ACT Children & Young People Death Review Committee

Report prepared for the

Justice and Community Safety Directorate

Consultation into the Family Violence Death Review Scheme: Proposed models for the ACT

January 2019

The ACT Children and Young People Death Review Committee is established under the *Children and Young People ACT 2008*

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Contents

About the Children and Young People Death Review Committee

The ACT Children and Young People Death Review Committee is established under the *Children and Young People Act 2008* to work towards reducing the number of deaths of ACT children and young people. The committee reports to the Minister for Children and Young People.

The legislation sets out the requirement for the committee members to have experience and expertise in a number of different areas, including paediatrics, education, social work, child safety products and working with Aboriginal and Torres Strait Islander children and young people.

The committee aims to find out what can be learnt from a child's or young person's death to help prevent similar deaths from happening in the future.

To assist with this aim, we keep a register of all the deaths of ACT children and young people who die before they turn 18 and use the information on the register to learn more about why children and young people die in the ACT.

We can make recommendations about changes to legislation, policies, practices and services to both government and non-government organisations.

The committee does not investigate or determine the cause of death of a particular child or young person. We do not place blame or seek to identify underperformance but seeks to help raise awareness or to spread prevention messages among professionals and in the broader community.

The committee is keen to receive advice and feedback from interested ACT community members

Introduction

The ACT Children and Young People Death Review Committee (the CYPDRC) is pleased to have the opportunity to make a submission to the Justice and Community Safety Directorate (JACS) on the Family Violence Death Review Scheme (FVDR). The CYPDRC was established in 2012 and over this time has developed considerable expertise in working within the ACT and in the national forums to prevent and reduce the likelihood of death for children and young people. The CYPDRC continues to undertake work to improve systems intended to support children, young people and their families and to work collaboratively towards national and international reporting.

The ACT is a small jurisdiction and is fortunate that a relatively small number of deaths of children and young people occur each year. As you are aware, similarly, the ACT experiences fewer family violence deaths per year compared with other jurisdictions. Nevertheless, every death of a child, young person or adult is a tragedy and made all the worse when the death was preventable. Anything that can be done to stop such deaths is, in the CYPDRC's view, extremely worthwhile.

The CYPDRC's submission addresses the pertinent issues raised in the consultation paper, and our responses are drawn from the expansive expertise that make up the committee membership, encompassing public administration, paediatrics, education, social work, policing, epidemiology, health, child safety and working with Aboriginal and Torres Strait Islander children and young people.

In response to the consultation paper

The CYPDRC concurs there is a strong intersection between a number of the functions and processes currently undertaken by the CYPDRC and those to be undertaken by the proposed FVDR scheme. The CYPDRC note it is suggested that the FVDR Senior Research Officer is co-located with the CYPDRC secretariat which currently sits within the Community Services Directorate. It is the view of the CYPDRC that the recommended FVDR committee would have some overlap with the work and purpose of the CYPDRC as well as the expertise of a number of the CYPDRC members.

While numbers of deaths are small in the ACT, there are a number of children and young people who have come to the attention of the CYPDRC who have experienced family violence prior to their deaths. A recent review of 11 children who died in the ACT prior to 2014 found that seven of the children under three years of age had experienced family violence in their lives prior to their death (CYPDRC, 2018). While family violence was not identified as the cause of death, the capacity for the CYPDRC to review deaths of all children and young people who die in the ACT has enabled the CYPDRC to understand the frequency that family violence occurs in the lives of children and young people who die. Small numbers and confidentiality provisions prevent the CYPDRC from reporting the number of children and young people who die as a result of family violence in the ACT, but the Institute of Criminology '*Homicides in Australia*' report, identifies that between 2012 and 2014, 32 children and young people across Australia were killed by their parent.

The CYPDRC is also aware that where adults die from family violence incidents, there are considerable consequences for children and young people. A key finding from the CYPDRC

Changing the Narrative report (2018) was that the experience and impact of family violence for children is frequently unrecognised by services, with children often remaining invisible to adult support services. The Australian Domestic and Family Violence Death Review Network report (2018) identified that 107 children under the age of 18 across Australia survived the intimate partner homicide involving one, or both, of their parents. It is the view of the CYPDRC that it is critical to look at this issue through the eyes of children and young people to get a greater understanding of how a death resulting from family violence can impact the child and their prospects through life.

Based on the experiences of the CYPDRC and the commonalities across the committees noted in the consultation paper, a third model for a death review mechanism is presented for consideration by JACS. This model, Model 3, is provided in Attachment A.

The rationale for this third model is based upon two key issues: the small numbers of deaths of both family violence related deaths and deaths of children and young people experienced by the ACT compared to that of other jurisdictions and, the similarities of the expertise and resources required to review these deaths.

CYPDRC notes that the national family violence network has well established data definitions and rules which will help in establishing the FVDR function. However, the setup period for the FVDR process will be intensive and will require dedicated resources to ensure its success.

Model 3 proposes a centre of excellence for the common capability across both committees; makes use of the existing FV and CYPDRC processes where relevant, creating efficiencies in time and resources where possible and improved business continuity by ensuring that the required specialist knowledge of issues pertaining to family violence and child death are available.

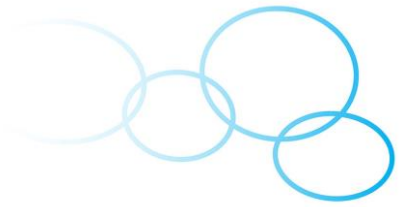
The responses provided below are based on the accumulated expertise and experience of the CYPDRC since its establishment and provide further rationale for this third model. Such learnings relate to:

- the structure, composition and location of a death review team;
- the timing of data collection, types of cases and deaths reviewed, use of a database and case reviews;
- the importance of actively contributing to the national forums and conversations; and
- the requirements for reporting and confidentiality.

The structure, composition and location of a death review team

Model 3	
Structure	Two-tiered structure: committee and committee support including a senior research officer and secretariat.
Composition	Independent multi-disciplinary committee with the capacity to appoint key experts.
Location	ACT Coroners court

The CYPDRC agrees that a two-tiered process that employs the use of a Senior Research Officer (SRO), secretariat and multi-disciplinary committee that has established standing,



authority and endorsement from Government would allow for the functions of a death review team to be successfully achieved.

The CYPDRC concurs that a committee reviewing potentially preventable deaths of individuals should consist of executive level representatives from government and non-government entities and of individuals with experience and expertise from subject areas identified in the consultation paper.

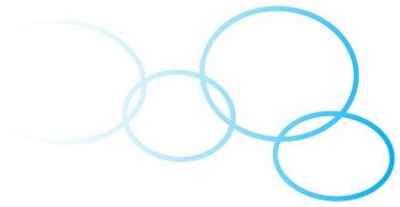
Members with such subject matter expertise and experience have provided the CYPDRC with a breadth of knowledge which has contributed to robust data analysis and the provision of recommendations for systemic change. The CYPDRC would like to highlight the importance of representation by ACT Policing, the Coroners Court and Canberra Health Services as these entities support the work of the CYPDRC considerably and are integral in providing and coding data.

The expertise and availability of committee members will be integral to the success of the FVDR committee's capacity to achieve its stated functions. Due to the ACT being a small jurisdiction, the CYPDRC has found that the required expertise of committee members means that there are sometimes only a few individuals that are able to undertake that role. Subsequently these members are 'spread thinly' across a number of committees in the ACT. Undertaking in-depth reviews of deaths requires a considerable time commitment from committee members and the research support capacity.

Adequate funding for staffing to support committee work is also critical. The CYPDRC currently has one Senior Research and Review Officer to undertake both research and secretariat activities. Funding had previously been provided for two positions, research and secretariat. Combining these roles has had considerable impact upon the level of research activities the CYPDRC may undertake and impacts the business continuity of the committee.

Not noted in the consultation paper is the work that the committee, research and secretariat will have with the *Australian Domestic and Family Violence Death Review Network* (National Network). This will also require adequate funding and resources to ensure that the ACT is able to collaborate effectively with the National Network and benefit from their research and findings. Resources need to ensure that the findings of any review and the data collected are provided in a timely and useful way.

The independence of the proposed committee is supported by Principle 8 of the *National Guiding Principles for Family Violence Death Review*. The CYPDRC has experienced that committee members frequently identify a conflict of interest due to their competing roles as a member of the CYPDRC and the role they have in the ACT community. Transparent and accountable processes to manage these need to be in place. Furthermore, placing the proposed committee in a non-service delivery directorate would assure community perceptions of independence. We note that most other FVDRC are placed with the Coroners Court and understand that this works well. The CYPDRC would propose that the optimal place for the co-location of any death review capability would be in the Coroners Court.



Timing of data collection, information sharing, types of cases and deaths reviewed

Model 3	
Types of cases and deaths reviewed	ACT residents who die in the ACT and ACT residents who die interstate. Closed criminal cases and open and closed coronial cases. Homicide, homicide-suicide, bystander homicides, and perpetrator or victim suicides, accidents such as transport, drownings and poisonings. Serious Injuries
Timing of data collection	Continuous data collection by the SRO. Development and use of a fit for purpose data base.
Information sharing entities	Including but not limited to: ACT Policing, Coroners Courts, Family Law Courts, Domestic Violence Crisis Service, ACT Health Directorate, Community Services Directorate, the ACT Education Directorate and any relevant community services and agencies.

The identification of the deaths to be included in the FVDR process will be essential to developing a robust data set. The proposed models do not identify who will have responsibility for this or how this task will be executed. For example, in NSW the review committee has access to all homicides, but in WA the police informs the Ombudsman of all relevant deaths. The CYPDRC emphasises the importance of access to all cases of deaths that include, homicide, homicide-suicide, bystander homicides, and perpetrator or victim suicides, accidents such as transport, drownings and poisonings. This will assist the committee to identify cases of deaths involving family violence risk factors, thereby reducing the risk of family violence not being identified in some deaths.

The CYPDRC also note the importance of reviewing serious injuries that are as a result of family violence (some of which may lead to a later death) as this may include information concerning suicides that were not completed. Gaining a detailed understanding of the circumstances surrounding these injuries will provide further data for the review team to understand the complexity of family violence, the significant factors for serious injuries and ongoing costs to the community and to offer recommendations for system improvement and change.

The CYPDRC currently records all deaths of ACT residents whether they occur in the ACT or elsewhere. The CYPDRC proposes that the family violence related deaths of all ACT residents that occurred in the ACT or interstate be reviewed.

Legislative provisions are required for inter-jurisdictional data sharing as well as seeking information from identified entities and from those who the committee believe can provide information that the committee considers necessary to perform its functions. The review process may require access to internal reviews and other sensitive information. Legislative provisions will need to ensure that the review committee is authorised to access sensitive information if the committee considers it necessary.

The CYPDRC agrees that data sharing entities should include but not be limited to those identified in the consultation paper. Legislative provisions for access to data on the deceased person is critical, but it may also be important for the review process to access data on living individuals including the perpetrator in order for the review team to exercise its functions.

The importance of timely data collection cannot be understated when undertaking in-depth reviews of deaths. The CYPDRC supports the review of closed criminal cases and open and closed coronial cases. Currently the CYPDRC is unable to review open coronial cases. The length of time that a coronial case may remain open frequently impedes the capacity of the CYPDRC to undertake reviews of deaths of children in a timely manner. This has considerable consequences for making timely recommendations for systemic change. It also has consequences for the access to and availability of other sources of data which may inform the review.

The CYPDRC emphasises the need for any review committee to maintain a fit for purpose data base for the continual storage and analysis of data. While there is continued recognition for the development of a national data set for the deaths of children and young people, currently each jurisdiction maintains its own data and data dictionary that may or may-not be consistent with other jurisdictions. The CYPDRC supports the approach to create consistent data collection protocols to both child and family violence death review processes so that data can be effectively shared at a national level and where cases overlap.

Requirements for reporting and confidentiality

Model 3	
Reporting & recommendations	Confidential interim reports with recommendations to the Minister and to relevant agencies as required. A three- five year systemic review report for public scrutiny
Privacy and Confidentiality	Limits to consultation processes with family and community

The CYPDRC concurs with JACS concerning the provisions to be established regarding privacy, confidentiality and the protection of information as outlined in Attachment D of the consultation paper. In addition, the CYPDRC argues for provisions for the protection of family and community members affected by family violence. The *Children and Young People Act 2008* has provisions in section 727Q that prohibit the request of information from family members of a child or young person who has died. While this does not preclude the family from providing information to the review if they desire, it does protect them from potentially distressing requests for information.

References

Children and Young People Death Review Committee (2018). *Changing the Narrative: Strengthening ACT systems*. Children and Young People Death Review Committee: Canberra.

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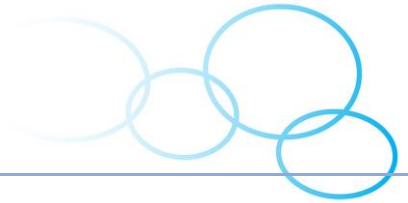
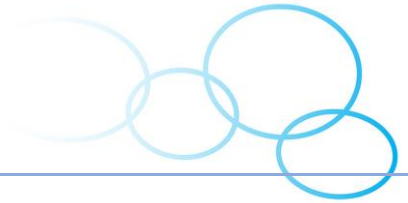
Bryant, W. & Bricknell, S. (2017) *Homicide in Australia 2012–13 to 2013–14: National Homicide Monitoring Program report.* Australian Institute of Criminology: Canberra.

Appendix A - Proposed Models

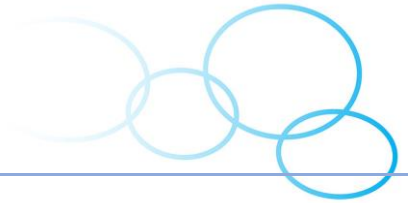
	Model 1 A legislative mandate for an ongoing death review capability	Model 2 A legislative mechanism to initiate a death review periodically	Model 3 A legislative mandate for an ongoing family violence death review capability co-located with CYPDRC death review capability	Comments – Model 3
Structure	Death review processes are undertaken by a Senior Research Officer (**SRO**) and the Family Violence Death Review Committee (**FVDR committee**).	Same as Model 1.	Death review processes are undertaken by a Senior Research Officer (SRO) and a statutory independent multi-disciplinary committee with capacity to seek the expertise of advisors. Over time opportunities for integration across both support functions could be explored	Co-located support would assist with maintaining research and review capability across both committees and in handling peaks and troughs in reporting/ review/secretariat workloads. Expert advisors could be appointed when interim reviews are undertaken for either family violence deaths or deaths of children and young people. Secure and recurrent Government funding is required for the adequate staffing levels. Support functions located in Coroners Court to assist with access to information and assure independence.
Roles	The SRO has an independent, full-time role involving data collection, maintenance of a database of family violence deaths and development of interim case reviews. The SRO also has a secretariat function when the FVDR committee is stood up. The FVDR committee is an independent, multidisciplinary team which undertakes a systemic review every 3-	Same as Model 1, but the SRO and FVDR committee are stood up only when a systemic review is needed – i.e. every 3-5 years (or after a certain number of deaths).	As per model 1 but including conducting interim reviews The SRO assists the committee to undertake family violence interim case reviews as required and supports the committee to prepare other confidential reports with recommendations for the Minister. The SRO assists the committee to undertake a systemic review every 3-5 year (or after a certain number of deaths). The secretariat provides administrative and appointment support.	Model 3 enables the research and support capability to be strengthened, improving data policy and integrity, corporate knowledge and business continuity. Model 3 envisages 2xSRO, supported by 1x RO.



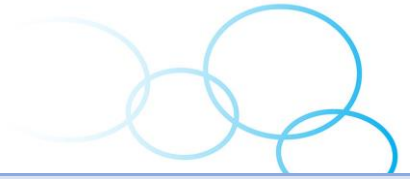
	5 year (or after a certain number of deaths).		The committee is an independent multi-disciplinary team with the capacity to seek expert advisors' dependent on the review being undertaken.	
Composition of FVDR committee	The FVDR committee consists of representatives from government and non-government entities, from areas including health, housing, police, family violence support services, courts, community services, corrections, child and youth protection, victim support, the Aboriginal or Torres Strait Islander community, legal services and academia.	Same as Model 1.	Same as Model 1 with the capacity to appoint other expert advisors for interim reviews.	The CYPDRC currently comprises a number of the committee members listed in Model 1, including ACT Policing, Health and forensic services, the Aboriginal or Torres Strait Islander community, academia and the Director General, Community Services Directorate (Child Youth Protection Services and Housing). Given membership overlap the Chairs could co-ordinate meetings to reduce impact on members.
Location	The Justice and Community Safety Directorate (JACS) is considering the option of co-locating the SRO with the ACT Children and Young People Death Review Committee secretariat, which is an independent role that sits within the Community Services Directorate. The SRO would be independently funded. Other options may be to locate the SRO with the	Same as Model 1.	The support capabilities would be co-located in the Coroners court.	With death review functions that would have some common data the CYPDRC suggests that the opportunity be taken to be co-located in the Coroners court. This would assist with independence, consistent systems and processes and access to information.



	ACT Human Rights Commission, Coroner's Court, or within JACS.			
Timing of data collection and information sharing	Continuous data collection by the SRO. Relevant information sharing entities in the ACT include ACT Policing, courts, Domestic Violence Crisis Service, ACT Health Directorate, Community Services Directorate, the ACT Education Directorate and any relevant community services and agencies. A clear legislative framework will enable information sharing from relevant entities, between FVDR teams across Australia, and with the Australian Domestic and Family Violence Death Review Network (National Network).	Same as Model 1, but data collection is not continuous – it occurs only at the time a systemic review process is initiated (i.e. every 3-5 years or after a certain number of deaths).	Same as Model 1	Note that some data on children and youth will occur in both data sets.



Types of cases reviewed	Closed criminal cases and open and closed coronial cases.	Same as Model 1	Same as Model 1	
Types of deaths reviewed	Reviews will be able to consider potential family violence-related homicides and deaths resulting from suicides of both family violence victims and perpetrators and accidental deaths of family violence victims.	Same as Model 1.	Same as Model 1	
Database for deaths	Continuously maintained.	Updated only at the time of systemic review (i.e. every 3-5 years or after a certain number of deaths).	Same as Model 1	
Case reviews (process and timing)	The SRO undertakes interim case reviews of individual deaths, which result in reports that may include recommendations. The FVDR committee, assisted by the SRO, undertakes systemic reviews every 3-5 years (or after a certain number of deaths) by decision of the Minister. The FVDR committee would meet periodically	No interim case reviews. Systemic review process is the same as Model 1, except reviews would take a longer time (i.e. 12 months) as identification, collection and analysis would occur only at the time of systemic review (as opposed to Model 1, where data would already be available	Same as Model 1	



	over a 6 to 12 month period.	at the time systemic review is initiated).		
Reporting and recommendations	Interim reviews result in confidential reports that may include recommendations to the Minister and relevant entities for system improvements. The interim reports will be informed by best practice developments by the National Network. Systemic reviews result in public reports to the Minister and relevant entities, with recommendations on system wide issues. Systemic reviews are based on interim reports and other relevant information.	Same as Model 1, except without the use of interim reports.	Same as Model 1	
Privacy and confidentiality	The SRO and FVDR committee will operate in accordance with confidentiality and privacy provisions.	Same as Model 1	Same as Model 1	Legislative provisions are required to ensure that the committee is enabled to access all information relating to the deceased and the perpetrator including internal reviews and other potential sensitive information.