

Queensland
Family & Child
Commission

Operational Guidelines

For agency reviews following the
death or serious physical injury
of a child known to the child
protection system

Acknowledgement

All children have a right to feel safe, protected and free from harm.

Each year, children known to the child protection system die or suffer serious physical injuries.

The loss of every child has long lasting impacts on family, friends, communities and the professionals that provided supports to the child and their family.

The Queensland Family and Child Commission acknowledges the difficult and important work of government agencies required to review the services they provided to these children.

These agencies are committed to working together to learn from these reviews and to make the changes needed to promote the safety and wellbeing of children and to help prevent future deaths that may be avoidable.

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Introduction and overview

Background

In July 2016, following the death of a 21-month old child, the Queensland Government requested the Queensland Family and Child Commission (QFCC) to oversee the reviews by Child Safety and Queensland Health to:

- confirm whether both departmental reviews into service delivery were conducted thoroughly, and
- provide any guidance on necessary system changes to improve the system.

In April 2017 the QFCC released its report titled *A systems review of individual agency findings following the death of a child*. This report found that while Child Safety's internal review processes were effective and comprehensive at an agency level, Queensland's current system of reviewing deaths of children known to Child Safety did not consider or identify the system changes needed to protect vulnerable children.

The QFCC's single overarching recommendation was to 'consider a revised external and independent model for reviewing the deaths of children known to the child protection system' that included the following features:

- a review model scope that extends to cover both government and non-government agencies
- extended powers and authority, including the power to make and monitor recommendations
- public reporting on the outcomes of child death reviews
- review of the panel governance arrangements, such as selection and appointment of panel members
- promotion of learning and analysis of decision-making, the timely and transparent consideration of systems issues and inter-agency collaboration during the internal review process.

The Government accepted the recommendation and the Hon. Yvette D'Ath, Attorney-General and Minister for Justice, introduced the Child Death Review Legislation Amendment Bill 2019 on 18 September 2019. The Bill was assented on 13 February 2020, becoming the *Child Death Review Legislation Amendment Act 2020*.¹

The Act established a new child death review model by:

- requiring more agencies involved in providing services to the child protection system, that is, the Department of Education, the Department of Youth Justice, the Queensland Police Service, and Queensland Health, in addition to the Department of Child Safety, Youth and Women (Child Safety) and the Director of Child Protection Litigation (DCPL), to conduct internal systems reviews of their service provision
- establishing a new, independent Child Death Review Board (CDRB) hosted by the QFCC and tasked to carry out systems reviews following the death of children connected to the child protection system to identify:
 - opportunities for continuous improvement in systems, legislation, policies and practices
 - preventative mechanisms to help children and prevent deaths that may be avoidable.

The new child death review model commenced 1 July 2020.

¹ Refer: <https://www.legislation.qld.gov.au/view/html/asmade/act-2020-002>

Purpose

Chapter 7A (Internal agency reviews following child deaths or injuries) of the *Child Protection Act 1999* (CP Act 1999) outlines the legislative responsibilities of agencies in carrying out reviews.

This document sets out the operational aspects to conducting reviews following the death or serious physical injury of a child known to the child protection system. It provides guidance to relevant agencies and the litigation director to promote collaboration and procedural consistency across agencies.

Agencies required to undertake reviews

These guidelines apply to agencies responsible for undertaking reviews under Chapter 7A of the CP Act 1999.

These agencies are:

- the Department of Child Safety, Youth and Women (DCSYW or Child Safety)
- the Department of Education (DoE)
- Queensland Health (QH)
- the Queensland Police Service (QPS)
- the Department of Youth Justice (DYJ)
- the Director of Child Protection Litigation (DCPL)

Definition



For the purposes of these guidelines:

- **relevant agencies** means the Department of Child Safety, Youth and Women, Queensland Health, the Department of Education, the Queensland Police Service, and the Department of Youth Justice
- **agencies** means relevant agencies and the Director of Child Protection Litigation.

The reviews to be conducted by relevant agencies have a different scope from those to be conducted by the DCPL.

| Relevant agency | DCPL |
|---|--|
| If the agency has been involved with the child, the head of the relevant agency must undertake a review of the relevant agency's involvement with the child. ² | If the DCPL has performed a litigation function in relation to the child, a review must be conducted of the Office of the Director of Child Protection Litigation's (ODCPL) involvement in the matter concerning the child. ³ |

² See sections 245H and 245I CP Act 1999 for details of requirements for reviews, and section 245K CP Act 1999 for further details on the scope of a relevant agency review.

³ See section 245J CP Act 1999 for details of requirements for reviews and section 245L CP Act 1999 for further details on the scope of a litigation director review.

The review process set out in legislation is summarised below.

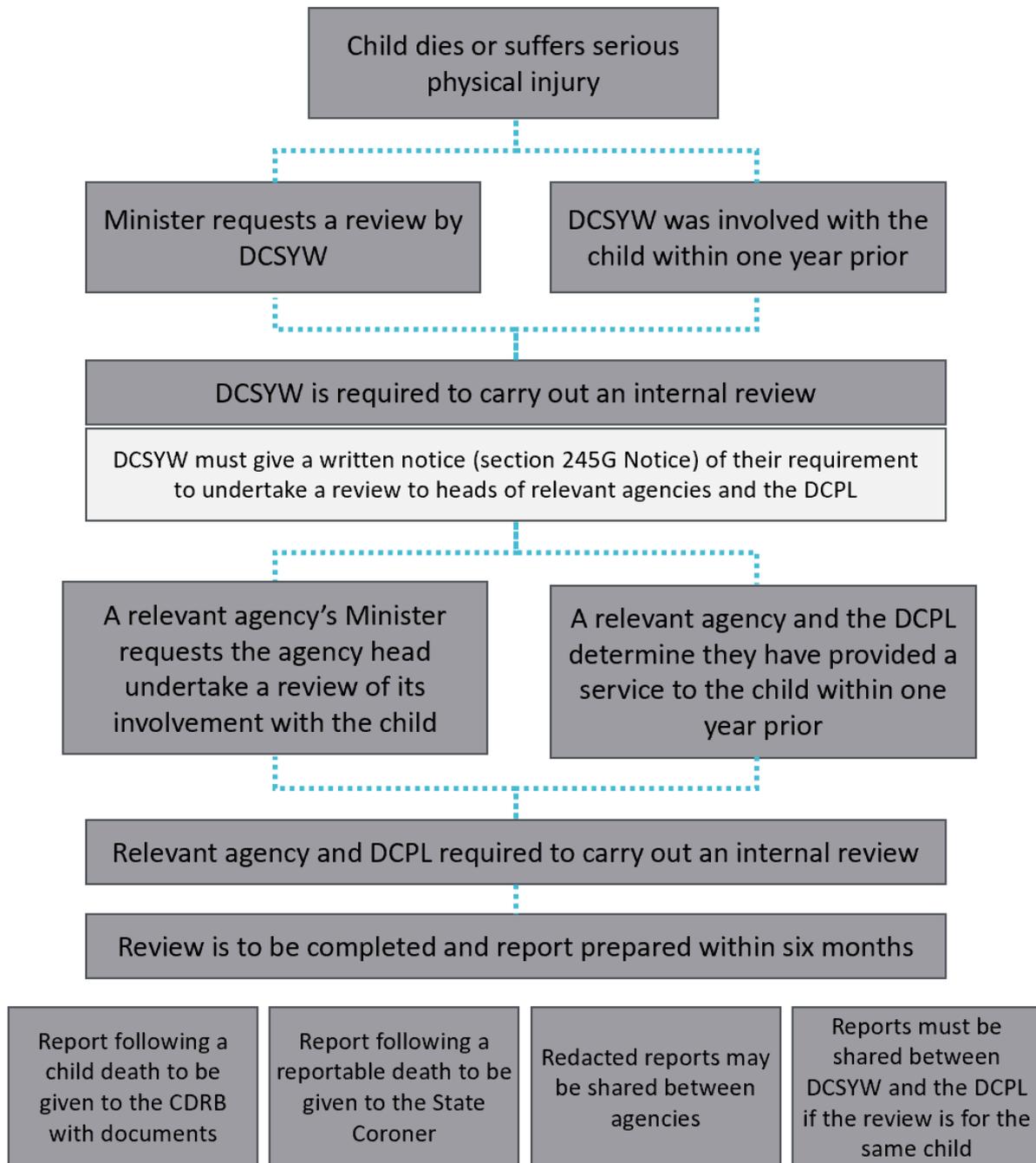


Figure 1—Agency review process

Guiding principles for agency reviews

The following principles provide the foundation for accountable and meaningful review processes that promote shared responsibility for the safety and wellbeing of children.

Purpose

Facilitating ongoing learning, improving services and promoting accountability will uphold the policy intent of the review model

Improve service delivery

Identify internal agency matters, as well as system matters, that facilitate ongoing learning and improve services for vulnerable children.

Promote accountability

Model impartiality and inspire a staff culture that respects review processes as a way to improve outcomes for children, promote accountability and mitigate reputational risk.

Joint learning

Target review reports (and the summary document) to inform agency learnings, as well as systemic learnings by the Child Death Review Board.

Values

Fostering a culture of learning and respect for review processes will promote meaningful outcomes

Child-focused

The best interests of children are at the centre of all reviews and decisions.

Transparent and accountable

Agency reviews will be transparent and accountable in methodology, consultation and information records.

Objective

Agency reviews will be objective and not influenced by, or protective of agency interests in representing the facts; or influenced by personal interests or bias.

Courageous

Agencies will be prepared to identify genuine issues, including resourcing and management issues. It is acceptable to say there was nothing the agency could have reasonably been expected to have done better and that not all tragic events can be prevented.

Respectful of staff knowledge

Agencies will recognise and respect the value of staff knowledge and professional practice in the review process and listen to what staff are identifying as the local and system issues.

Non-adversarial

Agency reviews will actively inquire into the facts of a case, rather than looking for fault in individuals or other agencies.

Support collaboration and joint learning

Relevant agencies will collaborate with each other when planning and conducting a review to support joint learning.

Provide information in a timely way

Agencies will put processes or delegative structures in place so that information can be shared in a timely way to support each other's reviews.

Share findings

Agencies will share review outcomes with other relevant agencies who have undertaken a review on the same case.

Privacy and Confidentiality

Agencies will protect the confidentiality of information in accordance with the CP Act 1999 and use appropriate data controls when sharing sensitive information.

Process

Applying flexible review processes will optimise agency efficiency, while having some consistent elements will support value across the broader review process

Flexible

Reviews may be undertaken in the manner most appropriate for the agency and the case being reviewed.

Summary document

Review reports will have a summary document appended to the front to make findings, recommendations and suggestions more accessible to each other and the CDRB.

Time period for review

Relevant agencies can determine the scope and time period for a review, however, at a minimum, must review the 12 months prior to the child's death or serious physical injury.

Scope to reflect agency or public value

The scope of an agency review will be determined by each agency and should allow greatest focus to be placed on matters that provide the greatest opportunity for learning and improvement to services.

Reflection on review process

Agencies will reflect on review processes and look at ways to continuously improve them over time.

Step 1—Establish an agency co-ordination point

Agency co-ordination point



Relevant agencies and the DCPL must establish a single point of contact for all matters relating to agency and CDRB reviews. This position is referred to as the **agency co-ordination point**.

The main purpose of the co-ordination point is to streamline practices, reduce duplication and maximise opportunities for shared learnings across the system. The person/s in this co-ordination point should remain constant, as far as possible, to build relationships and mature practices across agencies.

The co-ordination point will have the appropriate authority, or have access to positions of authority, to undertake its roles and responsibilities.

It is important that each agency puts strategies in place that allow for timely approvals, as some legislative responsibilities sit with the chief executive of Child Safety, the DCPL, or the heads of relevant agencies (such as determining a triggering event). This can be done through formal delegative structures or timely workflow processes.

Agency co-ordination points need to be aware of their agency's delegations to co-ordinate decision making. Agencies should make delegations available so that each agency is aware of persons authorised to request and share information. This will help to avoid uncertainty about with whom, and when, information can be shared.

Collaboration and responsive communication between the co-ordination points will be critical. This will help improve the overall quality of review processes and build a culture of learning across agencies.

The co-ordination points will be established with the roles and responsibilities shown below.

Co-ordinate the receipt and provision of information and advice about the requirement to undertake a review

| Responsibility | Co-ordination point | Responsibilities |
|----------------|--|---|
| | Child Safety co-ordination point | <ul style="list-style-type: none"> determine triggering event⁴ as soon as practicable issue Section 245G Notice⁵ and allocate case number allocate case number for agency reviews triggered by a request for a review by the Minister for Child Safety |
| | All co-ordination points (other than Child Safety) in response to a Section 245G Notice | <ul style="list-style-type: none"> determine if a review is required as soon as practicable notify agencies if a review will be conducted and the date of the triggering event (and the CDRB when the matter relates to a child death) as soon as practicable notify agencies if no review is required (and the CDRB when the matter relates to a child death) |
| | Co-ordination points (other than Child Safety) in response to request for a review by a Minister | <ul style="list-style-type: none"> notify Child Safety of triggering event and request case number from Child Safety notify other relevant agencies of triggering event and case number notify the CDRB when the matter relates to the death of a child |

⁴ A 'triggering event' is defined at s 245M CP Act 1999. The triggering event happens at different points for relevant agencies. See Figure 2 – Agency review flowchart.

⁵ Child Safety provides the Section 245G Notice to the DCPL when it is performing, or has performed, a litigation function in relation to the child.

See Step 2— Determine the requirement for an agency review

Co-ordinate information, advice and assistance for agencies planning a review

Responsibility

All co-ordination points

- request and provide information necessary to assist with determining the scope and time period for a review
- notify agencies of terms of reference or aspects of a review that have shared value or impact
- if requested, organise access to data, information, people and funded organisations within an agency's remit

See Step 3—Plan for an agency review

Co-ordinate information, advice and assistance for agencies conducting a review

Responsibility

All co-ordination points

- issue information requests to relevant agencies
- receive, negotiate and co-ordinate requests from relevant agencies for information and access to personnel
- receive requests from other co-ordination points for information from funded or licensed organisations
- issue information requests to funded or licensed organisations
- receive information from funded or licensed organisations in response to requests (from other co-ordination points)
- receive and co-ordinate requests for information from the CDRB Secretariat about the agency review
- provide information requested to a relevant agency as soon as practicable and in a reasonable format, or advise of delays or if information is not available/unable to be provided
- notify agencies on draft recommendations likely to impact them and co-ordinate consultation (noting that agencies will only make recommendations for their own agencies)

See Step 4—Conduct an agency review

Co-ordinate the provision of reports and review outcomes

Responsibility

All co-ordination points within six months of the triggering event

- provide the summary document to relevant agencies which undertook a review on the same matter (to share the outcomes of the review)
- consider if there is value in providing the summary document to a relevant agency that did not conduct a review (to share the outcomes of the review)
- may provide the review report to relevant agencies or the DCPL which undertook a review on the same matter (the report must be redacted before sharing) (Child Safety and DCPL do not need to redact reports when sharing with each other)
- following a child death, provide a copy of the review report, summary and documents to the CDRB

| | | |
|---|--|--|
| | | <ul style="list-style-type: none"> • following a reportable death under the <i>Coroners Act 2003</i>, provide a copy of the review report to the State Coroner |
| | Child Safety and DCPL co-ordination points within six months of the triggering event | <ul style="list-style-type: none"> • provide the review report to each other |
| | <p><i>See Step 5–Prepare a report about the review</i></p> <p><i>See Step 6–Share the review outcomes and provide a report</i></p> | |
| Provide central co-ordination to monitor recommendations and quality processes | | |
| Responsibility | All co-ordination points | <ul style="list-style-type: none"> • keep a register of recommendations specific to their agency and monitor implementation of agency responses • co-ordinate agency responses to requests from the CDRB on the implementation status of recommendations |
| | All co-ordination points after 12 months implementation of the new legislation | <ul style="list-style-type: none"> • undertake a review of implementation within their agency • participate in the CDRB implementation review |
| | <p><i>See Step 7–Monitor recommendations and other matters</i></p> | |

Step 2—Determine the requirement for an agency review

The head of relevant agencies and the DCPL (or their delegates) must carry out a review following a triggering event.

Triggering event



A **'triggering event'** is defined at section 245M of the CP Act 1999. The criteria for triggering event for a relevant agency are set out in section 245M(1). The criteria for a triggering event for the DCPL are set out in section 245(M)2. See Figure 2—*Agency review flowchart*.

Relevant agencies are the:

- the Department of Child Safety, Youth and Women (DCSYW or Child Safety)
- the Department of Education (DoE)
- Queensland Health (QH)
- the Queensland Police Service (QPS)
- the Department of Youth Justice (DYJ)

For a relevant agency, the review is of the agency's involvement with the child.⁶

For the DCPL, the review is of the ODCPL's involvement in the matter concerning the child.⁷

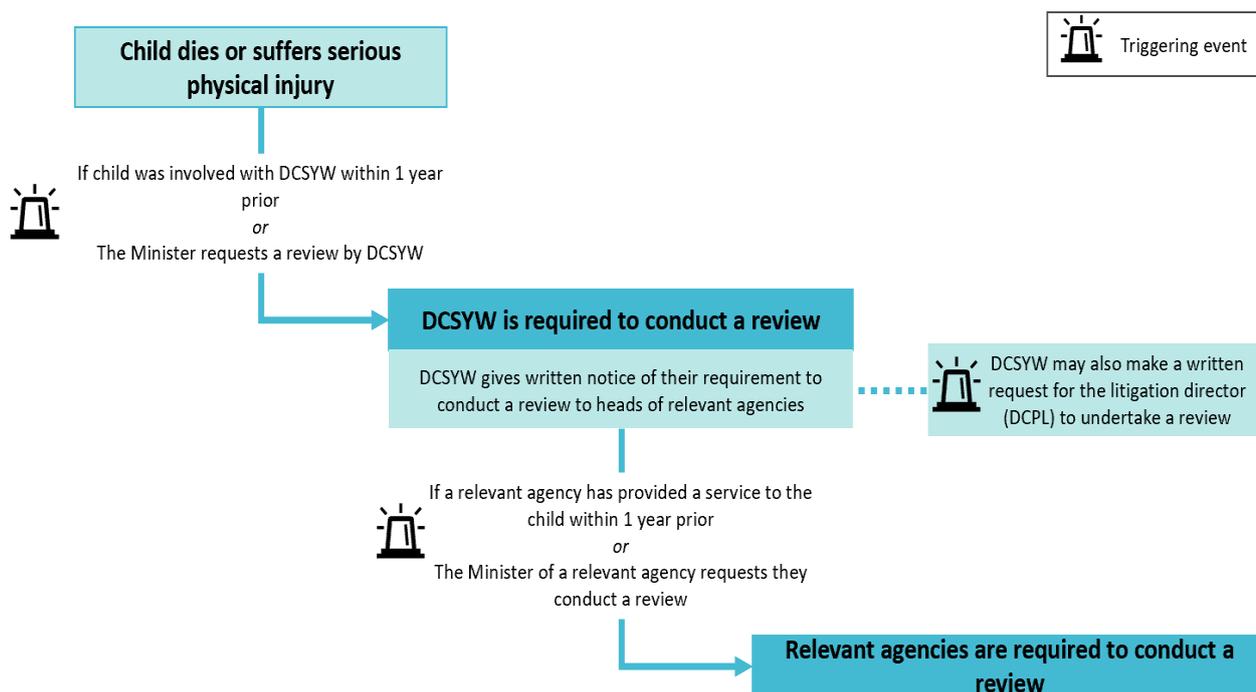


Figure 2 – Agency review flowchart

⁶ See s 245K CP Act 1999, for further details on the scope of a relevant agency review.

⁷ See s 245L CP Act 1999, for further details on the scope of a DCPL review.

Issue a notice

Child Safety must give a written notice (using the standardised Section 245G Notice) of its requirement to undertake a review to heads of relevant agencies and the DCPL (or delegates).⁸

The Section 245G Notice must include:

- child's name
- an internal agency review case identifier generated by Child Safety (to be used by all agencies)
- the Information Client Management System (ICMS) number for the child
- child's date of birth
- child's date of death or serious physical injury⁹
- child's address
 - indicative cause of death or serious physical injury, including a brief description of circumstances
 - parent/carer name/s, including address of primary residence or last known.

See Appendix 1 for a copy of the Section 245G Notice.

Queensland Health will determine whether there is Hospital and Health Service (HHS) involvement, and if so, will forward the Section 245G Notice to the HHS.

Child Safety will forward a copy of the Section 245G Notice where it relates to a child death (and not to a serious physical injury) to the CDRB Secretariat and include with the notice the date of the triggering event.

Determine if a review is required

On receipt of the Section 245G Notice, relevant agencies must promptly make inquiries to identify whether services have been provided to the child within 12 months prior to their death or serious physical injury.

Services provided to a child



Services provided to a child include interactions with a member of the child's family in relation to a matter relevant to the child's safety and wellbeing.

If the relevant agency is required to undertake a review, the date this decision is made is the date of the triggering event. The decision must be made as soon as practicable after receiving the Section 245G Notice from Child Safety.

The DCPL will confirm, as soon as practicable, whether the criteria¹⁰ is met to undertake a review on receipt of the Section 245G Notice. If the DCPL is required to undertake a review, the date of the triggering event is the date that Notice is received from Child Safety.

Notify other agencies

Each agency will notify the other agencies whether or not the agency is required to undertake a review. This notification is to include the Child Safety allocated case number, and the date of the agency's triggering event (if a review is required). See Appendix 2 for a response example.

⁸ For Queensland Health, this is the Director-General of Queensland Health, and not the chief executive of a hospital and health service.

⁹ Serious physical injury means (a) the loss of a distinct part or an organ of the body; or (b) serious disfigurement; or (c) any bodily injury of a nature that, if left untreated, would endanger or be likely to endanger life, or cause or be likely to cause permanent injury to health.

¹⁰ Section 245J CP Act 1999

Where the matter relates to a child death (and not a serious physical injury) the CDRB Secretariat must be included in the notification email.

If a Minister requests a review

If a Minister requests an agency to undertake a review, this will automatically result in a triggering event for that agency. A triggering event by Ministerial request will occur in exceptional circumstances.

If the Child Safety Minister requests a review, Child Safety will prepare a Section 245G Notice and issue the notice to relevant agencies.

If another Minister requests a review, the agency will advise Child Safety of the triggering event, and the CDRB Secretariat if the matter relates to a child death. In this circumstance, Child Safety will generate a case file identifier and provide this to the agency, and to the CDRB Secretariat for matters relating to a child death.

If a Minister (other than the Minister for Child Safety) requests a review, this does not trigger any other agency to undertake a review.

Step 3—Plan for an agency review

Determine the terms of reference for the review

Terms of reference



The **terms of reference** set out the focus areas for a review.

The terms of reference should align to the overarching purpose of reviews—to promote the safety and wellbeing of children who come into contact with the child protection system. Ways to facilitate ongoing learning, improve services, promote accountability and support collaboration and joint learning, must also be considered.

Each agency review must have terms of reference.

The terms of reference for a relevant agency may include any of the following matters¹¹:

- a. determining whether the agency's involvement with the child complied with legislative requirements and the agency's policies
- b. considering the adequacy and appropriateness of the agency's involvement with the child
- c. commenting on the adequacy of the agency's involvement with other entities in the provision of services to the child
- d. commenting on the adequacy of legislative requirements and the agency's policies relating to the child
- e. making recommendations related to matters mentioned in paragraphs (a) to (d) and suggesting strategies to put into effect these recommendations.

The terms of reference for a DCPL review may include any of the following matters¹²:

- a. whether the ODCPL complied with:
 - i) legislative requirements
 - ii) guidelines made by the DCPL under the section 39 of the *Director of Child Protection Litigation Act 2016* (DCPL Act), and
 - iii) any policies relevant to the performance of a litigation function in relation to the child
- b. the adequacy of the legislative requirements, guidelines and policies mentioned in paragraph (a) for performing litigation functions
- c. the sufficiency of evidence made available to the ODCPL for the purposes of making decisions under the *DCPL Act*, and
- d. recommendations relating to matters mentioned in paragraphs (a) to (c) and strategies to put into effect the recommendations.

Agencies are not required to share the terms of reference for a review with each other. If it would be of benefit to another agency to be informed about the terms of reference, or an aspect of them, they should be shared.

¹¹ Section 245K CP Act 1999

¹² Section 245L CP Act 1999

Determine the scope and time period for the review

Agencies will decide on the scope and extent of each review. This will inform the terms of reference and review approach.

Scope and time period for review



The **scope** refers to the intended depth and breadth of the review. For example, an agency may review all responses provided to the child or look at a specific matter such as preventing the child from disengaging from school.

The **time period** refers to how far back an agency will go in exploring its involvement with the child. For example, an agency may review the last 12 months of its involvement or the last 3 years if this provides an opportunity for greater learning (such as if there was a change to policy and the agency is looking at the impact of that change on the services delivered to the child).

Agency procedures should be established to allow greatest focus to be placed on matters that provide the greatest opportunity for learning and improvement to services.

These are likely to include matters where a child dies from fatal assault or neglect, is in state care at the time of their death or serious physical injury, there are serious concerns raised about the services provided, or there is significant history of state involvement with the child's family.

The scope of the review is likely to be more limited where a death may have been predictable, for example, through severe disability or illness, and agency contact is only relevant to meeting the medical needs of the child.

The time period for a review should be determined on a case-by-case basis. At a minimum, relevant agencies must review involvement with the child—or a member of a child's family in relation to a matter relevant to the child's safety and wellbeing—over the 12 months before their death or serious physical injury to consider the issues identified in section 245K of the CP Act 1999. The time period for a review undertaken by the DCPL will be determined by reference to the litigation function being performed in relation to the child and matters listed in section 245L of the CP Act 1999.

This means findings and recommendations will be targeted towards current policies and practices. This does not remove the need for agencies to identify whether services provided adequately considered the child and family's vulnerabilities and cumulative needs over time.

A relevant agency can request information from another relevant agency or entity, including the DCPL, to support its decision about the scope and time period for a review.

Consider opportunities for collaboration

When planning a review, agencies will consider opportunities for collaboration and shared learnings. This includes planning ways to maximise shared benefit and avoid duplication for:

- areas of inquiry relevant to other reviewing agencies
- stakeholders who may be common to other reviewing agencies
- legislation, policies and procedures relevant to other reviewing agencies
- cross-cutting issues, such as multi-disciplinary teams and professional reporting about child harm
- learnings of relevance to the CDRB.

The summary templates, *Summary of internal agency review outcomes* and *Summary of DCPL review outcomes* (Appendix 3A and 3B) will be used to share review outcomes with relevant agencies and the CDRB.

Step 4—Conduct an agency review

Agencies to establish procedures for conducting a review

Agencies must establish internal procedures for carrying out reviews (see section *Guiding principles for agency reviews*). They should include providing appropriate guidance, templates and tools to:

- undertake a review within 6 months of a triggering event
- facilitate ongoing learning and improvement in the provision of services
- promote accountability
- support collaboration and joint learning
- develop terms of reference that will be most appropriate for the case, and
- engage staff in the review, including holding non-confrontational and non-blaming discussions.

Information sharing for purpose of agency reviews

The legislation enables relevant agencies to share information to effectively carry out reviews.¹³ A person who honestly gives information for this purpose is not liable in any way and cannot be held to have breached any professional standards.¹⁴

Information can be requested and shared in different circumstances. They include:

- a relevant agency asking another for information relevant to a review¹⁵
- an entity giving confidential information to a relevant agency for the purpose of an internal agency review, whether the information was requested or not¹⁶
- relevant agencies sharing the outcomes of their internal review with each other¹⁷
- providing a copy of the review report (See *Step 6 – Share the review outcomes and provide the report* for details).

Information sharing will occur through the agency co-ordination points. This includes requesting and sharing information required from third parties associated with an agency, such as an organisation funded, contracted or licensed by an agency to provide a service.

Where information is required from one or several service providers, the co-ordination point of the agency which licenses, funds or has an agreement with the service provider/s is to be issued with the request.

The co-ordination point is responsible for liaising with the service provider/s to request, receive and collate the information for completeness, before providing it to the co-ordination point of the requesting agency.

See *Step 1 – Agency co-ordination point roles and responsibilities* for further information.

Giving information to the CDRB

A relevant agency may give confidential information to the CDRB whether or not the information was requested.¹⁸ The person providing the information is protected from liability.¹⁹

¹³ Section 245S CP Act 1999

¹⁴ Section 245V(2) – (4) CP Act 1999

¹⁵ Section 245T(1) CP Act 1999

¹⁶ Section 245T(2) – (3) CP Act 1999

¹⁷ Section 245T(3) CP Act 1999

¹⁸ Sections 5 (dictionary in schedule 1), 29P and 29T of the *Family and Child Commission Act 2014* (FCC Act 2014) and s 245T(4) CP Act 1999

¹⁹ Section 29T FCC Act 2014

Information should be shared with the CDRB in a collaborative and timely way.²⁰ Doing this will improve the quality of systemic findings and recommendations to improve the child protection system.

²⁰ Section 290 FCC Act 2014

Step 5—Prepare a report about the review

Agencies must determine the appropriate format for an agency review report.

An agency may need to prepare a report on the same case for other agency purposes, as well as for the requirements of section 245K of the CP Act 1999. The agency may use the same report or a section of it for both purposes.

Attach a completed summary document to the report

Summary document



The summary document is designed to synthesise agency findings and insights for the CDRB members and to share review outcomes with other relevant agencies that undertook a review for the same child.

The summary document also provides an opportunity for agencies to outline findings in relation to system matters to support CDRB findings and recommendations.

Agencies will attach a completed summary document to the front of each review report when providing it to the CDRB. The summary templates, *Summary of internal agency review outcomes* and *Summary of the Director of Child Protection Litigation (DCPL) review outcomes*, are provided at Appendix 3A and 3B.

If more than one HHS undertakes a review, Queensland Health is responsible for completing a single summary document for the HHS review reports on the same matter.

Collaboration with other agencies

Relevant agencies should share information at any stage during a review process if it becomes clear that it would help another agency's review or if it would enhance the safety, wellbeing or best interest of children.

Example



During a review, Child Safety identified the child did not have access to a Community Visitor for several months while in detention when they should have. The Child Safety and Youth Justice co-ordination points share information to help examine the issue and co-ordinate recommendations across agencies.

In writing a report, if an agency includes a recommendation that is likely to impact another agency, consultation with that agency must occur prior to completing the report.²¹

Example



If the Department of Education is recommending changes to Education Support Plans (for children on child protection orders), it may impact on Child Safety's case planning requirements. In this situation, the agency co-ordination points must consult prior to completing the report.

If Child Safety is planning to recommend changes to the Suspected Child Abuse and Neglect Team System policy and procedures, it must consult with the agencies which would be impacted by these changes (because of their participation in the multi-agency system).

²¹ Note: Agencies will only be making recommendations for their own service provision and not for other agencies.

Report approval

Agencies must establish their own approval mechanisms for agency review reports. Once a report is approved, it must be shared per legislated and operational requirements.

See *Step 6 – Share the review outcomes and provide the report* for details.

Step 6—Share the review outcomes and provide the report

Relevant agencies may share the outcomes of a review with each other to promote learnings across the child protection system. The legislation also sets out when the report may, and must, be provided to others. This is outlined below.

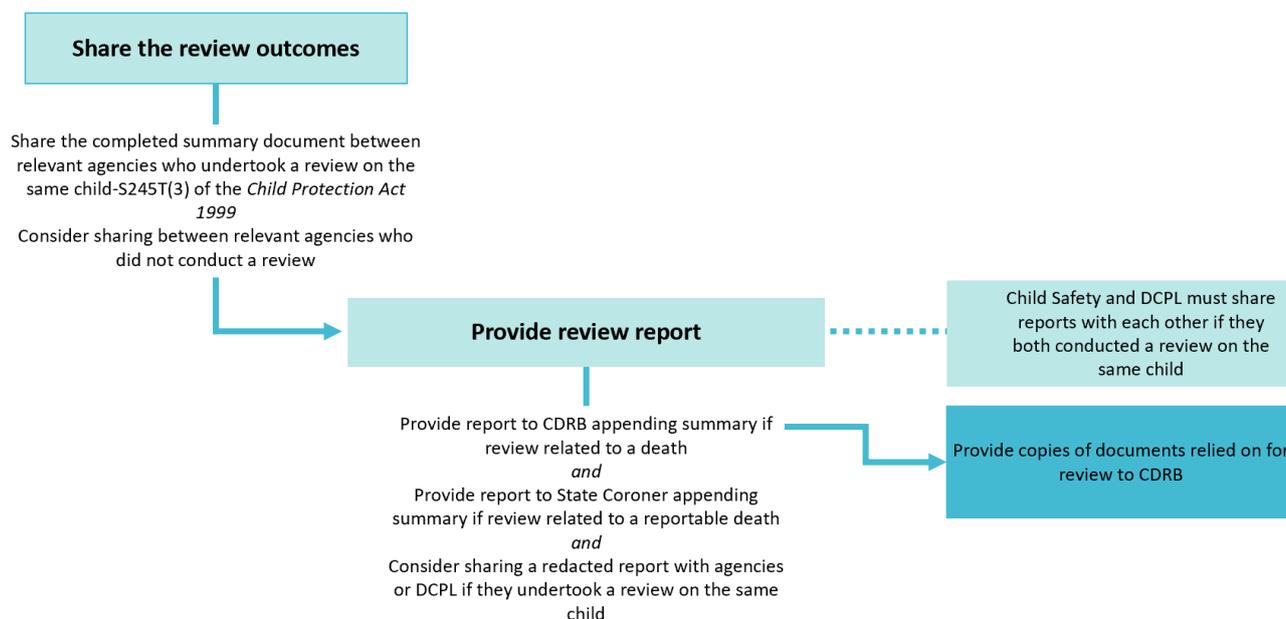


Figure 3 – Providing review outcomes and report flowchart

Share a summary of the review outcomes with relevant agencies who carried out an internal review

Section 245T(3) of the CP Act 1999 allows the head of a relevant agency to give confidential information to the head of another relevant agency for the purpose of sharing the outcomes of an internal agency review (the DCPL is unable to do so as it is not a relevant agency).²²

To do this, relevant agencies will provide the completed summary document, the *Summary of internal agency review outcomes* (Appendix 3A) to other relevant agencies that conducted a review about the same child.

The summary document may also be shared with a relevant agency that did not conduct a review of the same child²³.

The summary documents will be shared through co-ordination points. The Queensland Health co-ordination point will be responsible for liaising with HHS about sharing their summary with other agencies.

²² As DCPL is not included in section 245T(3) CP Act 1999, it is unable to share a report with a relevant agency that has not conducted a review.

²³ This is permissible under section 245T(3) CP Act 1999.

Requirement to provide reports to others

The DCPL and the chief executive of Child Safety must give a copy of their review report (appending the summary document) to the other if both have carried out a review for the same child.²⁴

If the DCPL and the head of a relevant agency (other than Child Safety) are both required to carry out a review for the same child, each may give a **redacted** copy of the review report to the other.²⁵

Redacted



Redacted means removing (or de-identifying) information that may identify an individual other than the child to whom the review relates.

Information does not need to be redacted if the DCPL and Child Safety share the report (and summary) between each other following a review for the same child.

The review report (appending the summary document) will be provided to the CDRB secretariat no later than six months after the date of the triggering event following the death of a child.

It must also be provided to the State Coroner if the review related to a reportable death under the *Coroners Act 2003*.

Information does not need to be redacted when providing the reports to the CDRB and State Coroner.

Documents relied on to prepare reports

The Agency head or DCPL who carries out a review must give the CDRB a copy of the review report²⁶ and copies of any documents obtained by the agency or the DCPL and used for the review²⁷. Copies of documents provided to the CDRB must be in digital form. These include documents obtained by the agency and used for the review, together with the report and summary document.

²⁴ Section 245Q CP Act 1999

²⁵ Section 245R(1) CP Act 1999

²⁶ Section 245O(1) CP Act 1999

²⁷ Section 245O(1) CP Act 1999

Step 7—Monitor recommendations and other matters

Monitor implementation of recommendations

Agencies will be responsible for implementing and monitoring recommendations relevant to their agency. This includes recommendations arising from the CDRB and agency reviews. To do this, agencies should establish a central register to record, track, monitor and report on recommendations.

The CDRB Secretariat will request updates from agency co-ordination points around June each year on the implementation status of CDRB recommendations from the previous year/s. A summary of the agency's response to that request will be reported in the annual report.

The CDRB will not report on the implementation status of agencies' recommendations made through agency reviews. That is the responsibility of individual agencies.

Agency co-ordination points must make sure status updates are made available to the CDRB Secretariat in the format it requests.

Agency and CDRB other review matters

Implementation review after 12 months of full operation

Agencies will be responsible for considering the implementation of agency review processes after at least 12 months of operation.

Implementation of the CDRB will also be reviewed around 18 months after commencement of the new model.

These reviews should consider:

- if implementation occurred as intended
- compliance with legislative and policy requirements including whether the operational guidelines are effective
- whether governance is appropriate
- opportunities for improvement.

The CDRB Secretariat and agencies will collaborate to share implementation learnings and participate in each other's reviews as required.

Agencies to review and provide comment on CDRB recommendations and adverse comment

If the CDRB intends to recommend in a report that a certain agency take responsibility for a recommendation, it must consult on that recommendation before finalising the report.²⁸

It must also provide agencies with a reasonable opportunity to make a submission about adverse information included in a report.²⁹

Where the agency makes such a submission, the CDRB must:³⁰

- consider the submission before finalising its report

²⁸ Section 29L(3) FCC Act 2014

²⁹ Section 29L(1) FCC Act 2014

³⁰ Section 29L(2) FCC Act 2014

- include the agency's submission, or a fair summary of it, in its report.

The CDRB Secretariat will notify agency co-ordination points of correspondence to heads of agencies seeking comment on recommendations or a submission in response to adverse comment. Agency co-ordination points are responsible for making sure a timely response is received within the timeframe specified.

Child Death Register will be source of truth on child death statistics in Queensland

The CDRB and agency annual reports should not include data on child death statistics, unless it is a specially commissioned research.

They may however include information about the number of systemic or internal agency reviews undertaken. If this is done, care must be taken to present the data in a way that avoids confusion and impact on public confidence. To remove any doubt, a reference should be included to the Queensland Family and Child Commission's Queensland Child Death Register and the *Annual Report: Deaths of children and young people, Queensland* being the source of truth for child death statistics in Queensland.

Appendices

Appendix 1 – Template for Section 245G notice

Section 245G Notice

This Notice is made pursuant to section 245G of the *Child Protection Act 1999* (CP Act 1999). The relevant agency is advised that the chief executive of the Department of Child Safety Youth and Women (Child Safety) must carry out a child death or serious physical injury review about Child Safety’s involvement with the child in accordance with section 245E or 245F of the CP Act 1999.

| | | |
|---|--|--|
| Section under which this review is being carried out | Section 245E <input type="checkbox"/> (Child Safety review following involvement with child) Section 245F <input type="checkbox"/> (Child Safety review at Minister’s request) | |
| | Case Review Number (assigned by Child Safety) | |
| Child’s details | | |
| Family name | | |
| Given names | | |
| ICMS Client Number | | |
| Date of birth | | |
| Death or serious physical injury | Death <input type="checkbox"/> If Death, is it a reportable death? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Serious physical injury <input type="checkbox"/> | |
| Date of death/serious physical injury | | |
| Sex | Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> | |
| Child’s primary place of residence (address) | | |
| Aboriginal or Torres Strait Islander status | Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Not stated <input type="checkbox"/> | |
| | | |
| Death/serious physical injury incident | | |

| | |
|---|--|
| Date of triggering event (Child Safety) | |
| Circumstances of death/injury (brief description) | |
| Location of death/injury incident | |
| | |
| Family details | |
| Mother's name | |
| Father's name | |
| Carer's name (if relevant) | |
| Sibling's name/s and DOB (if known) | |
| | |
| Child protection status | |
| Child protection status at time of death/injury | |
| Missing person at time of death/injury | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Comments | |
| | |
| Form administration | |
| Form completed by | |
| Date | |

Appendix 2 – Example of notification to other agencies

The following is an example of a notification to other agencies/DCPL identifying if the agency will/ or will not be undertaking a review.

All other relevant agencies, and the DCPL, are to be included in the email notification. If the matter relates to the death of a child, the Secretariat of the CDRB is to be included.

Agency undertaking a review

Subject in email: **Case Review Number – 12345** [assigned by Child Safety] - **DoE will be undertaking a review**

The Department of Education is undertaking a review following the death/serious physical injury of [SURNAME]–[Case Review Number - 12345].

Date of triggering event: [DD/MM/YYYY]

Louise Black

DoE Co-ordination point

[contact details]

Agency NOT undertaking a review

Subject in email: **Case Review Number – 12345** [assigned by Child Safety] - **DoE will NOT be undertaking a review**

The Department of Education is not undertaking a review following the death/serious physical injury of [SURNAME]–[Case Review Number - 12345].

Louise Black

DoE Co-ordination point

[contact details]

Agency undertaking a review at request of own agency Minister

Subject in email: **Case Review Number – To be assigned** by Child Safety [assigned by Child Safety] - **DoE will be undertaking a review**

The Department of Education is undertaking a review following the death/serious physical injury of

[SURNAME]–[Case Review Number - 12345].

Date of Ministerial request: [DD/MM/YYYY]

Child Safety to reply e-mail with the allocated Case Review Number for this matter.

Louise Black

DoE Co-ordination point

[contact details

Appendix 3A – Summary document template for relevant agencies

Summary of internal agency review outcomes following the death or serious physical injury of a child

Document details

1. Purpose

The purpose of this summary is to support joint learning by relevant agencies³¹ and the Child Death Review Board (CDRB).

The document summarises findings and recommendations arising from an internal review following the death or serious physical injury of a child.

2. Use

- 2.1 This document is to be completed and shared with other relevant agencies³² that carried out a review on the same matter.
- 2.2 This document is to be completed and appended to the front of a child death review report and given to the CDRB.
- 2.3 This document is to be completed and appended to the front of a child death review report following the death of a child that is a reportable death under the *Coroners Act 2003* and given to the State Coroner.
- 2.4 This document must be redacted to be appended to a redacted report that is shared with the DCPL who carried out a review on the same child.³³

Agency details

Agency name:

Agency contact person:

Email:

Phone number:

Child's details

| CASE NUMBER | | | |
|-------------|--|---------------------------------|--|
| SURNAME | | GIVEN NAMES [of child/children] | |

³¹ Section 245B *Child Protection 1999* (CP Act 1999)

³² Section 245B CP Act 1999

³³ Section 245R CP Act 1999

| | | | |
|-----|--|--------------------------------|--|
| DOB | | DOD OR SERIOUS PHYSICAL INJURY | |
|-----|--|--------------------------------|--|

Review details and outcomes

1. Review terms of reference

2. Timeline of agency involvement

| Brief summary of agency’s main contact points with the child (or the child’s family in relation to a matter relevant to the child’s safety and wellbeing) | |
|---|--|
| Date /time period | Services provided and reason for service |
| | |
| | |

3. Overview of findings

| <p>3.1 Brief description of review findings</p> <p><i>Include a summary of review findings and identify whether any of the findings relate to:</i></p> <ul style="list-style-type: none"> • <i>compliance with legislative and policy requirements³⁴</i> • <i>adequacy and appropriateness of agency involvement³⁵</i> • <i>adequacy of agency involvement with other entities in the provision of services to the child³⁶</i> • <i>legislation and policy requirements³⁷</i> | |
|---|--|
| <p>3.2 Include recommendations and actions relevant to the above findings³⁸</p> | |
| Recommendation/s and actions | Strategy/ies to give effect to the recommendations ³⁹ |
| | |

³⁴ Section 245K(3)(a) CP Act 1999 [paraphrased]
³⁵ Section 245K(3)(b) CP Act 1999 [paraphrased]
³⁶ Section 245K(3)(c) CP Act 1999 [paraphrased]
³⁷ Section 245K(3)(d) CP Act 1999[paraphrased]
³⁸ Section 245K(3)(e) CP Act 1999 [paraphrased]
³⁹ Section 245K(3)(e) CP Act 1999 [paraphrased]

| | |
|--|--|
| | |
|--|--|

4. Broader system level comment

Complete this section if systemic matters were identified during the review.

This may include comments on system-wide policies, services, culture and processes or gaps across the system (such as multi-agency mechanisms, system-wide referring and reporting processes, safety standards for home-based regulated services, gaps in accommodation services, access to home-based support services for vulnerable families).

Include a summary of review findings and identify whether any of the findings relate to:

- *effectiveness of services provided to a child or a child's family before the child death⁴⁰*
- *interactions between services provided to a child or a child's family before the child's death⁴¹*
- *services provided to children or families that could have been, but were not, provided to a child or a child's family before the child's death⁴²*
- *issues relating to practices or systems that may expose children to risk⁴³*
- *ways of improving practices or systems relating to identifying or responding to risks⁴⁴*
- *ways of improving communication and collaboration between service providers⁴⁵*

⁴⁰ Section 29H(4)(a)(i) *Family and Child Commission Act 2014* (FCC Act 2014)

⁴¹ Section 29H(4)(a)(i) FCC Act 2014

⁴² Section 29H(4)(a)(ii) FCC Act 2014

⁴³ Section 29H(4)(b) FCC Act 2014

⁴⁴ Section 29H(4)(c) FCC Act 2014

⁴⁵ Section 29H(4)(d) FCC Act 2014

Appendix 3B – Summary document template for DCPL

Summary of Director of Child Protection (DCPL) review outcomes following the death or serious physical injury of a child

Document details

1. Purpose

The purpose of this summary is to support joint learning by agencies and the Child Death Review Board (CDRB).

The document summarises the DCPL's findings and recommendations arising from an internal review following the death or serious physical injury of a child.

2. Use

- 2.1 This document is to be completed and appended to the front of a review report and given to Child Safety if it carried out a review for the same child.
- 2.2 This document is to be completed and appended to the front of a child death review report and given to the CDRB.
- 2.3 This document is to be completed and appended to the front of a child death review report following the death of a child that is a reportable death under the *Coroners Act 2003* and given to the State Coroner.
- 2.4 This document must be redacted to be appended to a redacted report that is shared with relevant agencies (other than Child Safety) who carried out a review on the same child.⁴⁶

Agency's details

Agency name:

Agency contact person:

Email:

Phone number:

Child/ren's details

| | | | |
|--------------|--|----------------------------------|--|
| CASE NUMBER: | | | |
| SURNAME: | | GIVEN NAMES [of child/children]: | |
| DOB: | | DOD OR SERIOUS PHYSICAL INJURY: | |

⁴⁶ Section 245R *Child Protection Act 1999* (CP Act 1999)

Review details and outcomes

1. Review terms of reference

2. Timeline of the Director of Child Protection Litigation (DCPL) involvement

| Chronology of significant events | |
|----------------------------------|--------------------------------|
| Date /time period | Litigation functions performed |
| | |
| | |

3. Overview of review findings

| <p>3.1 Brief description of review findings</p> <p><i>Include a summary of review findings and identify whether any of the findings relate to:</i></p> <ul style="list-style-type: none">• <i>compliance with legislation, guidelines and policies relevant to the performance of a litigation function in relation to the child⁴⁷</i>• <i>adequacy of legislative requirements, guidelines, and policies for performing litigation functions⁴⁸</i>• <i>sufficiency of evidence made available to the DCPL to enable it to make decisions⁴⁹</i> | |
|--|--|
| <p>3.2 Include recommendations and actions relevant to the above findings⁵⁰</p> | |
| Recommendation/s and actions | Strategy/ies to give effect to the recommendations ⁵¹ |
| | |

⁴⁷ Section 245L(3)(a)(i)(ii)(iii) CP Act 1999 [paraphrased]

⁴⁸ Section 245L(3)(b) CP Act 1999 [paraphrased]

⁴⁹ Section 245L(3)(c) CP Act 1999 [paraphrased]

⁵⁰ Section 245L(3)(d) CP Act 1999 [paraphrased]

⁵¹ Section 245L(3)(d) CP Act 1999 [paraphrased]

4. Broader system level comment

Complete this section if systemic matters were identified during the review of the DCPL's litigation functions.

This may include comments on system-wide policies, services, culture and processes or gaps across the system (such as multi-agency mechanisms, system-wide referring and reporting processes, safety standards for home-based regulatory services, gaps in accommodation services for young people, access to home-based support services for vulnerable families).

Include a summary of review findings and identify whether any of the findings relate to:

- *effectiveness of services provided to a child or a child's family before the child death⁵²*
- *interactions between services provided to a child or a child's family before the child's death⁵³*
- *services provided to children or families that could have been, but were not, provided to a child or a child's family before the child's death⁵⁴*
- *issues relating to practices or systems that may expose children to risk⁵⁵*
- *ways of improving practices or systems relating to identifying or responding to risks⁵⁶*
- *ways of improving communication and collaboration between service providers⁵⁷*

⁵² Section 29H94)(a)(i) *Family and Child Commission Act 2014* (FCC Act 2014)

⁵³ Section 29H(4)(a)(i) FCC Act 2014

⁵⁴ Section 29H(4)(a)(ii) FCC Act 2014

⁵⁵ Section 29H(4)(b) FCC Act 2014

⁵⁶ Section 29H(4)(c) FCC Act 2014

⁵⁷ Section 29H(4)(d) FCC Act 2014