers.

Analysis:

Case example three is a case where I would expect a 96-hour order to be sought, but again, I fail to see how the circumstances of Brooke's removal, given her existing injuries, did not warrant a similar order.

Case Example Four:

Two children, siblings aged 21 months and 12 months, were brought to the Gold Coast Hospital by ambulance and police officers following an incident of domestic violence between their parents at their home. The father allegedly punched the mother as she was holding the youngest child. The elder child was in the room at the time. The father was taken into custody, but the mother attended the hospital with the children. She was observed to be intoxicated, and admitted to staff that she had consumed alcohol that night.

The medical practitioners who examined the children observed a scratch mark to the youngest child's neck, but no other obvious injuries.

A 96-hour order was issued over the children, and they were both admitted to the paediatric ward. The records show that the mother was swearing and being otherwise verbally abusive, and refusing to allow medical observations to be taken of the children. The mother made statements indicating that she was unhappy with the children's admission to the hospital. Security was notified of the situation.

The following day, a hospital social worker contacted DOF and arrangements were made, with the consent of the children's father, to have the children delivered into the custody of their paternal grandparents. The children were discharged into the grandparent's care that evening.

Analysis:

Case example four is another example of a domestic violence incident, where intoxication was an issue. However, the only injury to the child in question was a scratch mark to the neck. The injuries that Brooke exhibited were far more serious.

None of these case examples assist QH to explain why a 96-hour order was not issued when Brooke was removed from the hospital. If anything, the examples serve to reinforce my view that any QH policy that applies to 96-hour orders is not applied consistently or in accordance with any defined criteria that I could audit for compliance.

However, regardless of any policy that might have existed in relation to 96-hour orders, what I am still required to determine is whether, at the time of Brooke's removal from the hospital, the decision not to issue an order under section 76L was reasonable.

Prescribed medical officers are clearly required to take into account the circumstances of each case before making a 96-hour order. I accept that the need to ensure a child's safety should be weighed against the fact that the making of such an order could have a considerable effect on the child and the family. However, a child's safety should be the paramount consideration.

The SCAN doctor was immediately notified upon Brooke's removal. He decided to refer the matter to QPS and DOF in accordance with QH's normal policy. However, he did not speak with anyone from these agencies until some considerable time after Brooke had been removed from the hospital. When the SCAN doctor finally made contact with QPS, he asserts that he requested QPS to attempt to locate Brooke immediately. He says he was informed by a QPS officer that QPS would be unable to do so and that he should contact DOF, which he was not able to do until about 3.00pm, more than seven hours after Brooke had been removed from hospital.

At any time during these events, the SCAN doctor, the medical superintendent or any of the other three prescribed medical officers for the Gold Coast Hospital, had they been apprised of the circumstances, had the power to issue a 96-hour order and require QPS to assist in the enforcement of that order. The SCAN doctor also had a duty as the authorised person notified of Brooke's condition to act in such manner as best ensured her safety and well-being[57].

QH have made some other submissions in relation to the operation and effect of 96-hour orders. Firstly, QH have claimed that a 96-hour order, of itself, does not provide the police with any additional powers in terms of taking a child into custody and returning it to the hospital than those which they already have. However, even assuming that QH is correct in its claim, it does not go to the issue of whether the making of a 96-hour order upon Brooke's removal from the hospital would have made a difference in this case. When a medical practitioner makes a 96-hour order and places his or her 'endorsement' upon that order stating that police assistance is required, any police officer notified of the endorsement has a duty to assist in the enforcement of that order 'as required'. In this case, the SCAN doctor said he telephoned QPS to request its assistance in locating Brooke. QPS, according to the SCAN doctor, declined this request because of resourcing issues. If the SCAN doctor had made a 96-hour order and placed his endorsement upon it, QPS would have been required to respond to any request from him for assistance.

QH's second claim in relation to the operation and effect of 96-hour orders is that, even if a 96-hour order is issued, QH has no control over the manner in which it may be enforced. In response to the provisional report, I invited QH to provide a further explanation for this view and its relevance to Brooke's case. QH advised as follows:

> It is QH's position that the prescribed medical officer (by nature of his or her training and qualifications) is only capable of asking QPS to assist in very general terms, for example by asking the Police to locate or, if necessary, return the child who is the subject of an order to hospital. The prescribed medical officer would not be qualified to give a police officer detailed directions about how to locate a child or take control of the method or process by which the police officer undertakes that task or influence the priority the Police afford the task.

57 Section 76K of the Health Act.

With respect, I do not accept QH's submission in this regard. QH agrees that section 76L of the *Health Act* imposes upon QPS a duty to 'assist the prescribed medical officer as required'. In my view, this provision clearly gives a medical practitioner who makes a 96-hour order the authority to require QPS's assistance in the enforcement of that order. The extent of the medical practitioner's control over the **manner** in which an order is enforced is irrelevant. In Brooke's case, QH alleged that the SCAN doctor requested QPS's assistance in locating Brooke and was refused. If the SCAN doctor had issued a 96-hour order and appropriately endorsed it, police officers would have been required to search for Brooke, take her into custody and return her to the hospital to be detained for not more than 96 hours. Such a period of detention would have provided a better opportunity for intervention by DOF officers in relation to Brooke's care and protection.

I was also concerned by QPS's apparent misunderstanding of its role in relation to 96-hour orders[58] because:

- The *Health Act* has clearly **not** been superseded by the *Child Protection Act*.

- Section 76L does not allow QPS or DOF to make an application for an order. A 96-hour order can only be made by a prescribed medical officer (as defined). It is then QPS's duty, if requested, to assist the medical practitioner in the *enforcement* of the order. (It is noted that QPS does have the power to make application to a magistrate under section 76L(7) for the issue of a *warrant* to assist in the enforcement of the 96-hour order.)

- Section 76L does not apply to all situations where a child is deemed to be at risk. It applies only to circumstances where a child is at hospital, has been admitted to hospital, or is removed from hospital, and is deemed to be at risk.

- Section 76L does not provide for children to be placed with DOF. It provides for children to be detained in hospital or, if they have been removed from hospital, to be taken into custody and returned to hospital to be detained there.

This misunderstanding on QPS's part suggests that its officers have had little, if any, experience with section 76L orders, at least in the Gold Coast area. This in turn suggests that such orders are rarely, if ever, made by QH or even discussed with QPS as an option. Given that QH and QPS liaise on a regular basis in relation to child protection issues as part of the SCAN team operations, at the very least, QPS officers should be aware of QH's ability to make an order to have a child detained in hospital for 96 hours and its responsibility to assist in the enforcement of that order if requested.

I invited QPS to comment about these concerns which I raised in the provisional report. QPS advised as follows[59]:

> With respect**, the view put forward by the Ombudsman regarding the operation of the orders and enforcement by QPS is accepted as correct**. The misunderstanding conveyed in the original response by QPS is regrettable and does not truly represent the understanding of QPS regarding the operation of such orders. (emphasis added)

QPS provided further information regarding the training that is provided to JAB officers and police officers in relation to 96-hour orders and their enforcement. QPS explained as follows[60]

- Information in relation to 96-hour orders and enforcement is contained in the Operational Procedures Manual at 7.8.5 and 7.8.6 and is available to all police on the Bulletin Board (an internal electronic website accessible by every officer in all the State).

58 See Part 4.3.5 of the report.

59 QPS's response to provisional report dated 19 February 2002.

60 Report by Detective Inspector dated 24 January 2002, enclosed with QPS's response to provisional report.

- First year constables are rotated through the JAB and the Criminal Investigation Branch (CIB) and become aware of these orders by working in that area with trained staff.

- All staff who attend the JAB Course, either prior to or after joining the JAB, are provided with training in these orders.

- Once a member of the JAB they gain experience in these orders whilst working in both the JAB and the Child Abuse Unit and attending SCAN meetings.

- The SCAN doctor or FSO requesting assistance would advise of what is required.

A copy of the relevant sections of QPS's *Operational Procedures Manual* (OPM) was also provided, and has been included in this report as Appendix I. The OPM accurately describes the operation and effect of 96-hour orders, with a focus on the manner in which such orders might be used to assist QPS during child abuse investigations.

It is unfortunate that QPS initially provided completely incorrect advice in relation to 96-hour orders. However, it appears that QPS officers are generally provided with sufficient training and information in relation to 96-hour orders and QPS's role in enforcing such orders. It appears that the initial QPS response was written without reference to the OPM.

Obviously, it is impossible to speculate as to whether the making of a 96-hour order at the time of Brooke's removal from the Gold Coast Hospital would have resulted in a better outcome in this case. However, if a 96-hour order had been made and police assistance had been requested, QPS officers would have been required to conduct a thorough search for Brooke. Police officers could have obtained a warrant authorising them to enter premises to search for Brooke and take her into custody to be returned to the hospital, thus allowing a better opportunity for DOF intervention.

5 Analysis of the Department of Families' Actions

5.1 Evidence

DOF received a telephone call in the Gold Coast Area Office from the Gold Coast SCAN doctor at approximately 3.00pm on 13 July 1999. The information recorded upon intake was as follows:

- Brooke was three years old and lived with her mother and the mother's partner.
- The child was admitted to the Accident and Emergency department the day before (12 July 1999) with a bruise to her finger and bruising around the face and on the lower abdomen.
- The injuries were deemed to be not "life threatening".
- The child was kept in the hospital overnight for observations.
- The child was allegedly with her mother's partner when the injuries occurred.
- There was a concern that the injuries were non-accidental. The mother's partner provided various explanations as to how the injuries occurred but these were not consistent with the observed injuries.
- The mother had discharged the child from the hospital at approximately 7.00am on 13 July 1999.

The Intake Officer did not record the exact circumstances of the child's removal. It was understood that the mother had removed the child, and there was some suggestion that this had been against the hospital's advice. It was not known whether the mother had actually sought the hospital's permission before removing the child[61].

Within approximately half an hour after the notification was received, the Intake Team Leader contacted two FSOs from the Gold Coast Area Office Intake Team, 'FSO X' (female officer) and 'FSO Y' (male officer), and allocated Brooke's notification to them for an immediate initial assessment. FSO X was in the office, while FSO Y was in the field attending to other matters. FSO X was dropped off at the Southport Court House and picked up in a car driven by FSO Y. They then drove to the address given by Ms A to the hospital, that is, 7/24 Back Street, Biggera Waters.

The FSOs gave the following account of their visit to the unit. They arrived at the address at approximately 4.00pm and found it to be a two-storey block of units. Unit seven was on the second storey, the last unit on the right. The FSOs proceeded upstairs to the unit and knocked on the front door, with no response. They knocked again, but still did not receive a response. The FSOs then knocked on the front door of the neighbouring unit. The neighbour answered, and the FSOs asked whether she knew if anyone was home next door. The neighbour told them that she believed someone was at home, as she had heard people inside the unit a short time ago. She also told the FSOs that the back door of the unit was open, and suggested they go around to the back door.

The FSOs walked downstairs and around the back of the units, then upstairs to the back door of unit seven. The back door was open and they could hear music playing. The FSOs knocked on the door and called out, but no one replied. FSO X remained in the doorway, while FSO Y entered the unit, calling out for anyone inside. FSO Y walked down a hallway and entered a bedroom to the left. On the bed was a piece of paper, which he picked up. The paper was a note addressed to a person named 'Troy'. It was signed by a person using a female name, who appeared to be Troy's partner. FSO Y took the note to FSO X who was waiting in the doorway and they both read it.

61 This is according to information provided by the two FSOs during their formal interviews with my officers. See Part 5.5.1 for further discussion of the FSOs' evidence in this regard.

FSO Y recalled[62] that the note contained the following information:

> The substance of the letter was that the mother…had written the letter…The letter indicated that she was leaving Troy. (It said) that she had spoken to hospital staff; that they had told her that the injuries were non-accidental (and) could not have been caused by an accident. The letter also went on to say that she realised now how Brooke got other bruises (and that) although she loved Troy, her daughter was priority one and she was leaving.

FSO X recalled[63] the contents of the note to be as follows:

> The contents of the note indicated that, although she didn't want to separate from him, she believed that he had been abusing Brooke (and) that he had previously abused her and caused injury to her…(She stated) that she would have liked to have remained in the relationship with him, (but) she felt for the safety of her own child she had to remove (herself) and her child from the relationship.

According to the FSOs' recollections, the note did not give any indication of where the female person and Brooke were going or where they intended to stay.

Ms A subsequently confirmed with my officers[64] that she was the author of the note. The written questions and her written answers in relation to this point were as follows:

Q: (DOF) has advised, and it was mentioned at the trial, that when their officers entered your unit, they found a note. Do you know what this note was? Did you write it?

A: Yes, it was a note saying that I wasn't the only one suspicious about Brooke. That a doctor at the hospital had agreed with me that something wasn't right. I wasn't taking any chances and I was leaving. If I was wrong to accuse him I'm sorry, but I was still leaving.

Q: The FSOs have reported that the note said something along the following lines:

'You had taken Brooke and you were leaving Troy because you believed that he had been responsible for causing the injuries that were noticed on Brooke at the hospital. You believed that Troy had also been responsible for injuring Brooke on a previous occasion. You regretted leaving Troy, but could not remain with him because of your belief that he had injured Brooke.'

Do you agree that this is basically what the note said?

A: Yes, what I've written already (previous answer).

FSO Y returned the note to where he had found it inside the unit. He called out a few more times, but did not detect anyone inside the unit. Both FSOs then went downstairs to the back of the units and searched the grounds. They paid particular attention to the back yard, the common areas and areas adjacent to the units, but did not see anybody or anything that indicated Ms A and Brooke were in the vicinity. The FSOs then returned to their car and drove back to the Gold Coast Area Office. They did not leave anything behind at the unit to indicate they had visited or to notify Ms A of their concerns.

Ms A later revealed during Mr Self's trial that she and Brooke were in fact home that afternoon when the FSOs visited the unit. Ms A told the court that she was hanging washing out at the back of the units when she saw two people walking up the driveway[65]. She gave evidence that she ran upstairs to her unit, grabbed Brooke, and took her downstairs into the laundry where they deliberately concealed themselves until after the FSOs had left.

62 During his formal interview with my officers.

63 During her formal interview with my officers.

64 Ms A's response to the written questions posed to her by my officers.

65 However, Ms A, in her answers to my officer's written questions, recalled that she saw two people in a 'late model Commodore' drive past, rather than seeing two people walking up her driveway.

Ms A gave evidence that she was concerned at the time about unpaid fines she owed. She said she feared that if she were arrested, Brooke would not have anyone to look after her. Ms A stated that this was the reason she removed Brooke from the hospital without notifying hospital staff, and also the reason she hid with Brooke in the laundry later that day. She claimed that she believed the two people she had seen were police officers.

QPS records confirm that there was a warrant in existence and available for execution against Ms A as at 13 July 1999. This warrant related to an unpaid restitution order. Ms A also had unpaid traffic infringement notices, and was in breach of community service orders made in relation to other offences. However, there were no existing warrants for these other matters at the relevant time.

When they searched the grounds of the units before leaving that afternoon, the FSOs say that they did not notice a laundry, a clothesline or any washing. One FSO did recall an old outbuilding, like a shed, which they briefly looked inside but did not search. The FSO did not recall the outbuilding to be a laundry. Unfortunately, my officers were unable to view the units to determine the location of the laundry Brooke and Ms A were hiding in because, as mentioned earlier, the units had been demolished. Ms A has since told my officers that the laundry was directly under her unit, and that it was a private laundry with a 'push-in' door lock that only herself and Mr Self had keys for. Ms A stated that she had locked the laundry door when she went inside it. If this is so, the FSOs would not have been able to open the door in any event.

The FSOs say that before completing their initial assessment, they made some further inquiries in an attempt to locate Ms A or Brooke[66]. Inquiries were made with the Gold Coast Hospital to ascertain whether it had another address for Ms A and Brooke, or the names of any other family members. The hospital had no other family names, and no forwarding address apart from the Back Street address. The Gold Coast JAB was contacted and asked to search for a more current address for Ms A under various names under a licence, vehicle registration, criminal record or any other record. JAB could not find a more recent address for either name. The FSOs said that they also conducted a search of all the available child protection information systems, both in Queensland and interstate, to check if they contained any information about the family. They say that nothing was found.

The FSOs recall that they then verbally reported what had occurred to the Intake Team Leader. The Intake Team Leader discussed the findings and issues with the FSOs and a decision was made to refer the case to the Gold Coast SCAN team for discussion at its meeting on 22 July 1999. These consultations were undertaken within 24 hours of the FSOs' visit.

According to the Gold Coast Area Manager's recollections, the Intake Team Leader discussed the case with the Area Manager prior to the SCAN team meeting to determine what further action was required. Given that the FSOs had been unable to locate the family, the Area Manager considered the matter in accordance with DOF's policy in relation to matters that cannot be completed for 'client reasons'[67]. Taking into account the circumstances of the case and the level of alleged harm, the Area Manager determined that all reasonable steps had been taken to complete the initial assessment, and DOF would not take any further action in relation to the matter.

FSO X prepared a written referral for the SCAN team. Under the heading 'Assessment', the referral stated: 'Unable to complete investigation as whereabouts of mother and child unknown. Mother appears to have taken appropriate action by leaving partner'.

Under the heading 'Current Case Plan', the referral stated: 'No further Departmental involvement at this point'.

66 There is some uncertainty about when these calls were made - see Part 5.2.5 for further discussion.

67 As contained in DOF's Child Protection Procedures Manual, discussed in this report at 3.2.

Brooke's case was discussed at a meeting of the Gold Coast SCAN team held on 22 July 1999 (nine days after Brooke had been removed from hospital and three days before her death). In attendance were a police officer, two representatives from DOF (neither of whom had previously been involved in Brooke's case), the SCAN doctor who was to have reviewed Brooke on the morning of 13 July 1999, and a representative from the Education Department. Minutes of the meeting indicate a recommendation was made to record the matter as 'investigation unable to be completed' and to 'close the case to SCAN' (i.e. to delete the matter from future SCAN discussions). The recommendation was reported back to DOF and no further action was taken in relation to Brooke's case.

Following media reports, the Gold Coast Intake Team Leader telephoned the Gold Coast JAB on 26 July 1999 and was told that Brooke had died at approximately 2.00am on 25 July 1999. JAB advised that Brooke was in the care of Mr Self at the time while Ms A was working at a Gold Coast nightclub. An ambulance was called but Brooke died before the ambulance arrived.

DOF was later informed of the charging and subsequent prosecution of Mr Self for Brooke's murder. Due to QPS's ongoing involvement in the matter, DOF was advised not to interview Ms A or other family members in relation to Brooke's death. As there were no other children in the family, DOF determined that it would not have any further involvement in the case at that time.

Sometime in August 1999, an internal review of Brooke's case was arranged in accordance with DOF policy PM95/17. A senior DOF officer (an Area Manager from a region external to the Gold Coast region) conducted the review. The internal review officer reviewed the material recorded on DOF's electronic child protection system, then interviewed the Gold Coast Intake Team Leader and the two FSOs who carried out the assessment in relation to Brooke. Subsequent to the interviews, the internal review officer researched the existing workloads of the Gold Coast Area Office Intake Team. The internal review officer then submitted a report titled *Case Review following the death of Brooke Brennan - Report for the Regional Director, Brisbane South* dated 14 September 1999.

5.2 Inconsistencies

During my investigation into matters relating to actions taken and decisions made by DOF, a number of inconsistencies have arisen amongst the reports of the various persons and agencies involved. Some have been resolved, whilst others have not. The five inconsistencies discussed below all relate to issues relevant to my consideration of the reasonableness of DOF's actions and decisions.

5.2.1 The first inconsistency: the date

The first inconsistency relates to the date DOF received the notification in relation to Brooke from the SCAN doctor. DOF's records, printed from its electronic child protection system and provided with its initial report, show the date of notification and subsequent initial assessment as 15 July 1999. However, the SCAN doctor stated that he notified DOF about Brooke during the afternoon of the same day she was removed from the Gold Coast Hospital. QH's records confirm the date of Brooke's removal to be 13 July 1999.

There is no doubt that Brooke was admitted to the Gold Coast Hospital on 12 July 1999 and removed on 13 July 1999. This is evidenced by the following:

- the GP's letter of referral is dated 12 July 1999;
- the notes made by the Emergency Physician regarding his telephone contact with the GP are dated 12 July 1999; and
- the hospital's records, including notes made by nurses on Brooke's chart regularly throughout her stay, all give the dates as 12 and 13 July 1999.

DOF's notification record does show that the notifier (the SCAN doctor) stated the child had been removed from the hospital on the morning of that day. Further, the initial assessment record states that the FSOs visited the unit in the afternoon of the same day the notification was received. Ms A's evidence at Mr Self's trial further supports this account. Ms A stated that the visit by the two people from whom she hid (i.e. the two FSOs) had occurred in the afternoon of the same day that she removed Brooke from the hospital. The only inconsistency among these accounts is the date.

When asked to provide a further report in relation to this issue, DOF conceded that the original notification record contained an erroneous date, and records created after the notification also contained the incorrect date because they had been drawn from the notification record. FSO Y, who created the notification record, confirmed that an error had been made in recording the date of notification. FSO Y explained that because of work pressures, the record had been created some time after the notification was received, in fact after Brooke's death. FSO Y had created the record from hand-written notes taken by the Intake Team Leader at the time the notification was received. The error occurred during this transcription. FSO X and FSO Y both agreed that the date of notification and subsequent initial assessment was 13 July 1999, not 15 July 1999.

It is therefore clear that DOF did in fact receive the SCAN doctor's notification about Brooke on 13 July 1999, the day she was removed from the hospital, and that the FSOs visited Ms A and Brooke's address to carry out an initial assessment later that same day.

5.2.2 The second inconsistency: actions taken

The second inconsistency relates to actions taken by the FSOs prior to their visit to Ms A and Brooke's address. The FSOs maintain that they contacted the Gold Coast JAB some time before arriving at the Back Street unit to request police attendance for the visit, in accordance with DOF procedures. The Gold Coast JAB maintains that it never received such a request from DOF in relation to Brooke.

QPS arranged for a search of the Gold Coast JAB's records covering the period 12 July 1999 to 16 July 1999. Specifically, those records consisted of daily occurrence sheets compiled by JAB staff to reflect work performed on each day. The sheets specifically make provision for entries relating to SCAN referrals, joint DOF child abuse investigations, child abuse inquiries and SCAN information. Throughout these documents (copies of which were provided to this Office) there is no record of any phone contact between DOF and the JAB for the relevant period.

QPS also made specific inquiries of the officers working shifts with the JAB for the relevant period. One officer (C) recalled receiving a phone call from FSO Y on 16 July 1999 seeking current address information for Ms A. According to officer C, FSO Y advised they had visited the premises the previous day, and the persons they were seeking appeared to have left the address. Officer C does not recall any request for the JAB's assistance. No reference to this phone enquiry appears in JAB's records for the period 12 to 16 July 1999.

FSO X and FSO Y both made statements to QPS on 31 August 1999 as part of QPS's investigation into Brooke's death. Both FSOs stated that FSO X contacted the JAB on 15 July 1999 to request their attendance and the JAB advised that they were unable to attend. No detail was provided as to whom they contacted. In FSO Y's statement, he stated he telephoned the Gold Coast JAB on 16 July 1999 and spoke to a particular officer (D) to ask if there was any record of a more current address for Ms A.

The minutes of the SCAN team meeting held on 22 July 1999 do not record any contact with the JAB in relation to the matter. No comment is made about the inability of the JAB to attend Ms A's address with DOF.

Clearly there is considerable conflict as to what contact was made between DOF and the JAB. It should be noted that the recollection of dates by the FSOs and officer C of the JAB reflects the error made by DOF when initially recording the notification. The date of the FSOs' visit to the unit was recorded as 15 July 1999 instead of the correct date, 13 July 1999. FSOs X and Y may well have reviewed these records before making their statements to QPS in August 1999. Officer C of the JAB may also have referred to the FSOs' statements, which were tendered as evidence in the prosecution of Mr Self. As officer C recalled receiving the phone call from FSO Y the day after their visit, she may have misunderstood this to be 16 July 1999 instead of 14 July 1999.

In relation to the contact made regarding the inquiry about a more current address, FSO Y recalls speaking to officer D, not officer C. This conflict remains unresolved, but is probably due to the lapse of time and frequency of contact between the two agencies in relation to child protection matters.

The main issue that remains unresolved is whether in fact the FSOs did contact the Gold Coast JAB on 13 July 1999 to request their attendance at the visit. Again, due to the lapse of time and the frequency of contact between the two agencies in relation to child protection matters, this issue has been difficult to resolve. Phone records are unlikely to be useful given the volume of calls made by numerous DOF officers and uncertainty over which phones were being used at that time.

I provided QPS with a further opportunity to comment upon the inconsistent evidence identified above. The report enclosed with QPS's response to the provisional report, prepared by the Detective Inspector, contained the following further information in relation to the alleged telephone call from DOF requesting JAB assistance:

> (A Detective Senior Sergeant) made inquiries into this matter. As stated by the Ombudsman, one of the FSOs who attended the Back Street unit stated that she contacted the JAB but can not recall who she spoke to. As of 21 January 2002, (the Detective Senior Sergeant) spoke to both those FSOs and they now confirm that the advice on Brooke came to them from (their Intake Team Leader), who had been advised by the SCAN doctor sometime after 3.00 pm. **(The Intake Team Leader) now states that he made a call to the JAB but cannot *recall and did not record whether he made contact or the phone rang out.*** (emphasis added)

QH commented upon this aspect of the report as follows:

> As it is impossible to identify what DOF officer spoke to what QPS officer, the nature, content and tenor of the conversation cannot be ascertained. It is not possible with the passage of time to establish whether any urgency was appreciated at the time and, if so, if it was communicated between the relevant agencies. It would appear to follow from the fact that no notation was made by DOF or QPS that this telephone communication was considered standard.

Given the further inconsistency that has apparently arisen from QPS's advice, my officers sought to confirm the evidence apparently gathered by the Detective Senior Sergeant directly with the FSOs and the Intake Team Leader. These persons all subsequently provided signed statements to this Office regarding this further evidence. Essentially, all officers stated that:

- they believed **telephone contact had been made** with the Gold Coast JAB on 13 July 1999, seeking JAB's involvement in the investigation of the Brooke Brennan matter;
- they believed that JAB's response was to inform them that they were not in a position to respond to the request; and
- they were not able to recall which staff member made the initial telephone contact with the JAB.

The QPS advised that even if the JAB had been requested to attend, it would not necessarily have done so. The QPS stated[68]:

68 QPS's report to this Office dated 3 August 2001.

> JAB staff do not attend every request by DFYCC (Department of Families, Youth and Community Care) for a police presence during a visitation for a variety of reasons, including availability of officers and operational requirements. Every request to JAB by DFYCC is considered on its merits and a determination is made in consultation with DFYCC as to whether JAB may attend.

In its response to the provisional report, QPS was asked to advise what alternative response is provided if no JAB officer is available to respond to a child protection matter. QPS stated:

> If the matter is urgent and no JAB staff are available, the matter is referred to the CIB Detective Senior Sergeant or the Detective Inspector for assessment. Arrangements would be made with uniform police to attend and assist if required. Non-urgent matters would be detailed to JAB staff to be actioned at a later time.

When asked by my officers (during the taped interview) whether the result of the search would have been any different if the JAB was able to attend, FSO Y stated:

> I don't think so… What the police are there to do is to gather evidence to see if there is someone they can actually lay a charge against and the police's role would have been, if we'd located mum and Brooke, would be to try and interview the child and as a result take some action in regard to Troy Self.

I do not necessarily accept this opinion as I explain later.

As was the case with the SCAN doctor's call to JAB, the lack of procedures for recording telephone calls from DOF requesting police assistance within QPS records is a matter of concern. The failure of DOF officers to keep records of such important requests made to QPS is also of concern.

5.2.3 The third inconsistency: entry to the unit

The third inconsistency that has arisen relates to the manner in which the two FSOs gained entry to the unit during their visit on 13 July 1999.

The DOF internal review report dated 14 September 1999 stated that the FSOs found the front door to the unit open, and that both of the FSOs entered the unit, presumably through the open front door. DOF's initial report to this office dated 31 May 2001 reported the same facts as were contained in its internal report.

FSO Y was called to give evidence at Mr Self's trial, and was asked to describe what he had found when he visited Ms A's address in Back Street, Biggera Waters. FSO Y stated that he had found the front door locked, and that he had gained entry to the unit and found a note. FSO Y was not asked to explain how he gained entry to the unit.

A second report was requested from DOF in relation to the conflicting accounts. DOF clarified the matter as follows:

> At approximately 4.00pm, (FSO Y) attended the address with (FSO X) and knocked on the front door, which appeared locked. No one answered the door.
>
> Inquiries with a next door neighbour revealed that she believed the family was at home as she had only moments before heard them inside. She indicated they may be out the back and directed (FSO Y) to the back of the units where the back door was located.
>
> The back door was open and music could be heard playing from inside. It was through this open door that (FSO Y) gained access to the unit and found the letter the mother had written to her de facto.
>
> (FSO Y)'s recollection is that during the murder trial they indicated to the Court in their evidence that the front door had indeed been locked and that they had gained entry through the open back door. This

> was also the information (FSO Y) provided to (the internal review officer) when they were investigating the matter in September 1999.

During the taped interviews with my officers, FSO X and FSO Y were able to clarify the matter further. FSO X stated:

> (FSO Y)'s statement in the trial is the correct one… The front door was, in fact, I don't know if it was locked but it was definitely closed. We didn't gain access to the unit through the front door. We were directed around to the back door by the neighbour. The back door of the unit was wide open. I didn't actually go into the unit at all. (FSO Y) went into the unit and I stayed outside.

FSO X was asked whether there was any explanation for how the internal review officer reported the wrong door. FSO X replied:

> No, no explanation. I don't know why (the internal review officer)'s put we went through the front door. We did explain the situation that we approached the unit from the front door, couldn't gain access there, went around the back door.

FSO X explained that they had never been shown the internal review report, and therefore never had an opportunity to correct the error.

FSO Y stated as follows:

> (The internal review report is) wrong… clearly the front door was locked. The difficulty was that I've never seen this report and if I'd actually seen it prior to it being in its entirety I would have corrected that. That's wrong. I clearly told (the internal review officer), my recollection is that I clearly told (the internal review officer) that the front door was locked and I was directed by a neighbour to the back door… The information I gave to the court was correct.

Therefore, according to the two FSOs, the internal review report contained two errors: it was the back door of the unit that was open, not the front, and only one FSO entered the unit during the visit. This subsequently led to the wrong facts being reported by DOF in its initial report.

5.2.4 The fourth inconsistency: location of the note

A further inconsistency that was discovered related to the location of the note found at the unit. DOF's initial report to this Office and DOF's internal review report both stated that FSO Y found the note inside the unit.

However, a DOF document titled *SCAN Referral, Gold Coast District SCAN Team* dated 22 July 1999 stated that the note was sighted on the open back door. This document was prepared by FSO X, in consultation with FSO Y, for the purpose of briefing the Gold Coast SCAN Team as to the particulars of Brooke's case. The minutes of the SCAN Team meeting held on 22 July 1999 repeat this account of events.

Both FSOs were asked to clarify this issue during the taped interviews. Both agreed that the SCAN referral document and the minutes of the SCAN team meeting contained an incorrect account as to where the note was found. The two FSOs explained that they had decided to report the note as being found on the door, because of a concern about whether or not FSO Y should have entered the unit. FSO X explained:

> I personally didn't want to go in but (FSO Y) was the senior worker and said we're checking to see if the child's inside and just said rather than go through that, just say we found it on the door… I didn't want, I didn't feel comfortable going in. I didn't see any reason for the two of us to be going in anyway. Only I guess purely to check that she wasn't in there, given that we thought we could hear music coming out of there. There was no need for me to go in. So, yes, I didn't feel comfortable going in.

FSO Y stated:

> The situation was when (FSO X) and I were there, we had some dilemma about whether I should have entered the unit. I felt legally I was probably entitled to. There was some debate as to whether I actually should have been in that unit. The decision that I made was because it wasn't a matter of where it was… it wasn't an issue about the note, about where it was located. I guess in haste that decision was made to say it was on the door to probably protect (FSO X) and myself if there were any repercussions of us going into the unit, not thinking this would be an issue later on down the track… Regardless on the door or on the floor, in the back yard or in the bedroom, I think it was more about our dilemma and our feeling as to whether we were actually covered by entering the unit… I discussed it later with the Intake Team Leader and I indicated to him that that was wrong. The note was clearly inside the unit. That was after I had discussions later on with the Intake Team Leader and the Area Manager about my role in entering that unit.

Therefore, the inconsistency in relation to where the note was found arose because of a misrepresentation by the two FSOs to the Gold Coast SCAN team. While it was inappropriate to report the matter in this way, the FSOs did properly report the matter to the Intake Team Leader, and the circumstances in which the note was found were correctly recorded in DOF's records.

I should explain at this point the actual powers of entry that DOF officers have when investigating allegations of harm to a child. At the time of Brooke's notification, DOF officers were operating under the *Children's Services Act*. This Act was completely silent as to whether DOF officers were authorised to enter a place for the purpose of investigating allegations of harm to a child.

The new *Child Protection Act*, which has replaced the *Children's Services Act*[69], specifically deals with powers of entry in these situations. Section 16 provides that if a DOF officer is investigating an allegation of harm to a child and has been denied contact with the child or cannot reasonably gain entry to the place where they reasonably believe the child is, the officer may enter the place and search the place to find the child, using such force as is reasonable in the circumstances. However, the officer must reasonably suspect that the child is at immediate risk of harm or is likely to be removed from a place and suffer harm if the officer does not take immediate action.

5.2.5 The fifth inconsistency: an alternative address

The final inconsistency relates to the inquiries made by the two FSOs when attempting to find another address for Brooke or Ms A. There is some conflict in the evidence gathered as to exactly when and by whom these enquiries were made.

During the taped interview conducted by my officers, FSO X's recollection was as follows:

- FSO X telephoned the Gold Coast Hospital (time of phone call not specified) some time before the initial assessment was completed; and
- FSO Y telephoned the Gold Coast JAB on the afternoon of the visit, as they were driving back to the Gold Coast Area Office.

FSO Y's evidence to my officers during the taped interview was as follows:

- FSO Y telephoned the Gold Coast Hospital on the afternoon of the visit, after they had searched the units but before returning to the office; and
- FSO Y telephoned the Gold Coast JAB on the afternoon of the visit, after they had searched the units but before returning to the office.

My officers also obtained copies of statements made by the FSOs to QPS during its investigation into Brooke's death in August 1999. FSO X's statement to QPS recorded the events as follows:

69 From 23 March 2000

- FSO X telephoned the Gold Coast Hospital the day following their visit.

FSO Y's statement to QPS was as follows:

- FSO Y telephoned the Gold Coast Hospital on the afternoon of the visit, after they had returned to the office; and
- FSO Y telephoned the Gold Coast JAB the day following their visit.

In addition, the minutes of the Gold Coast SCAN team meeting held on 22 July 1999 record that the FSOs telephoned the Gold Coast Hospital in relation to address information on the day of their visit. The minutes do not mention any phone call to the Gold Coast JAB.

As mentioned previously, officer C from the Gold Coast JAB did recall receiving a phone call from FSO Y seeking current address information for Brooke's mother. Officer C's recollection is that this call was made the day following the FSOs' visit to the unit.

Whether the telephone calls were made the afternoon of the visit or the following day, the evidence indicates that the calls were in fact made, and were made before the FSOs completed their initial assessment in relation to Brooke.

5.3 Department of Families' response to complainant's allegations

DOF's initial report of 31 May 2001 in response to the complainants' allegations did not specifically address each allegation. Rather, DOF referred to its internal review conducted in accordance with PM95/17, stating:

> From this review, officers were found to have acted promptly, appropriately and within current procedures. However, it was noted that the procedures could provide more structured guidance as to the action required to determine and respond to the immediate safety of a child in such circumstances.

The main part of DOF's report contained an outline of the facts of Brooke's case as well as an explanation of DOF's legislation, policies and procedures. Other than the paragraph extracted above, the report did not make any comment on the substantive issues raised by the complainants in their allegations.

A copy of DOF's internal review report dated 14 September 1999 was provided to this Office with DOF's initial report. I have assumed that this report essentially contains DOF's response to the complainants' allegations (except, of course, in relation to the complainants' allegation concerning the adequacy of the internal review and report, upon which I received no initial comment from DOF). I have also included as part of DOF's response, statements made by the two FSOs during the taped interviews with my officers and written advice from the Gold Coast Area Manager in response to written questions from my Office.

My analysis of each issue appears in Part 5.5 of this report.

5.3.1 That DOF officers did not make reasonable attempts to establish the whereabouts of Brooke/did not properly investigate the factual situation

These allegations are inter-related and can be examined in two different contexts. Firstly, in the context of actions taken by the FSOs that afternoon when visiting the unit and, secondly, in the context of the final decision made by DOF not to take any further action to investigate the matter.

The Gold Coast Area Manager explained the basis for DOF's decision not to take any further action to investigate Brooke's situation. He stated that the decision was made in accordance with DOF's policy in relation to matters that are unable to be completed because of an inability to locate the family. Accordingly, he took into account the circumstances of the case and the level of alleged harm. The particular factors the Area Manager says were taken into account were:

- advice from the Intake Team Leader that the FSOs had sighted a letter in the unit from the mother of the child which said that she was leaving her defacto partner;
- phone calls by the FSOs to the Gold Coast JAB and to the Gold Coast Hospital to ascertain if they were aware of any alternative addresses for the mother and child;
- no previous child protection history in relation to Brooke;
- the matter was to be further discussed at SCAN on 22 July 1999; and
- acute resourcing issues.

The Area Manager stated that on consideration of the above, he and the Intake Team Leader were of the view that the mother was acting protectively towards Brooke.

The allegations are also addressed by the findings of DOF's internal review report. These findings can be summarised as follows:

- The manner in which the notification was recorded upon intake was in accordance with agency guidelines. However, more details as to the severity of the abuse would have been helpful in the initial assessment, particularly given the vulnerable age of the child.

- The initial response to Brooke's notification was a 'best practice response'. It was appropriately rated in the most urgent category and responded to immediately, and due process, such as consulting with the JAB, was followed.

- The subsequent assessment of Brooke's situation was according to procedures. The Team Leader consulted with the Area Manager, the case was referred to SCAN and was discussed within a week, and attempts were made to ascertain the mother's address.

- The decision not to take any further action in relation to Brooke's case was a decision about the future safety of the child, influenced largely by the note found at the unit, which suggested the mother had acted protectively and left the relationship. This decision was made in accordance with DOF procedures and workload pressures. However, the decision highlights a system-wide problem within DOF.

- The current standards contained in the Manual in relation to actions required 'when Initial Assessment is not possible due to Client Reasons' are inadequate. The procedures require that the Manager should take into account 'the level of alleged harm'. However, the procedures fail to identify the issue of imminent safety/danger.

- The Intake Team at the Gold Coast Area Office was operating under considerable workload pressures due to a lack of resources. This had a number of impacts on the Team, including:

- an inability to maintain contemporary records on notifications and initial assessments, and
- a need to prioritise cases at the various critical decision-making points in an attempt to target the most urgent, the most severe, the most risky etc, while cutting out the lowest 10 per cent or 20 per cent

- The prioritising approach taken by the Gold Coast Area Office operated effectively in relation to its initial response to Brooke's case; i.e. the Intake Team was able to respond to the notification immediately. However, once the initial assessment had commenced, the prioritising approach forced the Intake Team to make a safety decision about Brooke in a very short time period, which was an either/or decision (i.e. either the child is safe or not safe).

- If DOF operated according to a different safety assessment system, where children are deemed to be 'safe', 'conditionally safe', or 'unsafe', then a different decision would have been made in relation to Brooke. Instead of being judged 'safe' because of the alleged protective action taken by her mother, Brooke would have been considered 'conditionally safe'; that is, her safety was conditional upon her mother sustaining her newfound protective behaviour. If such a decision was made under that system, DOF would have been required to monitor Brooke's situation until she could be considered 'safe'.

The internal reviewer concluded as follows:

> I am not in any way suggesting that the team made an error of judgement in not following this course of action. They were following standard departmental procedures, with the emphasis on harm rather than safety, and they made the best decisions they could within that framework.
>
> Nor am I suggesting that safety assessment would necessarily have changed the outcome for this particular child. What I am saying is that the safety of the entire population of such "conditionally safe" children in the department's CP system would likely be enhanced by adopting these processes.
>
> I would recommend that the department look at the safety assessment systems in use elsewhere given the current levels of CP demand and the existing workload pressures on front-line staff.

5.3.2 That DOF Officers failed to leave information for Ms A

This allegation was not addressed by the internal review report, as it was not considered to be an issue. However, my officers asked the FSOs, as part of the taped interviews, why they did not leave any information at the unit for Ms A during their visit.

FSO X responded as follows:

> Depending on the nature of the notification, somewhere where there's possibility of police involvement, we would not be tipping off an alleged perpetrator that we were on the case. In that case we would not leave a card and given the nature of what the allegations were, and we did actually ask the police if they would accompany us and they were unable to send anybody out but we were aware that this could be a matter where police may be involved. So yes, a decision was made not to leave a card… And also based on what we found, or what (FSO Y) found, in the unit also added to that decision… You don't want to tip off something that might become a police matter to an alleged perpetrator. And we would have no reason to be speaking to, in this instance, Troy Self, given the information that (FSO Y) discovered in the unit. That would be strictly a police matter. It wouldn't be our involvement at all.

FSO Y gave a similar explanation:

> It is certainly recommended to leave a card but it depends on the circumstances. See, once we read the letter, our information would have been that Ms A would have left. We really needed to talk to her and the child before we talked to Troy Self, and our assumption was that if we left a card it would be Troy that got the card. Now we would rather talk to the victim and the mother prior to talking to him so that's why a card was not left on this occasion. On normal occasions, on most occasions we do leave a card

> but there are some circumstances where we don't want to alert the alleged offender prior to speaking to the mother and the child… We believed that was Troy's unit. We didn't want him to get the card.

Both FSOs also stated that DOF did not have any written or informal policies in relation to leaving information for people. Rather, it was left to their discretion and was something they developed as part of the experience in the job.

Both FSOs were also asked whether they considered leaving any contact details with the neighbour they spoke to, in case Ms A and Brooke returned. FSO X stated that they did not consider doing this because:

> We don't advise people, when we're undertaking an investigation, we wouldn't identify ourselves to neighbours as Family Service Officers. We are supposed to be operating on a confidential basis, so we don't alert other people who we are. So we wouldn't have left any identifying information with a neighbour.

FSO Y stated:

> We don't particularly like neighbours to know that Family Services are calling on people. It's very unusual for us to leave information with neighbours. In fact, we wouldn't do that at all because allegations that we discuss with parents are strictly confidential and it's really not the business of somebody else in a block of units to know our business… And we don't actually, normally we don't introduce ourselves as Family Service workers. It's just that sometimes it's a bit of a stigma so we try to remove neighbours from these sorts of scenarios.

5.3.3 That DOF's subsequent internal review and report in relation to Brooke's case were inadequate

As explained previously, DOF did not provide any specific response to this allegation. However, the internal review officer did provide some information relevant to this allegation during the taped interview with my officers.

The information provided by the internal review officer can be summarised as follows:

- The internal review officer is a senior officer within DOF. The officer has twenty years experience in child protection in numerous jurisdictions within Australia and the United Kingdom. The officer has formal qualifications in social science and social work at degree and postgraduate level.

- The internal review was conducted in accordance with DOF policy PM95/17.

- The internal review was conducted solely by the officer, with no assistance from any other officers within DOF.

- The investigations carried out by the internal review officer included reviewing the material in DOF's electronic Child Protection Information System (CPIS) and interviewing the Intake Team Leader and the two FSOs involved in the initial assessment. No other persons were interviewed. The internal review officer was directed[70] to limit the report to an inquiry of persons within DOF.

- Subsequent to the interviews, the internal review officer carried out some research into the existing workloads within the Gold Coast Area Office.

- The internal review officer acknowledged he may have been mistaken in reporting that the front door was open when the FSOs visited the unit.

70 By either the Regional Director for the Brisbane South Region or the Operator for Child Protection for the Brisbane South Region.

5.4 Resourcing

During the course of my investigation into the administrative actions taken by DOF in relation to Brooke, I have received a considerable amount of evidence in relation to resourcing constraints within the Gold Coast Area Office.

The evidence I have gathered to date is outlined below. My analysis of this evidence appears in Part 5.5.5 of this report.

5.4.1 Evidence from the internal review officer

The internal review report identified resourcing as a major issue within the Gold Coast Area Office, one that impacted upon the decisions made in this case and upon child protection work in general. The research carried out by the internal review officer in relation to workloads within the Gold Coast Area Office revealed the following:

- On the day Brooke's notification was received, FSO X's caseload was 58 families, comprising:
    - 41 initial assessments either not started or requiring completion,
    - 10 cases referred to the Team Leader for sign off, and
    - 7 cases assigned for follow-up casework.

- The above caseload was about average for officers within the Gold Coast Area Office Intake Team. Comparable offices in South Australia operated with average caseloads of about 20 families, while in Victoria average caseloads between 12 and 15 families.

- In the nine-month period from July 1998 to March 1999, the Gold Coast Area Office received an average of 84 notifications per month. The next four busiest offices within Queensland received 63, 58, 46 and 45 notifications per month. At the time of Brooke's notification, the Gold Coast Area Office was receiving an average of 89 notifications per month.

The internal review officer constructed a table to measure the workload in terms of required and available hours, which was included in his report. A copy of this table can be seen in Appendix J to this report. The internal review officer concluded from these calculations that the resource shortfall in the Gold Coast Area Office Intake Team at the time of the review was about 350 hours per month, or three full-time FSOs.

During the taped interview with my officers, the internal review officer stated:

> I don't know what the current level of caseloads are at the Gold Coast but as you say I felt strongly that they were excessive at the time to provide real safety for children…
>
> As I alluded in my report I think the workloads here are much higher than what I've experienced not in every place, but in most other places. I'd have to admit I've worked in offices in Melbourne where the workload was even worse with very similar consequences in terms of staff morale and sick leave and anxiety about whether children are safe. But I think it is a fairly reasonable view of what is happening.

5.4.2 Evidence from the QPSU

My officers received information that the QPSU had data relating to workloads of the various DOF area offices. A request was made to the QPSU to provide that data.

It purported to show the number of notifications received by each Area Office in the Brisbane South Region from July 1998 to June 1999 as follows:

Area Office	Notifications received July 1998 to June 1999
Beenleigh	657
Gold Coast	986
Logan	732
Mt Gravatt	292
Redlands	263
Stones Corner	320
Wynnum	157

Also, according to this information, the number of outstanding initial assessments as at 19 July 1999 for each Area Office was as follows:

Area Office	Outstanding initial assessments 19 July 1999
Beenleigh	302
Gold Coast	252
Logan	239
Mt Gravatt	40
Redlands	52
Stones Corner	61
Wynnum	25

In other words, as at 19 July 1999, six days after Brooke's notification was received and three days prior to the SCAN team's decision not to take any further action in relation to Brooke, the Gold Coast Area Office Intake Team (five field officers working in teams of two with one officer on intake) had 252 other initial assessments which either had not been commenced or required completion.

An effective comparison of workloads between Area Offices can not be made without the relevant staffing numbers. I therefore asked DOF to provide this information. I also asked DOF to comment upon whether it agreed with the above figures.

DOF advised that it did not agree with the evidence provided by the QPSU about the number of notifications received by the Gold Coast Area Office during the relevant period. DOF provided the following figures regarding cases notified during the relevant period (extracted from its *1998-99 annual child protection tables*):

Area Office	Child protection cases notified 1 July 1998 to 30 June 1999
Beenleigh	1079
Gold Coast	1557
Logan City	1277
Mt Gravatt	480
Redlands	451
Stones Corner	505
Wynnum	264

DOF further advised that it was unable to provide evidence about the number of outstanding initial assessments as at 19 July 1999. However, DOF did provide the following figures regarding outstanding assessments from 1 July 1998 to 30 June 1999 (again extracted from its annual child protection tables):

Area Office	Total initial assessments 1 July 1998 to 30 June 1999	Initial assessments - not finalised 1 July 1998 to 30 June 1999
Beenleigh	842	567
Gold Coast	1275	580
Logan City	986	439
Mt Gravatt	384	99
Redlands	367	121
Stones Corner	471	63
Wynnum	214	43

DOF explained that the outstanding initial assessments 'include those where no assessment is possible, where there is a part assessment (no outcome), where staff are unable to commence/ complete an assessment and where assessments are still under investigation'. DOF subsequently confirmed[71] that the figure of 580 initial assessments not finalised from 1 July 1998 to 30 June 1999 at the Gold Coast Area Office represented the number of outstanding initial assessments for the Gold Coast Area Office as at 30 June 1999.

In relation to staffing numbers, DOF advised that officer resourcing as at 30 June 1999 was as follows (based on substantive headcounts of FSO positions):

Area Office	Family Services Officers
Beenleigh	22
Gold Coast	19
Logan City	24
Mt Gravatt	8
Redlands	12
Stones Corner	17
Wynnum	9

As can be seen from the above tables, the figures provided by the QPSU and DOF differ greatly. In fact, the DOF figures in relation to notifications received are considerably higher than those provided by the QPSU. Both sets of figures demonstrate that the Gold Coast Area Office received the highest number of notifications compared to other Area Offices.

Unfortunately, in providing staffing numbers to aid in the assessment of comparative workloads regarding notifications received, DOF failed to identify the number of FSOs within each Area Office who were actually undertaking intake and assessment work (i.e. receiving and responding to notifications). The FSO figures provided are 'whole of office' figures, representing the total number of FSOs working within an Area Office (including those working in case management areas). Therefore, I have been unable to make an effective comparison of workloads between Area Offices regarding notifications received during the period relevant to Brooke's case.

In relation to outstanding initial assessments in the Gold Coast Area Office at the time of Brooke's notification, DOF was unable to confirm or refute QPSU's figures. However, the figures provided by DOF regarding outstanding initial assessments for the period 1 July 1998 to 30 June 1999 demonstrated that as at 30 June 1999, the Gold Coast Area Office had 580 outstanding initial assessments. This is significantly more than the QPSU's figure of 252 initial assessments outstanding as at 19 July 1999.

It is noted that DOF's figure included initial assessments where no further action was to be taken (e.g. where no assessment was possible, where there was a part assessment with no outcome, and where staff were unable to commence or complete an assessment) as well as assessments still under investigation. The QPSU's figure represented only those initial assessments that either had not been commenced or required completion. This appears to explain the discrepancy. In any case,

71 By email correspondence dated 4 April 2002.

it is clear that at the time of Brooke's notification the Gold Coast Area Office had a significant number of other initial assessments that required further action by the Intake Team.

DOF provided the following further advice in relation to the above issues:

> Notwithstanding that this data differs from the data provided by the QPSU, there is no doubt that there have been significant increases in activity and demand. For example, the average increase of cases notified in Queensland over the last 10 years is approximately 9% per annum.
>
> In relation to the Gold Coast Area Office, the cases notified have increased as follows:
>
> - In 1997-98, 1229 cases were notified.
> - In 1998-99, 1557 cases were notified representing an increase of 26.6% over the previous year.
> - In 1999-2000, 1595 cases were notified representing an increase of 2.4% over the previous year.

Again, the above information is not helpful in determining what the workloads were like within the Gold Coast Area Office Intake Team at the time of Brooke's notification. Although the above figures show 'significant increases in activity and demand' within the Gold Coast Area Office in the relevant financial year (1998-1999), DOF did not explain the effect these increases had upon the Area Office's ability to effectively perform child protection work.

Accordingly, the figures provided by DOF did not significantly assist my assessment of the resourcing issue within the Gold Coast Area Office at the time of Brooke's notification.

5.4.3 Evidence from the Family Service Officers

Both FSOs involved in the assessment of Brooke's situation also claimed resourcing was a major issue influencing the decision not to take any further action in relation to Brooke. The FSOs were asked, during the taped interviews, why DOF did not make another visit to the unit at any time in the following two weeks prior to Brooke's death. FSO Y stated:

> Firstly, I guess, there was the letter, which suggests that mum had left and we had no forwarding address. But I would also suggest that at that time with the amount of staff and the workload, it was just not possible to follow all these matters up. It was just a fact of life. We were managing with five workers… we recorded over 90 notifications prior to the notification, and 90 notifications the month of that notification, and with five workers with sick leave, rec leave, people on RDOs, there was a real resource issue and it's still a resource issue for the Gold Coast that at that time we just didn't have the manpower or the resources or the time to follow up every single matter.

The interview between my Assistant Ombudsman and FSO X was as follows:

AO: Do I understand what you're basically saying there… in response to the allegation 'Why didn't they go back a second time, a third time, a fourth time or just keep calling at the unit to see if Brooke was there'. Basically you had other work which was of a similar priority and urgency as the Brooke Brennan notification.

FSO X: Certainly.

AO: And you did not have the staff or the luxury to stay there and do that because you had to go to the next job.

FSO X: That's correct.

AO: And the next job could be the next Brooke Brennan.

FSO X: That's right.

AO: Did you have any personal view at the time that if you had the resources, did you feel a second visit would have been prudent or needed?

FSO X: Certainly, if time was available, we would have investigated further. I believe that we would have if we had that luxury. If we'd had enough time to go back just to, I guess, satisfy ourselves totally but there was just no chance of that whatsoever. It was an impossible situation work-wise.

AO: Then that would be true of a lot of these notifications I suppose. A lot of the time you would turn up, someone's not there, you've got to make a decision whether you stay there for an hour or two hours and wait for someone to come back or you go and do another job.

FSO X: Certainly, I mean there were some notifications you would go out on where there was neither parent acting protectively and in Brooke's case there was information that the mother had, so that would have lowered the risk factor at that point in time because there was someone who is acting protectively of her daughter.

Both FSOs were asked to explain what the workloads were like within the Gold Coast Area Office in July 1999. FSO X stated the following:

> We had, at that point, 5.5 workers investigating child abuse on the Gold Coast. This was the month of July with 94 notifications. Out of those 5.5 workers for one week in every five you were required to be pulled off line and to answer or be on intake which means you stay in the office and answer phone calls from the public. So basically you've got three weeks out of every month basically that you can actually actively go and investigate matters. I think, at the time of this, Brooke's death, I had currently 40 investigations under way that I was completing. A lot of those notifications would have been, what we call now Priority Ones, so we had a very significant staff resource shortage… Now I wouldn't have been alone in having, I think it was 40-odd currently under investigation at the time. The other four workers would have also had those or perhaps greater workloads even… Over a long period of time the work just backed up and backed up and backed up. So every case could have been as urgent or as important as the Brooke Brennan case. We did not have the luxury of remaining involved in cases that we believed a parent had been acting appropriately…

FSO Y said:

> Basically the workload at that stage was probably unworkable. We were operating with five Family Service Officers recording, at that stage in July, 94 child protection notifications. Now that would be roughly about 20 each. However, we go out in teams of two, so what you're looking at is two people basically trying to respond to 40 notifications a month, which is more than one a day. Some of these notifications require us going to court. Some of them require us placing kids in voluntary placements. During those months it was just totally unworkable. We were not providing an efficient service to our clients. We were not being able to investigate matters to the best of our ability and it has been regularly highlighted through that document I gave you through this stuff in '99 through current industrial action the department was involved in, that workloads are just too big and too huge and in those days it was just not possible to give the most efficient response to these notifications. You know, we have for a long time tried to highlight this problem and one of the repercussions obviously is that a child has died but, I mean, given the amount of resources we had, given the workload and the other cases we had to service, it's just, it was a disaster waiting to happen.
>
> I mean, I'm not making excuses or anything. It's just a matter of highlighting at the time how difficult it was working with…the amount of work we had. And we did have people off on sick leave. We had people off on rec leave, people on RDOs. So at any one time you wouldn't have had five workers, you might have had three or four… And some notifications take all day and you get a backlog, ones that you've got to go back and see. We have to see, with notifications we have to sight the children. If we go to a house and mum's there with two of the kids and two are at school we have to go back a second time, so then you've got to fit those into your program. We have matters before the court. We've got to service those sorts of things. Write affidavits, write reports, write ministerials. It was just intolerable.

The warning memo

During the taped interview, FSO Y provided my officers with a document in support of his statements about workloads. The document was a DOF inter-office memo[72] dated 2 March 1998 (some 16 months before Brooke's death), addressed to the Regional Director of the Brisbane South Region. It was signed by the Team Leader and each of the five FSOs working within the Gold Coast Area Office Intake Team at that time (which included FSO Y but not FSO X).

The memo outlined the level of workloads carried by the Gold Coast Area Office Intake Team at that time. The memo then went on to address what the FSOs considered to be the effects of these workloads. Among other things, the memo stated:

- all team members feel that the daily work loads being carried are impossible to manage regardless of extremely effective personal management strategies and the high level of worker experience within the team;

- all team members are demonstrating stress related behaviours and symptoms: e.g. chronic ill health, headaches, anxiety and/or long work hours (i.e. outside average work hour requirements) and so on…;
- all team members often feel uncomfortable taking recreation, rostered days off and sick leave entitlements due to the inevitable loads that will fall on co-workers and/or a feeling of 'letting the team down'; and

- all team members are carrying anxieties in relation to incomplete work and the possible repercussions should 'something go wrong'. These anxieties have intensified over recent months as a result of recent child death cases (northern New South Wales), and the generally negative media coverage in relation to Departmental cases and decision making processes.

The memo documents that in 1998, the Gold Coast Area Office was receiving between 50 to 70 notifications per month. FSO Y stated that at the time of Brooke's notification more than one year later, the Gold Coast Area Office was receiving around 80 to 90 notifications per month, with the same number of FSOs in the Intake Team. FSO Y stated that the situation at the time of Brooke's notification in 1999 in relation to workload pressures was actually worse than at the time the memo was written.

FSO X also provided a document in support of their claims in relation to workloads. This document detailed the number of notifications received within the Gold Coast Area Office in the months of June and July 1999. In June 1999, 96 notifications were received, while in July 1999, 94 notifications were received.

5.4.4 Evidence from the Gold Coast Area Manager

In his advice to this Office, the Gold Coast Area Manager stated that one of the factors taken into account when determining whether to take further action in relation to Brooke's notification was 'acute resourcing issues'.

The Area Manager was asked specific questions about resourcing within the Gold Coast Area Office at the time of Brooke's notification. In response to the question, 'In your opinion, was the Gold Coast Intake Team adequately resourced at the time of Brooke's notification to carry out its child protection obligations?', the Area Manager stated:

> The office overall and, in particular, the Intake Team were inadequately resourced to provide service beyond a 'minimalist' level. Whilst the office had well developed systems and a dedicated work force the following factors were evident in a high growth area:
>
> - Approximately 1000 child protection notifications per year;

72 A copy of the memo is included in this report as Appendix K.

- At any one time approximately 200-300 assessments required data entry by Family Services Officers;

- Stress level of individual FSOs to the extent that they signed a document indicating the risk level to clients serviced by the Intake Team[73]; and

- Memos from the Gold Coast Area Manager to senior management clearly stating the workload issues (then existing)[74].

The Area Manager was further asked, 'Was resourcing a significant or decisive factor in your decision that all reasonable steps had been taken to complete the assessment in relation to Brooke?'. He replied that: 'Resourcing was definitely a significant factor in decision making regarding how resources were allocated and utilised - remember there were in excess of 90 notifications in July 1999'.

Finally, the Area Manager was asked, 'if the Gold Coast Area Office had been better resourced at the time, would your decision have been any different? Would you have asked the FSOs to return to the unit in an attempt to locate Brooke again? Would you have asked the FSOs to do anything more to complete the initial assessment?'. His response was: 'Best child protection practice which is of course largely dependant on adequate resourcing would indicate FSOs should return and, further, more than one interview should occur with a family'.

5.4.5 Evidence from the Gold Coast Area Office

A considerable amount of data and other documents were prepared by the Gold Coast Area Office and provided to me in relation to workloads within the office, both in 1999 and currently.

A memorandum dated 12 April 1999 was among the documents provided. It was from the Gold Coast Intake Team Leader to the Area Manager, and was entitled *Intake and Assessment Team Workload for the Month of April*. The memo stated as follows (in part):

> I advise that the intake and assessment team recorded in excess of 100 notifications for the month of March… Given the above circumstance the following work areas will be significantly affected:
>
> 1. Initial assessments. Significant impact on the rate of completion of initial assessments.
> 2. Multiple Notification Reviews. Inability for intake assessment team to give priority to the completion of Multiple Notification Reviews…
> 3. Practice Standards for completion of Notification Initial Assessments will not be met.

From the various data provided by the Gold Coast Area Office, a comparison was made of the number of notifications received from April to July of 1999 and the number of notifications received during the same period in 2001. This comparison is illustrated in Appendix L. The average number of notifications received per month in 1999 for the period April to July was 83.5. In 2001 for the same period, the average was 87.5.

When considering this comparison, it must be noted that staffing levels within the Gold Coast Area Office have significantly increased since 1999. At the time that Brooke's notification was received, the Gold Coast Area Office had only one Intake Team consisting of five full-time FSOs, one part-time FSO and a Team Leader. Currently, the Gold Coast Area Office has two Intake Teams (one for the 'South' and one for the 'North'), each consisting of six full-time FSOs and a Team Leader.

73 The Area Manager is referring to the memo of 2 March 1998, discussed at Part 5.4.3 above and included in this report as Appendix K.

74 An example of such a memo was provided to this Office by the Gold Coast Area Office and is discussed at Part 5.4.5 below.

5.4.6 Currently in 2001

There is information to suggest that, even with the increase in staffing, workloads are still a cause for concern within the Gold Coast Area Office Intake Team.

When the FSOs were asked to comment upon the situation within the Gold Coast Area Office currently, FSO Y stated:

> The situation now is that we have 12 workers doing child protection but we are still extremely busy and there are still issues that we need more staff, but we've doubled it plus added a couple, which has helped. But in 1999 it was just horrendous.

FSO X stated:

> …Since then we've now got 12 workers covering the same area and we investigate, there's a north and a south, so you're only allocated to work, say, the south half now, and we're still struggling work wise… I mean we still struggle at times too because, I guess, with the new Child Protection Act 1999…there's more paper work, other jobs we have to do in association with administering that Act, so our time's spent a lot more paper work sort of things, stuck in the office, when I think what we need to be doing is out in the community. We are spending less and less time there, rather than doing administrative tasks related to the administering of the Act. That's just a personal observation.

FSO Y agreed with FSO X's comments in relation to the *Child Protection Act* and its effect on workloads.

The Gold Coast Area Manager also commented upon the resourcing situation currently within the Gold Coast Area Office. He stated:

> I would stress that whilst there has been some improvement in staffing levels, the present number of child protection notifications that require workload managing is unacceptably high and present a significant risk factor.

The phrase 'workload managing' refers to a written policy within DOF which gives formal recognition to the fact that an Area Office may not always have the ability to respond to child protection notifications appropriately, due to a lack of resources. I have mentioned this policy previously in my report. It is DOF's Policy Memorandum PM00/03, titled *Child Protection Notification (Initial Assessment) Response and Specific Workload Management Strategy*, dated 28 February 2000.

The purpose of PM00/03 is stated to be as follows:

> The purpose of these guidelines is to outline the approved strategy for prioritising responses to child protection notifications (initial assessment) and **managing those initial assessments that cannot be responded to in a timely way due to workload demands**. These guidelines should be viewed as one component of the overall workload management processes utilised in managing client service delivery (emphasis added).

As I explained previously in this report[75], the first part of PM00/03 outlines DOF's strategy for prioritising responses to child protection notifications requiring initial assessments. Such a strategy is required because resources do not allow DOF to carry out an initial assessment on every notification immediately, and those that are most urgent need to be given priority according to an established set of guidelines.

Notifications are rated as priority one, two or three. Initial assessments of priority one notifications must be commenced within 24 hours. Initial assessments of priority two and three

75 See Part 3.2.

notifications must be commenced within a fortnight of receiving the notification, or completed within one month of commencing the assessment.

The second part of PM00/03 outlines DOF's procedure for managing and processing notifications that cannot be responded to within an appropriate time period. This procedure is called the 'Specific Workload Management Strategy'.

As background to the Specific Workload Management Strategy, PM00/03 states:

> The workload management strategy for notifications does not alter the existing framework for determining the level of response to a child protection notification as outlined in the Child Protection Procedures Manual. This response and strategy recognises through the prioritisation process that the **need** to respond is separate from the **capacity** to respond.
>
> **Capacity to respond**
>
> The ability of an Area Office to respond to a child protection notification will vary from time to time depending upon available resources and the number of notifications received. Where there is an inability to commence or complete the appropriate response to a notification according to practice standards, use of the specific workload management strategy to write-off may be applicable

The Specific Workload Management Strategy only applies to notifications with a priority rating of two or three. All initial assessments with a priority rating of one are to be commenced within 24 hours. If this is not possible, the Area Manager is required to contact his/her Regional Director and establish a strategy to ensure that the initial assessment is undertaken.

The Specific Workload Management Strategy operates as follows:

> Where an initial assessment response with a priority rating of 2 or 3 is unable to be:
>
> - COMMENCED within a fortnight of RECEIVING THE NOTIFICATION, or
> - COMPLETED within one month of COMMENCING THE ASSESSMENT
>
> the response may be recorded as 'Initial Assessment unable to be commenced/completed (workload reasons)' AFTER approval by the Area Manager.

Effectively, this policy allows the following to occur. An Area Office may receive information that leads it to reasonably believe a child has suffered harm or is at risk of suffering harm, and that the level of harm is 'significant'. The matter would be categorised as a child protection notification requiring an initial assessment. If the child was at low risk of immediate danger, but high or low risk of future significant harm, then the initial assessment would be allocated to an FSO to be commenced within a fortnight and completed within a month. However if, because of a lack of resources, an initial assessment was unable to be carried out within these timeframes, the Intake Team Leader may ask for the Area Manager's approval to apply the Specific Workload Management Strategy. If the strategy is applied, **no further action is taken in relation to the notification and no contact is made with the family whatsoever**. Essentially, the matter is 'written off'. The matter is only revived if another notification is received about the child.

The effects of this workload management strategy are best illustrated by case examples of matters that have been 'workload managed'. Two examples of priority two notifications that have been workload managed within the Gold Coast Area Office in 2001 were examined.

The first example was a notification received by the Gold Coast Area Office in relation to a seven year old girl. The information provided by the notifier was as follows:

> One evening, the child was locked outside the house at 8.30pm for at least 10 minutes. The child was crying "Mummy, Mummy, Mummy". The mother opened the door and said "You fucking little bitch.

> How dare you wet the bed. You won't live here anymore and you'll be dead. Get inside you bitch." The mother was heard to hit the child twice. The child was crying and then went inside.

The second example was a notification received in relation to four children in the one family, all between the ages of three and six. For this notification, two calls were made to the Gold Coast Area Office from two separate notifiers, both expressing similar concerns. The first notifier provided the following information:

- Notifier reports frequent verbal abuse being directed at the children. Language is described as "positively foul" and "horrific" and includes phrases such as "you fucking shit…" and "you bloody arsehole…". Both mother and father have been heard.
- Abuse can be heard, without fail, regardless of the day or time.
- Children are heard to be in a constant state of crying.
- A second party informed the notifier that…the screaming often continues until 10pm.

The second notifier called three days later and informed the Gold Coast Area Office as follows:

- The severe verbal abuse is a daily occurrence that can be heard from early morning until dusk. Profanities are heard throughout outbursts e.g. "eat your fucking pizza or I'll break your fucking legs." Noise can be heard from within the family's home (door closed) and from some distance.
- Recently children were playing on the lawn before being hollered at, with the use of several expletives, to come inside.
- Children are heard crying 2-3 times a day for periods up to 15 minutes.

In relation to the second example given above, both notifiers also provided further information suggesting drug dealing from the premises. Both notifications were given a priority rating of two. This means that the risk of future significant harm to the children was considered to be high.

DOF officers explained that these examples were probably at the highest end of cases that are workload managed, i.e. written off, within the Gold Coast Area Office. They stated that all staff involved felt ‘very uncomfortable’ writing off these notifications.

When the workload management strategy is applied, the initial assessment record must note the rationale for the decision and record the specific outcome (i.e. "’unable to commence/complete assessment - workload reasons’). The record must also document any assessment information or partial assessment that occurred.

PM00/03 outlines a specific workflow process that must be followed when applying the workload management strategy. The Intake Team Leader is responsible for recommending to Area Managers on a monthly basis what initial assessments are required to be workload managed. Area Managers are responsible for deciding which initial assessments will be workload managed. The Area Manager then provides monthly written advice to the Regional Director about these decisions.

In one such report from the Gold Coast Area Manager to the Regional Director of the Gold Coast region, dated 2 May 2001, the Area Manager stated as follows:

> I would advise that I am concerned by the level of risk that the Gold Coast Area Office is carrying due to its inability to assess these notifications given significant workload constraints.
>
> Indeed without a comprehensive assessment to inform appropriate intervention strategies for category 2 children, it should be noted these children remain vulnerable to serious emotional or physical injury.

It should be noted that although PM00/03 only took effect from 6 March 2000, a workload management strategy has in fact been operating within DOF since 1995. A policy memorandum issued in January 1995 formally implemented the strategy. It was called the *Child Protection Workload Management Strategy*, and provided a procedure to manage and process notifications that could not be responded to within an appropriate period due to workload demands and resource issues. However, this prior document did not include reference to the professional decision making process for prioritising responses and determining which initial assessments would be undertaken.

The Gold Coast Area Office was able to provide me with information as to the number of matters workload managed in 1999 and currently. According to this data, during 1999 between three and 18 matters were written off each month. During 2001, between six and 16 matters have been written off each month.

5.5 Analysis of evidence gathered

5.5.1 Receipt of notification

The SCAN doctor stated that he had great difficulty getting through to DOF. However, the arrangements for receiving telephone calls, both within DOF and within the Gold Coast Area Office specifically, seem to be adequate. When callers telephone the Gold Coast Area Office outside business hours, they are directed to the 24-hour Crisis Care service. During business hours, two DOF officers are available to answer calls on five telephone lines and a recorded message is played to all callers whose calls are not immediately answered, asking them to wait. The SCAN doctor may have had to wait for an available operator but his call should have been answered within a reasonable period of time.

The extent of information recorded by DOF upon receiving the SCAN doctor's notification appears to be in accordance with the information the Gold Coast Hospital would have been able to provide except in two areas.

Firstly, the internal review officer suggested that more details as to the severity of the abuse might have been helpful for the DOF officers making the initial assessment. The Gold Coast Area Office was aware that Brooke had bruising to her finger, around her face and on her lower abdomen. It is unclear whether the hospital could have provided any better information than this, except to say that the bruising was 'extensive' or 'severe'.

The intake officer recorded that the injuries occurred while Brooke was in the mother's partner's care, and that there was a concern the injuries were non-accidental. Perhaps the SCAN doctor could have better expressed the hospital's concerns, given that the examining doctors had concluded there was no other possible cause than abuse. However, the level of alleged harm described by the SCAN doctor was sufficient for the Gold Coast Area Office to determine that Brooke's notification should be rated in the most urgent category. Also, the FSOs appear to have demonstrated an appropriate amount of concern for Brooke's situation. It is unlikely that further details as to the severity of Brooke's injuries would have better assisted the FSOs during the initial assessment process.

The other area in which more information might have been provided is the circumstances in which Brooke was removed from the Gold Coast Hospital. My officers asked both FSOs during the formal interviews whether their suspicions had been raised because of the circumstances in which Ms A removed Brooke from the hospital. FSO X stated:

> …we didn't have any information. There was a suggestion that it was against the hospital's advice but I don't know if she was told that or if it was against the hospital's intention that the child be removed…We weren't privy to what exactly were the circumstances of (Ms A) removing (Brooke).

> Had she sneakily gone in and just grabbed Brooke and left the hospital or had she gone with their consent? We just weren't aware of that.

FSO Y stated:

> All the information we had was that at 7.00am that morning she'd left with the child. I don't even know whether she discharged the child officially or whether she just took the child off the ward…The concern for us was that she was aware that this child had suspicious injuries and, for whatever reason, decided to take that child away from the hospital. So there was an issue of the possibility of her not acting protectively.

It appears from this evidence that either the SCAN doctor did not explain, and was not asked to explain, the exact circumstances of Brooke's removal, or the Intake Officer did not record this information. The Gold Coast Area Office should have been made aware that Ms A did not consult hospital staff about discharging Brooke and that she removed Brooke from the ward in a deceptive and deliberate manner. If the FSOs had been provided with this information, it may have heightened their concerns in relation to the mother and raised further doubt about the mother's ability or willingness to protect her child. However, in my opinion, this would not necessarily have altered the decisions made in relation to Brooke's initial assessment for reasons given later in my analysis.

Upon receiving the notification, the Intake Team Leader rated the notification in the most urgent category and arranged for two FSOs to commence an initial assessment immediately. Within an hour of the SCAN doctor's telephone call, two FSOs had arrived at Ms A and Brooke's address. Given Brooke's age and the nature of her injuries, I would agree that this was an appropriate initial response.

5.5.2 Investigations

The two FSOs who were sent to assess Brooke's situation maintain that they requested the Gold Coast JAB's attendance for the visit. Indeed, the evidence is that this is DOF's normal practice in relation to matters where a criminal offence may have been committed. It is certainly good practice.

QPS does not actually dispute that the request was in fact made, although the JAB officers on duty at the time say they have no recollection of the call and there is no written record of it. QPS maintain that, if the request had in fact been made, JAB would have responded if the matter had been conveyed by DOF as being urgent. The evidence does not indicate the degree of urgency conveyed by the DOF officer during the call to the JAB officer or the appropriateness of the response that JAB assistance was unavailable.

If an experienced police officer had attended the visit to the Back Street unit with the DOF officers, the search for Ms A and Brooke may have been more successful. However, FSOs X and Y, who are not investigators, did not have that assistance. In those circumstances, I am of the view that they took reasonable steps to attempt to locate Brooke. I say this on the basis of their unchallenged evidence that:

- They knocked on the front door of the unit and received no reply. However, they took further steps to explore the possibility that someone might in fact be home. That is, they made inquiries with the adjacent neighbour, asking her if she knew whether somebody might be home next door. These inquiries led the two FSOs to the open back door.

- Despite some misgivings and doubts as to whether they were legally entitled to do so, one of the FSOs entered the unit through the open back door and checked to see if Brooke or someone else was there.

- FSO Y found the note indicating Ms A had removed Brooke from the threat.

- After finding the note, the FSOs did not immediately leave the units. Instead, they went downstairs and carried out a search of the grounds and surrounding areas in case Brooke and Ms A were in the vicinity.

Obviously, the FSOs' searches did not locate Ms A and Brooke's hiding place. Even if the FSOs had located the laundry, Ms A said that she had locked the door. Therefore, the available evidence suggests that the extent of their search was reasonable in the circumstances.

After failing to find Ms A and Brooke, the FSOs were left with the evidence of the note they had found inside the unit, written by a female person to 'Troy'. The information DOF had been given by the hospital was that Brooke's mother's christian name was a name other than the name written on the note. However, the FSOs reasonably concluded from the contents of the note and what they had been informed about Brooke's circumstances that Brooke's mother was the author of the note, and that the note was addressed to her de facto partner (the alleged abuser).

According to the FSOs, Ms A told Mr Self in the note that she believed he had injured Brooke, and that she was leaving the relationship because of this. There was no reason for the two FSOs to suspect that Ms A had written the note to deliberately mislead them into thinking Brooke was safe. They say they believed the note was a genuine communication from Ms A to Mr Self and that it was likely Ms A had moved out of the unit in order to protect Brooke from any further abuse by her partner. Ms A confirms the note expressed her true intention at the time she wrote it.

Given this information, the FSOs made further inquiries in an effort to find an alternative address for Ms A and Brooke. They contacted the hospital and QPS, as well as searching all the child protection information systems they had access to. No record of a more recent address was found.

As the FSOs were unable to complete their initial assessment of Brooke that afternoon, they returned to the office and informed the Intake Team Leader of what had occurred. They advised the Intake Team Leader they had been unable to locate Ms A or Brooke and had found evidence to suggest Ms A and Brooke had in fact moved to a new, unknown address. It was then for the Intake Team Leader to decide what further action would be taken. The FSOs had no further involvement in the matter and moved on to other urgent cases.

The evidence I have gathered does not support the complainants' allegations that the FSOs did not properly investigate the factual situation in relation to Brooke's welfare, or that they did not make reasonable attempts to establish Brooke's whereabouts or follow up on their concerns for her welfare. The complainants' also alleged that the FSOs made incorrect assumptions based on insufficient evidence. The 'assumption' made by the FSOs that afternoon was that it was *likely* Ms A and Brooke had moved out of the unit. However, the FSOs have never asserted that they were certain of this fact. The assumption was largely based on the note they found. The FSOs acted on this assumption in searching for another address for Ms A and Brooke.

The evidence obtained supports the view that the FSOs acted reasonably in making the assumption that Ms A had removed Brooke from the situation of risk and making their supervisor aware of the basis of their assumption.

5.5.3 Leaving information for Ms A

Both FSOs gave the same explanation as to why they did not leave any information at the unit for Ms A during their visit.

Given the nature of the allegations in relation to Brooke, the FSOs were aware that QPS might become involved. Therefore, the FSOs did not want to tip off Mr Self, who was the alleged

perpetrator of the abuse suffered by Brooke, that DOF was investigating the matter. I accept that the FSOs needed to speak to Ms A and Brooke prior to alerting Mr Self to their involvement.

The information the FSOs had from the note was that it was Mr Self's unit and Ms A and Brooke no longer resided there. They assumed that if they did leave a card at the unit, it would be Mr Self who received it. The FSOs did not want to alert Mr Self in this way and had no reason to speak to him about the allegations, as that was strictly a matter for QPS.

The FSOs also explained why they did not leave any contact details with the neighbour they spoke to that afternoon. Essentially, they stated that DOF operates on a strictly confidential basis when investigating allegations of abuse against children. FSOs do not identify themselves to neighbours as DOF officers, so as not to alert them to the fact that allegations of abuse are being investigated. Therefore, the FSOs would not leave contact details with a neighbour, as this would mean identifying themselves as persons from DOF.

The decisions made by the FSOs not to leave information at the unit or contact details with the neighbour were made with the benefit of their many years of experience.

The evidence gathered supports the view that their actions in this regard were reasonable in the circumstances.

5.5.4 Decision not to take further action

Once the initial assessment had been completed, or attempts had been made to complete it, the FSOs reported their findings to the Intake Team Leader in accordance with DOF's procedures. It was then for the Intake Team Leader to determine what further action, if any, DOF would take in relation to the matter.

The Intake Team Leader decided to refer Brooke's case to the Gold Coast SCAN team for discussion. The Team Leader then discussed the case with the Gold Coast Area Manager. This is when the decision was made not to take any further action in relation to the matter.

The reasons for this decision were explained somewhat in the written referral prepared by the Gold Coast Area Office to be provided to the Gold Coast SCAN team. Under the heading 'Assessment', the referral noted two things:

1. "Unable to complete investigation as whereabouts of mother and child unknown."
2. "Mother appears to have taken appropriate action by leaving partner."

The Gold Coast Area Manager advised that the decision was made in accordance with the Child Protection Procedures Manual, which provides that DOF is not required to take further action to assess notifications that are unable to be completed because of 'client reasons', such as an inability to locate a family. To make this decision, the Area Manager had to be satisfied that all reasonable steps had been taken to complete the assessment. The Manual states that in determining what is reasonable, the Area Manager must take into account the general circumstances, the level of alleged harm, and any factors making the assessment difficult to complete.

The Area Manager advised my Office in writing that he had considered a number of factors when taking these matters into account. The evidence provided by the note found in the unit, which suggested that Ms A and Brooke had moved out of the unit, was one of these factors. It led the Area Manager to the belief that Ms A had acted protectively to remove Brooke from the situation, which would have made the risk of further harm to Brooke less likely. Given the belief that Ms A and Brooke had moved out of the unit, another factor taken into account was the attempts already made by the FSOs to obtain an alternative address for the family, all of which had been unsuccessful. The Area Manager also stated that a significant factor in deciding whether all reasonable steps had been taken was acute resourcing issues. He explained that the Gold Coast

Area Office Intake Team was operating under considerable workload pressure due to a lack of resources, which was making assessments difficult to commence or complete.

Therefore, the Area Manager made a decision that all reasonable steps had been taken to complete the assessment in relation to Brooke, and no further action was required. It appears that all procedures were properly followed in the lead up to this decision (i.e. the Team Leader consulted with the Area Manager and a decision was made to refer the case to the Gold Coast SCAN team[76]). DOF stated that it agrees officers acted in accordance with the policies and procedures of the day[77].

However, regardless of whether policy was followed or not followed, what must be determined is whether DOF's decision not to take any further action in relation to Brooke was reasonable. The evidence indicates that the two most significant factors that influenced the decision not to take further action were the evidence of the note and the workloads of the officers at that time.

The issue as to whether DOF, in deciding to take no further action, should have relied on the evidence of the note is raised in the complainants' allegations. The complainants alleged that DOF officers made (incorrect) assumptions based on insufficient evidence.

The circumstances in which the note was found led DOF officers to believe that the note was a genuine communication between Ms A and Mr Self. This belief was correct. DOF officers also believed that Ms A had acted protectively and left the relationship. Unfortunately, this assumption was incorrect. In fact, Ms A remained in the relationship and she and Brooke continued to reside in the unit with Mr Self until Brooke's death.

The Area Manager has conceded that as a 'best practice' response, more evidence should have been sought as to whether Ms A had in fact left the relationship and moved out of the unit. However, there is reliable evidence to suggest that the Gold Coast Area Office Intake Team was operating under significant workload pressures. The Area Manager and the FSOs have submitted that given this fact, they could not afford to devote over-stretched resources to further investigation and were forced to rely on the evidence at hand.

I will discuss the question of workload pressures shortly. This decision of the Gold Coast Area Manager, in consultation with the Intake Team Leader, also highlights a problem with the decision-making process DOF was required to follow. Based on the available evidence, DOF's officers concluded that Ms A had taken action to protect Brooke from further harm. The Area Manager was then required to assess, among other things, the level of alleged harm. He concluded that the risk of future harm to Brooke was low. It was this conclusion which then allowed the Area Manager to make the decision, in accordance with DOF's policy, that no further action was required to be taken.

As was argued by the internal review officer, the question of whether Brooke was at risk of further harm was a decision about her safety, of which the only possible answers were essentially either 'Yes, she is safe' or 'No, she is not safe'. Based on the assumption that Ms A had acted protectively, DOF decided that Brooke was safe from further harm.

However, even if Ms A had left Mr Self as the note stated, Brooke's safety was conditional upon her mother maintaining her protective behaviour (i.e. staying away from her partner). Hence, the internal review officer believed that DOF should be asking different questions when deciding whether to take further action in relation to a matter. The officer suggested a 'safety assessment system', whereby the question to be asked is whether the child is 'safe', 'conditionally safe' or 'unsafe'. Under such a system, DOF would be required to monitor 'conditionally safe' children until they could be considered 'safe'.

76 See Part 6 of this report for further discussion regarding DOF's referral of Brooke's case to the SCAN team.

77 DOF's response to provisional report, dated 11 January 2002.

If such a safety assessment system had been in use at the time of Brooke's notification, she would have been considered 'conditionally safe'. DOF would have been obliged to take further action to ensure that Ms A had the intention and the means by which to remain away from that relationship.

Of course, as the internal review officer was careful to point out, the individual DOF officers involved in Brooke's case were not required to make such a safety assessment. The decisions that were made were in accordance with DOF's procedures and were decisions made within the context of the workload pressures that existed at the time.

In its response to my provisional report, DOF was requested to advise whether it agreed that its policies and procedures were inadequate in that they did not sufficiently address whether a child is safe. DOF replied that it did not agree with this conclusion. In support of this view, DOF made the following points:

> Chapter 11 (of the Manual) outlined procedures in relation to situations requiring urgent action that included:
>
> When a 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
>
> The Brennan case required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable. In these circumstances, the child's immediate safety would have been the primary consideration.

The procedures contained in chapter 11 of the Manual list 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, taking a child into temporary custody, emergency placement and hospitalisation. Obviously, these actions are only possible **during an initial assessment once the child has been located**. In Brooke's case, the DOF officers were unable to **commence** an initial assessment because they were **unable to locate Brooke or her mother**. Hence, the procedures contained in chapter 11 were not applicable. The relevant procedures followed in Brooke's case are contained in chapter 6, point 6.2 (iv) of the Manual (notifications for which initial assessments are unable to be commenced or completed because of 'client reasons').

In addition, I do not see how the last paragraph of DOF's submission supports its view that its procedures were adequate. If anything, it highlights the fact that DOF procedures were not sufficient to ensure the safety of a child who was obviously in need of protection.

I should mention at this point a matter I raised earlier, namely, the fact that DOF's officers were not aware of the exact circumstances of Brooke's removal from the Gold Coast Hospital. Although DOF was aware that Ms A had 'discharged' Brooke against the hospital's advice, DOF was not aware that Ms A did not consult hospital staff about discharging Brooke and had removed Brooke from the ward in a deceptive and deliberate manner. I suggested that this would have heightened DOF's concerns in relation to Ms A and raised some doubt about her ability to protect Brooke.

However, based on DOF's policy at that time, this would not necessarily have altered the decisions made in relation to Brooke's initial assessment. The reason I say this is that the evidence that Ms A had acted protectively towards Brooke was not the only factor that influenced the decision not to take further action. The other significant factor was the lack of resources to devote to the case.

5.5.5 Resourcing

Workloads and inadequate resources were frequently mentioned by DOF officers as reasons for not taking any further action in relation to Brooke. There is overwhelming evidence of the existence of severe under-resourcing in DOF's Gold Coast Area Office at the time of Brooke's notification.

Firstly, there are the findings of the internal review officer, who specifically researched the level of workloads within the Gold Coast Area Office Intake Team at that time. From this research, the internal review officer concluded that the Intake Team did not have sufficient resources to carry out the child protection work it was required to perform in accordance with DOF's obligations. This shortfall in resources amounted to about 350 hours per month, or the equivalent of three full-time FSOs. The internal review officer also reported that comparable offices in South Australia and Victoria operated with significantly smaller average caseloads than the Gold Coast Area Office.

Clearly, the internal review officer felt strongly about this lack of resources and its effect on child protection work. He considered that workloads at the time of Brooke's notification were too excessive to provide real safety for children.

These internal review findings were presented to this Office by DOF as part of its initial report to this Office in response to the complainants' allegations. DOF has not sought to make any further submissions or comments upon the internal review officer's findings in relation to resourcing within the Gold Coast Area Office. These findings remain unchallenged.

However, DOF was specifically asked to comment upon whether it agreed with the internal review officer's findings in relation to comparable caseloads in other jurisdictions[78]. DOF stated:

> There are significant differences between the states in how child protection matters are defined and therefore counted. The definition of what constitutes a "case" varies and as such, is difficult to compare.

DOF went on to explain that in 2001, a new methodology called the 'Work Activity Profile' was developed to assess workloads across all Area Offices. Unfortunately, this method of measuring workloads was not available at the time of the internal review into Brooke's case. Also, it is unclear whether this method could effectively be compared with workload measures in other States. Therefore, DOF was unable to provide any evidence to confirm or refute the internal review officer's findings in relation to comparable workloads in other jurisdictions.

There is also the evidence of the two FSOs involved in Brooke's initial assessment. Clearly, the FSOs felt that, at the time, they did not have sufficient resources to properly investigate child protection matters to a reasonable standard. More than a year prior to Brooke's notification, the FSOs within the Gold Coast Area Office Intake Team had brought to the attention of regional management the effect that this workload pressure was having on child protection work and on staff members personally. Yet from the time of that memo until the time that Brooke's notification was received, no additional resources had been made available to the Gold Coast Area Office Intake Team to assist in addressing those workload issues.

The Gold Coast Area Manager's written advice to my Office is strongly indicative of significant resourcing problems within the Gold Coast Area Office at the time of Brooke's notification. The Area Manager's opinion, which should be given considerable weight given his position and responsibilities at the time, was that the Gold Coast Area Office Intake Team was inadequately resourced and could not provide service beyond a 'minimalist' level.

78 As part of its response to the provisional report.

The evidence obtained during my investigation to date clearly supports the Gold Coast Area Manager's opinion and the findings of the internal review officer. Firstly, there is the data provided by the QPSU, which shows that at the time Brooke's notification was received, the Gold Coast Area Office Intake Team had 252 other initial assessments which either had not been commenced or required completion. The evidence from the FSOs and the Area Manager was that many of these outstanding notifications would have also required similar urgent responses. The data provided by DOF did not contradict this evidence. Therefore, it appears the Intake Team did have a significant workload to attend to at the time of Brooke's notification.

The QPSU and DOF both provided data in relation to the number of notifications that were received and the number of outstanding initial assessments that existed across a number of DOF area offices. This data shows that the Gold Coast Area Office had the highest number of notifications during that period and the highest number of outstanding initial assessments. However, as my Office was unable to obtain any information in relation to the comparative staffing levels within these Area Offices, I have been unable to compare workloads within the Gold Coast Area Office Intake Team with those within other Area Offices. Therefore I can not make any comment in relation to DOF's coordination of workloads across the various regions.

The Intake Team Leader also prepared a memo dated 12 April 1999, which shows that at that time, workload issues were seriously affecting the Intake Team's ability to meet DOF's practice standards for completion of initial assessments.

There is also the comparative analysis of the number of notifications received by the Gold Coast Area Office over a certain period during 1999 and 2001. The number of notifications received during that period in 1999, as compared to 2001, was approximately the same. However, the level of resources within the Gold Coast Intake Team was significantly lower in 1999 than in 2001. In fact, it was less than half. Effectively, the Intake Team was required to perform the same amount of work in 1999 with five and a half FSOs, as it is required to perform now with twelve FSOs.

There is evidence that, even now, workload pressures are affecting the ability of the Gold Coast Area Office Intake Team to effectively carry out child protection work. The FSOs and the Gold Coast Area Manager have given evidence to this effect. The Area Manager expressed his concerns in relation to the matters that were workload managed within the Gold Coast Area Office. The Intake Team is still 'writing off' matters (i.e. not commencing or completing initial assessments) because of a lack of resources. As the examples provided at 5.4.5 show, these are not insignificant matters. They are matters where children have been assessed to be at high risk of future significant harm.

These examples of matters that are 'workload managed' have been drawn only from the Gold Coast Area Office. However, the Specific Workload Management Strategy under which the Gold Coast Area Office writes-off these matters is an official DOF policy which is currently operational statewide.

In my opinion, the evidence outlined above suggests that inadequate resourcing was a significant factor in the decision not to take any further action in relation to Brooke's case and that resourcing for the Gold Coast Area Office may still be inadequate.

DOF was provided with a copy of my provisional report, which contained all the evidence set out above in relation to the apparent lack of resources within the Gold Coast Area Office. DOF was invited to address the resourcing issues I had identified and was specifically asked a number of questions in relation to these issues.

Firstly, DOF was asked whether it agreed that, at the time of Brooke's notification, the Gold Coast Area Office was not adequately resourced to meet its statutory obligations under the *Children's Services Act*. DOF's response was as follows (in full):

> The issue of the adequacy of resources is a matter for the Government. In relation to resources, the role of DOF includes:
>
> - the management of available resources; and
> - the provision of all necessary information to enable the Minister to advocate for resources.

Secondly, DOF was asked whether it agreed that lack of resources was a significant factor in the decision of the Gold Coast Area Intake Team to take no further action in relation to Brooke's notification. DOF's response was as follows (in full):

> The decision not to take any further action was in accordance with the policies and procedures of the day and was subsequently endorsed at the SCAN Team meeting on 22 July 1999. Members of the SCAN Team meeting included QPS, DOF, QH and Education Queensland.

As can be seen from these answers, DOF did not confirm nor refute the suggestion contained in my provisional report that, at the time of Brooke's notification, resourcing within the Gold Coast Area Office was inadequate. Further, DOF did not directly respond to the question whether the lack of resources significantly impacted upon its decision not to take any further action in Brooke's case.

I therefore provided DOF with a further opportunity to comment upon this issue. By letter dated 12 February 2002, I asked DOF the following question:

> I queried whether DOF agreed that, at the time of Brooke's notification, the Gold Coast Area Office was not adequately resourced to meet its statutory obligations under the Children's Services Act. As you are aware, the issue of resourcing was offered by your FSOs, the Area Manager and the internal reviewer when they were interviewed by my officers as a significant reason for the administrative conduct that took place in this case. The point of the question was to determine whether DOF agreed with their assessments that resourcing was a significant factor in the decisions that were made in that the Gold Coast Area Office was under-resourced compared with other Offices throughout the State, having regard to their respective workloads. The question did not relate to general resourcing provided by the Government to DOF.

DOF's response was as follows:

> DOF is unable to identify any substantive evidence to indicate that the issue of resourcing was a significant reason for the administrative conduct that took place in this case and/or a significant factor in the decisions that were made.
>
> As outlined in the response dated 11 January 2002, the decision not to take any further action was in accordance with the policies and procedures of the day and was subsequently endorsed at the SCAN Team meeting on 22 July 1999.
>
> In the absence of a reliable tool to provide an overview of the Area Office activity and workload to staff ratios at the time of Brooke's notification, DOF is unable to respond further in relation to the resourcing and workloads of the Gold Coast Area Office.

Although my provisional report contained significant evidence of a critical lack of resources within the Gold Coast Area Office at the time of Brooke's notification, DOF stated that it was **unable to identify 'any substantive evidence'** that the issue of resourcing was a significant factor in the decisions that were made in Brooke's case. This response fails to acknowledge and address the evidence of the Gold Coast Area Manager and the FSOs, who were the primary decision-makers, that the lack of resources within the Gold Coast Area Office was a significant factor in the actions taken and decisions made in Brooke's case.

I also asked DOF to comment upon whether its offices were now adequately resourced to effectively discharge its child protection responsibilities under the *Child Protection Act*. DOF again stated that the issue was 'a matter for the Government'. DOF provided some information in relation to the amount of funding it had been allocated and advised that there had been significant

increases since 1999/2000. However, the figures DOF provided are, on their own, incapable of any analysis to determine whether DOF is now adequately resourced to fulfill its child protection obligations.

In my opinion, the evidence I have gathered suggests to me that inadequate resourcing of the Gold Coast Area Office at the time of Brooke's notification was indeed a significant factor in the decision that was made not to take any further action to locate Brooke.

5.5.6 DOF'S internal review and report

The manner in which the internal review was conducted appears to be substantially in accordance with DOF's policy PM95/17. However, my investigation has revealed that the following procedures were not followed:

1. PM95/17 provides that the internal review must be carried out by a review team consisting of a minimum of *two* DOF officers external to the region. In this case, only one officer conducted the review.

2. PM95/17 provides that individual staff members must not be named in the report. In this case, individual staff members were named.

3. PM95/17 provides that once the review is completed, staff members who were interviewed as part of the review must be invited to comment on and/or discuss the draft report. This allows for alterations to the report to be made in relation to matters of fact, or, at the discretion of the reviewing officers, in relation to other aspects of the report. The two FSOs whose actions were the subject of the review in relation to Brooke's case, and who were interviewed as part of the review, were not invited to comment on and/or discuss the draft report. The two FSOs also say that they were never provided with a copy of the report or allowed access to the report, and had not read any part of the report prior to being interviewed by my officers on 2 August 2001. There were a number of errors contained within the report in relation to the facts of the case, which caused some confusion during the course of my investigation. The FSOs were able to point out these errors during their interviews with my officers. Obviously, if the FSOs had been invited to comment on the draft report as required by PM95/17, these errors would have been corrected prior to the internal review report been finalised.

4. PM95/17 states that the individual staff members who were involved in the matter under review must be provided with appropriate and timely support and debriefing services. It is the responsibility of the Regional Manager to ensure that this occurs. In contrast, both FSOs advised my officers that they were not debriefed about Brooke's case at any time after her death, and have not been provided with any information about the circumstances of her death or other related matters, apart from what has been reported in the media.

As part of its response to the provisional report, DOF was invited to comment upon whether it considered the internal review was adequate and was carried out in accordance with its policy. In response, DOF conceded that the following procedures were not followed:

- The review should have been conducted by a minimum of two departmental staff members. It would appear that only one officer was involved.

- Section 8.1 required that the panel "determine the facts, establish findings and make recommendations". The report contains many personal observations of the reviewer with only one recommendation.

- Individual staff members were named in the report whereas the policy specifically stipulated that they should not be named.

- Section 8.5 allowed for other agencies or professionals to be consulted "in order to fully review departmental procedures". Although safety assessment was mentioned on numerous occasions in the report, it does not appear that the reviewer consulted senior policy officers. Further, both health and police personnel were mentioned in the report and neither agency appears to have been approached by the reviewer.

- There was no information to suggest that the report was provided to staff who had been involved in the review or that their comments had been incorporated in the final report.

DOF further stated: 'Notwithstanding these issues, the report clearly identified the facts of the case, provided sound analysis of the issues and remains a valuable resource for DOF'.

However, DOF failed to comment upon my fourth observation above, regarding the failure by DOF to provide the officers involved in the matter with appropriate and timely support and debriefing services.

DOF is also impliedly critical of the internal reviewer for including in the internal review report his 'personal observations' and making only one recommendation. However, his 'personal observations' were based on his knowledge and experience of child protection issues within DOF and elsewhere. DOF did not identify any specific findings or observations within the internal review report that it disagreed with.

A further comment by DOF related to the extent to which the internal review officer consulted other persons as part of the review. DOF referred to section 8.5 of PM95/17. This section states (in full):

> 8.5 Other agencies or professionals may be consulted in order to fully review departmental processes. In doing so it must be clear that the review does not include the actions of those persons/agency.

DOF has suggested that, in accordance with this section, the internal reviewer should have consulted senior agency personnel regarding policy issues, and should also have consulted health and police personnel as they were mentioned in the report. With respect, I do not agree with DOF's view in this regard. It is clear that section 8.5 provides for consultation with **external** agencies and professionals **if this is required in order to fully review departmental procedures**. The section does not envisage consultation with internal DOF personnel. In fact, no where in PM95/17 is it suggested that the internal reviewer should consult with senior DOF personnel before making any comments or recommendations in relation to policy issues.

In my view, other than the procedural issues identified above, the internal review was conducted professionally and effectively. The internal review officer had extensive experience in child protection matters and was an appropriate, well-qualified person to conduct such a review. However, I should note that the failure to observe the policy in this case did cause me some concern, particularly in relation to the failure to provide feedback to the FSOs concerned. Although I appreciate that this policy has now been replaced by a new policy that requires the reviewer, in some cases, to be external to DOF, I will be making a recommendation to DOF that it put procedures in place to ensure that feedback and support are provided to officers whose actions are the subject of a review.

The internal review was limited to just that, a review of the conduct of persons within DOF. The investigations carried out by the internal review officer involved interviewing the two FSOs and the Intake Team Leader, as well as reviewing the material documented by DOF on its electronic recording system. I consider that these investigations were adequate for the purpose of the review.

In my opinion, the evidence obtained during my investigation did not support the complainants' allegations that the internal review was inadequate in that it should have revealed shortcomings in DOF's initial assessment and investigation of Brooke's circumstances. My opinion relates to the standard of professionalism exhibited by the relevant DOF officers in making decisions about the

case. The two main problems identified by the internal review were inadequate procedures and a lack of resources. To his credit, the internal review officer did not shy away from making these findings.
I consider the findings made by the internal review officer were appropriate, well researched and well reasoned.

5.5.7 DOF'S reponse to the internal review's findings

During the interview conducted by my officers with the internal review officer[79], he was asked to comment upon DOF's response to the findings of his internal review, and in particular to his recommendation that a new safety assessment system be introduced within DOF. The internal review officer made the following comments:

> There wasn't any immediate action as a result of this recommendation except that the Regional Director did contact me to say that he was passing this on to the Office of Child Protection…
>
> I then went and worked in that office…and I continued to strongly advocate for the introduction of safety assessment and to express my concerns about the safety, the way that the department was dealing with safety. Now, after a long and complicated history of discussions, let's put it that way, at the beginning of this year, the Deputy Director-General…decided to introduce safety assessments in the Department. I drafted up a version of this, which has gone to the Office of Child Protection, and there has been further work done on that.
>
> So there is now in existence a draft procedure and assessment framework that is being developed and I understand that it is to be piloted, subject to funds, in the Gold Coast region and possibly two others…
>
> So there has been some slow progress towards this.

The internal review officer was also asked to comment upon whether there were any procedures in place within DOF currently that would require DOF officers to carry out initial assessments and make decisions any differently from the time of Brooke's notification in 1999. The internal review officer stated:

> Required, no. There was a document that came out in 1999…regarding safety and risk at the point of initial report, which is more in the line of a guidance document, so it's not mandatory. It doesn't actually step through a particular procedure that they have to follow, but it does embrace the safety issues that previously probably hadn't been made that explicit. You're right in saying, as I understand it, there wouldn't be anything as of now that was probably different. That is the point of the new pilots that are about to be embarked upon.

The two FSOs who were interviewed by my officers stated that they were also unaware of any new procedures or requirements that had been implemented within DOF subsequent to, or as a result of, Brooke's case.

When provided with the provisional report, DOF was specifically invited to comment upon the actions it had taken in response to the internal review report. DOF was asked to explain why the safety assessment system recommended by the internal reviewer in September 1999 had not been implemented. In response, DOF made the following comments:

> Upon receipt, the internal review report particularly the recommendation in relation to the safety assessment system was contested by senior officers at the time. Nevertheless, the following has occurred since that time:
>
> - In October 1999, DOF published A Practice Guide: For the Assessment of Harm and Likely Harm. This Practice Guide currently being used by child protection staff includes the concept of safety as a critical feature of assessment.

79 On 2 August 2001

- In May 2000, DOF commenced significant work to reform Queensland's child protection service system. The Child Protection Service System Improvement Project (CPSSIP) addresses every element of the system, from notification of harm to children to the type of intervention required when it is determined that children have been harmed.

- The overall objective of CPSSIP is to improve the efficiency and effectiveness of the child protection service delivery system. In consultation with Queensland Treasury, DOF has developed a five year reform plan to address the service delivery framework, both in terms of a viable and stable alternative care network and in developing a range of interventions directly linking assessment of client needs with the type and level of intervention. In addressing the more critical issues of the service delivery system within the first few years, the capacity of DOF to then focus increasingly upon effective prevention and early intervention strategies (particularly in partnership with the non-government sector) will be enhanced.

- In October 2001, the pilots of regionally based specialist intake teams in the Gold Coast, Central Queensland and Toowoomba and South West Regions commenced using a new intake tool to determine child risk, harm and safety (Safety Phase 1).

- During 2001-02, CPSSIP will evaluate and revise the pilots and determine whether to retain, make changes to, or extend pilot sites.

- During 2001-02, CPSSIP will develop a new investigative tool to determine child risk, harm and safety (Safety Phase 2).

- During 2001-02, CPSSIP will develop family strengths/needs assessment capacity.

By letter dated 12 February 2002, I asked DOF to provide me with further information in relation to its claim that the report was 'contested by senior officers'. DOF explained as follows:

> Upon receiving the Internal Review Report, senior officers in the former Office of Child Protection reviewed the report.
>
> Senior officers identified that the Safety Assessment tool referred to in the report was a very specific tool dealing with concepts of immediate safety and danger. This tool did not assess factors relating to significant harm or on-going risk to the child. If implemented in the specific form recommended, this tool would not have integrated well with the Queensland policy and practice framework of assessing and responding to immediate danger, significant harm and on-going risk factors.
>
> Subsequent advice received from the South Australian Department revealed that after using the Safety Assessment tool for a number of years, it considered that 'danger-focussed' safety assessments had led to a number of near miss situations and deaths when risk should have been the driving indicator in the assessment.
>
> These learnings from South Australia have informed the development of the Assessment of Risk, Harm and Safety Phase One tool being piloted in the Regional Intake Teams (RITs). This tool integrates the concepts of safety, harm and on-going risk and assists the worker in forming a more comprehensive assessment of a child's need for protection.
>
> Further, senior officers identified that the review did not follow the procedures outlined in the policy in relation to the conduct of reviews as at September 1999 being PM95/17. Refer to the previous reply by DOF dated 11 January 2002.

I also asked DOF to provide me with a copy of its *Practice Guide: For the Assessment of Harm and Likely Harm* (the Guide). A copy was provided with DOF's response to my letter of 12 February 2002. In the introduction to the Guide, the following summary is contained under the heading 'Use of the Practice Guide':

> 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)
- 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
- 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
- the level or degree of harm experienced or likely to be experienced by the child or young person.

The Guide was published in October 1999 and it is clear that it could not have been created as a reaction to the internal review report, which was dated 14 September 1999. In fact, from my perusal of the Guide, it appears the procedures for assessment are unchanged from the procedures that were contained in the Manual and followed in Brooke's case. The Guide makes no reference to the internal review report and the report's recommendation for safety based assessments.

However, it does appear that some further steps have been taken since this time to review DOF's child protection procedures and incorporate the concept of ‘safety assessment’ put forward by the internal reviewer. I note that although DOF indicated there was some resistance to the internal reviewer's recommendation in relation to safety assessments, it appears further investigations were carried out and a determination was made to incorporate the concept of ‘safety’ into DOF's assessment processes.

DOF advised that in May 2000 (ten months after Brooke's death), it commenced work on the Child Protection Service System Improvement Project (CPSSIP) to reform Queensland's child protection service system. DOF explained that a five-year reform plan had been created in consultation with Queensland Treasury. However, it is unclear exactly what reforms are envisaged by DOF as part of the CPSSIP. The only information made available to this Office is that contained in DOF's response to the provisional report, as set out above.

DOF further advised that in October 2001 (more than two years after Brooke's death), it commenced pilots of regionally based intake teams (RITs) using a new intake tool, referred to as the *Assessment of Risk, Harm and Safety Tool Phase One*. In its further advice to this Office in response to my letter of 12 February 2002, DOF explained the framework for this new intake tool. DOF advised that the tool represents one stage in a series of interrelated reforms to be carried out as part of the CPSSIP.

However, despite my request to be provided with copies of any manuals or other documentation relating to the implementation and use of the new intake tool, none were provided. DOF explained that the tool was ‘in draft form only and supporting documentation is likely to be significantly reviewed and amended’. It was therefore not possible to make an independent assessment of the tool to determine whether it incorporates any of the internal reviewer's suggestions in relation to ‘safety assessment’.

I will note that the following is apparent from DOF's response:

- The new intake tool is **only used upon intake**, to determine what priority is given to notifications. It does not relate to assessments at any other stage of child protection work (e.g. at initial assessment stage). The new intake tool will be evaluated at the end of June 2002.

- During 2001/2002, DOF will develop a new *investigative tool* to determine 'child risk, harm and safety'. This will be *Safety Phase Two* of the CPSSIP reforms. There is no indication as to when this tool will be ready for implementation.

I have therefore formed the following views from my perusal of this material:

- **There was no immediate action taken by DOF to implement the internal review report's recommendation or to otherwise make changes to DOF procedures in relation to child protection.**

- **DOF has commenced a project (the CPSSIP) to reform its child protection service system. The extent of this reform, or how it will impact upon DOF's ability to carry out its statutory responsibilities in relation to child protection, is unclear. The reform process will be very protracted, as it is intended to occur over a period of five years. It was not until May 2000, ten months after Brooke's case highlighted a need for better procedures, that the CPSSIP was commenced.**

- **It was not until October 2001, more than two years after Brooke's death, that pilots of new procedures were commenced. Furthermore, these pilots relate only to *intake* procedures. In Brooke's case, the procedures that were identified by the internal review officer as lacking were those relating to the initial assessment process and decisions about further intervention.**

- **Currently, there are no new procedures in place within DOF that would require a different decision to be made if a case similar to Brooke's was to occur again. It is unclear whether, and if so when, such procedures will be implemented within DOF.**

5.5.8 Matters reported to the public

In March and April 2001 following the trial and conviction of Troy Self for Brooke's murder, the following articles appeared in the *The Sunday Mail* and *The Courier-Mail* about the DOF's handling of Brooke's case:

- Sunday Mail article on 11 March 2001 titled: *Why Did We Fail Little Brooke? Premier Demands Inquiry After Girl's Savage Murder.*

- Sunday Mail article on 25 March 2001 titled *Rules to Make Kids Safer.*

- Courier-Mail article on 27 March 2001 titled *System Neglects At-Risk Children.*

- Sunday Mail article on 1 April 2001 titled *Brooke: Probe of Two Departments.*

The articles variously stated that:

- The Premier would call for a report into DOF's failure to protect Brooke.

- The Families Minister would seek an urgent review of procedures.

- Future inquiries of children's deaths would be undertaken by persons independent of DOF.

- The Premier had called for an inquiry following Self's sentencing.

- DOF's internal inquiry had resulted in a strengthening of procedures.

- The Premier and the Families Minister had called for the inquiry.

Some parts of the articles could also have been construed by some readers as critical of the DOF officers who had handled Brooke's case. This may not have been intended by the authors of the articles, but they were interpreted in this way by the relevant officers in the Gold Coast Area Office.

I make the following comments in relation to the contents of those articles:

- DOF's internal review of Brooke's case was completed in September 1999 and DOF had been aware of its findings since that time. I am unaware of any other inquiry into DOF's handling of the matter except for my own. Certainly, DOF has not told me of any.

- The changes to procedures reported in *The Courier-Mail* article on 27 March 2001 appeared to refer to the same safety assessment system recommended in September 1999 by the officer who conducted the internal review.

- *The Sunday Mail* article on 1 April 2001 stated that: 'Department officers are now compelled to take action unless they are satisfied a child is safe'. At that time, the new safety assessment system had not been implemented or piloted.

The Minister for Families issued a media statement on 23 March 2001 entitled *Reviews to be Independent*. A copy of the statement is included in this report as Appendix M.

The Minister's media statement correctly explained how DOF's internal review of Brooke's case came about. It did not suggest that the review occurred as a result of any call for an inquiry from the Minister or the Premier following Self's conviction. The statement clearly explained that DOF's internal review of Brooke's case was undertaken 'under past arrangements' pursuant to which all cases involving the injury or death of a child the subject of DOF intervention, were reviewed internally by senior DOF officers.

Finally, any inference drawn from the articles that the FSOs involved in Brooke's case may have acted unprofessionally or incompetently is not supported by the evidence gathered during my investigation.

6 Analysis of SCAN team involvement

6.1 Evidence

Brooke's case was referred to the Gold Coast SCAN team by DOF, and was discussed at a meeting of the SCAN team on 22 July 1999, nine days after Brooke had been removed from the Gold Coast Hospital. The minutes record that the SCAN doctor was in attendance at this meeting, as well as representatives from DOF and QPS.

A copy of the minutes of the meeting was provided to this Office and has been included in this report as Appendix N (with names deleted). A copy of the written referral prepared by DOF and provided to the SCAN team was also provided to this Office. This document has been included in this report as Appendix O (with names deleted). Both documents conform to the standard formats contained in the Queensland SCAN Team Manual.

The following information was conveyed to the SCAN team by DOF in its written referral:

- Brooke's name, date of birth, and Brooke's mother's name.
- Brooke was admitted to the Gold Coast hospital with 'bruise on finger, bruising around face and on lower abdomen'.
- Brooke was allegedly with mother's partner when injuries occurred. Injuries not consistent with information provided by mother's partner. Mother's partner providing various explanations as to how injuries occurred.
- DOF visited Brooke's address the day following her admission to hospital, but no one was home.
- Back door of home was open and note sighted on door 'indicating that mother believed partner was responsible for child's injuries and as a result, had left partner'. No information as to whereabouts of mother or child.
- DOF telephoned hospital and SCAN doctor to ask for an alternative address. None was found.
- 'Assessment: Unable to complete investigation as whereabouts of mother and child unknown. Mother appears to have taken appropriate action by leaving partner.'
- 'Current case plan: No further departmental involvement at this point.'

The minutes of the SCAN team meeting indicate that the discussions held in relation to Brooke's case were consistent with, and did not expand upon, the information conveyed by DOF in its written referral.

The minutes further record that the SCAN team approved and recommended the following actions:

- 'Matter to be recorded as investigation unable to be completed.'
- 'Delete to SCAN.'

The SCAN team's recommendation was reported back to DOF. No further action was taken in relation to Brooke's case.

6.2 Inconsistencies

The SCAN doctor, in his statement to this Office dated 6 June 2001, initially reported the following in relation to the involvement of the SCAN team in Brooke's case:

> At the next meeting of the SCAN team I asked whether Brooke had been located. I was told she had not been. I said that it was an extremely important matter and every effort should be made to locate her. The next SCAN team meeting before the child died was the 17th or 18th of July 1999. At the meeting I raised Brooke's case again with DOF. They told me that a representative had gone to the house and found a note…

As part of my investigation, I requested QPS to provide me with copies of the minutes of any meetings of the Gold Coast District SCAN Team that were held in the period from 13 July 1999 to 25 July 1999. I further advised: 'I only require copies of those parts of the minutes that relate to Brooke Brennan'. In response, QPS supplied me with a copy of the minutes of the meeting held on 22 July 1999[80]. QPS advised that: 'there were no other meetings held during the period in question…at which issues dealing with Brooke Brennan were raised'.

It therefore appeared that, although the SCAN doctor had initially indicated two SCAN team meetings had been held between the time of Brooke's removal and the time of her death, in fact only one SCAN team meeting had been held.

My officers subsequently approached QH, outlined the evidence provided by QPS and requested QH to speak with the SCAN doctor and clarify what had occurred in relation to SCAN team discussions of Brooke's case.

By letter dated 12 September 2001, QH advised as follows:

> (The SCAN doctor) advises that the SCAN meeting in July would have been held on Thursday, 22 July 1999.

From this evidence, it was my understanding at the time I published the provisional report that only one SCAN meeting had been held at the Gold Coast during the period 13 July 1999 to 25 July 1999.

However, after completing my provisional report, I became aware of a further SCAN team meeting held **two days after Brooke's removal from the hospital and prior to the SCAN team meeting held on 22 July 1999**. This information was contained in the report of the Detective Inspector dated 24 January 2002 which was provided with QPS's response to my provisional report. The report contained the following statement:

> …and in fact (the Detective Senior Constable) coordinated the SCAN meeting on **15 July 1999** where the matter involving the child Brooke Brennan **was not raised by either DOF or the SCAN doctor.**

I subsequently requested QPS to provide me with a copy of the minutes of the SCAN team meeting held on 15 July 1999. This document was received on 1 March 2002. My perusal of the minutes confirms that Brooke's case was not listed on the agenda for discussion, and there is no notation or recording amongst the documents provided indicating that the matter was raised during the meeting. I note that the persons listed as being in attendance at the meeting included the SCAN

80 Received by this Office via facsimile on 20 August 2001.

doctor and representatives from the Gold Coast Area Office of DOF and the Gold Coast JAB (the DOF representative was not either of the FSOs who carried out the initial assessment in relation to Brooke).

I then wrote to the Gold Coast Area Manager of DOF outlining the evidence obtained from QPS regarding the SCAN team meeting on 15 July 1999 and requesting his further advice. By letter dated 4 March 2002, the Area Manager advised as follows:

> I advise that the Brooke Brennan matter was formally referred to the SCAN Team on 22 July 1999. The reason for this related to the way SCAN is managed on the Gold Coast. The SCAN agenda is set and distributed to workers for completion the Friday beforehand. Matters received after the Friday are set down for the following week.
>
> As per the above process, Brooke Brennan's matter was scheduled for 22 July 1999
>
> The above notwithstanding, I would also alert you to the fact that core members of the SCAN Team were aware of the situation in relation to Brooke Brennan by 15 July 1999 and thus had the opportunity for input into decision making.

It is appropriate that I now consider this additional evidence.

6.3 Analysis of evidence gathered

6.3.1 SCAN Team meeting of 15 July 1999

I am concerned that I was not informed of the SCAN team meeting held on 15 July 1999 until after the completion of the provisional report.

I accept that my initial request to QPS for copies of the minutes of any SCAN team meetings held during the relevant time included the proviso that I only required copies of 'those parts of the minutes that relate to Brooke Brennan'. This appears to have led QPS to believe it was not required to inform me of the meeting held on 15 July 1999 where Brooke's case was not discussed. I have only become aware of the SCAN team meeting held on 15 July 1999 because it is mentioned in a QPS report provided to this Office in relation to unrelated issues.

The Gold Coast Area Manager of DOF advised that, in accordance with 'the way SCAN is managed on the Gold Coast', Brooke's notification was received too late to be placed on the agenda for discussion at the meeting on 15 July 1999. In accordance with this advice, it appears that the actions taken to refer Brooke's case to the SCAN team were as follows:

Friday 9 July 1999	Agenda for meeting of Gold Coast SCAN team on 15 July 1999 finalised
Monday 12 July 1999	Brooke admitted to Gold Coast Hospital
Tuesday 13 July 1999	Brooke removed from hospital, DOF received Brooke's notification and attempted an initial assessment
Thursday 15 July 1999	Gold Coast SCAN team meeting - Brooke's case not listed on agenda and not formally discussed
Friday 16 July	Agenda for meeting on 22 July 1999 finalised
Thursday 22 July 1999	Gold Coast SCAN team meeting - Brooke's case discussed and recommendation made to 'delete to SCAN'

I am unsure whether the procedures referred to by the Gold Coast Area Manager for finalising SCAN team meeting agendas are DOF procedures or SCAN team procedures. In any case, it is my

opinion that the manner in which DOF referred Brooke's case to the SCAN team was inappropriate. I say this for the following reasons:

- The Queensland SCAN Team Manual states that 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**, and that referrals should be made '**in a timely way'**. It further provides that if an urgent matter arises which requires SCAN team consideration, the coordinator should be contacted to arrange an emergency meeting.

- DOF has stated that: 'the Brennan case **required urgent action** as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable'[81]. DOF initially responded appropriately to Brooke's notification by rating it in the most urgent category and immediately arranging for an initial assessment to be carried out.

- When the FSOs returned to the Gold Coast Area Office and reported the results of the attempted initial assessment to their Intake Team Leader, a decision was immediately made[82] to refer the matter to the Gold Coast SCAN team for discussion.

- The Intake Team Leader then discussed Brooke's case with the Gold Coast Area Manager, and the decision was made not to take any further action in relation to the matter. This decision was made subsequent to the decision to refer the matter to the SCAN team. It took a period of some days for this decision to be made.

- In all the circumstances, once the decision was made to refer Brooke's case to the SCAN team, this referral should have been made immediately **as a matter of urgency**. No assessment had yet been made by the Gold Coast Area Manager that the matter did not require the same urgent action that was required when the notification was received. At the very least, Brooke's case should have been formally discussed at the next available SCAN team meeting, that is, on 15 July 1999.

My assessment also has implications regarding the actions taken by QH to refer the matter to the Gold Coast SCAN team. The Gold Coast Area Manager rightly pointed out that QH was also aware of Brooke's situation prior to the SCAN team meeting on 15 July 1999 and thus had the opportunity to refer the matter for the SCAN team's consideration. It is clear that Brooke's case met the criteria for referral by QH, as contained in the Queensland SCAN Team Manual.

It is noted that initially, the SCAN doctor gave evidence that he recalled having raised Brooke's case at **two** SCAN team meetings. This suggests that the SCAN doctor may have raised the matter at the meeting of the SCAN team on 15 July 1999. However, if this was in fact the case, the SCAN doctor could only have raised Brooke's case on an informal basis, or if he did raise the case formally, there is no record that he did so. My perusal of the minutes of the SCAN team meeting on 15 July 1999 confirm that Brooke's case was not listed on the agenda for discussion, and was not raised as part of any formal, recorded discussions.

I also note that QH and DOF have both alleged that QPS had also been notified of Brooke's case. If this was so, then QPS may also have had an opportunity to refer the matter for discussion at the SCAN team meeting on 15 July 1999. However, QPS claim that it did not receive any child protection referral from QH or DOF regarding Brooke's case. I have previously discussed this issue.

6.3.2 SCAN team meeting of 22 July 1999

81 DOF's response to provisional report dated 11 January 2002.

82 Within 24 hours of the FSOs' returning to the Gold Coast Area Office.

From my perusal of DOF's written referral of Brooke's case to the Gold Coast SCAN team meeting on 22 July 1999, it appears that two important pieces of information were not provided to the SCAN team:

1. There was insufficient information in the referral regarding the serious nature of Brooke's injuries, and no mention of the fact that medical practitioners were of the opinion the only possible cause of Brooke's injuries was physical abuse.

2. No information was provided regarding Brooke's removal from the hospital by her mother, and the manner in which she was removed.

I note that this information may not have been available to DOF at the time of preparing the written referral, as it is unclear whether this information was conveyed by QH to DOF, or recorded appropriately by DOF, upon intake of the SCAN doctor's notification on 13 July 1999.

Moreover, there is no indication in the minutes of the meeting that this further information was provided to the SCAN team by the SCAN doctor during the team's discussion of Brooke's case. The SCAN doctor certainly would have had knowledge of these facts.

Significantly, although there is some information within the minutes of the SCAN team meeting regarding what facts were discussed, there is no information regarding **the basis upon which the SCAN team made its recommendation** that the matter be 'recorded as investigation unable to be completed' and 'deleted to SCAN' (i.e. not to be the subject of any further discussion or follow-up by the SCAN team).

It may be that the SCAN team merely *endorsed* the decision made by DOF not to take any further action in relation to Brooke's case. DOF's written referral informed the SCAN team that its 'current case plan' was for no further departmental involvement at this point. DOF explained the reason for this case plan under the heading *Assessment*, where it stated that DOF was: 'unable to complete investigation as whereabouts of mother and child unknown' and that: 'mother appears to have taken appropriate action by leaving partner'.

If the SCAN team's recommendation was merely an endorsement of DOF's decision, then the SCAN team's role in Brooke's case was not as envisaged by the Queensland SCAN Team Manual. This document makes it very clear that: 'the SCAN team system is not intended to be a monitoring body sanctioning the work completed by core departments'. The involvement of the SCAN team in a case should add value to the planning and coordination of child protection investigations to be carried out by each of the core agencies in relation to that case.

I am concerned that the SCAN team endorsed DOF's decision not to take any further action in this particular case. Brooke was clearly extremely vulnerable and at risk of serious injury, and her safety was dependant solely on her mother continuing to act protectively by remaining away from her partner. Although DOF made a decision not to take any further action in accordance with its procedures and having regard to its limited resourcing, the SCAN team was not operating under the same constraints. The Queensland SCAN Team Manual specifically states that SCAN teams are to: 'provide an inter-agency forum for case discussion and planning to ensure the safety of the child, that assistance is available to the family and child, and that intervention is effective and co-ordinated'.

For example, any member of the Gold Coast SCAN team could have recommended that:

- The QPS representative arrange for police officers to visit the Back Street unit or conduct other inquiries to determine whether the mother and child had in fact left the address. Such a visit could have been made at any time convenient to QPS, when appropriate resources were available.

- The matter be referred to QPS for follow-up to determine whether assault charges should have been laid against Mr Self. Although DOF officers did not locate the mother or child, they were aware that Mr Self appeared to reside at the Back Street address.

6.3.3 Reliance on SCAN team's involvement

In DOF's response to the provisional report, and particularly in response to the question whether resourcing was a significant factor in its decision not to take any further action, DOF stated:

> The decision not to take further action…**was subsequently endorsed at the SCAN Team Meeting on 22 July 1999**. Members of the SCAN Team Meeting included QPS, DOF QH and Education Queensland. (emphasis added)

Also in DOF's response to the provisional report, DOF provided the following concluding remark:

> With the benefit of hindsight, it has been suggested that the officers should have returned to the residence to establish that the mother had not returned and this has been noted. However, there is no evidence that this action was considered at the time by the officers involved, by their supervisor, by the Police who were contacted about the mother's possible whereabouts, **or by the SCAN Team Meeting**. (emphasis added)

I do not see how DOF can seek to rely upon the SCAN team's recommendation in this matter. The Queensland SCAN Team Manual repeatedly emphasises that SCAN teams make **recommendations** for action rather than **decisions**, and that **each core department retains individual responsibility for its actions based upon its own legislation**.

DOF's decision not to take any further action in relation to Brooke's case was entirely its own. Regardless of the SCAN team recommendation, DOF had a responsibility in accordance with its statutory child protection obligations to take action to ensure that Brooke was safe from further physical harm. Unfortunately, DOF failed to discharge this responsibility because of its inadequate procedures for assessing whether a child was safe.

6.3.4 Review of the SCAN Team System

I am aware that DOF and the Coordinating Committee on Child Abuse (CCOCA) have already commissioned a review of the SCAN team system (*the SCAN team review*). The brief was to assess the performance of SCAN teams throughout Queensland and make recommendations about the ongoing management of the teams. A draft report was prepared in December 2001. A copy of that draft was provided to me on a confidential basis.

The CCOCA met on 19 February 2002 to discuss the recommendations outlined in the draft report and I understand that feedback will now be provided to the authors of the report to assist their finalisation of the document. One of the key issues identified by the SCAN team review is the need to develop clear protocols amongst the key agencies addressing the issues of inter-agency collaboration, the sharing of information and the operation of SCAN teams in general.

In this case, the evidence gathered supports the SCAN team review's findings in relation to lack of protocols for documenting recommendations and outcomes, and for inter-agency collaboration in relation to the initial referral of child protection matters to the SCAN team. I have made specific recommendations in relation to these issues[83].

I do not consider it appropriate to make any further recommendations, based on the investigation of this case, about general SCAN issues that are presently before the reviewers and the relevant stakeholders for assessment. However, it is clear that in this case the SCAN team's involvement did not lead to:

[83] See Part 9.

- DOF's mistaken belief (that Ms A and Brooke no longer lived with Mr Self) being further investigated; or

- the SCAN doctor's concerns about Brooke's safety being addressed.

Instead, the SCAN team's endorsement of DOF's decision that no further action be taken was seen by DOF as justification for that decision.

7 Overview

A chain of unfortunate circumstances culminated in the murder of Brooke Brennan by Troy Self. My role is to investigate administrative decisions by officers of public sector agencies, in this case, primarily DOF and QH and consider whether those decisions were:

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

I am also empowered under the *Ombudsman Act* to make recommendations to the principal officer of the appropriate agency to improve administrative practice within the agency.

My jurisdiction in respect of QPS is extremely limited in that the Ombudsman Act provides that an operational action of a police officer is not 'administrative action'. However, because of the interaction in this case between officers of QH and QPS, and DOF and QPS, I have had to consider the actions of QPS officers for the purpose of assessing administrative actions made by officers of QH and DOF.

I also have no jurisdiction to express opinions about Ms A's conduct except to the extent that her conduct is relevant to an assessment of the decisions made by officers of QH and DOF. On that basis, the evidence suggests that her conduct is relevant in the following ways:

- removal of Brooke from the Gold Coast Hospital without informing hospital staff of her intention prevented QH staff from further caring for Brooke;

- it also resulted in a situation where the making of a 96-hour order could have been considered by any prescribed medical officer at the Gold Coast Hospital;

- her conduct in hiding herself and Brooke from DOF officers visiting her unit prevented those officers from properly assessing Brooke's situation and taking action to ensure her safety;

- hiding from the officers and preparing the note found at the unit led the FSOs to believe it was likely she had removed Brooke from the suspected cause of abuse; and

- this belief, together with a lack of resources, resulted in DOF's procedures in relation to initial assessments that are unable to be completed for 'client reasons' being applied and a decision being made to take no further action in the case.

Although Brooke was removed from the hospital by her mother, QH retained some responsibility to ensure that appropriate action was taken for her safety. DOF also took on this responsibility once it had received notification. Assuming that the SCAN doctor did request assistance from the Gold Coast JAB, QPS also had some responsibility to provide an appropriate response.

Because of a combination of factors, the response of these agencies and the involvement of the SCAN team were insufficient to prevent Brooke from being further harmed.

8 Opinions

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

The administrative actions of QH and DOF were, at various times:

- unreasonable (section 49(2)(b));
- based wholly or partly upon a mistake of fact (section 49(2)(f)); and
- wrong (section 49(2)(g)).

The particulars of such maladministration are:

8.1 Queensland Health: particulars of maladministration

The particulars of maladministration by QH are that:

8.1.1 There are no written policies or procedures to address when, and in what circumstances, prescribed medical officers of QH should make a 96-hour order in relation to a child, which resulted in inconsistent application of section 76L of the *Health Act* by QH officers.

8.1.2 A 96-hour order should have been issued by the SCAN doctor, or another prescribed medical officer, given the circumstances of Brooke's presentation and subsequent removal from the Gold Coast Hospital. As a result, the SCAN doctor failed to fulfil his obligation as an authorised person pursuant to section 76K of the *Health Act* to act in such manner as would best ensure Brooke's safety and well-being.

8.1.3 There are no written policies or procedures requiring the documenting of verbal child protection referrals/requests made by QH officers to other agencies that have a concurrent child protection role. This encourages the making of verbal referrals or requests that:

- lead to uncertainty as to the nature and priority of the referrals/requests; and
- cannot be effectively audited.

The present case highlights these problems.

8.1.4 The SCAN doctor's verbal referral/request was ineffective. Despite the absence of any written policies or procedures, the SCAN doctor, in view of his concerns, should have documented the child protection referral/request that he made to QPS on 13 July 1999 following Brooke's removal from the Gold Coast Hospital.

8.1.5 Despite having an opportunity to do so, QH failed to formally refer Brooke's case to the first available SCAN team meeting held on 15 July 1999, some two days after Brooke had been removed by her mother from the Gold Coast Hospital.

8.1.6 Lines of communication between QH and QPS and between QH and DOF were inadequate – the SCAN doctor says he was unable to contact QPS until after 1.00pm and unable to contact DOF until after 3.00pm.

8.2 Department of Families: particulars of maladministration

The particulars of maladministration by DOF are that:

8.2.1 No remedial action was taken in response to a memo dated 2 March 1998 (some 16 months before Brooke's death) prepared by the Gold Coast Area Office Intake Team

concerning resourcing constraints that were impacting upon the team's ability to effectively perform child protection work.

8.2.2 Brooke's case was not referred to the first available SCAN meeting held on 15 July 1999, two days after Brooke had been removed by her mother from the Gold Coast Hospital, despite DOF's assessment that her case "required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable".

8.2.3 The decision-making process the Gold Coast Area Manager was required to follow in Brooke's case, in accordance with DOF procedures, was inadequate. The procedures did not require consideration to be given to whether Brooke was truly 'safe' from future physical abuse before the case was closed.

8.2.4 Given the circumstances of Brooke's case, the decision not to take any further action in relation to Brooke's case was unreasonable. DOF should have taken further action to ensure Brooke was safe.

8.2.5 Inadequate resources were allocated to the Gold Coast Area Office at the time of Brooke's notification to meet its statutory child protection obligations pursuant to the provisions of the *Children's Services Act*.

8.2.6 Policy PM95/17 - *Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons*, was not complied with.

8.2.7 No immediate action was taken to implement the recommendation contained in the internal reviewer's report or to otherwise make any changes to DOF procedures in respect of child protection.

8.2.8 Lines of communication between DOF and QH and between DOF and QPS were inadequate.

8.2.9 There is no requirement for recording of requests by DOF officers for JAB or other QPS assistance. This encourages the making of verbal referrals or requests that:

- lead to uncertainty as to the nature and priority of the referrals/requests; and
- cannot be effectively audited.

The present case highlights these problems.

8.3 SCAN Team: particulars of maladministration

The particulars of maladministration by the SCAN team are that:

8.3.1 The minutes of the SCAN team meeting of 22 July 1999 did not record the reasons for the recommendation made that the matter be deleted to SCAN, that is, not considered further by SCAN, and why other courses of action were not recommended, such as referring the matter to QPS for further action.

8.3.2 The recommendation made to 'delete the case to SCAN' was unreasonable given the circumstances of Brooke's case. The SCAN team should have recommended that further action be taken to ensure her safety.

9 Recommendations

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

9.1. Queensland Health

9.1.1 Develop written policies and procedures to address when and in what circumstances prescribed medical officers of QH should make a 96-hour order in relation to a child. The policies and procedures must provide that 96-hour orders are to be issued in any circumstances (within the terms of section 76L of the *Health Act*) where it will best ensure the safety of a child who is likely to be subject to unnecessary injury, suffering or danger;

9.1.2 Develop written policies and procedures that require the documentation of verbal child protection referrals/requests made by its officers to other agencies with a concurrent child protection role;

9.1.3 Review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that all suspected child abuse and neglect matters are referred to the SCAN team for discussion in a timely and appropriate manner, and in accordance with its child protection obligations; and

9.1.4 Review its lines of communication with QPS and DOF to ensure a rapid response in priority child protection cases.

9.2 Department of Families

9.2.1 Review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that such matters are treated with an appropriate level of priority and, specifically, that urgent matters are referred to the first available SCAN team meeting, irrespective of when notifications are received;

9.2.2 As part of the Child Protection Service System Improvement Project (CPSSIP), replace the policy contained in chapter 6, point 6.2(iv) of its *Child Protection Procedures Manual* (in relation to notifications for which initial assessments are unable to be commenced or completed because of 'client reasons') with a policy that addresses the deficiencies identified by this report;

9.2.3 Engage a suitably qualified independent expert to review whether the Gold Coast Area Office of DOF is currently adequately resourced to meet its statutory child protection obligations under the *Child Protection Act.* The independent expert should report to the Minister and the Director-General of DOF and provide a copy of the report to this Office;

9.2.4 Implement procedures to ensure that feedback and support are provided to DOF officers whose administrative actions are the subject of a review pursuant to DOF's recently developed policies entitled *Child Death Reviews Policy and Procedures* and *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures*; and

9.2.5 Review its lines of communication with QH and QPS to ensure a rapid response in priority child protection cases.

9.3 Suspected Child Abuse and Neglect Team

9.3.1 QH, DOF and QPS develop a Memorandum of Understanding in relation to the referral of child protection matters to SCAN teams to ensure that:

- each core agency appreciates its role and obligations for referring matters to SCAN teams;
- formal procedures for referral of child protection matters are followed consistently; and
- referrals are made in a timely fashion, having regard to the level of priority of the particular matter.

9.3.2 QH, DOF and QPS develop a proforma for minutes taken at SCAN team meetings to ensure that the basis upon which recommendations are made is recorded; specifically, the reasons for selecting a particular course of action over other possibilities should be documented.

10 Matters for the Queensland Police Service

As I have already pointed out, the *Ombudsman Act* essentially prohibits my consideration of police operational matters. However, the circumstances of this particular matter required me to take into account the interaction of other departmental officers (within jurisdiction) with members of the Gold Coast JAB. Accordingly, 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 QPS. It was for this reason that I provided the Commissioner for Police, Mr Atkinson APM, with a notice that I proposed to include adverse comment about QPS in this report.

For the sake of completeness and with a view to improving the quality of decision-making and administrative practice of QPS where its officers interact with other agencies having a child protection responsibility, I have made the following observations and suggestions for improvement that I would ask be considered by QPS in any review of how it responded in this case.

10.1 Observations

10.1.1 QPS did not have in place adequate policies and procedures for recording all incoming telephone calls received in relation to child protection referrals or requests. Therefore, there was no method for recording or assessing the decisions made by JAB officers as to the type of response to be given to each call.

10.1.2. The JAB officer failed to record any details of the telephone call made by the SCAN doctor on 13 July 1999 in which he requested police assistance. The lack of any such record:

- led to uncertainty as to the nature and urgency of the request; and
- means that the reasonableness of the decision refusing assistance cannot be audited.

10.1.3 There were no procedures in place between QPS and QH for making or following up child protection referrals or requests to QPS in writing (e.g. by facsimile or email).

10.2 Suggestions for improving administrative practice

10.2.1 Appropriate policies and procedures be implemented to record all incoming telephone calls received in relation to child protection referrals or requests and QPS's responses;

10.2.2 In consultation with QH, appropriate policies and procedures be implemented to ensure that any child protection referrals or requests made by QH to QPS are confirmed in writing (e.g. by facsimile or email) as soon as possible after any referrals or requests are made.

11 Response to the recommendations

11.1 Queensland Health

QH's response to my recommendations is set out in full in Appendix P. QH has agreed to give effect to all of the recommendations that were made.

11.2 Department of Families

DOF's response to my recommendations is set out in full in Appendix Q. DOF has agreed to give effect to all of the recommendations that were made.

11.3 Suspected Child Abuse and Neglect team

Both QH and DOF have agreed with the recommendations that were made. QPS did not address this issue in its response.

11.4 Queensland Police Service

QPS's response to my suggestions for improving administrative practice is set out in full in Appendix R. QPS agreed to action suggestion 10.2.2 in relation to consulting with QH in respect of appropriate policies and procedures concerning child protection referrals or requests made by QH to QPS.

However, QPS did not unconditionally agree with the suggestion that I made at 10.2.1 in relation to the development of appropriate policies and procedures to record **all** incoming telephone calls received in relation to child protection referrals or requests and QPS's responses.

In his response, the Commissioner said, in part, that:

> After careful consideration of those issues and careful examination of existing Service practice, I believe the policy and procedure in place for reporting the receipt of information concerning complaints of child abuse is appropriate and generally satisfactory. Formal policy and procedure is contained in s.7.6.1 of the Operational Procedures manual requiring the recording of all child abuse complaints on a crime report for investigation. This procedure also provides a process for recording assessments, decisions and action taken in respect of the investigation. Other procedures have been implemented locally by the Service including the requirement upon JAB officers to record all issues and requests of significance on Job Occurrence Sheets. Administrative procedures have also been adopted including the completion of a telephone record register for messages taken for and on behalf of JAB staff.
>
> Most regrettably, it would appear from the assessment of the material provided by your office that a member of the Service has failed to record the information provided by the SCAN doctor according to the existing procedure. I agree with your assertion that the lack of such a record leads to uncertainty as to the nature and urgency of the request and the reasonableness of any decision taken thereafter. I advise that the Ethical Standards Command of the Service will be undertaking an internal investigation in this respect.

While I appreciate the Commissioner's explanation, the rationale for my suggestion was to ensure that **every** incoming telephone call in relation to child protection referrals or requests is recorded

rather than only those that concerned ‘complaints of child abuse’ or ‘issues and requests of significance’. The lack of procedures for recording all telephone calls led to uncertainty as to the nature and urgency of the request made by the SCAN doctor and meant that the reasonableness of the decision to refuse assistance could not be audited either by the officer’s superior or by my Office.

Therefore, I would encourage QPS to reconsider my suggestion for improving administrative practice as outlined at 10.2.1 to ensure that all incoming telephone calls received in relation to child protection referrals or requests are recorded.

I am pleased to note the Commissioner’s advice that the Ethical Standards Command of the Service will be undertaking an internal investigation with respect to the alleged actions of the officer concerned in failing to record the information provided by the SCAN doctor.

Appendices

Appendix A — Queensland Health's response to provisional report

Thank you for providing me with the opportunity to respond to your Provisional Report into the investigation relating to Brooke Brennan.

I will first address some of the issues raised in the body of the preliminary report.

Whether the general practitioner's referral of Brooke to the hospital amounted to a notification to an "authorised person" (the hospital's medical superintendent) within the meaning of s.76K of the Health Act (see pages 30 and 31 of the Provisional Report).

In relation to the interpretation of this section, I have obtained legal advice that I summarise below:

1. s.76K(1) and (2) required the general practitioner, if he suspected abuse, to notify an authorised practitioner of the suspected abuse by the most expeditious means available and to send a formal notification to me within 7 days.

2. The general practitioner was in breach of the requirements of s.76K in that the general practitioner did not notify the authorised person, this being the Medical Superintendent or the Visiting Paediatrician Gold Coast Hospital. The general practitioner notified the Emergency Department (ED) consultant on duty and referred the patient to the ED Department. The ED consultant notified the "authorised person".

3. The referral by the general practitioner also did not strictly comply with the requirements of s.76K(4) in that it did not state the observations and opinions upon which the suspicion of suspected abuse was based.

You disagree with this Department's interpretation of s.76L of the Health Act that the Department has no control over the manner in which that section is enforced by the Queensland Police Service (page 36).

I agreed that s.76L of the Health Act imposes upon the Queensland Police Service a duty to "assist the prescribed medical officer as required". It is this Department's position that the prescribed medical officer (by nature of his or her training and qualifications) is only capable of asking the Queensland Police Service to assist in very general terms, for example by asking the Police to locate or, if necessary, return the child who is the subject of an order to hospital. The prescribed medical officer would not be qualified to give a police officer detailed directions about how to locate a child or take control of the method or process by which the police officer undertakes that task or influence the priority the Police afford the task.

I now turn to the specific questions raised in Part 6 of your Provisional Report.

6.2.1 Why wasn't a 96 hour order issued by a prescribed medical officer for Gold Coast Hospital when Ms A took Brooke from the hospital?

In response to this question, I refer to my response to your inquiry dated 17 July 2001. As I stated in that response, it is Queensland Health Department policy that a "96 hour" order is only issued in those circumstances where without it, it is not possible to adequately assess and/or treat the child. This is evidenced by the fact that in any year I receive notification of only a small number of "96 hour" orders, usually less than 15.

The assessment of Queensland Health staff in Brooke's case was that Brooke was not at "immediate risk of serious injury" for the following reasons:

1. Although Ms A had acted inappropriately in removing Brooke from hospital, she had, during the time of Brooke's admission, exhibited appropriate concern for Brooke's welfare, a caring attitude towards Brooke and had expressed a plan to protect Brooke by ending her relationship with Mr Self. Queensland Health staff had, at that time, no reason to doubt Ms A's expressed intentions. There was never any reason to believe that Ms A would harm Brooke.

2. The Queensland Police Service and the Department of Families had been notified of Brooke's removal from hospital and the importance of her being located. Queensland Health staff then believed that those departments would investigate the situation and take all necessary steps to protect Brooke. Indeed, you have concluded in your preliminary report that the Department of Families officers' initial response to the notification of Brooke's disappearance was appropriate. (See page 63).

In addition, an agreement has been reached with the Department of Families about the circumstances in which Queensland Health will issue "96 hour" orders. In 1999, the *Child Protection Act* was introduced to completely replace pre-existing, outdated legislation under which the Department of Families functioned. The *Health Act* (in which Section 76L appears) is also a very old piece of legislation. The new *Child Protection Act* reflects current practice in child protection.

During the drafting process for the *Child Protection Act*, discussions were held between officers of Queensland Health and the Department of Families. At that time the issue of whether S76L of the *Health Act* should be repealed was discussed. After internal discussions with senior child protection paediatricians, Queensland Health identified some very specific circumstances when there would be a need for medical officers to order the detention of a child under those provisions. Also, Queensland Health was in the process of conducting a legislative review of the *Health Act* (which has not yet been completed). Therefore, it was agreed that S76L should be retained in the *Health Act* for the time being.

It was clearly identified at that time by the Department of Families that this provision in the *Health Act* was not intended to be used by medical officers to over-ride the decisions made by appropriately appointed statutory child protection officers of the Department of Families or the Queensland Police Service in the routine pursuit of their duties.

It was agreed that it would be appropriate for a medical officer to invoke the powers in s.76L (so as to over-ride the immediate child protection decision by officers of the Department of Families or the Queensland Police Service not to detain a child under the *Child Protection Act*) if the child had an acute medical/surgical problem which required immediate return to the medical facility and the officer of Department of Families or the Queensland Police Service was not of the view that there was a medical/surgical imperative to do so. In that circumstance, it can be argued that the medical officer had specific expertise by nature of his/her professional credentials which justified activation of powers to return the child while further discussion occurred. That was not the case in this instance.

In this case, the officers of the Department of Families and the Queensland Police Service were fully informed (in a timely manner) of all of the allegations of abuse/neglect that had been passed to the medical service and the circumstances under which the child presented, was admitted, and subsequently left the health facility. It was not appropriate in that circumstance for a medical officer to activate S76L, and in effect, to become a 'de-facto' statutory child protection officer and legally coerce the formally appointed child protection officers of the Department of Families or the Queensland Police Service in the performance of their duties.

It could perhaps be argued that in a case of 'extremus' – i.e. if the medical officer had certain knowledge that the child was at imminent risk of death or serious injury (i.e. the mother told him/her of an intention to leave the hospital and kill the child), and was aware that statutory officers of the Department of Families or the QPS were unable to activate their powers under the *Child Protection Act* – activation of S76L might be a reasonable, if extreme, utilisation of medical powers in response to an extreme situation. Again, that was not the scenario in this case.

6.2.2 Have prescribed medical officers for Gold Coast Hospital issued 96 hour orders in the last five years

Prescribed medical officers have issued "96 hour" orders in the past five years.

6.2.3 If the answer to 6.2.2 is "yes", how many have been issued and provide some examples of the circumstances in which orders were made and by whom (that is, the position held by the person who made the order)?

The prescribed medical officers have issued two "96 hour" orders in the past five years, on 20 August 2000 and on 5 February 2000. They were issued in similar circumstances to those described in 6.2.1.

6.2.4 Have any procedures or guidelines for making 96 hour orders been issued since the Brooke Brennan case and, if so, please provide details.

It remains this department's position that "96 hour" orders should only be issued when no other option will protect a child from danger including allowing appropriate assessment and/or treatment.

However, your Provisional Report has identified that there is scope for knowledge about the issue and execution of "96 hour" orders amongst Queensland Health staff and officers of Queensland Police Service and the Department of Families to be improved. This Department will work with the Queensland Police Service and the Department of Families to develop guidelines for the issue and execution of "96 hour" orders within Queensland and instigate education programmes to ensure that relevant staff within all three departments are familiar with the guidelines and their operations.

A Chief Health Officer circular about s.76K written by Dr (*name deleted prior to publication*), Paediatric Adviser was circulated to all medical practitioners in the State last year. Furthermore, the Gold Coast Hospital conducts regular education sessions for its staff about the SCAN process.

6.2.5 If a similar case were to occur, is it likely that a 96 order would be made?

As I have already said, Queensland health staff believed that, given the information which was available at the time, all appropriate steps had been taken to protect Brooke's interests. Ultimately, these steps and the steps taken by other departments proved to be insufficient to prevent the tragic outcome. After review of the notes provided, Dr (name deleted), Paediatric Adviser is of the view that the medical staff performed their duties appropriately, and that activation of S76L in the particular clinical scenario as described, would not be appropriate.

Appendix B — Department of Families' response to the provisional report

6.3.1 Does DOF agree with the finding of the internal reviewer that the decision not to take any further action to complete Brooke's initial assessment was made in accordance with it policies and procedures then operating.

In July 1999, the key policy and procedures document governing child protection practice was the Child Protection Procedures Manual (CPPM). This version was in use prior to the proclamation of *Child Protection Act 1999*. The relevant sections that outline the actions to be taken by staff during an Initial Assessment are in Part 3 "Initial Assessment and Departmental Intervention": Chapters 6 – 16.

Chapters 6 – 16 of the CPPM provided clear procedures for staff including a step-by-step decision-making framework in conducting assessments regarding children being harmed or at risk of harm.

Chapter 6 outlined procedures for staff when it was impossible to commence or complete an assessment within one month, due to client reasons. (eg inability to locate the family).

The procedures required staff to ensure that all reasonable steps have been taken to commence or complete the assessment. The Manager had to determine what steps were reasonable taking into account the general circumstances, the level of the alleged harm and any factors making the assessment difficult to commence or complete.

The Department of Families agrees that officers acted in accordance with the policies and procedures of the day.

6.3.2 Does the DOF agree that those policies and procedures were inadequate and should be varied in that they did not sufficiently address whether a child is safe.

As outlined above, Chapters 6 – 16 of the CPPM provided clear procedures for staff including a step-by-step decision-making framework in conducting assessments regarding children being harmed ot at risk of harm.

Chapter 11 outlined the procedures in relation to situations requiring urgent action that included:

When a 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

The Brennan case required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable. In these circumstances, the child's immediate safety would have been the primary consideration.

In the Brennan case, the Department of Families does not agree that the policies and procedures were inadequate as they did sufficiently address whether the child was safe.

However, the Department of Families has developed a new intake took to enhance child safety since that time. In October 2001, regionally based specialist intake teams in the Gold Coast, Central Queensland and Toowoomba and South West Regions commenced using this new intake tool. (Safety Phase 1)

6.3.3 Does DOF agree that, at the time of Brooke's notification, the Gold Coast Area Office was not adequately resourced to meet its statutory obligations under the Children's Services Act.

The issue of the adequacy of resources is a matter for the Government. In relation to resources, the role of the Department of Families includes:

- the management of available resources; and
- the provision of all necessary information to enable the Minister to advocate for resources.

6.3.4 Does DOF agree that lack of resources was a significant factor in the decision of the Gold Coast area intake team to take no further action in relation to Brooke's notification.

The decision not to take any further action was in accordance with the policies and procedures of the day and was subsequently endorsed at the Suspected Child Abuse and Neglect (SCAN) Team Meeting on 22 July 1999. Members of the SCAN Team Meeting included Queensland Police, the Department of Families, Queensland Health and Education Queensland.

6.3.5 Does DOF agree with the evidence provided by the QPSU (in part 5.4.2 of this provisional report) about the number of notifications received by the Gold Coast Area Office during the relevant period and the number of outstanding initial assessments then requiring attention. If not, is DOF able to supply what it says are the correct figures. Could DOF also supply particulars of officer resourcing for each of the area offices referred to in Part 5.4.2 of the provisional report.

The Department of Families does not agree with the evidence provided by the QPSU in part 5.4.2 of the provisional report about the number of notifications received by the Gold Coast Area Office during the relevant period.The data outlined below is an extract from the 1998-99 annual child protection tables and represents recording on the Child Protection System for cases notified during the relevant period.

Area Office	Child protection cases notified 1 July 1998 to 30 June 1999
Beenleigh	1,079
Gold Coast	1,557
Logan City	1,277
Mt Gravatt	480
Redlands	451
Stones Corner	505
Wynnum	264

The Department of Families is unable to provide evidence about the number of outstanding initial assessments as at 19 July 1999.

The data outlined below is an extract from the 1998-99 annual child protection tables and represents recording on the Child Protection System for outstanding initial assessments during the relevant period. Outstanding initial assessments including those where no assessment is possible, where there is a part assessment (no outcome), where staff are unable to commence/complete an assessment and where assessments are still under investigation.

Area Office	Total initial assessments 1 July 1998 to 30 June 1999	Initial assessments – not finalised 1 July 1998 to 30 June 1999
Beenleigh	842	567
Gold Coast	1,275	580
Logan City	986	539
Mt Gravatt	384	99
Redlands	367	121
Stones Corner	471	63
Wynnum	214	43

Nothwithstanding that this data differs from the data provided by the QPSU, there is no doubt that there have been significant increases in activity and demand. For example, the average increase of cases notified in Queensland over the last 10 years is approximately 9% per annum.

In relation to the Gold Coast Area Office, the cases notified have increased as follows:

- In 1997-98, 1229 cases were notified.
- In 1998-99 1,557 cases were notified representing an increase of 26.6% over the previous year.

- In 1999-2000, 1,595 cases were notified representing an increase of 2.4% over the previous year.

In response to the request for particulars of officer resourcing for each of the area offices referred to in Part 5.4.2 of the provisional report, the data outlined below is an extract from the current resourcing information for each of the area offices.

Area Office	**Approved establishment as at 1 July 2001 – Family Services Officer's**	**Additional Services Officer's 1 July 2001 – 31 December 2001**
Beenleigh	11.5	2
Gold Coast	27	3
Logan City including the now separated Browns Plains Office	31.5	8
Mt Gravatt	9.5	-
Redlands	11.5	-
Stones Corner	13.5	-
Wynnum	7	-

6.3.6 Does DOF consider that officer resources are appropriately co-ordinated and distributed across DOF regions. Could DOF supply data to support its view.

Since July 2001, the new Forde direct service delivery positions and associated "on-costs" have been allocated according to the Work Activity Profile methodology that was developed during 2001. This methodology is a tool to provide the department with a statewide overview of Area Office activity, workload to staff radios and associated practice variations. The method applies generally accepted measurement principles to Area Office Activity data. Eight core Area Office activities are measured. Weighting (based on indicated relative resource usage) is applied to each core activity measure and these are then moderated against practice, outcome and local variations between Area Offices. The residual employee budget in Area Offices is based on historical staff levels. The Work Activity Profile is now used to allocate resources to Area Offices.

The Work Activity Profile has been utilised in resource allocation exercises such as the direct service delivery rounds. It has been accepted that the methodology will continue to be refined. To enable this to occur a Reference Group has been formed[1]:

Attached is a copy of the work Activity Profile that was used to allocate additional direct service delivery staff in the second half of 2001. The Department of Families is currently in the process of applying this methodology for allocation of additional staff for the first half of 2002.

6.3.7 Does DOF agree with the evidence provided by the internal reviewer that comparative caseloads are significantly lower in other Australian jurisdictions. If not, what does DOF say the statistics are in relation to this issue.

There are significant differences between states in how child protection matters are defined and therefore counted. The definition of what constitutes a "case" varies and as such, is difficult to compare.

In relation to an "average case load for family services officers", the Department of Families does not measure workload on this basis. Caseloads are generally viewed as a crude measure of workload owing to:

- the significant variation in the interventions required with different cases; and
- the work that is involved in other areas eg assessment of child protection notifications, court support work in both child protection and youth justice, the support of foster carers etc.

Rather, the Department of Families has adopted a far more sophisticated approach to the assessment of workloads as outlined previously. The Work Activity Profile methodology measures eight core area office processes with relative resource weighting's being applied.

Area Office Process	**Pure Weighting**
Initial Assessments	7.9

1 DOF supplied details of the Reference Group but the Ombudsman has requested that names be deleted prior to publication

Workload Managed Initial Assessment's	1.5
Child Protection Follow Up	17.6
Child Protection Order	22.5
Court Assessment Order – Provisions	3.9
Placement	5.4
Youth Justice Order	12.5
Court Appearances	0.9

The weightings reflect the relative difference in resource consumption between these core activities based on the estimated average time taken by direct service staff to carry out these activities.

Key modifications under review by the Work Activity Profile reference group for the next version including using "distinct children on orders" as a measure of work and at some stage using "intake" as another measure of work undertaken.

6.3.8 Does DOF consider that its offices (including Gold Coast Area Office) are now adequately resourced to effectively discharge its child protection responsibilities under the Child Protection Act.

As stated above, the issue of adequacy of resources is a matter for the Government.

However, successive State Budgets have increased funding for the Department of Families since 1999/2000.

In 1998/99, expenditure on child protection of the Department of Families was approximately $80 million. The 1999/2000 State Budget allocated $100 million over 4 years to implement the recommendations of the Forde Inquiry. The $100 million over 4 years included $10 million in 1999/2000, rising by $10 million/year to $40 million in 2002/03 to improve services for the care and protection of children.

The investment represented an almost 50% increase in the child protection budget and was the single largest commitment to increase child protection spending by an Queensland Government.

Both the 2000/01 and 2001/02 State budgets allocated additional funds to build on the commitment to implementing the recommendations from the Forde Inquiry.

The Department of the Premier and Cabinet, Department of Families and Treasury are undertaking a joint review of foster care allowances and related child protection issues. The review is considering all aspects of the current child protection system and also determine whether the system is generating the best possible outcomes for Queensland's children and young people within the allocated resources. The terms of reference also include developing options or models for early intervention and prevention to prevent children and young people from coming into the system. The Review will be completed by February 2002.

Further, the Department of Families has recently reviewed the Regional Director's position and as a result, the position has been upgraded from Senior Officer Level to SES 2. A new Regional Director will be appointed in the near future.

6.3.9 Does DOF consider that the internal review conducted following Brooke's death was adequate and carried out in accordance with its policy.

The policy in relation to the conduct of reviews as at September 1999 was PM 95/17: Procedures for recording and reviewing the death or serious injury of children and young persons.

The internal review did not contain full information about the manner in which the Brennan review was conducted. However, it has been possible to establish from the information provided that the following procedures were not followed:

- The review should have been conducted by a minimum of two departmental staff members. It would appear that only one officer was involved. (Section 7.1)
- Section 8.1 required that the panel "determine the facts, establish findings and make recommendations". The report contains many personal observations of the reviewer with only one recommendation.
- Individual staff members were named in the report whereas the policy specifically stipulated that they should not be named. (Section 8.2).

- Section 8.5 allowed for other agencies or professionals to be consulted "in order to fully review departmental procedures". Although safety assessment was mentioned on numerous occasions in the report, it does not appear that the reviewer consulted senior policy officers. Further, both health and police personnel were mentioned in the report and neither agency appears to have been approached by the reviewer.
- There was no information to suggest that the report was provided to staff who had been involved in the review or that their comments had been incorporated in the final report.

Notwithstanding these issues, the report clearly identified the facts of the case, provided sound analysis of the issues and remains a valuable resource for the Department of Families.

6.3.10 Does DOF consider that its response to the findings of the internal review has been appropriate, in particular, why hasn't the safety assessment system recommended in September 1999 by the internal reviewer been implemented.

Upon receipt, the internal review report particularly the recommendation in relation to the safety assessment system was contested by senior officers at the time. Nevertheless, the following has occurred since that time:

- In October 1999, the Department of Families published *A Practice Guide: For the Assessment of Harm and Likely Harm.* This Practice Guide currently being used by child protection staff includes the concept of safety as a critical feature of assessment.
- In May 2000, the Department of Families commenced significant work to reform Queensland's child protection service system. The Child Protection Service System Improvement Project (CPSSIP) addresses every element of the system, from notification o harm to children to the type of intervention required when it is determined that children have been harmed.
- The overall objective of CPSSIP is to improve the efficiency and effectiveness of the child protection service delivery system. In consultation with Queensland Treasury, the Department of Families has developed a five year reform plan to address the service delivery framework, both in terms of a viable and stable alternative care network and in developing a range of interventions directly linking assessment of client needs with the type and level of intervention. In addressing the more critical issues of the service delivery system within the first few years, the capacity of this Department to then focus increasingly upon effective prevention and early intervention strategies (particularly in partnership with the non-government sector) will be enhanced.
- In October 2001, the pilots of regionally based specialist intake teams in the Gold Coast, Central Queensland and Toowoomba and South West Regions commenced using a new intake tool to determine child risk, harm and safety. (Safety Phase 1)
- During 2001-02, CPSSIP will evaluate and revise the pilots and determine whether to retain, make changes to, or extend pilot sites.
- During 2001-02, CPSSIP will develop a new investigative tool to determine child risk, harm and safety (Safety Phase 2)
- During 2001-02, CPSSIP will develop family strengths/needs assessment capacity

6.3.11 If a similar case were to occur now, how would DOF respond.

In relation to this particular case, the Department of Families believes that the response at the time was appropriate. On the evidence presented and after examining the events, it is difficult to see what might have been done better. The officers followed departmental procedures and exercised their judgement based on what they knew at the time. With the benefit of hindsight, it has been suggested that the officers should have returned to the residence to establish that the mother had not returned and this has been noted. However, there is no evidence that this action was considered at the time by the officers involved, by their supervisor, by the Police who were contacted about the mother's possible whereabouts, or by the SCAN Team Meeting.

Much has occurred in the two years since the Brennan case. Significant lessons have been learnt, the *Child Protection Act 1999* has commenced, new policy and procedures are in place to support this legislation and a new intake tool to enhance child safety has been developed.

However, if a similar case were to occur now, Family Services Officers would still be required to exercise their best judgement within the parameters set out by policy and procedures.

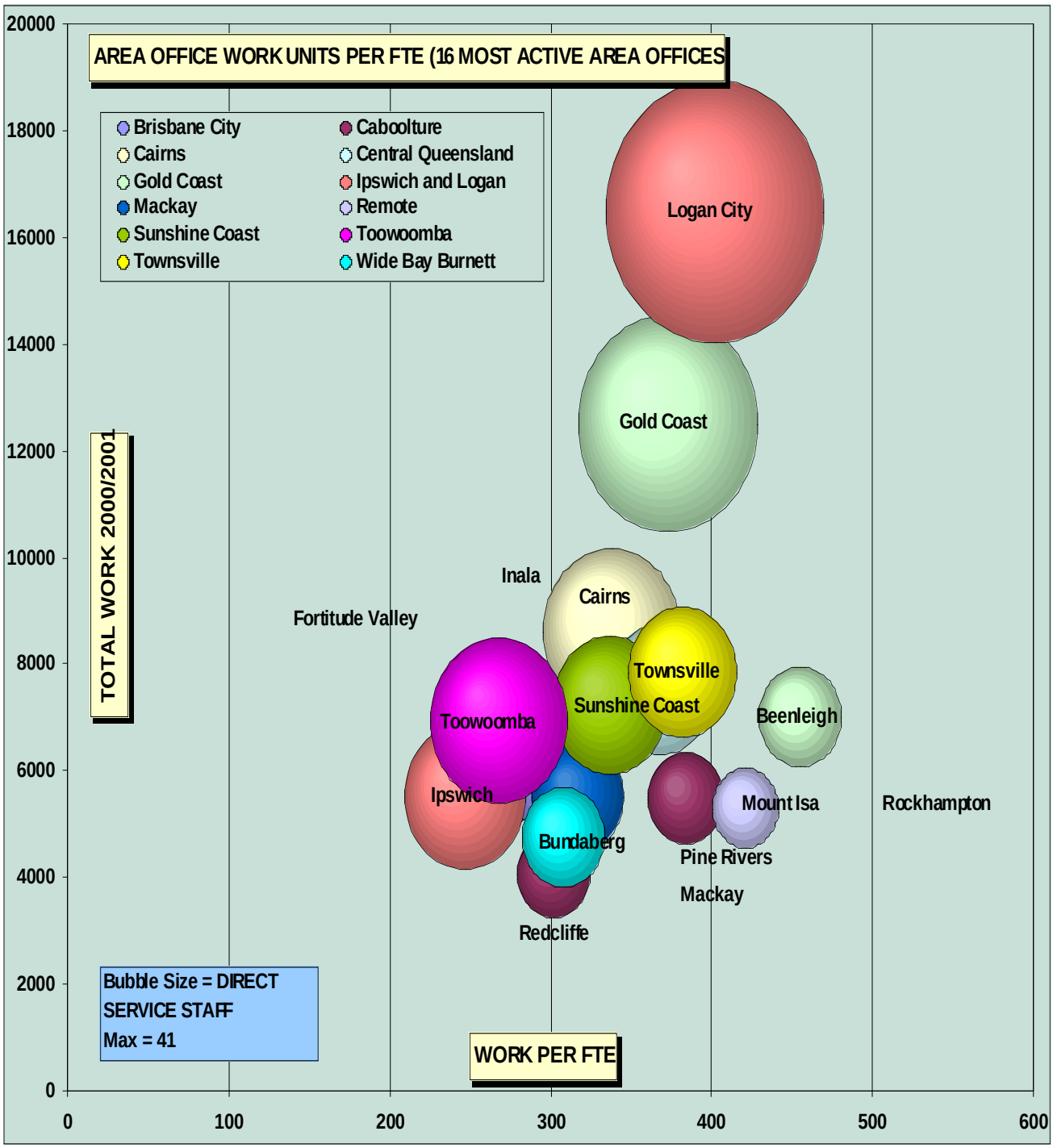
In the event of a child death, the new Child Death Reviews Policy and Procedures endorsed on 23 May 2001 would apply.

This policy provides that 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.

Attached is a copy of the new Policy and Procedures.

WORK ACTIVITY PROFILE



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.

2. 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.

Purpose

To establish procedures for reviewing the death of a child who has been subject to 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 a 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 Procedure*s, 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.

4. Make recommendations in relation to departmental practice and procedures, any further actions required in relation to departmental 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 Report*s.

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.
- 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 5 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

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.

Appendix C – QPS response to proposed adverse comments extracted from provisional report

I would appreciate your consideration of the following comments raised in response to the draft issues proposed by your report

Health Act – 96 hour orders

I welcome the opportunity to clarify original comments provided to the Ombudsman with respect to the operation of such orders. The process of training is adequately set out by Detective Inspector *(name deleted prior to publication)* report dated 24 January 2002. Further, the contents of Chapter 7 and Chapter 12 of the Operational Procedures Manual issued pursuant to s.4.9 of the *Police Service Administration Act 1990* clarify the roles of and obligations on officers with respect to such orders.

With respect, the view put forward by the Ombudsman regarding the operation of the orders and enforcement by the Queensland Police Service is accepted as correct. The misunderstanding conveyed in the original response by the Service is regrettable and, does not truly represent the understanding of the Service regarding the operation of such orders. Unfortunately, time frames required in complying with the original request of the Ombudsman may have led the investigating officer into error as to what was required. I trust that the detailed and comprehensive report of Detective Inspector (name deleted) and the provisions of the Manual clarifies the situation as regards QPS understanding of these matters. The Operational Procedures Manual is available on the internal electronic website called the "Police Bulletin Board" accessible by every officer in all the State.

Contact between SCAN doctor and JAB

The enclosed report reaffirms that, notwithstanding the results of further investigation by the Ombudsman, police personnel do not have a recollection of the conversation with the SCAN doctor referred to. Equally, upon further investigation, there appears no written recordings of such conversation. That said, the material merely shows that the doctor indicated that a child had been taken from the hospital by her mother. There also appears no material to suggest that the doctor indicated the child was or would become the subject of a 96 hour order.

There is significant detail in the report of Detective Inspector (name deleted) regarding procedures in place for when officers are unavailable for telephone calls. From a police perspective, it is clear that depending on the tone of the caller, and the nature of the information received, a determination must be made by the officer or administration officer as to whether the call is of significance and should operate as a notification. In the absence of any recording, in this case, it would seem to follow that the person involved with the phone conversation with the doctor did not consider the matter to be such to warrant a notification for recording in the necessary job sheets. This would seem to bear out the doctor's recollection that he was requested to contact DFYCC for assistance and that DFYCC could contact police if they required further assistance.

With respect, it is not necessarily of suspicious note that an officer does not recall some two and a half years later the content of a call made to JAB with a doctor. The only conclusion that can be drawn is that the two persons, the parties to the conversation may not necessarily have treated the information with the same significance or priority as the other. However, it appears clear that the doctor concerned did not have such significant concerns as to warrant the making of a 96 hour order or take some other preventative step. This is further borne out by the absence in later SCAN documents as to concern by the response of the Service to the initial contact.

It appears quite clear from the annexed material that the contact between the doctor and police was not considered sufficient to merit noting by the QPS, SCAN, DFYCC or Health at the time. The Service remains committed to assessing every contact made and, if determined to be a notification, investigating the same. It would seem to follow that the conversation with the doctor was not considered to be a notification based on its content and tenor.

Contact between DFYCC and QPS

The report of Detective Inspector (name deleted) appears to resolve some of the confusion existing in this matter. It has been established that a DFYCC officer did receive the request from Dr (name deleted) after 3

o'clock on July 1999. An officer from DFYCC states he did phone JAB but cannot recall if he spoke to anyone or if his call went unanswered. There is no notation by DFYCC of that call. As it is impossible to identify what DFYCC officer spoke to what QPS officer, the nature, content and tenor of the conversation cannot be ascertained. It is not possible with the effluction of time to establish whether any urgency was appreciated at the time, and if so, if it was communicated between the relevant agencies. It would appear to follow from the fact that no notation was made by DFYCC, QPS or the hospital or later referred to in SCAN notes, that this telephone communication was considered standard.

Appendix D — Documents obtained during the course of the investigation

The following documents were provided or obtained during the course of this investigation:

Queensland Health

1 QH's initial report to this Office dated 8 May 2001.
2 Copies of Sections 76K and 76L of the Health Act.
3 A copy of the *Queensland Government SCAN Team Manual*.
4 Brooke Brennan's medical records, as held by the Gold Coast Hospital.
5 Referral letter dated 12 July 1999 from Brooke's GP to the Emergency Department of the Gold Coast Hospital.
6 Statement of the emergency physician at the Gold Coast Hospital Emergency Department who received a telephone call on 12 July 1999 from Brooke's GP (in relation to her referral).
7 Notes made by the emergency physician at the time of the telephone call from Brooke's GP.
8 Statement of the Emergency Registrar who examined Brooke on 12 July 1999 at the Gold Coast Hospital.
9 Statement of the Paediatric Registrar who examined Brooke on 12 July 1999 at the Gold Coast Hospital.
10 Statement of the Nurse in Charge of the Paediatric Unit who spoke with Ms A on 12 July 1999, and who was in the area when Ms A removed Brooke from the hospital ward on 13 July 1999.
11 Statement of the Nurse on Duty who spoke with Ms A on 13 July 1999 when she was removing Brooke from the ward.
12 Statement of the Gold Coast SCAN doctor who was to have reviewed Brooke on 13 July 1999.
13 Copies of floor plans of the ground floor and fifth floor (Paediatric Unit) of the Gold Coast Hospital.
14 QH's further report to this Office dated 10 August 2001.
15 QH's further report to this Office dated 22 August 2001.
16 QH's further report to this Office dated 12 September 2001.
17 QH's further report to this Office dated 30 November 2001.
18 QH's response to the provisional report, dated 18 January 2002.
19 QH's further report to this Office dated 18 February 2002.
20 Chief Health Officer Circular published by the Medical Board of Queensland, entitled *Medical Practitioners in Queensland are Mandated to Report Suspicions of Child Abuse and Neglect.*
21 Copies of QH medical records of certain patients of the Gold Coast Hospital in relation to whom an order pursuant to section 76L of the Health Act had been issued.

Department of Families

1 DOF's initial report to this Office dated 31 May 2001.
2 DOF's Gold Coast Area Office report titled *Report Per PM95/17 - Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons*, dated 27 July 1999.
3 DOF's internal report titled *Case Review following the death of Brooke Brennan - Report for the Regional Director, Brisbane South*, dated 14 September 1999.
4 DOF Policy titled *PM95/17 - Procedures for Recording and Reviewing the Death or Serious Injury of Children and Young Persons*, dated 2 August 1995.
5 DOF document titled *Notification*, dated 15 July 1999, in relation to Brooke Brennan.
6 DOF document titled *Initial Assessment*, dated 16 July 1999, in relation to Brooke Brennan.
7 DOF document titled *Notification*, dated 26 July 1999, in relation to Brooke Brennan.
8 DOF document titled *Initial Assessment*, dated 27 July 1999, in relation to Brooke Brennan.
9 Various documents titled *Parliamentary Brief, Issue Brief, Background Brief*, various dates, in relation to Brooke Brennan.
10 Document titled *Report on the Death of Brooke Brennan (DOB 05/08/95)*, undated.
11 Copy of QPS document titled *Minutes of SCAN Team Meeting*, dated 22 July 1999.
12 DOF document titled *SCAN Referral - Gold Coast District SCAN Team*, dated 22 July 1999, in relation to Brooke Brennan.
13 Various correspondence from members of the public to DOF in relation to Brooke Brennan, and ministerial replies to those correspondence.
14 DOF's further report to this Office dated 23 July 2001.
15 DOF's further report to this Office dated 16 August 2001.

16 DOF's further report to this Office (undated), with attachment titled *Work Activity Profile*, received by this Office on 21 September 2001.
17 DOF's further report to this Office dated 24 September 2001, with attachments titled *Child Death Reviews Policy and Procedures* and *Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures*.
18 The Gold Coast Area Manager's response to written questions from my officers, dated 26 November 2001.
19 DOF's response to the provisional report, dated 11 January 2002.
20 DOF's further report to this Office dated 28 February 2002.
21 DOF document titled *A Practice Guide: For the Assessment of Harm and Likely Harm*.
22 Draft report titled *Review of the Queensland Suspected Child Abuse and Neglect (SCAN) Team System*, dated December 2001 and prepared for DOF and the Coordinating Committee on Child Abuse (CCOCA).
23 Further report from the Gold Coast Area Manager, dated 4 March 2002.
24 Statutory Declaration of the Gold Coast Area Office Intake Team Leader, dated 28 February 2002.
25 Statement of FSO X, dated 28 February 2002.
26 Statement of FSO Y, undated, received on 6 March 2002.
27 Email correspondence from DOF received on 4 April 2002, in response to email correspondence sent by my officers on 27 March 2002.

Documentation obtained from other sources

1 Copies of newspaper articles relating to the Brooke Brennan case from July 1999 to the date of this report.
2 Various letters from members of the public to this Office seeking to provide information.
3 A copy of the transcript of the trial of Troy Self, conducted in the Supreme Court of Queensland from 28 February 2001 to 8 March 2001.
4 A report from QPS dated 1 August 2001.
5 A report from QPS dated 3 August 2001, which included documents listed at 6 to 9 following.
6 QPS documents titled *South Eastern Region, Northern JAB Detectives Occurrence Sheet*, dated 12 to 16 July 1999 (five in total).
7 Copies of statements made by the two FSOs to QPS on 26 and 31 August 1999.
8 Report titled *Queensland Ombudsman - Statutory Investigation into Matters Relating to the Death of Brooke Brennan*, from a Detective Senior Sergeant of the Gold Coast District Criminal Investigation Branch, to the Detective Inspector of the Gold Coast District Criminal Investigation Branch, dated 31 July 2001.
9 Letter of advice from QPS Solicitor to the Commissioner of QPS, dated 3 August 2001, titled *Queensland Ombudsman - Statutory Investigation into Matters Relating to the Death of Brooke Brennan*.
10 Documents provided by QPS on 20 August 2001 in relation to SCAN team meetings.
11 The Gold Coast SCAN doctor's telephone records for 13 July 1999, as provided by Telstra Corporation Limited on 18 September 2001.
12 Various documents provided by the QPSU, including internal DOF documentation.
13 Various documents provided by the DOF officers during the interviews conducted by my officers on 2 August 2001, as listed at 14 to 18 following.
14 DOF document titled *PM00/03 - Child Protection Notification (Initial Assessment) Response and Specific Workload Management Strategy*, dated 28 February 2000.
15 Various documents outlining a 'Safety Assessment' framework for responding to child protection notifications.
16 DOF document titled *Child Protection Procedures Manual*, Chapters 1 to 26.
17 DOF records of notifications received for the months of June and July 1999.
18 DOF Memorandum from the Gold Coast Area Office Intake Team to the Regional Director, Brisbane South Region, dated 2 March 1998, titled *Report from Gold Coast Child Protection Team in Relation to Workload Issues and Staff Limitations*.
19 Various DOF documents containing data and other information relevant to workloads and resourcing within the Gold Coast Area Office, as provided to my officers during their attendance at the Gold Coast Area Office on 23 August 2001.
20 Media statement of Minister for Families titled *Reviews to be Independent*, dated 23 March 2001.
21 Transcript of committal hearing of Mr Self, pages 31 to 36 only (containing the evidence of Ms A).
22 Transcript of Police Record of Interview with Ms A, conducted on 25 July 1999.
23 Statement of Ms A to QPS dated 1 February 2000.

24 Statement of Gold Coast general practitioner (who examined Brooke on 12 July 1999) to QPS dated 26 July 1999.
25 Ms A's response to a series of written questions posed to her by this Office on 10 August 2001, received on 20 December 2001.
26 Ms A's response to proposed adverse comment, dated 1 February 2002.
27 QPS' response to the provisional report, dated 19 February 2002.
28 QPS report prepared by a Detective Inspector of the Gold Coast District Criminal Investigation Branch, dated 24 January 2002.
29 Various versions of QPS' Operational Procedures Manual, Chapter 7 and Chapter 12.
30 QPS' further report to this Office dated 1 March 2002.
31 Copy of minutes of Gold Coast SCAN team meeting (including agenda) for meeting held on 15 July 1999.

Appendix E — Sections 76K and 76L of the *Health Act*

Division 6—Maltreatment of children

76K Notification of maltreatment

(1) A medical practitioner who suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger shall, within 24 hours after first so suspecting, notify by the most expeditious means available to the medical practitioner a person authorised under a regulation to be so notified.

(2) Where notification is given to an authorised person pursuant to subsection (1), the medical practitioner so notifying shall, within 7 days after doing so, forward to the chief executive a further notification in the approved form.

(3) 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 so doing, may communicate the notification to other persons for the purpose of having investigations or inquiries made or other things done to enable full effect to be given to the provisions of this division.

(4) A notification given pursuant to subsection (1) or subsection (2) shall state the observations and opinions upon which the medical practitioner's suspicion is based.

(5) In addition to receiving the notification pursuant to subsection (2), the chief executive may require the medical practitioner so notifying or any other medical practitioner associated with treatment of the child in question to forward to the chief executive any statement or further information that the chief executive considers the chief executive should have concerning the child; and the medical practitioner concerned shall comply with such requirement.

(6) Where in compliance or purported compliance with this section a notification is given or a statement or further information furnished in good faith by a medical practitioner—

(a) no liability at law is incurred in respect of the giving or furnishing thereof by the medical practitioner;

(b) the giving or furnishing thereof shall not in any proceedings before any court or tribunal or in any other respect be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.

(7) A person does not incur any liability as for defamation by the publication of any defamatory matter contained in a notification or statement or further information as aforesaid where such publication is made in good faith and pursuant to any provision of or otherwise in the execution of this division.

76L Temporary custody of children

(1) In this section—
"prescribed medical officer" means the medical superintendent or other medical officer in charge of a hospital in question or any nominee (being a medical practitioner) of such medical superintendent or other medical officer (such medical superintendent or other medical officer being hereby authorised to make any such nomination as the person thinks fit).

(2) Where—

(a) a child has presented itself or been presented at a hospital; and

(b) the prescribed medical officer suspects upon reasonable grounds the maltreatment or neglect of the child in such a manner as to subject or be likely to subject it to unnecessary injury, suffering or danger;

the prescribed medical officer—

(c) may order in writing the admission of that child as a patient to, and the detention of that child in, that hospital for a period not exceeding 96 hours from the time of that presentation; or

(d) if prior to the making of that order the child leaves or is removed from the hospital without the permission of the prescribed medical officer—may order in writing that the child be taken into custody and conveyed to such hospital as that officer directs and detained there for a period not exceeding 96 hours from the time of the making of the order.

(3) If whilst a child is a patient in a hospital the prescribed medical officer suspects upon reasonable grounds the maltreatment or neglect of the child in such a manner as to subject or be likely to subject it to unnecessary injury suffering or danger, the prescribed medical officer—

(a) may order in writing the detention of that child in hospital for a period not exceeding 96 hours from the time of the making of that order; or

(b) if prior to the making of that order or at any time within the duration of that order the child leaves or is removed from the hospital without the permission of the prescribed medical officer—may order in writing that the child be taken and conveyed to such hospital as that officer directs and detained there as a patient for a period not exceeding 96 hours from the time of the making of that order.

(4) Where the prescribed medical officer who makes an order in writing pursuant to either subsection (2) or (3) is of the opinion that the assistance of a police officer is necessary for the purpose of enforcing the order, the medical officer may certify as to the medical officer's opinion by endorsement upon the order.

(5) It shall be the duty of a police officer to whose notice that endorsement is brought to assist the prescribed medical officer as required and in accordance with this Act and a police officer so assisting may without other authority than this Act detain or assist in detaining in hospital, prevent any person from removing from hospital or take and convey or assist in taking and conveying to such hospital as the prescribed medical officer directs that child, for the purpose of enforcing that order.

(6) It is lawful for any police officer acting in accordance with any authority vested in the police officer by this section and all persons acting in aid of the police officer to use such force as is necessary to detain or assist in detaining in hospital, prevent any person removing from hospital.or take and convey or assist in taking and conveying to hospital a child, for the purpose of enforcing an order made pursuant to this section with respect to that child.

(7) A justice who is satisfied upon the complaint of a police officer acting in accordance with authority vested in the police officer by this section, that there is reasonable cause to suspect—

(a) that an order has been made by a prescribed medical officer in respect of a child pursuant to either subsection (2) or (3); and

(b) that the child has left or been removed from the hospital without the permission of that prescribed medical officer; may issue a warrant authorising all police officers to search for that child and for that purpose to enter any place or premises and to take into custody that child and to convey the child to the hospital.

(8) For the purpose of executing the warrant made pursuant to subsection (7) the person executing the same—

(a) may enter any place or premises wherein the person executing the warrant reasonably suspects that child to be; and

(b) may search that place or those premises; and

(c) may exercise therein the powers conferred upon a police officer by this Act; and

(d) may use such force as may reasonably be necessary to perform any of the things referred to therein.

(9) For the purpose of gaining entry to any place or premises a police officer may call to the officer's aid those persons that the officer thinks necessary and those persons, while acting in aid of the officer in the lawful exercise by the officer of the officer's power of entry and search shall have a like power of entry and search.

(10) Where an order has been made by a prescribed medical officer in respect of a child pursuant to either subsection (2) or (3) shall cause the parent, guardian or person entitled to custody of the child to be informed of the whereabouts, from time to time, of the child unless that officer is of opinion that the giving of that information is not in the best interests of the child.

(11) A person who—

(a) without the permission of the prescribed medical officer removes from a hospital a child in respect of which an order has been made pursuant to either subsection (2) or (3); or

(b) aids, counsels or procures that child to leave a hospital; or

(c) knowing that child to have left or been removed from a hospital and that an order pursuant to either subsection (2) or (3) has been made with respect to that child, harbours or conceals that child;

commits an offence against this Act.

(12) Notwithstanding the wishes of any parent, guardian or person claiming to be entitled to the custody of a child in respect of whom an order has been made in accordance with subsection (2) or (3), it shall be lawful for—

(a) the child to be detained in, or taken into custody and conveyed to and detained in, the hospital for the period specified in the order;

(b) the child to be subjected to such diagnostic procedures and tests as the prescribed medical officer considers necessary to determine its medical condition;

(c) such treatment to be administered to the child as the prescribed medical officer considers necessary in the interests of the child, subject to the conditions specified in subsection (13).

(13) Where treatment is administered to a child pursuant to subsection (12)(c), neither the prescribed medical officer administering the treatment or in charge of its administration nor any person acting in aid of the prescribed medical officer and under the prescribed medical officer's supervision in the administration of the treatment shall incur any liability at law by reason only that any parent, guardian or person having authority to consent to the administration of the treatment refused consent to the administration of the treatment or such consent was not obtained if—

(a) in the opinion of the prescribed medical officer the treatment was necessary in the interests of the child; and

(b) either—

(i) upon and after in person examining the child, a second medical practitioner concurred in such opinion before the administration of the treatment; or

(ii) the medical superintendent of a hospital, being satisfied of the unavailability of a second medical practitioner to examine the child and of the necessity of the treatment in.the interests of the child, consented to the treatment before it was administered (which consent may be obtained and given by any means of communication whatsoever).

(14) Treatment administered to a child in accordance with this section shall, for all purposes, be deemed to have been administered with the consent of the parent or guardian or person having authority to consent to the administration of the treatment.

(15) Nothing contained in this section relieves a prescribed medical officer from liability in respect of the administration of treatment to a child to which liability the medical officer would have been subject had the treatment been administered with the consent of the parent or guardian or person having authority to consent to the administration of the treatment.

(16) Where an order has been made pursuant to subsection (2), a copy thereof shall be forwarded as oon as practicable to—

(a) the chief executive;

(b) any person recorded at the hospital as being the parent, guardian or person claiming to be entitled to the custody of the child.

(17) Failure to comply with subsection (16) does not invalidate the order.

Appendix F — Department of Families document:

Practice Guide for Assessing High/Low Level of Risk – Notifications Requiring Initial Assessment

Risk Indicator	High	Low
ALLEGED HARM **Severity of Harm/Risk**	• Any alleged abuse of a child under 1	
• *Sexual Abuse*	• Current abuse and child/young person in danger, or child/young person's disclosure, or the presence of a corroborating witness	• Abuse by family members/significant other who is no longer living in the family home or having contact with the child/young person
• *Physical Abuse*	• Injuries regarding medical attention	• Minor injuries, previous incident or no current indication of abuse
• *Neglect*	• Actual or likely injury or medical impact	• Potential harm or distress, distress or discomfort for the child/young person
• *Emotional Abuse*	• Child/young person afraid or disturbed, observable impact on child/young person	• Signs of deprivation or distress impacting on child/young person's functioning
• **Frequency of Harm** – pattern and/or escalation	• Chronic pattern of behaviour • Rapid escalation of behaviour over a short period of time	• No discernible pattern of behaviour • No escalation
• **History of harm**	• Previous History of serious notifications • Recent History of serious notifications	• No previous history • History of unsubstantiated notifications • No recent serious notifications •
CHILD/YOUNG PERSON • **Vulnerability** – age, development, special needs, capacity to protect themselves	• Child/young person unable to protect themselves from current harm, due to age, development, disability or circumstances • Child/young person under five and/or not having independent contact outside the family home • Child/young person fearful of parents, indicating unwillingness to return home, severe acting out/withdrawn behaviour • Child/young person is having current contact with alleged perpetrator	• Child/young person over five and having contact outside of the family • Child/young person does not appear fearful and there are no signs of disturbance Child/young person is not having contact with current perpetrator

Parents		
• **Perpetrator's behaviour**	• Severe, dangerous • Violent, out of control • Threatening serious harm • Serious lack of care or failure to meet basic needs • Very negative toward child/young person • Abandonment • Coercing child/young person	• One-off incident • Excessive punishment, discipline issue not causing injury • Occasional lack of care or supervision • Parenting skills lacking or limited • Minor rejection, relationship issues
• **Non-perpetrator's behaviour**	• Blaming • Unable or unwilling to protect • Coercing child/young person	• Ambivalent • May not protect • Supportive of child/young person
• **Presence of other issues** impacting on parenting and capacity to protect child/young person – alcohol or drug addiction, psychiatric illness, intellectual disability, domestic violence	• Major issue impacting on parenting and capacity to protect • No awareness of impact of behaviour, not willing to seek or use assistance	• One or more issues present but not significantly impacting on parenting or capacity to protect
• **Willingness to seek assistance**	• Parents avoiding contact with support services • Parents avoiding contact with authorities, have removed child/young person from home, absconded	• Some awareness of difficulties and are currently receiving assistance • Parents currently receiving assistance from support authorities • Parents cooperative with authorities
ENVIRONMENT		
• **Support networks**	• Parents isolated from family and external supports	• Parents have some supports
• **Stresses within household** – unemployment, financial, health, disability	• Major stresses impacting on family functioning	• Some stress but not of major significance or relevance to protective issues

Appendix G – Extract from Department of Families' *Child Protection Procedures Manual*

Chapter 6 point 6.2(iv): When Initial Assessment is not possible due to Client Reasons

When it is impossible to commence or complete an Initial Assessment within one month, due to client reasons (eg inability to locate the family):

- ensure that all reasonable steps have been taken to commence or complete the assessment. The Manager must determine what steps are reasonable. The Manager should take into account:
  - the general circumstances
  - the level of alleged harm
  - any factors making the assessment difficult to commence or complete
- fully document the:
  - attempts to conduct the Initial Assessment
  - results of all actions
  - decisions and reasons for decisions
- complete an Initial Assessment record with as much information as possible.

In the case of a partially completed assessment, do not record a decision about the allegations if essential parts of the assessment eg meeting a child, did not occur. The appropriate outcome to be recorded in these circumstances is "Partial Assessment (Client Reasons)".

Where the assessment could not even be commenced eg where the family could not be located, the appropriate outcomes is "No Assessment Possible (Client Reasons)".

Appendix H – Extract from Queensland SCAN Team Manual

Chapter 16 – Guidelines for referral of cases to SCAN teams (June 1998)

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 coordinator of the SCAN team in a timely way. If an urgent matter arises which requires SCAN team consideration, the coordinator should be contacted to arrange an emergency meeting. This may be particularly necessary for SCAN teams that do no 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 assessment
- when 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 I - Extract from QPS Operational Procedures Manual

Ninety-six hour detention order – *Health Act*

POLICY

Section 76L of the *Health Act*, as well as providing specific authorities for police, provides for a prescribed medical officer to order the detention in a hospital for a maximum period of ninety-six hours of a child suspected upon reasonable grounds to have been maltreated, neglected or to be at risk. Officers may make use of this provision where there is a need to have a child medically examined as part of a child abuse investigation and the parents have demonstrated non-cooperation in the investigative process. Officers should note that the section does not give police the authority to take the child to the hospital. The order can only be made once the child has been presented to the hospital.

PROCEDURE

The *Health Act* provides that an order be made for a maximum of ninety-six hours. A prescribed medical officer may make a detention order for a shorter period of time.

Once a child is presented to the hospital, an officer should make a request to the prescribed medical officer to detain the child for a period of ninety-six hours. The hospital casualty section maintains the necessary forms (see Appendix 7.1).

Once the ninety-six hour order has been made, the officer conducting the investigation into the alleged abuse is responsible for providing the medical staff at the hospital with as detailed a case history as possible to enable medical staff to determine what medical examinations are appropriate.

7.8.13 Breach of ninety-six hour detention order

PROCEDURE

Refer to Chapter 12: 'Missing Persons' of this Manual where a child is unlawfully removed from the hospital during the ninety-six hour period. However, should the child leave or be removed from the hospital without the permission of the prescribed medical officer, either before the order is made, or during the ninety-six hour period of the order, the prescribed medical officer may, by way of a separate order in writing, direct that the child be taken into custody, conveyed to a hospital and detained there for a period not exceeding ninety-six hours from the making of that order. Persons who remove a child from the protection of the ninety-six hour order commit an offence against the *Health Act.*

Where a child, the subject of a ninety-six hour order, leaves or has been removed from the hospital, the order continues to be in force until the expiration of the ninety-six hour period. When a ninety-six hour order has expired, consideration may be given to the making of a care and protection application.

A warrant must be obtained to enter premises. The *Health Act* does not provide for any power of arrest (see appendixes to Chapter 12: 'Missing Persons' of this Manual for the wording of a warrant and grounding under s.76L of the *Health Act*).

Appendix J – Extract from Department of Families internal review report dated 14 September 1999

Table showing workload measurements for the Gold Coast Area Office Intake Team

Looking somewhat closer at workload measurement, the table below shows how a workload of 84 CP notifications a month looks for a team of 5.5 FSO's if one applies reasonable workload measures for performing the basic CP intake/assessment tasks for a standard.

1. Receiving/Recording CP Notifications	84 x 1.5 hrs	126 hrs
2. Allocated FSO on Initial Assessments	74* x 9 hrs	666 hrs
3. Second FSO on Initial Assessments	55** x 3 hrs	165 hrs
(* Assumes Statewide IA/PA ratio of 89/11 applies to the Gold Coast		
** Assumes 25% IA's are joint Police/FSO visits, probably a high estimate)		
Monthly hours required for CP notifications & assessments		957 hrs
Maximum hours available (5.5 FSO's working 145 hrs p.m)		798 hrs
Actual hours available (5.5 FSO's doing casework for 111 hrs p.m)		610 hrs

In other words, even if the Gold Coast Intake Team did NO other work (eg other intakes, CPFUs, court applications) they would simply not have enough hours in the month to complete the required tasks. Once one allows for leave and other essential activities such as supervision & training, **the shortfall in available staff resources in the team appears to be about 350 hours per month or 3 full time FSO's.**

Appendix K – Department of Families memo, 2 March 1998

Memo prepared and signed by the FSOs in the Gold Coast Area Office Intake Team

DEPARTMENT OF
FAMILIES, YOUTH AND COMMUNITY CARE

INTER OFFICE
MEMO

DATE 2 March 1998

TO [redacted] **Regional Director, Brisbane South Region**

COPIES TO [redacted] Team Leader, [redacted] Manager, [redacted] A/Operations Manager

FILE NO

SUBJECT **REPORT FROM GOLD COAST CHILD PROTECTION TEAM IN RELATION TO WORKLOAD ISSUES AND STAFF LIMITATIONS**

Please find attached the abovementioned report for your perusal and feedback.

Staff have requested that a copy of this report be attached to their personnel files. In addition, a copy of the report is being forwarded to the Departmental Union Representative to discuss with appropriate senior Departmental personnel.

Whilst Regional management is seen to be sympathetic to workers' issues, it is not seen as being able to allocate sufficient resources to complete statutory requirements at the Gold Coast Area Office.

[redacted] Family Services Officer

[redacted] Family Services Officer

[redacted] Family Services Officer

[redacted] Family Services Officer

[redacted] Family Services Officer

[redacted] Locum Family Services Officer

GOLD COAST AREA OFFICE

REPORT TO

BRISBANE SOUTH REGIONAL MANAGEMENT

ON

GOLD COAST OFFICE - CHILD PROTECTION TEAM

WORKLOAD ISSUES AND STAFF LIMITATIONS

****

CONTENTS

1. Current loads

1.1 Intake services

Workers respond to callers with protective issues in relation to children under 12 years . On average 5-6 intake calls are taken per day taken that require recording on the Child Protection Information System (CPS) as either intakes, Protective Advice or as Notifications. It is to be noted that:

- a recent study of the CPS noted that the minimum recording time of any type of matter on CPS is 69 minutes. Taking the call is additional to this time. Calls require on average about 20minutes.

- the Gold Coast Area Office has, over at least a four year timeframe taken between 50 - 70 notifications per month.

- Bureau of Statistics 1996 figures, recently released, reveal Oxenford and Helensvale to have had the highest and second highest population growth *in Australia* between 1991- 1996.

1.2 Initial Assessment services

Team members are required to follow up all incoming notifications other than those relating to children in long term care. The Gold Coast Area Office managed 27 % of all notifications taken in the Brisbane South Region in the 96/97 financial year period. It is to be noted that completion of Initial Assessments requires the key elements of:

- completing the assessment. This process often requires 1-3 family contacts and 1-3 agency contacts.

- writing up the assessment on the CPS. An average write up takes workers 60 minutes to complete. This time takes in to account both 'thinking time' and CPS 'systems time'.

1.3 Case follow up services

In about one third of situations where Initial Assessments are given a Substantiated or Substantiated at Risk outcome, team members are responsible for the management of:

- Child Protection Follow up cases. Workers have on average, 3-4 such cases requiring follow up servicing in accordance with Case Management (CMS) guidelines.

- Care And Protection cases taken and remanded before the Children's Court. Workers have on average 2-3 such cases in any month requiring intensive follow up and servicing in accordance with CMS guidelines.

- many non -statutory case follow up tasks, such as, 91 B report writing for the Family Court and Interstate or Inter Office protective assessment and/or follow up requests. Workers have on average 1-2 such requests per month to complete.

1.4 Community education and student supervision services

Each month workers receive a number of miscellaneous requests to give lectures for bodies such as careproviders, welfare students etc.. Workers respond to such requests approximately once per month.

In addition, team members provide the bulk of supervision services to students from varied educational institutions. Such supervision services are deemed organisationally 'desirable'. Whilst student supervision has benefits for the workgroup, such benefits significantly increase workload for supervisors, who are usually the most experienced workers already with significant and complex workloads to manage.

1.5 Current regional staff management requirements

The above high work loads are on many occasions carried out by less than 5.5 staff. This is due to regional staff management requirements that no backfilling occur when staff take recreation, long service or sick leave. In essence the above loads are managed at any one time by 4.5 or less staff.

1.6 Management of the Child Protection System (CPS)

On 6 March 1997 members of the Child Protection team became primary users of the CPS. In terms of loads, this meant that workers of the team had to:

- bear the long list of initial 'systems glitches'.
- bear the ongoing burden of 'system functionality' limits. CPS limits have been outlined to Regional management in a recent evaluation report prepared by the computer project team in late 1997.

2 Current Workload Management strategies

As noted in a number of previous memos written to Regional Management, the Team, over many years, has had a number of pro active strategies in place to manage high work loads. Some of the key strategies currently used include:

- Alternative Response time proposal (memo to Regional Manager dated 28 October 1997 and as yet, not acknowledged)
- monthly reports to Regional manager by Team Leader.
- weekly team allocation meetings to manage loads in the most effective ways e.g. giving workers a number of jobs in similar locations to minimise 'wasted trips' due to people not being home etc..
- ongoing manual recording of intakes.
- utilisation of the workload management strategy.
- rostering of off-line days to assist workers manage CPS loading tasks.

Historically Gold Coast Office has always received positive feedback from regional staff in relation to workload completion rates and in turn, the quality of assessment and case work services.

3. Effects occurring as a result of current loads

3.1 Organisation - general

Resources on a daily basis are targeted to high risk notifications and their CPS recording, court and ministerial driven matters, rather than 'backend' CPS tasks. Given this:

- initial assessment write ups, requiring extensive CPS and worker time to complete are not being done in an expedient manner. As a result:

  - the organisation is not getting necessary statistical information e.g. for annual reports.
  - the organisation is not getting the desired benefits of centrally available information.
  - workers feel that assessment outcomes are less accurate than they should be.

- the opening of case management screens is not being done expediently. This adds to an already existing organisational problem with accuracy of case management information.

- Case Management System (CMS) documentation is increasingly not up to date as per departmental policy requirements.

- Court remand and Child Protection Follow Up case tasks are not being completed as adequately as workers would like. Again minimum CMS standards are not currently being met as per Departmental policy.

- workers tend to always be rushing their work and assessments which has the capacity to lead to quality control issues. Workers feel 'good practise' expected by the organisation may not be being met on some occasions and that this can in turn potentially jeopardise community perceptions of the Department and its workers.

- staff are increasingly finding it difficult to manage routine case management tasks e.g. writing case notes and returning calls within 24 hours.

3.2 Organisational - Workplace Health and Safety.

Workplace Health and Safety legislation states that employers should not maintain employees in what could be deemed *'a system of abuse'*. It is the opinion of team members, especially those that have many years experience in team, that *'a system of abuse'* is currently occurring.
The advent of the CPS, along with an absence of *effective* centrally supported work load control options, have been critical factors in the loads of workers reaching intolerable and critical levels in both 1997 and 1998.

3.2 Personal

Currently:

- all team members feel that the daily work loads being carried are impossible to manage regardless of extremely effective personal management strategies and the high level of worker experience within the team.

- all team members are demonstrating stress related behaviours and symptoms: e.g. chronic ill health, headaches, anxiety and/or long work hours (ie outside average work hour requirements) and so on....

- all team members often feel uncomfortable taking recreation, rostered days off and sick leave entitlements due to the inevitable loads that will fall on co-workers and/or a feeling of 'letting the team down'.

- all team members are carrying anxieties in relation to incomplete work and the possible repercussions should 'something go wrong'. These anxieties have intensified over recent months as a result of recent child death cases (northern New South Wales), and the generally negative media coverage in relation to Departmental cases and decision making processes.

[redacted]
Family Services Officer (PT)
9 years service

[redacted]
Family Services Officer (FT)
9 years service

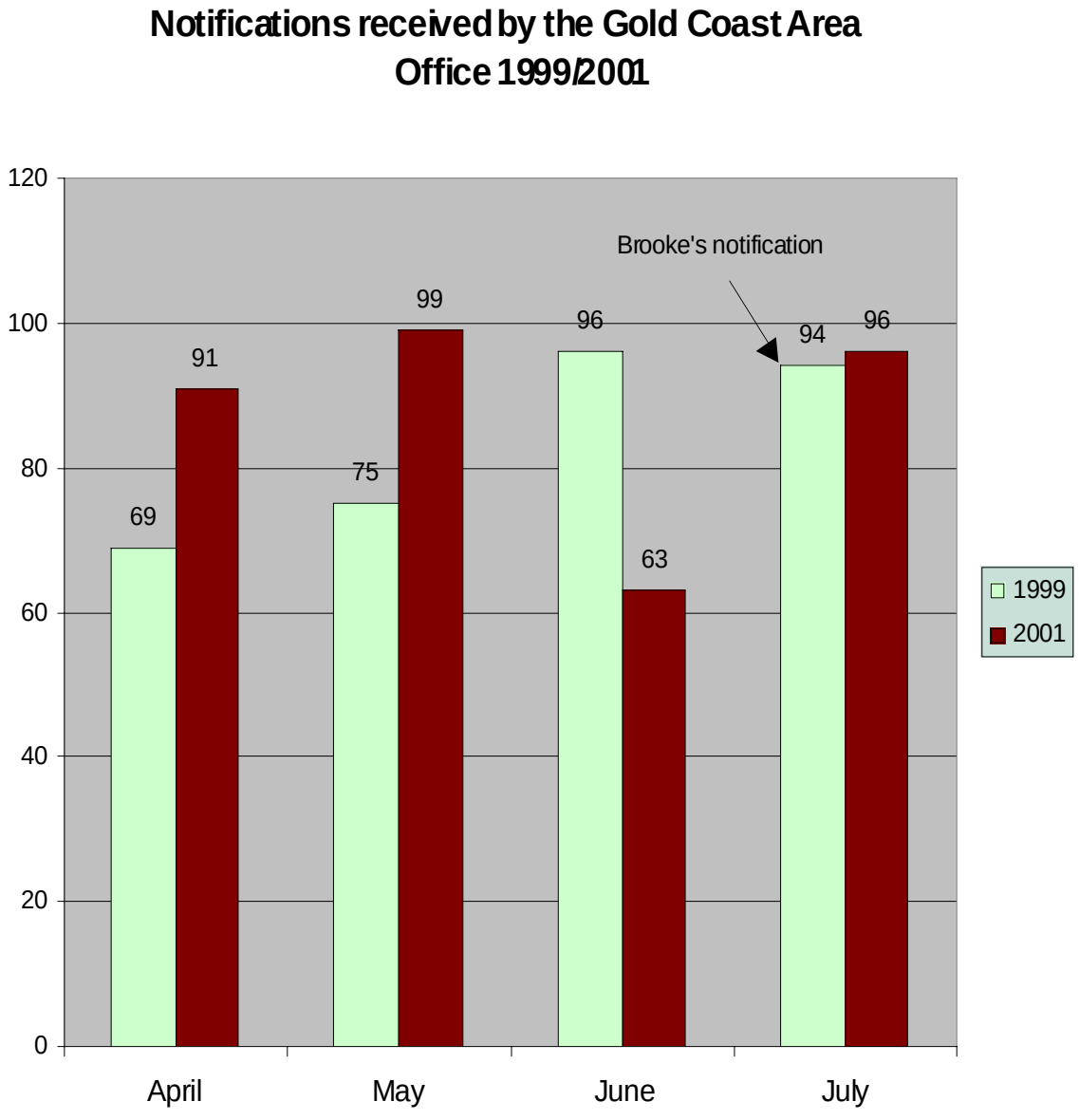
[redacted]
Family Services Officer (FT)
9 years service

[redacted]
Family Services Officer (FT)
1 years service

[redacted]
Family Services Officer (FT)
6 months service

[redacted]
Locum Family Services Officer (PT)
18 months service.

Appendix L – Notifications received by the Gold Coast Area Office 1999/2001



Appendix M — Statement released by Minister for Families

March 23 2001

Reviews to be independent

The Department of Families will introduce independent reviews of cases involving the death of a child as part of the ongoing process of rebuilding the Child Protection System, the Minister for Families, Judy Spence announced today.

Ms Spence said the use of independent reviews was one of the recommendations resulting from an examination of the circumstances surrounding the death of Brooke Brennan.

"We believe this is an important step to ensure the process is seen as impartial and to provide community confidence in the process," she said.

Ms Spence said under past arrangements, all cases involving the injury or death of a child who are subject to a departmental order were investigated and reviewed by senior officers from another part of the Department.

The review involved a file search and interviews with relevant departmental officers.

In the case involving Brooke Brennan, the review found that:

- departmental officers acted appropriately under the circumstances.
- procedures should be strengthened, especially in relation to determining the safety of the child.
- external, independent reviewers for child deaths would increase public accountability and transparency.

Ms Spence said the review had highlighted the need for better procedures relating to how safety assessments are made. At the moment current procedures focus on harm and significant harm (including the risk of harm) and not on the securing of ongoing safety.

She said these procedures were being revised to establish minimum standards for securing safety. This is being undertaken as part of the Child Protection Service System Improvement Project.

Ms Spence said under revised procedures, review and/or monitoring of such cases will be led by a reviewer external to the Department and appointed by the Director-General to ensure accuracy and impartiality and community confidence in the process.

"The Implementation of recommendations arising from a review of a child's death will be submitted to the Child Abuse Coordinating Committee (CCOCA). Trend data from the Department will be submitted to the Commission for Children and Young People for statewide data collection on child deaths," she said.

Ms Spence said the Beattie Government was committed to rebuilding an overworked and neglected child protection system.

"We have delivered the largest increase in recurrent child protection funding in the history of Queensland - an additional $45 million in funding by 2003. In the past two years we have delivered 154 new frontline workers – a significant part of our commitment to increase the number by 250 by 2002. We will deliver a further increase in front line staff next financial year," she said.

Appendix N – Minutes of Gold Coast SCAN team meeting, 22 July 1999

QUEENSLAND POLICE SERVICE

GOLD COAST DISTRICT

Juvenile Aid Bureau/Child and Sexual Assault Unit,
Level 4, Surfers Paradise Police Centre, 68 Ferny Avenue,
SURFERS PARADISE QLD 4217

TELEPHONE (07) 55707961 FACSIMILE (07) 55707904

14/1/99 Our Ref:

MINUTES OF SCAN TEAM MEETING

22/7/99

PRESENT: **Coordinator - Det Snr Const [redacted] NTH JAB**
[redacted] - DFYCC
[redacted] - DFYCC
[redacted]
[redacted] - Education Dept.

Caseworker: **[redacted]**

New Referral

Child's name: **BRENNAN**

ADDITIONAL INFORMATION:

CONCERNS: Physical Abuse to child by mother's partner

DISCUSSION SUMMARY:
15/7/99 - Home visit by DFYCC - nil person home and note sighted on door to partner, mother believed partner responsible and had left.
15/7/99 - Phone call Dr [redacted] and Hospital unable to lcoate mother and child and no other address provided.

Matter to be recorded as investigation unable to be completed.

RECOMMENDATIONS: Delete to SCAN

CLOSED TO SCAN TEAM (tick)

QUEENSLAND POLICE SERVICE

GOLD COAST DISTRICT

Juvenile Aid Bureau/Child Abuse Investigation Unit,
Level 4, Surfers Paradise Police Centre, 68 Ferny Avenue,
SURFERS PARADISE QLD 4217

TELEPHONE (07) 55707961 FACSIMILE (07) 55707904

ORIGINAL SCAN

CRISP ref:
DFYCC ref:

22 July 1999

TO: **Case Officer -** [redacted]

FROM: **Det Snr Const** [redacted] **- SCAN Co-ordinator**

SUBJECT: **BRENNAN**

This case was discussed by the GOLD COAST S.C.A.N. team on the 22/7/99.

The S.C.A.N. team has made the following recommendations in the best interest of the child:

☐ This matter is scheduled for **Review** at S.C.A.N on the **and:**

☐ Please provide a **CRISP** report.

☐ Please **see me** to discuss this case.

☐ A review form **is required** from you no later than **ONE** day before the scheduled review date.

☐ Due to the complex nature of this case you are required to **attend personally** at the next meeting.

☑ The case is **closed** to all agencies at S.C.A.N.

☐ This case is remaining open at S.C.A.N. for review by other agencies however this case has been **closed to Police.**

☐ In this case **charging** of the offender:-

- ☐ **is supported or ;**
- ☐ **is not supported ;**

by the S.C.A.N. team.

Appendix O – Department of Families document *SCAN Referral – Gold Coast District SCAN team, 22 July 1999*

DEPARTMENT OF FAMILIES YOUTH AND COMMUNITY CARE

SCAN REFERRAL

Gold Coast District SCAN Team

Date:	22/07/99

Names	D.O.B.	Sex
Brooke Brennan	05/08/95	F
Address		
7/24 Back Street, Labrador		

Mother	D.O.B.	Father	D.O.B.
[redacted]	[redacted]	Unknown	

Siblings	D.O.B.

Family Doctor	Phone

Aboriginal		

Previous Notifications -
Nil

Medical Examination by:	Date

Other Agencies	

NOTIFICATION/INITIAL ASSESSMENT SUMMARY

15/07/99
Child admitted to Accident and Emergency at Gold Coast Hospital yesterday. Child has bruise on finger, bruising around face, and on lower abdomen. Child allegedly with mother's partner when this occurred. Hospital indicating that injuries are not consistent with information provided by mother's partner.
Mother's partner providing various explanations as to how injuries occurred.

15/07/99
Home visit by FSOs [redacted] and [redacted] No-one was at home. Back door of home was open and a note sighted on door indicating that mother believed partner was responsible for child's injuries and as a result, had left partner. No information as to whereabouts of mother or child.

15/07/99
Telephone call to Gold Coast Hospital and Dr. [redacted] No alternative addresses were provided to either by mother.

ASSESSMENT:
Unable to complete investigation as whereabouts of mother and child unknown. Mother appears to have taken appropriate action by leaving partner.

CURRENT CASE PLAN

No further Departmental involvement at this point

RECOMMENDATIONS

MENTION ☐ DELETE ☐

Family Services Officer: [redacted]

Police Officer:

Appendix P — Queensland Health's response to final report

I refer to your letter dated 11 April 2002, enclosing your Report and Recommendations concerning the administrative conduct of the Department of Health, the Department of Families and the Queensland Police Service in relation to the death of Brooke Brennan ("the Report").

Pursuant to the provisions of Section 51(2)(a) and (b) of the *Ombudsman Act 2001*, I advise that the steps taken or proposed to be taken by my Department to give effect to the recommendations that you have made in the Report are as outlined below. Specifically Queensland Health supports the recommendations, all of which are already being progressed.

Queensland Health Recommendations

1. Queensland Health develop written policies and procedures to address when and in what circumstances prescribed Medical Officers of Queensland Health should make a 96-hour Order in relation to a child. The policies and procedures must provide that 96-hours are to be issued in any circumstances (within the terms of Section 76K of the *Health Act*) where it will best ensure the safety of a child who is likely to be subject to unnecessary injury, suffering or danger.

Officers of my Department have produced draft guidelines for Queensland Health staff about how, when and in what circumstances 96-hour orders should be made in relation to a child. Now that I have received your final Report, these guidelines can be finalised to be consistent with your Recommendations. I expect to be able to publish the final guidelines within the next few weeks.

2. Queensland Health develop written policies and procedures that require the documentation of verbal child protection/requests made by its officers to other agencies with a concurrent child protection role.

Queensland Health has in place written policies and procedures about appropriate record keeping by Queensland Health staff, including health workers. However, it would be timely to remind staff about the importance of proper record-keeping. The guidelines for 96-hour orders will reinforce the need to appropriately document child protection action taken by officers of Queensland Health and a new form for 96-hours orders to be approved by me will assist in identifying the significant matters to be documented by staff.

3. Queensland Health review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that all suspected child abuse and neglect matters are referred to the SCAN team for discussion in a timely and appropriate manner, and in accordance with its child protection obligations.

The Suspected Child Abuse and Neglect (SCAN) Team Review that you mention in your Report has already highlighted that there are inadequate protocols for administrative processes within SCAN Teams. The outcomes of that Review will be implemented through the Co-ordinating Committee on Child Abuse (CCOCA). The new form for 96-hour orders that I refer to above will prompt staff to ensure that their SCAN Team representative knows about the matter and the guidelines for 96 hour orders will reinforce the requirement to refer cases of suspected abuse to a SCAN Team meeting.

4. Queensland Health review its lines of communication with Queensland Police Service and Department of Families to ensure a rapid response in priority child protection cases.

This recommendation is on the agenda of COCCA for the May 2002 meeting. It is the appropriate forum to consider how communication can be improved between the agencies.

SCAN Recommendations

1. **Queensland Health, Department of Families and Queensland Police Service develop a Memorandum of Understanding in relation to the referral of child protection matters to SCAN teams to ensure that:-**

    - **each core agency appreciates its role and obligations for referring matters to SCAN teams;**
    - **formal procedures for referral of child protection matters are followed consistently, and**
    - **referrals are made in a timely fashion, having regard to the level of priority of the particular matter.**

The SCAN Team Review has already identified the need for such a Memorandum of Understanding. Queensland Health is presently working with Department of Families about the types of matters to be covered in the agreement, which will include the matters listed above.

2. **Queensland Health, Department of Families and Queensland Police Service develop a proforma for minutes taken at SCAN meetings to ensure that the basis upon which recommendations are made is recorded. Specifically, the reason/s why a particular course of action was selected over other possibilities should be documented.**

The SCAN Team Review identified the need for an updated proforma for the data that SCAN teams collect. The issue of recording of minutes will be examined as part of the implementation of the report into the review of SCAN Teams. The SCAN Team Review clearly identified that the Department of Families has ultimate responsibility for the provision of administrative and secretarial support for CCOCA and the SCAN Teams.

Appendix Q — Department of Families response to final report

SUMMARISED RESPONSE BY THE DEPARTMENT OF FAMILIES TO RECOMMENDATIONS ARISING FROM THE BROOKE BRENNAN REPORT

9.2 DEPARTMENT OF FAMILIES RECOMMENDATIONS

9.2.1
Department of Families review its procedures in relation to the referral of child protection matters to SCAN teams to ensure that such matters are treated with an appropriate level of priority and, specifically, that urgent matters are referred to the first available SCAN team meeting, irrespective of when notifications are received.

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

In May 2001, an evaluation of the SCAN team system was commenced by Ms Lisa Kennedy and Mr Paul Mazerolle from the Social and Economic Research Centre, University of Queensland. The terms of reference for the SCAN team evaluation included an assessment of the performance of SCAN teams in terms of:

- meeting their aims and objectives,
- the principles of the *Child Protection Act 1999;* and
- achieving the outcome of coordinated child protection service delivery.

The final report was received by the Chair, Coordinating Committee on Child Abuse (CCOCA) in December 2001. Subsequently, this report was considered by the CCOCA at their first meeting in February 2002.

This evaluation report was considered by the Executive Management Committee, Department of Families on 23 April 2002 before distribution to the SCAN team member departments for consideration of the recommendations and the development of a joint plan of action.

The Gold Coast Area Office advise that a telephone conference is now held for all urgent, life-threatening cases when SCAN team core members are unable to meet. Other matters are dealt with through the normal SCAN team process and are referred to the next available SCAN team. All new referrals are completed in writing and cases being reviewed are accepted verbally as well as in writing.

9.2.2
As part of CPSSIP, DOF replace the policy contained in chapter 6, Point 6.2.(iv) of its Child Protection Manual (in relation to notifications for which initial assessments are unable to be commenced or completed because of “client reasons”) with a policy that addresses the deficiencies identified by this report.

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

The contents of the Child Protection Procedures Manual are in the process of being reviewed as part of a policy translation and development project initiated by the Director-General.

The policy contained in Chapter 6, point 6 (iv) of the manual will be amended to include ‘unacceptable risk of harm’. This will provide scope for the question of imminent safety/danger to

be asked in relation to an initial assessment of a child or young person where a decision is being made about whether or not an Initial Assessment is possible due to client reasons. This approach properly relies on the wording of section 10 of the *Child Protection Act 1999* and is a practical application of the object of the legislation to protect children from harm.

9.2.3
DOF engage a suitably qualified independent expert to review whether the Gold Coast Area Office of DOF is currently adequately resourced to meet its statutory child protection obligations pursuant to the provisions of the Child Protection Act. The independent reviewer should report to the responsible Minister and the Director-General of DOF and provide a copy of the report to this Office.

The Department agrees to hire an independent expert to review the process (the WAP methodology) by which resources are allocated to Area Offices, and whether the process has been applied properly to the Gold Coast Area Office. The decision about the quantity of resources allocated to the Department of Families is ".. a policy decision, made by a Minister or Cabinet", and Section 16 of the *Ombudsman Act 2001* prohibits the Ombudsman from questioning the merits of such a decision.

Action to date:

Since July 1999, the Department of Families has progressed the following:

- the Department has reviewed the Regional Directors position and the position has been upgraded from Senior Officer Level to SES 2. A new Regional Director has been recently appointed;
- the Gold Coast Area Office (the Office) has been allocated an additional 11.5 FSO's and 1 Family Resource Worker;
- the Office has appointed another manager to be able to maintain and facilitate a focus on alternative care and child protection (initial assessments);
- the Office has appointed another team leader that has resulted in two team leaders for alternative care;
- the Office has appointed another administrative staff member;
- the Office has gained a number of additional staff through a short-term budget bid (until June). This includes the appointment of FSO locums to address Initial Assessments, a Team Leader to look at the configuration of the Child Protection service response team and the realignment of roles with a view to developing specialist roles (eg, babies, pre-school age group, adolescents). The Team Leader will also review workload structures and recommend system types to assist in case efficiencies and effectiveness; and
- A small but significant shift has been made in respect of the Gold Coast regional boundaries to more equitably distribute the demographic load with the Beenleigh office.

9.2.4
Department of Families implement procedures so as to ensure that feedback and support are provided to Department of Families officers whose administrative actions are the subject of a review pursuant to the Department of Families recently developed policies entitled ' Child Death Reviews Policy and Procedures" and Reporting of Deaths, Serious Incidents and Missing Persons Policy and Procedures:"

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

The Director-General, Department of Families met with the Commissioner for Children and Young People on 15 March 2002 to discuss a number of matters relating to the child deaths review process. Following this meeting, a letter was forwarded to the Commissioner dated 5 April advising that the Department of Families would be reviewing the policy and procedures that were implemented in September 2001 and inviting the Commissioner to be a member of the CCOCA - Child Deaths sub-committee.

The Department acknowledges that the* Child Deaths Reviews Policy *implemented in September 2001 needs to include procedures that will enable officers whose administrative actions are the subject of a review to participate in the review process.

It has been agreed that feedback and support will be provided to Department of Families officers whose administrative actions are the subject of a review with officers specifically being invited to respond to the final review report. This agreement has been communicated to officers who are the subject of current reviews pending the finalisation of the policy review.

9.2.5
Department of Families review its lines of communication with Queensland Health and Queensland Police Service to ensure a rapid response in priority child protection cases.

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

The CCOCA was established by Cabinet and provides a formal mechanism to co-ordinate the activities of various Departments in relation to child abuse and neglect. The CCOCA has on ongoing role in guiding and maintaining the activities of SCAN teams. The CCOCA meet six-weekly and acts as a forum for the relevant Government departments to discuss and devise policy.

The Department of Families has included this recommendation on the agenda for the May 2002 meeting of the CCOCA.

Since the death of Brooke Brennan, the Gold Coast Area Office have arranged with the Queensland Police Service (QPS) to place high risk, mobile families on the QPS database. This will also enable QPS to notify Crisis Care when appropriate. Families at high risk of domestic violence are also to be listed on the QPS database.

9.3 SCAN TEAM RECOMMENDATIONS

9.3.1
Queensland Health, Department of Families and Queensland Police Service develop a Memorandum of Understanding in relation to the referral of child protection matters to SCAN teams to ensure that:-

- each core agency appreciates its role and obligations for referring matters to SCAN teams
- formal procedures for referral of child protection matters are followed consistently, and
- referrals are made in a timely fashion, having regard to the level of priority of the particular matter.

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

The CCOCA provides advice to the Minister for Families and other Ministers where appropriate, on matters relating to child abuse and neglect and on SCAN team operations. At the CCOCA meeting held on 19 February 2002, members identified the need for a Memorandum of Understanding that provides clarity about the roles and responsibilities of the member departments involved in SCAN team operations.

The Director-General, Department of Families was advised of this proposal and wrote to the Directors-General of Queensland Health, Department of Justice and Attorney General, and Education Queensland and the Commissioner for Police on 25 March 2002 requesting a clear statement of their roles and responsibilities in relation to child abuse and neglect to assist in the development of the Memorandum of Understanding.

The responses will be tabled at the next CCOCA meeting to be held in May 2002. Drafting of the Memorandum of Understanding will follow.

9.3.2
Queensland Health, Department of Families and Queensland Police Service develop a proforma for minutes taken at SCAN team meetings to ensure that the basis upon which recommendations are made is recorded. Specifically, the reason/s why a particular course of action was selected over other possibilities should be documented.

The Department of Families endorses this recommendation. It is noted that the Department is already progressing this recommendation.

Action to date:

As outlined previously, an evaluation of the SCAN team system was commenced by Ms Lisa Kennedy and Mr Paul Mazerolle from the Social and Economic Research Centre, University of Queensland in May 2001.

The final report was received by the Chair, CCOCA in December 2001 and was subsequently considered by the CCOCA at their first meeting in February 2002.

This evaluation report is due to be considered by the Executive Management Committee, Department of Families on 23 April 2002 before distribution to the SCAN team member departments for consideration of the recommendations and the development of a joint plan of action.

The SCAN team evaluation recommends (Rec 2.11) that DOF in consultation with SCAN Teams develop a proforma for minutes taken at SCAN Team meetings. This recommendation will be actioned when the plan of action is developed.

Appendix R – QPS response to final report

Thank you for the opportunity to comment on issues arising from the investigation conducted by the Office of the Queensland Ombudsman into the administrative conduct of the Department of Families, Queensland Health and the Queensland Police Service in relation to the death of Brooke Brennan.

The Service has been invited to respond to specific issues identified in the report as follows:-

1. The QPS did not have in place adequate policies and procedures for reporting all incoming telephone calls received in relation to child protection referrals/requests, and therefore no method for recording or assessing the decisions made by Juvenile Aid Bureau officers as to the type of response to be afforded each incoming call;

2. A JAB officer failed to record any details of the telephone conversation made by the SCAN doctor on 13 July 1999 in which he requested police assistance;

3. The lack of any such record:-

    - led to uncertainty as to the nature and urgency of the request; and
    - means that the reasonableness of the decision refusing assistance cannot be audited.

4. There were no procedures in place between QPS and Queensland Health for making or following up child protection referrals/requests to QPS in writing (eg by facsimile or email) as soon as possible after a telephone referral/request had been made.

After careful consideration of those issues and careful examination of existing Service practice, I believe the policy and procedure in place for reporting the receipt of information concerning complaints of child abuse is appropriate and generally satisfactory. Formal policy and procedure is contained in s.7.6.1 of the Operational Procedures Manual requiring the recording of all child abuse complaints on a crime report for investigation. This procedure also provides a process for recording assessments, decisions and action taken in respect of the investigation. Other procedures have been implemented locally by the Service including the requirement upon JAB officers to record all issues and requests of significance on Job Occurrence Sheets. Administrative procedures have also been adopted locally including the completion of a telephone record register for messages taken for and on behalf of JAB staff.

Most regrettably, it would appear from the assessment of the material provided by your office that a member of the Service has failed to record the information provided by the SCAN doctor according to the existing procedure. I agree with your assertion that the lack of such a record leads to uncertainty as to the nature and urgency of the request and the reasonableness of any decision taken thereafter. I advise that the Ethical Standards Command of the Service will be undertaking an internal investigation in this respect.

In view of the circumstances of this matter, I have also called for the Deputy Chief Executive (Operations) of the Queensland Police Service to remind all members of the correct policy and procedure for the recording of all information concerning complaints of child abuse.

I have also called upon the Deputy Chief Executive (Operations) to consider a review, in consultation with Queensland Health and Department of Families, of policies and procedures which currently exist between our agencies to ensure best practice is formulated and maintained for the notification and assessment of child abuse matters.