Queensland Government

Response to the Queensland Ombudsman's report

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

October 2003

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

David Bevan, Queensland Ombudsman

There is no higher priority for the Queensland Government than the wellbeing of children.

The tragedy of baby Kate's death has highlighted a range of critical challenges for Queensland's child protection system.

The Government is reforming child protection, and the focus in the Ombudsman's report on systemic issues goes to the heart of the reform agenda.

The Ombudsman's thorough investigation of circumstances before and after baby Kate's death is guiding the Government on further refinements to the reforms.

Our response to the Ombudsman shows most recommendations have been implemented, and others are under consideration.

The Government makes this response as the Crime and Misconduct Commission (CMC) undertakes a broader inquiry into foster care. The Ombudsman's report is available to the CMC for consideration.

We will review the scale and extent of our response to the Ombudsman in the light of the outcomes and recommendations of the CMC inquiry.

The Queensland Government began reforming the child protection system in 1998, and will continue to drive reforms.

The baby Kate report underlines that our task will not be complete until Queensland's most vulnerable children have the best possible protection from all forms of abuse and neglect.

Peter Beattie MP
Premier

Judy Spence MP
Minister for Families
Minister for Aboriginal and Torres Strait Islander Policy
Minister for Disability Services
Minister for Seniors

INTRODUCTION

The Queensland Ombudsman commenced an investigation into the adequacy of the administrative actions of certain government agencies in relation to the safety, well being and care of the late baby Kate who died aged 10 weeks. This investigation was initiated after a written complaint was made to his Office on 14 January 2002. The complainant alleged that baby Kate should not have been released into her mother's care and that the actions or lack of action, of the Department of Families and Queensland Health contributed to her death.

On 15 November 2002, the Ombudsman advised the Directors-General of the Department of Families and Queensland Health of his intention to conduct a formal statutory investigation of the complainant's allegations pursuant to the *Ombudsman Act 2001.*

The Ombudsman distributed a provisional report in July 2003 to the Department of Families, Queensland Health and Queensland Police Service, and received feedback from those agencies in relation to the draft recommendations.

On 6 October 2003, the Report was presented to the speaker of the Legislative Assembly.

The Ombudsman's functions under the *Ombudsman Act 2001* are to:

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

Department of Families

The investigation identified systemic problems within the Department of Families in the management of child protection cases and problems in communication and coordination among the public agencies involved in child protection issues, including child deaths.

The Ombudsman has made 29 recommendations. Some recommendations as well as other systemic issues, will be addressed through a review of the *Child Protection Act 1999* in 2004.

The issues identified by the Ombudsman include:

- workers' lack of understanding in relation to key provisions of the *Child Protection Act 1999*, including application of statutory practice principles and access to information that is subject to the confidentiality provisions of the *Health Services Act 1991*;
- the need to improve child protection workers' skills in undertaking assessments of risk;
- the lack of available information in relation to appropriate services for referral;

- inadequate procedures for transferring cases between departmental area offices and SCAN teams in a timely manner; and
- deficiencies in maintaining accurate child protection records.

Queensland Police Service

The Ombudsman has made five suggestions for improving administrative practice within the Queensland Police Service. The suggestions are mainly related to the interface between members of the Queensland Police Service and pathologists investigating the sudden unexplained deaths of children. One suggestion requires collaboration with Queensland Health to implement.

The Queensland Ombudsman has jurisdiction to investigate the administrative actions of Queensland Government agencies. The term "administrative action", as defined under the *Ombudsman Act 2001*, specifically excludes an operational action of a police officer. However, the Ombudsman has taken into account the interaction of officers from other agencies within the Ombudsman's jurisdiction with members of the Queensland Police Service. Due to this jurisdictional issue, the Ombudsman's proposals regarding Queensland Police Service procedure have been framed as "suggestions" rather than recommendations.

Queensland Health

The Ombudsman did not direct any recommendations specifically to Queensland Health. However, a number of recommendations related to the interface between Queensland Health, Department of Families and Queensland Police Service in delivering child protection services.

GOVERNMENT RESPONSE TO RECOMMENDATIONS

The Ombudsman's Report contains a series of recommendations aimed at ensuring that any systemic issues identified in the way the baby Kate case was handled can be addressed to prevent these types of tragedies occurring in the future.

A number of recommendations relate directly to matters being considered by the Crime and Misconduct Commission Inquiry into Abuse of Children in Foster Care, and have also been addressed in the Queensland Government's submission to that process.

The recommendations, and a summary of the Government's response to the recommendations, are outlined below.

Decisions about Intervention

Recommendation 6.4.1

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

POSITION:

The Government agrees with this recommendation and acknowledges the need to put in place improved procedures for dealing with children assessed as being at risk before they are born, and for taking immediate action to ensure that the necessary follow up is undertaken after the child is born.

ACTION:

The Department of Families will have an improved focus on early intervention when dealing with families and children assessed as being at risk before they are born. The Department will work to provide appropriate assistance and support to parents directed at planning for the baby's safety needs.

The Department of Families will develop a policy and procedures for working with parents before birth where the parents are known, or refer themselves, to the Department. This will include recording information about concerns, and casework with the parents.

The policy and procedures will articulate a clear framework for working with these parents prior to the birth of the child, and will outline the types of intervention that can be undertaken.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

The *Child Protection Act 1999* will require amendment to facilitate notification in relation to unborn children.

Recommendation 6.4.2

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

POSITION:

The Government endorses this recommendation and recognises the need to strengthen the links between government agencies in dealing with concerns about the safety and well being of an unborn child and to put in place appropriate procedures to establish and maintain adequate communication and collaboration across relevant agencies

ACTION:

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

The MOU will include procedures for timely notification and appropriate action between agencies regarding concerns about the safety and well being of unborn children assessed as being at risk of significant danger or harm following birth due to parental factors. To ensure that the MOU is as comprehensive as possible, ways of including private hospitals and facilities in the arrangements will also be investigated.

RESPONSIBILITY:

Department of Families, Queensland Health, Queensland Police Service and Education Queensland.

LEGISLATIVE IMPLICATIONS:

No legislative change required.

Recommendation 6.4.3

The Child Protection Act 1999 be amended to enable the Department of Families to intervene where it is suspected before the birth of a child that the child may be at risk of harm after birth.

POSITION:

The Government endorses this recommendation and supports the need to ensure there are no impediments to agencies taking action to intervene in cases where they suspect an unborn child may be at risk of harm after birth.

ACTION:

Queensland's *Child Protection Act 1999* will be reviewed to enable the recording of pre-natal notifications and subsequent intervention with the family. This, together with the development of new and improved policies and procedures for working with parents whose unborn children have been identified as assessed at risk, will provide a focus on early intervention and support. The review will be undertaken in 2004.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

Review and amendments to the *Child Protection Act 1999* will be required.

Recommendation 6.8.1

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

POSITION:

The Government agrees with this recommendation and believes adequate training in risk assessment is vital for departmental officers dealing with child protection assessments.

ACTION:

Current Situation

Training on learning and development for staff has always been a priority for the Department of Families. The Department currently spends an estimated $3.8 million per year on learning and development for departmental employees. This includes $1.42 million specifically for child protection workers. The training programs are regularly reviewed and there has recently been a stronger focus on risk assessment and management.

One of the key training documents provided to departmental officers is the *Practice Guide for the Assessment of Harm and Likely Harm.*

Intended Activities:

In addition, the Government recently announced an extra $700,000 to provide for a new training program for service delivery staff. This will include an improved focus on risk management as well as mandatory and improved training for new child protection workers and better and more systematic training for existing staff.

RESPONSIBILITY:

Department of Families.

LEGISLATIVE IMPLICATIONS:

There are no legislative implications associated with this recommendation.

Recommendation 6.8.2

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

POSITION:

The Government endorses this recommendation and has begun implementation. The Government recognises the importance of adequate information sharing processes and procedures to ensure that relevant agencies and officers are fully aware of their respective roles and responsibilities in child protection matters.

ACTION:

Effective case management requires information sharing between agencies in contact with children in care or at risk. The Coordinating Committee on Child Abuse provides a mechanism for coordinating the efforts of a range of agencies in this area including the Department of Families, Queensland Health, Queensland Police Service, the Department of Justice and Attorney-General and Education Queensland.

A number of new and improved policies and procedures have recently been introduced across government to improve the coordination of effort of agencies involved in child protection matters. *Information Sharing: pre-notification (Policy No: 330-1)* which involves other agencies in providing information to the Department of Families has now been implemented state-wide. This enables better decision-making about whether allegations constitute a child protection notification and what action is warranted regarding the allegations.

The Differential Response Trials Policies and Procedures are being trialled by the Department of Families. These are based on providing responses and services that can be tailored to the needs of the child and family, that facilitate early assistance and intervention and that provide collaboration with government and community agencies. *The Differential Response Trials Policies and Procedures* will be further finetuned to document the roles and responsibilities of other agencies involved in joint assessments.

A new draft protocol, *Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm* is under development. This draft protocol sets out clearly the steps to be followed when Families Department officers need to involve other agencies in child protection matters. The protocol is being trialled from October 2003 to March 2004 in the Sunshine Coast and Brisbane City (North) Regions.

RESPONSIBILITY:

Department of Families, Queensland Health, Education Queensland, and Queensland Police Service

LEGISLATIVE IMPLICATIONS:

There are no legislative amendments necessary to implement this recommendation.

Recommendation 6.8.3

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

POSITION:

The Government has endorsed and implemented this recommendation. The Government acknowledges the critical importance of ensuring that officers are aware of their ability to access information held by other agencies so that all relevant information can be brought to bear in making an assessment of the risks posed in child protection matters.

ACTION:

The Department of Families gives staff relevant information through a range of mechanisms including training and development. The message is being reinforced with staff of their entitlement to access otherwise confidential information to protect the safety of children.

A memo advising all Department of Families staff of the authority provided under section 194 of the *Child Protection Act 1999* to obtain relevant information was circulated on 18 July 2003. Awareness of staff will be further enhanced with the implementation of the *Information Sharing Protocol between Queensland Police Service, Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm.*

RESPONSIBILITY:

Department of Families and Queensland Health.

LEGISLATIVE IMPLICATIONS:

No legislative amendments are required in relation to this recommendation.

Recommendation 6.12.1

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

Recommendation 6.12.2

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

POSITION:

The Government supports this recommendation and will ensure that responses are warranted to the circumstances of the case and that the principle of "minimal intervention or least intrusive approach" is not weighted inappropriately in child protection assessments.

ACTION:

The Department of Families will work with the Coordinating Committee on Child Abuse to review its approach to child protection. Staff will be made aware of the need to ensure they give an appropriate weight to the safety of the child when applying the principle of "least intrusive approach" in dealing with child protection matters.

Significant work is underway within the Department concerning the development of definitions for the meaning of key terms to guide the weighting of the concept of a "least intrusive" approach in practice.

This work includes:

- drafting a Practice Direction for all staff in relation to the application of the principles in Section 5 of the *Child Protection Act 1999*;
- developing training for Family Services Officers, Team Leaders and Area Managers throughout the State in 2004 about key terms used in legislation and practice; and
- informing the review of the *Child Protection Act 1999* as proposed in the Queensland Government Submission to the Crime and Misconduct Commission (CMC) to ensure inconsistencies in translating the intent of the legislation to practice are addressed.

The outcomes of this work will be referred to the Coordinating Committee on Child Abuse. Government will also review the operations of the Coordinating Committee on Child Abuse and its membership to ensure it is functioning effectively with respect to providing guidance on child protection assessments. This will include consideration of the role of the Commissioner for Children and Young People.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

Work on implementing this recommendation may require legislative change to the *Child Protection Act 1999.*

Case Management Decisions

Recommendation 7.3.1

In consultation with Queensland Health, the Department of Families provide information to its officers about the services provided by Riverton and the criteria for admission there.

POSITION:

The Government endorses this recommendation and the need to ensure that information sharing about key services occurs in a timely and coordinated manner.

ACTION:

Access to information is central to enabling departmental officers to perform their duties effectively. Action has already been taken by the Department of Families to improve the dissemination of information to its officers about the services provided at Riverton. Most recently, an Information Paper outlining the range of services provided and the criterion for admission was circulated to all staff.

Awareness of existing information sharing processes has also been reinforced with staff. Riverton now sends information packages to all Department of Families' Area Offices. The package includes information about Riverton's referral criteria and referral forms. The information package is updated as necessary to reflect any change in processes and referral criteria. This information will also be incorporated into induction and training and development for staff.

RESPONSIBILITY:

Department of Families and Queensland Health.

LEGISLATIVE IMPLICATIONS:

There are no legislative implications associated with this recommendation.

Recommendation 7.3.2

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

POSITION:

The Government has already implemented this recommendation and is continuing to improve Suspected Child Abuse and Neglect (SCAN) processes and resources. Specifically, the Government acknowledges the need to ensure that gaps do not arise in SCAN Team cases as a result of the relocation of families who have been identified as assessed at risk from the jurisdiction of one SCAN team to another.

ACTION:

SCAN Teams play a critical role in child protection. The Department of Families recently reviewed the role of SCAN Teams and additional funding has been provided for 25 new SCAN team Coordinators to commence in early 2004.

Existing processes are already in place to ensure that case transfers are handled appropriately. To further strengthen these processes, the SCAN Team Manual is being updated in readiness for the new SCAN Team Coordinators. This will include reviewing the procedures for the transfer of all cases including open and closed cases between SCAN Teams.

Upgrades will also be made to the Department's Integrated Client Management System (ICMS) which will allow greater sharing of information and an enhanced capacity to track matters referred to SCAN teams across the state.

RESPONSIBILITY:

Department of Families and Queensland Health

LEGISLATIVE IMPLICATIONS:

No legislative amendments are associated with this recommendation.

Recommendation 7.3.3

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

POSITION:

The Government supports this recommendation and recognises the need to improve information about available support services for officers working with families in need.

ACTION:

In performing their roles, Family Services Officers require information about a whole range of services including emergency, support and residential services that could be made available to their clients. Currently, an electronic database of services across the State is maintained at Crisis Care which is a state-wide 24 hour, seven days a week telephone counselling and crisis intervention service provided by the Department of Families.

Area Offices also have access to information about resources available in their local area. These local systems are supported by regional Community Support Services (CSS) staff who communicate relevant information about funded services to the area offices in the region. Further enhancements will be made to ensure that this information is kept up to date and is readily available.

Further improvements to better coordinate existing data collection systems will be included in the new Integrated Client Management System (ICMS). Functionality will be improved so that the myriad of local systems that store details about support services can be replaced by one that is up-to-date and centrally maintained.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

No legislative implications associated with this recommendation.

Recommendation 7.7.1

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

POSITION:

The Government endorses this recommendation and has already instigated standardised referral processes across the Department of Families and its offices to improve the effectiveness of case management.

ACTION:

Effective referral processes are central to good case management. A standardised referral process was developed specifically to support the prevention and early intervention trials outlined in Future Directions. These trials are being undertaken by the Department of Families to identify innovative service delivery models that reduce the risk of harm to children and young people and strengthen people's abilities to cope and protect themselves within their family or informal support networks.

The referral documentation that is required to be completed as part of the trials includes the reason for referral, identified needs of the family, goals for intervention, and area office contact.

This referral process and accompanying documentation will be evaluated and amended, if necessary by December 2003. Implementation of a revised format will occur during the pilot phase of the Prevention and Early intervention services currently underway.

In addition, the Differential Response Trials that commenced in April 2003 have also incorporated the new standardised referral process and documentation in the provision of the assisted referral response and will be evaluated at the completion of the trials in June 2004.

Implementation of standardised referral processes will be built into organisational training and induction.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

No direct legislative implications.

Recommendation 7.11.1

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

Recommendation 7.11.2

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

Recommendation 7.11.3

The Department of Families provide appropriate training to all relevant staff once the policy has been developed. (in relation to 7.11.1)

POSITION:

The Government endorses these recommendations and recognises the need for appropriate case management policies and procedures to be established and adopted across the Department of Families and for staff to be adequately trained in applying these policies and procedures.

ACTION:

Providing appropriate support for staff is a priority for the Department of Families. The staff work in a very complex area of human services and it is important that procedures and policies provide adequate guidance for officers in fulfilling their roles. The Department of Families has approved and implemented a new and improved policy and procedure on *Transfer of case management and casework responsibility.*

This new policy and procedure is a comprehensive document which clearly describes processes of case management, case coordination, case work responsibility, negotiation of case transfer and transfer of case management including interstate transfers of Child Protection Orders and proceedings.

The policy provides for casework responsibility to be temporarily given to another office without the transfer of case management responsibility. There is a range of circumstances outlined in the policy when this action is justified.

The policy outlines a range of documents to be completed before case management transfer can occur. The purpose of this is to ensure that the receiving office has full and current information on the family. In accordance with the Ombudsman's view, the policy will be amended immediately to require the completion of a Case Transfer Summary prior to transfer of case management responsibility and where significant casework responsibility is required.

The Department of Families will be implementing a new and better training system for service delivery staff as announced by the Minister in early October. The system will comprise mandatory and improved training for new child protection workers,

better and more systematic training and professional development for existing child protection staff, and improved partnerships with universities to guarantee undergraduate and post-graduate qualifications are more relevant to future departmental employees.

The improved training scheme will cost $700,000 this financial year. This is in addition to the Department's existing training commitment of $3.8 million in 2003-04. It will significantly enhance the Department's ability to develop and retain permanent child protection workers. The commitment for 2004-05 and beyond is $1 million extra per year. The training initiative is a major boost for service delivery staff.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

There are no direct legislative implications associated with this recommendation.

Recommendation 7.11.4

The Department of Families investigate the claim that transfers are generally not accorded priority and, in some cases, refused or deliberately delayed by the receiving office, by:

7.11.4.1 auditing a sample of transferred cases; and

7.11.4.2 consulting with Managers and/or Team Leaders

POSITION:

The Government is committed to continuous review and improvement of case management transfers to ensure that cases are transferred, and responded to, in a timely manner. A new review process will achieve the aims of the Ombudsman's recommendation 7.11.4.

ACTION:

Encouraging good professional practices is critical to enhancing the quality of services provided. The Department has commenced Collaborative Area Office reviews. Information about any delays in case transfers will be targeted for specific attention as part of these reviews.

The Collaborative Area Office review process is a mechanism that will ensure a much better quality of decision making than has been the case in the past. The reviews will monitor, validate and evaluate professional decision-making. The Collaborative Area Office Reviews involve a number of phases including: -

- the area office will undertake a process of self assessment;
- an external review team from the Quality Assurance Unit will visit area offices for approximately five days to seek additional information to expand on that obtained from the self-assessment and also to quality assure work practices;
- the Quality Assurance unit will write a *Collaborative Area Office Review Report* about the office's performance;
- the Area Office Manager will write an improvement plan for the Office based on key themes highlighted in the *Collaborative Area Office Review Report; and*
- this will form the basis for the subsequent Collaborative Area Office Reviews.

In addition, the case transfer policy will be reviewed in December 2003 where information regarding priority or delaying of transfers will be examined.

The new Integrated Client Management System will also provide the opportunity to electronically record the details of a client at the closest source, once only. It will also mean that any officer who deals with the same client will have the full profile of details about that client to support decision making. The Integrated Client Management System will be accessible from all work locations by all Family Services Officers and client records will be automatically available should a client transfer from one Area Office to another.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

No legislative implications.

Record Keeping

Recommendation 8.4.1

The Department of Families undertake a State-wide audit of record keeping practices in its offices to determine whether the record keeping deficiencies identified in Area Office Green also exist in those offices.

POSITION:

The Government is keen to identify the nature and extent of deficiencies in current record keeping within the Department of Families. Measures now in place will achieve the aims of Recommendation 8.4.1.

ACTION:

Good record keeping is crucial to the efficient functioning of any organisation. A number of reviews are currently underway which will provide an opportunity to improve the Department of Families' understanding of record keeping deficiencies across the State. These include the current Audit of foster carers and the Collaborative Area Office Reviews.

As announced in September 2003, Client Record Improvement teams will be deployed to Department of Families areas offices to ensure their filing systems and record keeping are overhauled and maintained at a high standard. Further, the teams will be checking that all client files are completed.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

There are no anticipated legislative implications associated with responding to this recommendation.

Recommendation 8.4.2

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

POSITION:

The Government is committed to effectively resourcing and supporting child protection officers to maintain appropriate records and perform their duties. Measures underway will achieve the aims of Recommendation 8.4.2.

ACTION:

The Collaborative Area Office Review process which commenced in August will provide the Department of Families with the capacity to identify specific issues about how work is prioritised in area offices. Further the review of Regional and Area Offices in 2004 will capture issues about office infrastructure and resource allocation.

The Department is also currently undertaking the development of a resource allocation model that will inform the allocation of staff across regions. This model will be implemented in late 2003 and will take into account the workload attached to case recording and records management for both professional and administrative staff.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

There are no direct legislative implications.

Recommendation 8.4.3

The Department of Families develop and implement consistent procedures for record keeping in order to eliminate the multiple systems presently used by officers.

Recommendation 8.4.4

The Department of Families provide training on proper record keeping procedures to officers in Area Office Green and officers in other offices identified in the audit as having inadequate record keeping practices. (refer 8.4.1)

Recommendation 8.4.5

The Department of Families investigate the use of digital recording devices to assist officers to record contemporaneous file notes while engaged in fieldwork.

POSITION:

The Government supports these recommendations and has already commenced implementation of a range of improvements. The Government recognises the need to improve information management across the Department of Families and in particular, the importance of better integrating and coordinating existing systems and providing appropriate training to staff.

ACTION:

The Government has implemented a suite of initiatives to improve information management involving information system enhancements and additional training for officers in keeping and maintaining records.

The Government has approved funding of $12M over four years in the 2002/2003 budget for the development of better information management tools and practices within the Department of Families.

- **Integrated Client Management System**

The Department of Families has targeted the renewal of its current information technology systems and infrastructure to respond to the demand to provide accurate and current integrated information for decision-making, reporting, performance measurement and analysis and monitoring purposes. In particular, the Department has targeted the development of a new Integrated Client Management System for child protection and youth justice.

Mapping the current baseline processes for child protection and youth justice will enable the Department of Families to look for ways to improve work practices that are supported by responsive and flexible business information systems.

- **Information Gathering Record**

In April 2003, the Department of Families introduced the *Information Gathering Record* to streamline recording on a statewide basis. This document is used to contemporaneously record observations and responses to allegations of harm when undertaking an initial assessment. Following the interviews this document is referred to when the initial assessment report is recorded on the Child Protection Information System (CPIS). The document is then retained on the child's file.

- **Records Management**

The Department of Families will develop and implement an Operational Record Keeping Implementation Plan (ORIP). Completion of the ORIP is planned for early 2004.Following the endorsement of this Plan, records keeping best practice procedures will be developed for implementation by all staff (May 2004). A training program will be launched to assist staff to implement these procedures and a monitoring program developed. This will target the multiplicity of systems used to manage records. The Department of Family Services will continue to provide records best practice training to all Area Offices.

- **Regional Systems Support Officers**

The Department also appointed 15 Regional Systems Support Officers who are attached to the 11 Regional Offices in 2002. These officers work with Family Services Officers to assist in the recording of case notes and to improve data entry quality. The officers will play a pivotal role in the release of the new client management system including change management and training.

- **Better tools trials**

Trialing of voice to text translation technologies using a remote device (PCEphone) and the PC desktop has been undertaken to assess business benefits and systems design features.

These technologies have been targeted specifically to assess the benefits in terms of reducing data entry as well as providing remote access to client information.

RESPONSIBILITY:

Department of Families and Queensland Police Service

LEGISLATIVE IMPLICATIONS:

None identified.

PART 9 – CHILD DEATH REVIEW

Recommendation 9.5.1

A body external to the Department of Families monitor and review the investigation of the deaths of all children known to the Department and, unless another body is established for that purpose, the Child Death Review sub-committee of Coordinating Committee on Child Abuse (CCOCA) carry out this role.

POSITION:

The Government supports the recommendation and recognises the importance of independent and external review of the investigation of the deaths of children known to the Department of Families to give the community confidence that these investigations are being handled appropriately.

ACTION:

Since this review was instigated two years ago, the Government has improved its child death review mechanisms including the development of clear criteria for conducting external reviews and the establishment of a register of suitably qualified external experts.

The Government plans to further strengthen its external review processes to provide greater independence and accountability. The functions and responsibilities of the Child Death Review Sub-Committee established under the Coordinating Committee on Child Abuse (CCOCA) will be expanded so that it can deal with all child deaths known to the Department of Families.

The terms of reference of the Child Deaths Review Subcommittee will be revised to provide for appropriate referral protocols and linkages with relevant agencies and to provide the Subcommittee with the necessary monitoring and review powers. Annual reporting requirements will also be incorporated in the responsibilities of the Sub committee.

In addition, the deaths of children and young people will continue to be monitored by the Commission for Children and Young People, the Ombudsman, and the Crime and Misconduct Commission.

The new *Coroners Act 2003* will ensure that the deaths of certain children in care are also investigated by a coroner. The new Act, which will come into force in December 2003, provides that the deaths of certain children in care have to be reported to a coroner. The Attorney-General will also have the power to direct that a death, even if it is otherwise not reportable under the new Act, be investigated by a coroner.

RESPONSIBILITY:

Department of Families, the Department of Justice and Attorney-General, the Commission for Children and Young People, and the Queensland Police Service.

LEGISLATIVE IMPLICATIONS:

Responding to this recommendation may require legislative change in terms of providing appropriate powers and functions to the Child Death Review Sub-Committee as the external review body.

Recommendation 9.5.2

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

Recommendation 9.5.3

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

Recommendation 9.5.4

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

POSITION:

The Government supports the need to ensure that the Coordinating Committee on Child Abuse and the Child Death Review sub-committee have an appropriate membership to perform their functions.

ACTION:

The Coordinating Committee on Child Abuse and the Child Death Review sub-committee play important roles in the State's child protection system. In order for these Committees to fulfil their roles effectively, they need an appropriate mix of skills and expertise in dealing with child protection issues and the review of child deaths.

Currently, the Coordinating Committee on Child Abuse comprises representatives from the Queensland Police Service, Queensland Health, the Department of Families, Education Queensland and the Department of Justice and Attorney-General. The Government will review the Coordinating Committee to ensure appropriate representation of the interests of children in the Committee's deliberations.

The State Coroner and the Commissioner for Children and Young People are currently members of the Child Death Review Sub-committee under the Coordinating Committee on Child Abuse. The State Coroner will continue to be actively involved in advising the Committee as an ex-officio member. Other members of the Child Death Review Sub-committee include representatives from the Department of Families, Queensland Health, Education Queensland, the Department of Torres Strait Islander Policy, and the Queensland Police Service.

The Government will consider further the role of the Chair of the Child Death Review Sub-committee and look to appoint an expert who has an appropriate level of independence and is able to avoid any conflicts of interest in discharging their functions.

RESPONSIBILITY:

Department of Families, the Office of the State Coroner, the Commission for Children and Young People, Queensland Health, Education Queensland, Justice and Attorney-General and the Queensland Police Service.

LEGISLATIVE IMPLICATIONS:

Legislative change may be required.

Recommendation 9.5.5

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

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

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

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

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

POSITION:

The Government is keen to ensure that any external body charged with reviewing child deaths has appropriate powers to discharge its functions effectively.

ACTION:

Government will strengthen its external review processes to independently monitor and review the investigation of deaths of children known to the Department of Families. This will include expansion of the roles and responsibilities of the Child Death Review Sub-Committee under the Coordinating Committee on Child Abuse.

To ensure that the necessary remedial action is taken as a result of the review of child deaths, relevant agencies will work together to implement recommendations to improve policies and procedures.

The Department of Families has already collaborated with other agencies to develop improved coordination mechanisms for incorporating recommendations from child deaths into the development of policies and procedures including an *Information Sharing Protocol between Queensland Police Service, the Department of Families, Queensland Health and Education Queensland in regard to the Child Protection Act 1999 for responding to children and young people who have been harmed or who are at risk of harm.*

RESPONSIBILITY:

Department of Families, Queensland Police Service, the Commission for Children and Young People, Queensland Health, Justice and Attorney-General, the Office of the State Coroner and Education Queensland

LEGISLATIVE IMPLICATIONS:

Legislative amendments may be necessary in responding to this recommendation to ensure that the external review body has appropriate powers.

Recommendation 9.5.6

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

Recommendation 9.5.7

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

POSITION:

The Government recognises the need for appropriate administrative support and enhanced accountability through the provision of annual reports into child deaths that have been the subject of review.

ACTION:

Depending on the appropriate external body that is charged with undertaking reviews, the source of administrative support will be determined based on the needs of the body. The Review of Serious Incidents Committee that has been set up will consider the provision of an annual report to Parliament in relation to child deaths that have been the subject of review.

RESPONSIBILITY:

Department of Families

LEGISLATIVE IMPLICATIONS:

Legislative change may be required depending on the model adopted.

Recommendation 9.5.8

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

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

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

POSITION:

The Government supports the need for improved reporting procedures in relation to child deaths.

ACTION:

Appropriate reporting procedures are necessary to ensure that reviews of the death of a child or young person have been handled properly and thoroughly. The suggested amendments to the "Review Policy Procedure following the Death of a Child or Young Person" as detailed in Recommendations 9.5.8.1 will be progressed within the existing child death review arrangements. This will clarify and report on the decisions made and the reasons for those decisions.

To provide greater scrutiny and accountability, a copy of the report of each child death review will be forwarded immediately on completion to the Commissioner for Children and Young People for comment. Consideration is also being given to supplying the report to coroners in certain circumstances. Such copies will not be de-identified.

Decisions about why a case is reviewed, or not, are currently recorded on the official file. Amendment of the policy to reflect this current practice will be progressed.

RESPONSIBILITY:

Department of Families, Commission for Children and Young People.

LEGISLATIVE IMPLICATIONS:

Legislative change may be required.

Queensland Police Service – Suggestions for Improvement

The Ombudsman's Report makes a number of suggestions for improvements regarding the administrative procedures, policies and training administered by the Queensland Police Service in relation to the investigation of the sudden and unexplained death of a child.

POSITION:

The Government is committed to ensuring that practices and procedures within the Queensland Police Service represent best practice in this area.

However, the Government notes that the actions of police officers taken in relation to the investigation of the sudden unexplained death of baby Kate fall within the definition of 'operational action' in the *Ombudsman Act 2001* and therefore fall outside the investigative jurisdiction of the Queensland Ombudsman.

ACTION:

A review of the transmission of information by investigating officers to the pathologist responsible for conducting the post mortem on a sudden unexplained infant death will be conducted.

The procedures contained within the Operational Procedures Manual are currently being reviewed with regard to the commencement of the *Coroners Act 2003*. Consideration will be given to incorporating the Ombudsman's suggestion contained in section 4.4.4 of the final report.

The Queensland Police Service in consultation with the Department of Justice and Attorney-General and Queensland Health are currently developing a Form 1 to replace the Form 4 'Report Concerning Death by Member of the Police Service'.

The Queensland Police Service in consultation with the Department of Justice and Attorney-General is currently considering the implementation of a standardised death scene investigation checklist similar to the NSW Police checklist for the investigation of sudden unexplained infant deaths. It is anticipated that this document will form an annexure to the Form 1, as previously discussed. These forms and checklists will provide an effective tool for enhancing communication between the Service and Pathologists.

A review of training provided to Queensland Police Service officers in relation to the investigation of a sudden unexplained infant death is currently being undertaken. The 'Child Abuse Investigations' work and reference book, which comprises a component in relation to the processes and guidelines for the investigation of sudden unexplained infant deaths is presently being reviewed and it is anticipated the workbook will be available for release in January 2004.

RESPONSIBILITY:

Queensland Police Service, Department of Justice and Attorney-General and Queensland Health

LEGISLATIVE IMPLICATIONS:

None identified.

THE WAY FORWARD

Since the tragic event that led to the instigation of the Ombudsman's review and report, the Government has initiated a number of strategies which address the systemic issues identified in his recommendations.

Some of these strategies are yet to be fully implemented. The Ombudsman's report provides valuable information on where Government needs to continue to focus its efforts in improving a whole range of policies and procedures relating to child protection.

The Minister for Families is committed to reporting on the Government's progress in implementing the Child Protection Strategic Framework on an annual basis. The first report is due in June 2004 at which time the Minister will also outline progress on the initiatives outlined in this response. This will include progress with respect to any initiatives developed in response to the Crime and Misconduct Inquiry into the Abuse of Children in Foster Care currently underway in Queensland.