

LEGISLATION AND CHILD DEATH REVIEW PROCESSES IN AUSTRALIA: UNDERSTANDING OUR FAILURE TO PREVENT CHILD DEATH

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‘Few crimes evoke emotions stronger than those caused by the killing of a child. That an adult would deliberately cause the death of a child strikes many as inexplicable, especially in the case of filicide – killing one’s own child. Yet homicide by family members is a common cause of death among children, especially if death due to neglect is included.’¹

I INTRODUCTION

In New South Wales (‘NSW’), in October 2007, two-year-old Dean Shillingsworth’s body was found inside a suitcase floating in a pond in Sydney’s south-west. The following month, seven-year-old ‘Ebony’ was found dead,

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¹ Grant T Harris et al, ‘Children Killed by Genetic Parents versus Stepparents’ (2007) 28 *Evolution and Human Behavior* 85, 85 (citations omitted).

apparently from starvation, at her home north of Newcastle.² In Victoria, in August 2007, Stuart John McMaster had pleaded guilty to manslaughter in the Supreme Court after inflicting sustained attacks (the post-mortem examination found more than 160 bruises) on five-year-old Cody Hutchings, the son of his partner.³ An eight-week-old Queensland baby, Mustapha Mohommed Osta-Burles, died in December 2007 of ‘serious neglect’, including broken ribs, dehydration and starvation, according to evidence presented to the Townsville Magistrate’s Court.⁴ These are but four examples of child death from family violence from the three Australian states whose legislation is the focus of this paper – Victoria, New South Wales and Queensland.

Between 2001 and 2003, 73 children died as a result of assault. Moreover, during 2003, assault was the third most common cause of injury leading to deaths, after transport accidents and drowning.⁵ Commentators such as Mouzou and Rushforth (2003) estimate that on average, 25 Australian children are killed by their parents each year.⁶ While younger children are those mainly at risk of death and serious injury,⁷ because the incidence of child deaths attributable to abuse and neglect is hard to assess, child deaths through family violence are argued to be considerably underestimated.⁸ Nonetheless, a sense of the scale of the problem may be gleaned from recent figures on the prevalence of child abuse cases in the Hunter Valley region of NSW. Despite police receiving 40 child abuse complaints a week, experts consider this to be a tiny proportion of the

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- 2 James Madden, ‘Police Called in as Girl “Starves to Death”’, *The Australian* (Sydney), 7 November 2007. Although Ebony’s full name was used in the initial media reporting of the case, at the time of her death, the *Children (Criminal Proceedings) Amendment (Publication of Names) Act 2007* (NSW) which was assented to on 4 July 2007, prevented any such further publication of her full name, in the interests of protecting the identity of her siblings. In June 2009, a NSW Supreme Court Judge, Hulme J convicted Ebony’s mother of her murder: her father was convicted of manslaughter. During the trial Justice Hulme stated that Ebony was ‘the subject of the most profound neglect and abandonment’ and that ‘She should not simply be some anonymous person and should have a name...To my mind, maintaining her anonymity would perpetuate the abandonment.’ In the light of this, it was agreed that the child would be identified in the proceedings by her middle name, Ebony: *R v BW & SW (No.2)* [2009] NSWSC 595. This practice has continued, thereby affording Ebony’s siblings the right to privacy, in accordance with Article 16 of the UN Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered in force 2 September 2009) <<http://www2.ohchr.org/english/law/crc.htm#art16>>.
 - 3 Chris Goddard, ‘Cody Lived Short and Died Long’, *Herald Sun* (Melbourne), 16 August 2007, 25.
 - 4 Malcolm Weatherup, ‘Couple Face Court Charged with Manslaughter of Their Child “A Case of Neglect”’, *Townsville Bulletin* (Townsville), 23 December 2008, 4.
 - 5 Mel Irenyi and Briony Horsfall, *Fatal Child Abuse Resource Sheet No 4* (Australian Institute of Family Studies National Child Protection Clearinghouse, August 2009) 1 <<http://www.aifs.gov.au/nch/pubs/sheets/rs4/rs4.html>>.
 - 6 J Mouzou and C Rushforth, ‘Family Homicide in Australia’, (2003) 255 *Trends & Issues in Crime and Criminal Justice* 255 <www.aic.gov.au/documents/9/C/B/%7B9CBFDFE5-F9B2-4FEB-A14A-3166810B564F%7Dtandi255.pdf>.
 - 7 Neil J Hochstadt, ‘Child Death Review Teams: A Vital Component of Child Protection’ (2006) 85 *Child Welfare* 653, 656–7.
 - 8 Marcia E Herman-Giddens et al, ‘Under Ascertainment of Child Abuse Mortality in the United States’ (1999) 282 *Journal of the American Medical Association* 463.

actual number, 'a drop in the ocean', because the vast majority of cases go unreported.⁹

A worrying proportion of deaths as a result of child abuse and parental neglect take place among children known to the child protection system (for example, 12 out of 14 child deaths investigated in Victoria in 2008).¹⁰ Further, a number of links have been established between child maltreatment – and in particular sexual abuse – and domestic violence in general,¹¹ although the 'totality of violence' in a family is as yet not fully appreciated.¹² As a result, the traditional policy approach has been to deal separately with sexual abuse, domestic violence, and neglect in families known to harbour at-risk children. One attempt to unpack the complexity of family issues underpinning child deaths is the child death review process. Such processes provide a legally mandated mechanism to investigate the circumstances surrounding a child's death and are intended to represent the most effective means by which to understand the connection between family violence and child death.

The purpose of this paper is threefold. First, we use a mix of academic and public policy sources, to provide an overview of the child death review practices extant in Australia. Second, in the light of this overview, we develop a framework of key items that, in an ideal world, might be present in child death review legislation to make it comprehensive and comparable between states. Third, we use this framework to examine the legislation governing the work of child death review teams in the three states in which Mustapha, Cody, Dean and Ebony died. This is in order to establish whether and to what extent the existing legislation provides for the necessary codification, professional multi-disciplinarity, autonomy, scope and accountability such that child death reviews can be effective. The paper begins by sketching the background rationale for child death reviews. It concludes by arguing that the complexities of multiple state jurisdictions constrain the capacity for equality of child care interdiction in Australia to the extent that the states are largely unable to prevent child death. A requirement of all child death reviews must be that all agencies concerned in the death of a child be legally required to act on the recommendations of a review; it is only in this way that future deaths may be preventable.

II THE ORIGINS OF AND RATIONALE FOR CHILD DEATH REVIEWS

Increased community concern over child deaths, particularly child homicides, is one of the key reasons for the development of child death review processes

9 Donna Page, 'Suffer the Children', *The Newcastle Herald* (Newcastle), 21 June 2010, 1, 4.

10 Irenyi and Horsfall, above n 5, 4.

11 Adam M Tomison, 'Exploring Family Violence: Links between Child Maltreatment and Domestic Violence' (2000) 13 *Issues in Child Abuse Prevention* 1.

12 Janet Stanley and Christopher R Goddard, *In the Firing Line: Violence and Power in Child Protection Work* (John Wiley & Sons, 2002) 150–2.

around the world.¹³ The first child death review team ('CDRT') was developed in Los Angeles in the United States in 1978, following increased levels of concern about child deaths as a result of abuse¹⁴ and the under-reporting of child abuse deaths.¹⁵ The inadequacy of sources for accurately identifying causes of unexpected deaths among children was recognised and processes for reviewing child deaths were developed.¹⁶ A multidisciplinary, multi-agency process was seen as an effective way of determining if abuse was a factor in a child's death, as abuse is harder to conceal and less likely to be overlooked when information in relation to the child and the circumstances of death are shared by professionals from different agencies and disciplines.¹⁷

During the Los Angeles team's first five years of operation, the cause of death in seven child fatality cases was changed from 'natural or accidental' to 'death at the hands of another', while one case was reclassified from 'homicide' to 'natural death'.¹⁸ As such, multidisciplinary, multi-agency review processes can reduce misclassification of deaths, identify specific interventions for surviving family members, develop public policy to address the prevention of child deaths from abuse, and prevent future deaths.¹⁹ Notwithstanding problems with 'resourcing, standardization, national coordination and inclusion/exclusion criteria',²⁰ the major achievement of child death reviews is the prevention of future deaths, both by exposing the family circumstances surrounding the death, and by the consequent improvement of systems providing services to children in at-risk families.²¹

III CHILD DEATH REVIEW PROCESSES: AN AUSTRALIAN PERSPECTIVE

The child protection system in Australia is not straightforward, as there is no one unified system but eight different state and territory based systems, with different legislative and operational frameworks, resulting in considerable

13 Commissioner for Children (Tas), *Advice to the Minister for Health and Human Services – A Child Death Review Process for Tasmania* (16 September 2006) Tasmanian Department of Health and Human Services, ii <http://www.dhhs.tas.gov.au/disability/family_support_services>.

14 Hochstadt, above n 6, 659.

15 Mary E Rimsza et al, 'Can Child Deaths Be Prevented? The Arizona Child Fatality Review Program Experience' (2002) 110 *Pediatrics* e11, 6 <<http://pediatrics.aappublications.org/cgi/content/abstract/110/1/e11>>.

16 Romi A Webster et al, 'Child Death Review: The State of the Nation' (2003) 25 *American Journal of Preventive Medicine* 58, 58–9.

17 Ibid.

18 Nanette R Elster and M Gabriela Alcalde, 'Child Fatality Review: Recommendations for State Coordination and Cooperation' (2003) 31 *Journal of Law, Medicine & Ethics* 303, 303.

19 Webster et al, above n 16, 59; Hochstadt, above n 7, 663–7.

20 Peter Sidebotham, 'Embracing Change' (2005) 14 *Child Abuse Review* 77, 78.

21 Hochstadt, above n 7, 663–7.

variability across the country.²² However, notwithstanding the existence of different frameworks, CDRTs or committees have been established in all Australian states, with the exception of Tasmania and the Australian Capital Territory ('ACT').²³

In Tasmania, there are no overarching legislative or operational frameworks in place which enable the review and reporting of child deaths. Rather, the child death review frameworks which are in operation are divergent and specialist, encompassing coronial, obstetric and paediatric, and child protection. The Tasmanian Department of Health and Human Services is in the process of developing a strategic framework to consolidate the child death review mechanisms that exist across the state; a working group has been formed to advise government on the establishment of a statewide 'strategic review body' (such as a CDRT or committee).²⁴

In the ACT, the matter is more complex. While there is no process in place for the regular presentation of an annual report into child deaths, a memorandum of understanding has been signed between ACT Health and the ACT Department of Disability, Housing and Community Services, including Care and Protection Services, enabling joint case review of clients known to both Care and Protection Services and ACT Health. This review process is carried out by the ACT Health Clinical Audit Committee. Cases referred to the Committee will include critical incidents, such as the death of an infant or child. With regard to the death of children known to Child Protection Services, recommendations will be provided for systemic improvements for individual agencies and for improved collaboration between ACT Health and Child Protection Services. An external investigator may also be engaged by Child Protection Services to review a child death in certain circumstances.²⁵

In broad terms, the processes in Australia's different states and territories vary considerably.²⁶ Two important points on which they differ are their level of independence and their scope of review. By level of independence, we mean 'the extent to which the CDRTs are influenced in favor of the government whose services are being reviewed'.²⁷ By scope of review, we mean 'have the capacity to evaluate the role of agencies or services involved, in addition to the child protection authority', which is to say having 'the capacity to look beyond the role

22 Department of Families, Housing, Community Services and Indigenous Affairs (Cth), *Australia's Children: Safe and Well* (May 2008) 13
<http://www.fahcsia.gov.au/sa/families/pubs/Pages/child_protection_discussion_paper.aspx>.

23 Irenyi and Horsfall, above n 5, 1–5.

24 *Ibid.* 2.

25 *Ibid.*

26 Queensland Commission for Young People and Child Guardian, *Annual Report: Deaths of Children and Young People, Queensland 2006–07* (2007) 147
<<http://www.bluecard.qld.gov.au/resources/publications/dcyp/dcyp07.html>>.

27 See also Joe Tucci, Chris Goddard and Katrina Stevens, 'Benchmarking Child Death Review Systems: Comparing Australian and International Approaches' (Paper presented at International Society for Prevention of Child Abuse and Neglect 15th International Congress on Child Abuse and Neglect: Working Together for a Child Safe World, Brisbane, 20 September 2004), Implications for Child Death Reviews (ss IV).

of the child protection authority in regard to a child's death'.²⁸ In some states the child death review committee is clearly more independent, such as in Queensland, where it is located with and supported by the independent Commission for Young People and Child Guardian.²⁹ Similarly, in NSW child death reviews are carried out by the Ombudsman, which is an office separate from and independent of the Department of Community Services.³⁰ Such independent processes, however, are not always in place. As alluded to above, the CDRT in the ACT still remains within ACT Health, even though the Vardon Report recommended it be located within an independent agency, such as a Commissioner for Children and Young People.³¹ In Victoria, also, although the Child Death Review Committee is supported by the Office of the Child Safety Commissioner, the Commissioner is responsible to the Minister, and therefore is not fully independent.³²

The scope of review is another important point of difference. To be of most value in achieving the goal of accurate identification of causes of unexpected death among children, a broad scope of review is necessary, both in terms of time and categories of cases. In NSW, child death review processes have a broad scope of reviewable cases, including such circumstances as: where death may be due to abuse or neglect; may involve suspicious circumstances; where the child was in care or custody; or where a child had a disability and was living in residential care.³³ Similarly, in NSW the timeframe for contact with the child protection system prior to death is three years, which is the equal longest time period in Australia.³⁴ In contrast, until 2009 Victoria only conducted a child death review where the child was known to the child protection system at the time of or three months prior to their death.³⁵ This timeframe was significantly less than all other states and territories. However, Victoria has now extended this timeframe to 12 months.³⁶

The Victorian Ombudsman has commented that the limitation of a three-month period for child death reviews was in his view insufficient and led to lost

28 See *ibid* recommendation v.

29 Commission for Young People and Child Guardian (Qld), *Annual Report: Deaths of Children and Young People Queensland 2005–06* (2006) 21–2
<www.cycpg.qld.gov.au/resources/publications/dcyp/dcyp06.html>.

30 Commissioner for Children (Tas), above n 13, 27–31.

31 Commission for Young People and Child Guardian (Qld), *Annual Report: Deaths of Children and Young People 2004–05* (2005) 20–1
<<http://www.bluecard.qld.gov.au/resources/publications/dcyp/dcyp05.html>>.

32 Max Liddell et al, *The State of Child Protection: Australian Child Welfare and Child Protection Developments 2005* (National Research Centre for the Prevention of Child Abuse, 2006) 36
<<http://www.nrcpa.monash.org/assets/files/childprotection.pdf>>.

33 Commission for Young People and Child Guardian (Qld), *Annual Report 2004–05*, above n 31, 16.

34 Commissioner for Children (Tas), above n 13, 55.

35 Ombudsman (Vic), *Own Motion Investigation into the Department of Human Services Child Protection Program* (November 2009) 122
<http://www.ombudsman.vic.gov.au/resources/documents/Investigation_into_the_Department_of_Human_Services_Child_Protection_Program.pdf>.

36 *Child Wellbeing and Safety Act 2005* (Vic) s 33.

opportunities for review and learning. However, he also noted that even this new period of review may need to be extended beyond 12 months.³⁷ A narrow scope can lead to the situation where many fewer children's deaths are reviewed: in Victoria, the deaths of 14 children were reviewed in their most recent report,³⁸ whereas in NSW, the number reviewed was 162.³⁹ In South Australia, the child death review system is distinct from other Australian systems in that it has the capacity to conduct an in-depth review of cases where a child has been seriously injured.⁴⁰ The South Australian Committee began its work on serious injury in 2007, and decided to review a sample of cases of serious injury to children under the guardianship of the Minister for Families and Communities.⁴¹ The South Australian Committee's review of serious injury in their *Annual Report 2008–2009* stated that five sample cases had been scrutinised and that common themes of experience had been identified. Additionally, the report indicated that the Committee would be provided with a final report by the end of 2009.⁴² However, at the time of writing, the report was not available in the public domain, and so the authors can only speculate that it may be included in the Committee's next annual report.

IV IMPLICATIONS FOR CHILD DEATH REVIEWS: TOWARDS THE DEVELOPMENT OF A BEST PRACTICE FRAMEWORK

To our knowledge, only a small number of academic studies and non-governmental organisation ('NGO') reports on child death review processes exist in the public domain. Rather than enter into a systematic critical review of each of their separate approaches and findings, space limitations restrict our purpose in this section of the paper to the development of a best practice framework that integrates those themes common to each; commonality of recommendations across studies and jurisdictions is in itself corroborative. We first suggest a number of key features are necessary for child death review processes. This is in the light of both the foregoing discussion of extant child death review practices in Australia, and also a set of best practice benchmarks in relation to child death review systems recommended by Tucci, Goddard and Stevens' international

37 Ombudsman (Vic), above n 35, 126.

38 Victorian Child Death Review Committee, *Annual Report of Inquiries into the Deaths of Children Known to Child Protection 2009* (June 2009) Victorian Office of the Child Safety Commissioner, 29 <http://www.ocsc.vic.gov.au/downloads/vcdrc/ar_vcdrc_2009.pdf>.

39 Ombudsman (NSW), *Report of Reviewable Deaths in 2007 – Volume 2: Child Deaths* (April 2009), 7 <<http://www.ombo.nsw.gov.au/publication/annualreports.asp>>.

40 South Australian Child Death & Serious Injury Review Committee, *Annual Report 2005–2006* (31 October 2006) 36 <<http://www.cdsirc.sa.gov.au/cdsirc/Publications/tabid/476/Default.aspx>>.

41 South Australian Child Death and Serious Injury Review Committee, *Annual Report 2007–2008* (31 October 2008) 48 <<http://www.cdsirc.sa.gov.au/cdsirc/Publications/tabid/476/Default.aspx>>.

42 South Australian Child Death and Serious Injury Review Committee, *Annual Report 2008–2009* (30 October 2009) 46 <<http://www.cdsirc.sa.gov.au/cdsirc/Publications/tabid/476/Default.aspx>>.

comparative study of child death review processes.⁴³ We then compare these recommendations with the findings of a report by two United States NGOs to derive a framework for the interpretation of CDRT legislation. The remainder of the paper then uses this framework as a mechanism for the systematic assessment of the efficacy of the child death review legislation under study.

To be effective and lead to accurate identification of causes of unexpected child deaths:

- a formal Child Death Review Team should be established;
- the CDRT should have a multidisciplinary composition. A multidisciplinary approach provides a range of perspectives to assist in identifying relevant social, medical, economic, familial, and agency factors.⁴⁴ A multidisciplinary membership is particularly useful when considering the involvement of other agencies, as well as the child protection authority,⁴⁵
- the CDRT should be legislatively based. Establishment in legislation is an important way to protect the independence of the CDRT;⁴⁶
- the CDRT should be independent. Independence is essential so that the findings and recommendations of the CDRT are not influenced in favour of the government whose services are being reviewed.⁴⁷ Preferably, the CDRT should be located externally to the department responsible for child protection and attached to an office that is independent of government;⁴⁸
- the CDRT should have a broad scope of review when considering child deaths. The CDRT should have the capacity to evaluate the role of agencies or services involved in addition to the child protection authority. Many reports which have recommended the establishment of child death review systems have recognised the necessity of looking beyond the role of the child protection authority in regard to a child's death;⁴⁹ and
- the CDRT should have a public reporting process. This is seen to contribute to the level of independence of the review body, as where findings and recommendations are made public, governments will be more accountable to act on the issues identified.⁵⁰

43 Tucci, Goddard and Stevens, above n 27. See also Chris Goddard, Katrina Stevens and Joe Tucci, 'A National Analysis of Child Death Review Systems in Australia' (Report, Australians Against Child Abuse and the Child Abuse and Family Violence Research Unit, Monash University, 2003), which makes very similar recommendations from a study of the Australian perspective alone.

44 Elster and Alcalde, above n 18, 304.

45 Commissioner for Children (Tas), above n 13, 52.

46 *Ibid* 47.

47 *Ibid*.

48 *Ibid* 48.

49 *Ibid* 59.

50 *Ibid* 50–1.

These recommendations are reinforced by those in the recent report of the Children's Advocacy Institute at the University of San Diego School of Law and First Star in the United States,⁵¹ entitled *State Secrecy and Child Deaths in the US*. This report advocates the following factors as key essentials of a 'good public disclosure policy':

There is a written statewide policy. The policy is codified in statute. The policy covers cases of both death and near death caused by abuse or neglect. The policy is mandatory. The policy contains no vague exceptions, limitations, or conditions on the availability of the information. The public is explicitly entitled to receive information including but not limited to the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports made to and investigations conducted by the child welfare agency regarding the child and/or the child's family, and the results of any such investigations; and information describing any services provided or actions taken by the child welfare agency on behalf of the child and/or the child's family, before and after the fatality or near fatality.⁵²

The Children's Advocacy Institute and First Star report outlined above makes the important point, which we emphasise, that a significant amount of taxpayer's money supports child protection investigations, and that as a consequence there is a public right to know if laws for the protection of children are being adhered to and that taxes are being well-spent.⁵³ In Australia, 'State and Territory governments currently spend in excess of \$2 billion annually on child protection alone, with average annual increases of more than 12 per cent'.⁵⁴ Public disclosure of information in relation to child abuse and neglect deaths, including near deaths, is considered essential to enable the public, advocates for children and policymakers to gain a full understanding of the issues so as to develop comprehensive policies and practices that will assist in reducing or preventing future tragedies.⁵⁵

It may be seen that the major elements of an effective child death review process as identified by Tucci, Goddard and Stevens, the Children's Advocacy Institute and First Star share key similarities. They are each concerned with: 1) formalising the establishment of the CDRT through statutory codification; 2) ensuring reviews are sufficiently broad in scope; and 3) providing appropriate levels of governmental accountability (in terms of the provision of explicit requirements for the mandatory public reporting of findings). There are also some important – but not contradictory – differences in emphasis. For example, Tucci, Goddard and Stevens emphasise the importance of ensuring that the

51 Emily Reinig, *State Secrecy and Child Deaths in the US* (24 April 2008) University of San Diego School of Law Children's Advocacy Institute <http://www.cachildlaw.org/Misc/State_Secrecy_Final_Report_Apr24.pdf>.

52 Ibid 6.

53 Ibid 5.

54 Council of Australian Governments, *Protecting Children Is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020* (2009), 9 <http://www.coag.gov.au/coag_meeting_outcomes/2009-04-30/docs/child_protection_framework.pdf>.

55 Reinig, above n 51, 4.

CDRT is characterised by a multidisciplinary membership and approach,⁵⁶ thus enabling a thoroughgoing review of the medical, familial, economic and agency impact factors. The existence of such a multidisciplinary team also facilitates both independence and a broadening of investigative scope, beyond merely an evaluation of the actions of the principal child protection authorities.

In this regard, the recommendations espoused by the Children's Advocacy Institute and First Star differ, insofar as the focus here appears to be predominantly on the 'efficiency' and 'effectiveness' of the principal child welfare agency, and specifically, compliance with child protection laws and the provision of fiscal value. Notwithstanding this difference in emphasis, in order to provide a coherent critical analysis of child death review processes, it seems appropriate to combine the recommendations of Tucci, Goddard and Stevens and the Children's Advocacy Institute and First Star report into a single interpretive framework. This encompasses: 1) the derivation of review powers; 2) the scope of the review powers; 3) the extent of autonomy enabled in the review; and 4) the degree of accountability, in terms for example of the extent of mandatory public reporting. This framework is summarised as Table 1 below:

Table 1: **A Framework for the Interpretation of CDRT Legislation**

Key Components of a CDRT	Indicators within Legislation
Statutory codification	CDRT is formally established by legislation.
Multidisciplinary composition	Provision of a range of perspectives; involvement of agencies other than child protection services.
Autonomy	CDRT is independent of the government.
Scope of review powers	CDRT is empowered to investigate incidents of both death and near death, and to evaluate the role of other responsible agencies, in addition to the principal child protection agency – for example, health care, education and law enforcement agencies.

56 Tucci, Goddard and Stevens, above n 27.

Key Components of a CDRT	Indicators within Legislation
Accountability	Mandatory public reporting of findings. Information reported to include: the age and gender of the child; information describing any previous reports made to and investigations conducted by the child welfare agency regarding the child and/or the child's family, and the results of any such investigations; and information describing any services provided or actions taken by the child welfare agency on behalf of the child and/or the child's family, before and after the fatality or near fatality.

The remainder of this paper applies this framework to the legislation governing child death reviews in Queensland, NSW and Victoria, to determine the extent of its capacity to ensure effective child death reviews can unpack the 'totality of family violence' circumstances surrounding child death.⁵⁷

V THE LEGISLATION GOVERNING CHILD DEATH REVIEWS IN AUSTRALIA: AN INITIAL ANALYSIS

A review of the Victoria, NSW and Queensland statutes reveals six Acts containing material purporting to provide governance legislation on child death reviews. These are given in Table 2, below. The purpose of this section of the paper is to analyse this legislation in terms of the framework set out in Section IV above. That is, in terms of the extent to which the relevant aspects of the legislation: 1) codify the establishment of the CDRT, 2) enable the creation of a multidisciplinary team, 3) ensure that the CDRT is autonomous, 4) provide review powers that are broad in scope and 5) create safeguards through mechanisms such as democratic accountability.

Table 2: **Child Death Review Governance Legislation in Victoria, NSW and Queensland**

NSW	Queensland	Victoria
<i>Commission for Children and Young People Act 1998 (NSW)</i>	<i>Commission for Children and Young People and Child Guardian Act 2000 (Qld)</i>	<i>Children Legislation Amendment Act 2009 (Vic)</i>

⁵⁷ Tomison, above n 11.

NSW	Queensland	Victoria
<i>Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009</i> (NSW)	<i>Child Protection Act 1999</i> (Qld)	<i>Child Wellbeing and Safety Act 2005</i> (Vic)

A Statutory Codification

The first aspect of the interpretive framework addresses whether the legislation codifies the establishment of the review team. Each of the three states establishes a CDRT (or committee) through law, although the manner in which they are established differs as follows.

1 NSW

In NSW, the CDRT was established in 1995 and constituted under part 7A and schedule 2A of the *Children (Care and Protection) Act 1987* (NSW). It was then amended in response to the recommendations of the 1997 Wood Royal Commission.⁵⁸ However, the provisions relevant to the CDRT, which are to be found within part 7A of the *Commission for Children and Young People Act 1998* (NSW) and subsequently the *Commission for Children and Young People Amendment (Child Death Review Team) Act 2003* (NSW), remain both similar to that within the preceding legislation and notable, insofar as they seek to ‘prevent and reduce the deaths of children’ within the state through the establishment of the CDRT.⁵⁹

2 Queensland

Similarly to the arrangements in NSW, the Child Death Case Review Committee (‘CDCRC’) in Queensland, is established in law through chapter 6 of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld). Section 117 of the Act specifies that the function of the committee is to ‘review all reviews carried out’ under chapter 7A of the *Child Protection Act 1999* (Qld).

3 Victoria

In Victoria, Part 6 of the *Child Wellbeing and Safety Act 2005* (Vic) codifies the establishment of the Child Safety Commissioner⁶⁰ and specifies that a key function is to undertake inquiries into child deaths in accordance with Division 4

58 New South Wales, Royal Commission into the New South Wales Police Service, *Final Report* (1997) vol 5, 1039, 1198–9, 1233.

59 *Commission for Children and Young People Act 1998* (NSW) pt 7A div 1 s 45A; *Commission for Children and Young People Amendment (Child Death Review Team) Act 2003* (NSW) sch 1 [6].

60 *Child Wellbeing and Safety Act 2005* (Vic) pt 6 div 1 s 18.

of the Act.⁶¹ Division 4 was amended by the *Children Legislation Amendment Act 2009* (Vic),⁶² thus enabling the Child Safety Commissioner to conduct inquiries into a broader range of child deaths, including, at the request of the Minister, current or closed child protection cases.

B Multidisciplinary Composition

The second aspect of the interpretive framework, as set out above, concerns the extent to which the legislation facilitates the creation of a multidisciplinary team, whose members may be drawn from agencies other than those in the field of child protection.

1 NSW

The changes afforded to section 45C(1) of the *Commission for Children and Young People Act 1998* (NSW) through schedule 3 of the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* (NSW) reverse the roles of the Ombudsman and Commissioner as Convenor of the CDRT. This has resulted in the NSW Ombudsman now convening the CDRT and the Commissioner for Children and Young People relinquishing the role of Convenor and becoming a team member. Notwithstanding these amendments to role, the provisions for the existence of a multidisciplinary team which were specified in section 45C(2) of the *Commission for Children and Young People Act 1998* (NSW) remain. This Act specifies that the team must include representatives from the Departments of Human Services (and specifically those employees from the Department of Ageing, Disability and Home Care), Health, Education and Justice, in addition to the NSW Police Force, and representatives from the Office of the NSW State Coroner. It is interesting to note that these representatives are nominated by the minister responsible for the organisation concerned.⁶³ Such a requirement implies that representatives lack independence, both from government and the agencies delivering the services. Indeed, the requirements contained within subsection (4) do little to mitigate this position, as they are reliant upon the ‘opinion of the Minister’:

In addition, the Team is to include persons recommended by the Convenor and who, in the opinion of the Minister, are:

- (a) experts in health care, research methodology, child development or child protection, or
- (b) persons who, because of their qualifications or experience, or both, are likely to make a valuable contribution to the work of the Team.

Notwithstanding this lack of independence, the inclusion of suitably qualified or experienced persons who may not necessarily be experts in the fields specified in subsection (4)(a) is ostensibly significant, as it facilitates the involvement of a wider range of individuals, such as community elders. Furthermore, the

61 *Child Wellbeing and Safety Act 2006* (Vic) pt 6 div 1 s 19(e).

62 *Children Legislation Amendment Act 2009* (Vic) pt 3.

63 *Commission for Children and Young People Act 1988* (NSW) s 45C(3).

provisions contained within section 45O allow for the appointment of expert advisers:

- (1) The Convenor may, otherwise than under a contract of employment, appoint persons with relevant qualifications and experience to advise the Team in the exercise of its functions.
- (2) A person so appointed is entitled to be paid such remuneration and allowances (including traveling and subsistence allowances) as may be determined by the Minister in respect of the person.

Although the terms seek to facilitate independence from government, in practice we suggest they fail to do so because the appointees' remunerations are decided by the minister. The implication of this for the autonomy of the review process is discussed further in part C of the model, below.

2 *Queensland*

The Queensland provisions, to be found in part 6 division 3 sections 120(2)(a)(i) and (ii) of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld), also allow for the minister to appoint experts in the field of paediatrics and child health, forensic pathology, mental health, or child protection. This is in addition to those whose qualifications, experience or 'membership of an entity' is 'likely to make a valuable contribution'. The Queensland legislation differs from its NSW counterpart, however, insofar as it requires the appointment of only one Aboriginal person and one Torres Strait Islander to the Committee under section 120(4)(a)(b), as opposed to two.⁶⁴ In addition to facilitating the development of a multidisciplinary team, similarly to the legislation in NSW, the Queensland legislation specifies that the Committee may seek assistance from expert advisors, whom the team consider to be 'appropriately qualified'.⁶⁵

3 *Victoria*

The legislation in Victoria is notable as, unlike its counterparts, neither the *Child Wellbeing and Safety Act 2005* (Vic) nor the *Child Legislation Amendment Act 2009* (Vic) makes any specific reference to the composition of the Victorian Child Death Review Committee ('VCDRC'). Rather, part 6 sections 21–2 of the 2005 Act stipulate that the Child Safety Commissioner may delegate any of the functions to an 'appropriately qualified person' and also be provided with 'assistance' where necessary.⁶⁶ At the time of writing, the VCDRC is chaired by a Human Services consultant, whilst the remaining eight members of the committee are drawn from the police, mental health services, an Aboriginal community health group, the state coroner, an alcohol and drugs services consultant, two members of the Department of Human Services (including a

64 *Commission for Children and Young People Act 1998* (NSW) s 45C(5).

65 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 119.

66 *Child Wellbeing and Safety Act 2005* (Vic) s 23.

regional director) and a representative from a large independent child and family welfare group.

A point of interest here is that with regard to the legislation in all of the states, irrespective of whether the law specifies and thus facilitates the creation of an inclusive, multidisciplinary team, the level of governmental control over appointment processes and remuneration does ensure a degree of proximity to government. In this regard, the advantages of a multidisciplinary team may be somewhat constrained by attendant questions of autonomy. This will be discussed in the following section.

C Autonomy

The third aspect of the interpretive framework addresses the extent to which the legislation ensures that the CDRT is autonomous, and in particular whether and to what extent the team is independent from the government. The discussion regarding multi-disciplinary composition, above, found that although the legislation facilitates the development of multidisciplinary teams, in practice there remains little independence from government. This is principally due to their appointment and remuneration, which are likely to be unwittingly or otherwise influenced by both political and budgetary agendas.

1 NSW

The question of autonomy has been at the forefront of debate concerning the oversight arrangements for child welfare. The 1997 Wood Royal Commission recommended the establishment of a Children's Commission with 'actual and perceived independence from Government and the relevant departments and agencies delivering services, so that it can report fearlessly and objectively on matters within its field'.⁶⁷

Following the recommendations of the Wood Royal Commission, the *Commission for Children and Young People Act 1998* (NSW) sought to improve child protection in NSW. However, like its counterparts in the other jurisdictions, this Act has been subject to a number of further amendments. The most notable of these occurred in April 2009, with the introduction of the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* (NSW). In common with the previous legislative changes that had taken place in NSW, these revisions were implemented in response to the recommendations of a further inquiry, the Wood Inquiry. This inquiry was instigated following the deaths of Dean Shillingsworth and Ebony, and reported in November 2008.⁶⁸

The Wood Inquiry proposed that a number of changes be made to the oversight arrangements. The *Children Legislation Amendment (Wood Inquiry*

67 New South Wales, Royal Commission into the New South Wales Police Service, above n 58, 1235.

68 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (New South Wales Department of Premier and Cabinet, November 2008)
<http://www.dpc.nsw.gov.au/publications/news/stories/special_commission_of_inquiry_into_child_protection_services_in_new_south_wales>.

Recommendations) Act 2009 (NSW) enacts a number of these recommendations. Significantly, from November 2010 this Act transfers the CDRT from the NSW Commission for Children and Young People to the Office of the NSW Ombudsman. Moreover, it was recommended that whilst the Ombudsman should retain overall responsibility for the investigation of ‘reviewable deaths’ and report every two years, the Department of Community Services (‘DoCS’) (rather than the Ombudsman) should review the death of any child or young person who are known (or whose sibling is known) to the department at the time of, or within three years (or six months in the case of a sibling) prior to, their death. Additionally, it was proposed that the chair, secretariat and research support for the CDRT be moved from the Commission to the Ombudsman. Significantly, the government did not implement this recommendation.

The impact of these changes on CDRT autonomy is as follows. First, the transfer of the review team from the Commission to the Ombudsman represents a significant improvement in autonomy since the Ombudsman is, at least in theory, less directly connected to the government than is the Commissioner. However, the fact that the chair, secretariat and research support for the team remain embedded in the Commission negates any benefit that may be derived from the move. Moreover, in empowering DoCS to undertake reviews of children known to them represents a significant reduction in autonomy, because the authority undertaking the review is the authority under review.

The constraints to autonomy extend also to the matter of special inquiries. Under section 17 of the *Commission for Children and Young People Act 1998* (NSW), it is the Commission that is requested to conduct inquiries rather than the Ombudsman and, further, in seeking to conduct a special inquiry, the Commission must obtain permission from the minister. Only once permission has been given can the Commission then ‘cause public notice of any such special inquiry to be given in a newspaper circulating throughout the State’.⁶⁹ Further, while section 19 of the Act provides for the conduct of the special inquiries, there is no specific mention of autonomy or independence; the conclusion is that independence is, in practice, most likely absent.

2 *Queensland*

The apparent lack of autonomy in the NSW legislation is in contrast somewhat to the Queensland legislation. The *Commission for Children and Young People and Child Guardian Act 2000* (Qld) specifies that a CDCRC member must disclose any direct or indirect interests in an issue which is either about to be, or under consideration.⁷⁰ Moreover, the legislation stipulates that the CDCRC ‘must act independently’ and remain free from ‘the control or direction of any other entity, including the Minister and the Commissioner, in relation to the way it performs its functions’.⁷¹

69 *Commission for Children and Young People Act 1998* (NSW) s 17(2).

70 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 131.

71 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 118.

The inclusion of such provisions raises two points of interest. First, bearing in mind the fact that, as discussed under ‘Multidisciplinary Composition’ above, the minister has influence over appointments and remuneration, we may question how the Committee can act with genuine autonomy. Second, this problem is compounded by the fact that the Chief Executive of Child Safety, as opposed to the Child Death Review Team, is responsible for undertaking some reviews.⁷² We suggest that these problems make autonomous reviews largely impossible in practice.

3 *Victoria*

In contrast to the requirement that the CDCRC in Queensland act independently from government, section 19 of the *Child Wellbeing and Safety Act 2005* (Vic) in Victoria provides that a principal function of the Child Safety Commissioner is ‘to provide advice and recommendations to the Minister about child safety issues, at the request of the Minister’. The implication of this is that the Commissioner’s role is not only advisory, but that such advice is provided at the minister’s request; if he does not request it there is no requirement to provide it. Similarly, section 1 of the *Children Legislation Amendment Act 2009* (Vic) states that one purpose of the Act is to ‘to give power to the Child Safety Commissioner to conduct enquiries into current or closed child protection client cases at the request of the Minister’.⁷³ Moreover, section 33A of the *Child Wellbeing and Safety Act 2005* (Vic), inserted by section 12 of the *Children Legislation Amendment Act 2009* (Vic), states that ‘the Minister may recommend that an inquiry be conducted in relation to a child protection client if the Minister considers that a review of that child’s case will assist in the improvement of child protection practices and the enhancement of child safety’.⁷⁴ Clearly, if it is not the minister’s view that a review would be beneficial then no such review will be carried out. These inclusions strongly indicate that, despite appearances, the autonomy of CDRTs is almost non-existent in Victoria.

D Scope of Powers

The fourth aspect of the interpretive framework addresses the extent of the powers of review. Two themes are apparent. First, the extent to which the CDRT is empowered to investigate incidents of both death and near death. Second, whether there exists a statutory obligation for them to evaluate the role of other responsible agencies involved in the case, in addition to the principal child protection agency. Examples of other agencies may include those in the field of health care, education and law enforcement.

72 *Child Protection Act 1999* (Qld) ch 7A.

73 *Children Legislation Amendment Act 2009* (Vic) s 1(b)(ii).

74 *Child Wellbeing and Safety Act 2005* (Vic) s 33A(1).

1 NSW

The *Commission for Children and Young People Amendment (Child Death Review Team) Act 2003* (NSW) part 7A division 1 section 45A charges CDRTs with the responsibility to ‘prevent and reduce the deaths of children’. The scope of this definition is of interest, as in comparison with other states (see below), the objective of the team is to prevent and reduce the deaths of children, irrespective of their circumstances, through what can best be described as overarching responsibility for the review of all child deaths. We describe this responsibility as ‘overarching’ because of the consequences, as discussed in the foregoing section, of the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* (NSW) transferring (from November 2010) the CDRT from the Commission to the Ombudsman. Whilst the Ombudsman will retain overall responsibility for the investigation of ‘reviewable deaths’ and report every two years, it is DoCS that will be responsible for reviewing the deaths of vulnerable children, including those known to DoCS, or those whose death was considered to be suspicious.⁷⁵

2 Queensland

Under the terms of section 246A of the *Child Protection Act 1999* (Qld), the Chief Executive of Child Safety is required to review his or her department’s involvement with a deceased child if, within the three years prior to the child’s death, the Department:

- (i) (A) became aware of alleged harm or alleged risk of harm to the child; or
(B) took action under this Act in relation to the child; or
- (ii) the child was born and, before the child was born, the chief executive reasonably suspected that the child might be in need of protection after he or she was born.

A point of interest is that the Queensland legislation makes specific reference to the unborn child. This is in contrast to the *Commission for Children and Young People Act 1998* (NSW), which merely refers to ‘children’, that is to say those persons under the age of 18. In addition, section 246B of the *Child Protection Act 1999* (Qld) specifies that the Chief Executive of Child Safety must decide both the extent and the terms of reference of the review.⁷⁶ These terms may include:

- (2) (a) finding out whether the department’s involvement with the child and the child’s family complied with legislative requirements and the department’s policies;
- (b) considering the adequacy and appropriateness of the department’s involvement with the child and the child’s family;
- (c) commenting on the sufficiency of the department’s involvement with other entities in the delivery of services to the child and the child’s family;
- (d) commenting on the adequacy of legislative requirements and the department’s policies relating to the child;

⁷⁵ Irenyi and Horsfall, above n 5, 3.

⁷⁶ *Child Protection Act 1999* (Vic) s 246B(1).

- (e) making recommendations relating to matters mentioned in paragraphs (a) to (d) and suggesting strategies to put into effect the recommendations.
- (3) In this section – policies include guidelines, procedures, protocols, standards and systems.⁷⁷

Similarly to the legislation in NSW, the Queensland CDCRC is empowered to make policy recommendations to the Chief Executive of Child Safety regarding improvements in service delivery, interagency collaboration and whether any disciplinary action should be taken against staff. However, a further point of departure with the legislation in NSW concerns the powers contained within section 117(c) of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld), which enable the Queensland committee to monitor the implementation of its recommendations. In addition, section 117(d) of the Act states that ‘if asked’ by the Minister, the committee must provide information regarding particular reviews, or classes of reviews undertaken. This aspect of the law is notable, as it suggests that apart from the requirement to provide an annual report, there is no specific requirement for the committee to update the Minister directly. Rather, the onus is placed on the Minister to request any such data.

Under the provisions contained within section 145 of the *Queensland Commission for Children and Young People and Child Guardian Act 2000* (Qld), a function of the Commissioner is to assist in the reduction of child deaths. This is achieved through classifying the deaths according to cause, demographic information and other relevant factors and identifying such data to identify patterns or trends. Furthermore, the Commissioner is empowered to identify areas of research and to undertake such work, either alone or in collaboration with others, which in turn informs recommendations regarding laws, policies and practices. We note that these Acts contain the most proactive powers of any of the legislation in the three states reviewed in this paper.

3 Victoria

With regards to reporting, division 4 section 33(4) of the *Child Wellbeing and Safety Act 2005* (Vic), amended by the *Children Legislation Amendment Act 2009* (Vic),⁷⁸ stipulates that the Secretary to the Department of Human Services must advise the Child Safety Commissioner of the death of each child who was a child protection client at the time of his or her death, or within 12 months before his or her death. Under the terms of the *Child Wellbeing and Safety Act 2005* (Vic) prior to this amendment, the time period was three months. However, notwithstanding the extension to a 12 month period, there remains a notable absence of parity with the legislation in NSW and Queensland, which specify a three year period.

77 *Commission for Children and Young People Act 1998* (NSW) s 246B.

78 *Children Legislation Amendment Act 2009* (Vic) s 11.

Furthermore, no provision is made in the Victorian legislation for unborn children or siblings [in contrast to the Queensland legislation]. Rather, section 33(1) of the *Child Wellbeing and Safety Act 2005* (Vic) merely states that the Commissioner ‘must conduct an inquiry and prepare a report in relation to a child who has died and who was a child protection client at the time of his or her death or within 12 months before his or her death’. In addition, sections 33(2) and (3) indicate that the purpose of any such inquiry ‘is to promote continuous improvement and innovation in policies and practices relating to child protection and safety’ and that it ‘must relate to the services provided, or omitted to be provided to the child prior to their death’. Like the legislation in Queensland, the focus is on improvements in internal policy and practice. However, notwithstanding these similarities, the wording of the Victorian legislation is notable, insofar as the use of the terms ‘continuous improvement and innovation’ suggest that the language of the law may be unduly influenced by managerialism.

E Accountability

The final aspect of the interpretive framework addresses the extent of public accountability of CDRTs. This is in terms of the public being explicitly entitled to receive information including but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports made to and investigations conducted by the child welfare agency regarding the child and/or the child’s family, and the results of any such investigations; and information describing any services provided or actions taken by the child welfare agency on behalf of the child and/or the child’s family, before and after the fatality or near fatality.

1 NSW

Under the requirements of sections 45P and 45Q of the *Commission for Children and Young People Act 1998* (NSW), the CDRT is required to prepare an annual report to each House of Parliament concerning both its operations and child deaths reviewed. In addition to detailing its operational activities over the course of the year, the report must provide information regarding the extent to which its previous recommendations have been accepted,⁷⁹ and optionally, the extent to which they have been implemented in practice.⁸⁰ In addition to the annual reporting requirements, section 45R enables the team to report its research findings to each House of Parliament, at any time.

2 Queensland

Chapter 6 part 1 division 6 of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld) concerns reviews and reports. The provisions contained within section 133 of the Act stipulate that the CDCRC

79 *Commission for Children and Young People Act 1998* (NSW) s 45P(2)(b).

80 *Commission for Children and Young People Act 1998* (NSW) s45P(3).

must develop and utilise review criteria and that in doing so, they must consult the chief executive of Child Safety and may consult other entities. The review criteria are a statutory instrument, the details of which must be published in the gazette.⁸¹ In undertaking a review, the CDCRC may require the Chief Executive of Child Safety to provide a supplementary report relating to the original review.⁸² Additionally, section 134 states that:

- (4) Also, for its review, the CDCRC may have regard to a report that –
 - (a) is given, under the *Ombudsman Act 2001*, section 57B, to the CDCRC; and
 - (b) relates to the child whose involvement with the child safety department is the subject of the review.
- (5) Without limiting what the CDCRC's report may contain, the report may recommend that the chief executive (child safety) take stated action within a stated time that is reasonable in the circumstances.

With regard to the requirements contained under part (b), under the terms of chapter 7A section 246D of the *Child Protection Act 1999* (Qld), the Chief Executive of Child Safety must undertake this initial review and report to the CDCRC within six months of having become aware of the child's death. Consequently, section 135 of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld) requires the committee to undertake a review, and report on the findings of the review within a three month period. Both the Chief Executive of Child Safety and the Commissioner must be furnished with a copy of the report. A point of interest concerns the requirements contained within section 135:

- (2) The CDCRC's report must not include any information identifying, or that is likely to lead to the identification of, any individual.
- (3) However, the CDCRC may include with the copy of its report given to the chief executive (child safety) a separate document that allows the chief executive (child safety) to identify individuals mentioned in the report.

The implication of this requirement is significant, as it is one which encompasses not only the child and their family members, but also those agency staff involved in their case. The provision enabling the Chief Executive of Child Safety to be provided with identifying information serves to substantially diminish the intended autonomy and transparency of the review process.

In addition, division 7 section 136 of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld) states:

The CDCRC may ask the chief executive (child safety) to notify the CDCRC, within a reasonable stated time, of the steps taken to give effect to the recommendations contained in its report and, if no steps have been taken, the reasons for this.

The provisions contained within section 137 empower the CDCRC to report to ministers, in the event that the Chief Executive of Child Safety has failed to take, or has taken inadequate or inappropriate, steps with regard to implementing

81 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 133(3).

82 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 134(3).

the recommendations of the committee. It is interesting to note that this requirement is not absolute, but rather section 137 states that the CDCRC ‘may’ report on the matter to the minister. Notwithstanding these reporting arrangements, division 8 section 141 requires the CDCRC to provide the minister with an annual report regarding the functions of the committee during the previous financial year. In turn, this must be tabled to the Legislative Assembly within 14 sitting days of receipt. The report must contain information regarding: the Commissioner’s activities relating to research about child deaths; any persons given access to information in the register for research purposes; recommendations the Commissioner has made about laws, policies or practices and the extent to which previous recommendations of the Commissioner have been implemented.⁸³

Moreover, under section 146(3), the Commissioner must not include in a report any comments adverse to an entity identifiable from the report, unless the entity has been given a copy of the comments and given a reasonable opportunity to respond to them. Although the Commissioner must include a copy of any written statements that have been made in response to the comments, they are not required to do so if they believe that public disclosure may adversely affect the outcome of a police or other investigatory body inquiry, or if the information concerns a matter before a court.⁸⁴

3 *Victoria*

The provisions contained within section 38 of the *Child Wellbeing and Safety Act 2005* (Vic) are principally focused around the disclosure of information to the minister and authorised persons:

- (1) The Child Safety Commissioner may use and disclose to the Minister or the Secretary any information acquired by the Child Safety Commissioner in carrying out his or her functions under this Division.
- (2) The Child Safety Commissioner must give a copy of any report of an inquiry under this Division to the Minister and the Secretary.
- (3) At the request of the Minister, the Child Safety Commissioner must give a copy of a report of any inquiry under this Division to an advisory committee established by the Minister.
- (4) The Child Safety Commissioner may disclose to an authorised person any information acquired by the Child Safety Commissioner that is relevant to carrying out any function under this Division for which the person is authorised under section 22.

The implication of this is that, notwithstanding the inclusion of the word ‘must’ in section 38(2), which requires the Commissioner to provide a copy of any report of an inquiry to the minister, the inclusion of the word ‘may’ in section 38(1) suggests that there is no requirement for all information to be disclosed. Therefore, information that has been acquired, but omitted from a report, is not subject to disclosure. Likewise, there is no requirement to disclose

83 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 146(1).

84 *Commission for Children and Young People and Child Guardian Act 2000* (Qld) ss 146(4)–(5).

information to an authorised person who is assisting the Commissioner. In common with the accountability requirements within the other jurisdictions, section 41 of the *Child Wellbeing and Safety Act 2005* (Vic) stipulates that the Child Safety Commissioner must submit an annual report on the operation of the child death review processes to the minister. In turn, this report must be laid before each House of Parliament within 21 sitting days of that House after it is received. This contrasts with the arrangements in both Queensland and NSW. part 1 division 8 section 141(3) of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld) requires reports to be tabled to the Legislative Assembly within 14 sitting days of receipt, and Part 5 section 26(1) of the *Commission for Children and Young People Act* (NSW) requires reports to be tabled within 15 sitting days of receipt.

VI CONCLUSION AND RECOMMENDATIONS

Australia does not have a consistent legislative approach to the review of child deaths, with the result that the processes involved in the investigation of the death of a child vary considerably depending on the particular state in which the child lived. This finding is commensurate with a recent study of child sexual abuse reporting legislation.⁸⁵ We concur with Mathews et al that significant problems arise as a result, in terms of the achievement of consistency, where such substantive disparities as noted above exist in, for example, definitions and recording systems, and with no national body coordinating the different states and territories. As a consequence, there is a lack of consistent planning, communication and policy development for the protection of Australian children.

Since the legislative frameworks within Australia are considerably different from state to state, legal difficulties are also inherent in regards to the capacity for different states to work with each other in inquiries. This problem is brought into sharper focus where families with abused children move from one state to the other and where different, competing agencies may be involved. Furthermore, the agencies responsible for investigating and overseeing individual cases lack autonomy, in terms of the way that they are appointed, their members employed and remunerated, and the extent to which they are in practice fully answerable to the minister of state. Only in Queensland does the legislation provide that the Committee must act independently, whilst the Victorian and NSW legislation clearly states that the Committee is answerable to the minister.

We purposely resist the temptation to derive binary yes/no summative findings in regards to the presence or otherwise of what we have suggested should be the key components of CDRT legislation. This is because we seek both to emphasise the nuanced nature of the legislation in regards to its efficacy and to

85 Ben Mathews et al, 'Teachers Reporting Suspected Child Sexual Abuse: Results of a Three-State Study' (2009) 32 *University of New South Wales Law Journal* 772. See also Ben Mathews and Maureen C Kenny, 'Mandatory Reporting Legislation in the United States, Canada, and Australia: A Cross-Jurisdictional Review of Key Features, Differences, and Issues' (2008) 13 *Child Maltreatment* 50.

prevent any impression being drawn that one state's legislation possesses a certain component sufficiently in comparison with another state whose legislation does not. Such a black and white presentation would defeat the purpose of the paper and potentially create an unwarranted impression that certain legislation in certain states is somehow 'perfect' in certain respects, when it plainly is not. Nonetheless, we do suggest the following conclusions can be drawn.

With regards to scope of powers, there is a problematic distinction in the NSW legislation between 1) the CDRT under the Ombudsman being responsible for the review of all deaths, and 2) DoCS being responsible for reviewing deaths of vulnerable children, *including those known to the Department*. We suggest this leads both to a lack of clarity in the review process and also prevents the necessary autonomy. A similar problem exists in terms of the impact of scope on autonomy in Queensland, where the Chief Executive of Child Safety is required to review the work of his or her own Department. Nevertheless, the Queensland legislation is notable for its specific mentioning of unborn children, thereby widening the scope of any inquiry to more likely be able to cover wider family abuse issues extant in the mother's circumstances, something wholly lacking in the Victorian legislation. Furthermore, the focus is on the development of internal policy and practice, through continuous improvement and innovation within the government organisations.

In terms of accountability, the measure contained within section 135(3) of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld) is particularly significant, as enabling the Chief Executive of Child Safety to be provided with identifying information serves to substantially diminish the intended autonomy and transparency of the review process. Furthermore, the wording of the provision in section 136 of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld), which specifies that the CDCRC may request the Chief Executive of Child Safety to notify of the action taken in response to their recommendations, suggests that this requirement is far from absolute. Similarly, the wording of section 38 of the *Child Wellbeing and Safety Act 2005* (Vic) is also most notable. This is because, although the Commissioner is required to furnish the Minister with a copy of a report of inquiry, there is no requirement for all information to be disclosed. Therefore, information that has been acquired, but omitted from a report, is not subject to disclosure. Likewise, there is no requirement to disclose information to an authorised person who is assisting the Commissioner.

More broadly, our review of the legislation in Victoria, Queensland and NSW shows that the provisions for and processes of child death investigations under the ambit of the CDRTs are so inextricably linked to the separate reviews undertaken by the individual agencies themselves that the CDRTs are more akin to a mechanism for providing ostensible state governmental oversight. However, because the CDRTs lack the necessary autonomy and the capacity to enforce their recommendations upon the agencies, there is little beyond the enactment of incremental legislative extensions that appears to result from them.

The problem is made yet more complex, we suggest, in that analysis of the child death review governance legislation reveals not only its close relation to other bodies of legislation, such as Coroners Acts, which can make the review team more akin to a entity for monitoring and statistics gathering, but also due to the prevalence of numerous incremental extensions to exiting legislation. This makes it important to trace legislative changes not just in terms of wholesale repeals but in terms of amendments to individual sections of otherwise unchanged acts. In comparison with other common law countries such as the United Kingdom, New Zealand and Canada, the regular use of incremental extensions appears to be a common feature of Australian law, and we surmise is indicative of its legislative bodies often adopting an immediate ‘as-needed’ approach to dealing with changes to laws in the light of recent public events (see, for example, the terrorism legislation).⁸⁶

If a child death review is to fulfill its purpose effectively it needs to be able to consider both deaths as well as cases of serious injury. This is because there are many similar features between the two situations; in reality, whether the outcome is death or serious injury may simply be a matter of chance.⁸⁷ Investigation of child deaths and serious injury provides a unique insight into child protection systems, enabling understanding of what works and what does not in this critical area; a process of continuous independent review of any systemic problems assists with necessary changes for improving services.⁸⁸

All state and territory governments should enter a process of cooperation with the federal government to put in place a nationally coordinated system to review the deaths of all children.⁸⁹ The recent adoption of a National Framework for Protecting Australia’s Children provides an opportunity to make improvements across all systems and jurisdictions. It is to be hoped that national leadership will provide the momentum for key improvements in critical areas such as data, research, information sharing and lead to national consistency.⁹⁰ As things stand, we suggest that the legislative discrepancies that exist between states prevents the necessary level of care from being afforded to at-risk children, thereby resulting in a widespread failure to prevent child death through family violence and neglect.

In sum, we make five recommendations. First, the remit of all CDRTs countrywide should be widened to include siblings, prenatal deaths, and also

86 Rebecca Newton, *Legislative Responses to Terrorist Movements: An Exploratory Study of Four Commonwealth Countries* (PhD Thesis, Victoria University of Wellington, 2008). See also Rebecca Newton, ‘Terrorism and the Law: Applying a Framework for the Conceptualisation of Counter-Terrorism Laws’ in James Veitch (ed), *International Terrorism, New Zealand Perspectives* (Victoria University of Wellington, 2005).

87 Stanley and Goddard, above n 12, ch 3.

88 Robyn Layton, *Child Protection Review Report: Our Best Investment: A State Plan to Protect and Advance the Interests of Children* (Department For Families and Community (SA), March 2003) ch 18.5 <<http://www.dfc.sa.gov.au/pub/tabId/283/itemId/379/moduleId/1127/Child-Protection-Review-Layton-report.aspx>>.

89 Goddard, Stevens and Tucci, above n 43.

90 Council of Australian Governments, above n 54, 9.

serious injury. Second, CDRTs should be empowered to monitor the implementation of their recommendations. Third, the agencies named in any review should be legally obligated to act on child death review recommendations. Fourth, the reporting of CDRT recommendations should always be made public, rather than merely reported internally within the government agencies. In short, fifth, CDRTs should always be empowered to act independently (that is, purposefully work at their own behest to investigate child deaths and engage in activity that will prevent future child deaths), as opposed to merely being empowered to advise ministers; we are struck by the particular inadequacy of Victorian legislation in this regard. Otherwise, like the persistent use of incremental extensions in the laws themselves, child death reviews amount at best to a series of post hoc sticking plasters to soothe political sores.

The federal government recognises Australian society's responsibility to protect children to the fullest extent, in its being a signatory to the United Nations *Convention on the Rights of the Child* – and this is so, even although there is no national human rights law.⁹¹ Indeed, Australian state governments spend millions of taxpayer dollars annually on child death reviews, at least ostensibly to uphold this responsibility. In spite of all this, CDRTs can at present do little if anything to prevent future occurrences of child death or serious injury from family violence, abuse or neglect; by omission, the legislation prevents it.

91 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990). The authors would like to thank one of the anonymous reviewers for this observation.