Accountability

Systems oversight

The oversight role of the Queensland Family and Child Commission (QFCC) focuses on monitoring, reviewing and reporting on Queensland's child protection system. As part of its role to help realise the rights of children, the QFCC is proactively overseeing the systems accountable for the safety and wellbeing of vulnerable children and young people. The *QFCC Oversight Strategy 2020–2022* details the schedule of proactive systemic reviews for the year.

Oversight Strategy 2020–2022

In 2020, the QFCC released its *Oversight Strategy 2020–2022*. It explains how we monitor system performance by focusing on children, families and system outcomes across three impact areas: system reliability, productivity, and sustainability.

It considers how well the child and family support system upholds and protects children's rights, wellbeing and safety and how well it generates positive outcomes.

It also identifies headline indicators and evidentiary sources for monitoring performance of the child and family support system.

We will review the strategy during 2021 to ensure it is compatible with our revised strategic plan.

We report annually on the performance of the child and family support system *(see **Appendix D**)*.

In 2020–21, we undertook the following major work:

Changing the Sentence: Overseeing Queensland's youth justice reforms

The Director-General of the then Department of Youth Justice asked the QFCC to undertake an oversight project to examine options for future youth justice systems and processes. This was to ensure investment decisions were implemented to support the best outcomes for children, young people and the community.

This *Changing the Sentence* project allowed us to examine youth justice initiatives, multi-agency responses, good practice and agency success in achieving positive outcomes. In doing so, we considered whether youth justice reforms were ensuring that:

- a reliable, trusted system is built on shared connections and commitment
- children's rights, wellbeing and safety are being upheld and protected.

During data collection for the report, the project team conducted 83 meetings and interviews with 125 stakeholders from Mount Isa, Townsville, and Brisbane. Participants came from 43 organisations including:

- 13 government agencies
- 10 non-government agencies
- 9 Aboriginal and Torres Strait Islander community-controlled organisations.

Throughout the report, we recognised the significant over-representation of Aboriginal and Torres Strait Islander children in the child protection system. One of the important themes that emerged was the need to return decision-making about Aboriginal and Torres Strait Islander young people to local communities and community-controlled organisations.

The report includes 13 findings and identifies future opportunities for the youth justice system. They identify a need to continue addressing the two ends of the spectrum, which means providing:

- very early interventions with families and children to reduce the risk of a young person coming in contact with the youth justice system
- specialised services for the small number of young people already in the statutory system who are committing most of the crime.

The report also calls for greater accountability by government agencies in upholding the rights and wellbeing of families and children with whom they are in contact.

The *Changing the Sentence* report released in June 2021 is available on the QFCC website.[3] We will use it in future monitoring of the youth justice system.

Seeing they are Safe: Responsiveness to 5-day and 10-day notifications of child harm in Queensland

In September 2020, the QFCC presented the final *Seeing they are Safe: Responsiveness to 5 day and 10 day notifications of child harm in Queensland* report to ministers and government agencies involved in investigating and assessing reports of child harm.

This review examined the differing contexts in which the Department of Children, Youth Justice and Multicultural Affairs (the department) delivers its investigation and assessment function and the complexities and challenges facing its frontline workforce.

The review found the department's service centres have considerable autonomy and display innovation in their investigation and assessment approaches. It also found that, as a result of policy changes, there have been some improvements in response timeliness—specifically in the number of 5-day and 10-day notifications commenced and completed within the set timeframes.

However, the data showed there is an unacceptable delay between when an investigation and assessment process is commenced and a child safety officer sights (physically sees) the child.

The review also highlighted the value of partnerships in supporting timely and high-quality investigation and assessment responses. This was particularly true for Aboriginal and Torres Strait Islander children, where partnerships with community-controlled organisations support the increased participation of families in decisions that affect the safety and wellbeing of their children.

We continue to monitor the time taken from when a report is received and an investigation commenced, to when a child is sighted.

Child and family support sector workforce environmental scan

In 2020–21, the QFCC shared the *Child and family support sector workforce environmental scan* with key stakeholders across the sector including peak bodies, major employers in government and non-government agencies and local-level networks. The scan detailed the current state of the child and family workforce and identified challenges and opportunities in building a strong and sustainable workforce in the future.

The report examined publicly available data on the sector and provided demand and supply projections to 2030.

3 Queensland Family & Child Commission 2021, *Changing the sentence*, https://www.qfcc.qld.gov.au/keeping-kids-more-safe/monitoring-reviewing-systems-protect-children/changing-sentence

The qualitative research we gathered provided deep insight into workforce challenges and opportunities. As part of this, we conducted eight focus groups with a total of 65 stakeholders from government, non-government and community-controlled organisations; children and young people advocacy services; regional, rural and remote services; foster and kinship care services; and place-based, community and volunteer initiatives.

We found:

- The sector is under increasing pressure now, and will be in the future.
- The size and capability of the workforce need to grow to meet increasing demand.
- Workforce trends indicate an ongoing demand for tertiary child protection services, despite increased investment in family support services.
- There are recruitment and retention challenges, particularly in rural and remote areas, including recruiting to identified positions[4] and finding staff with qualifications and specialist skillsets.
- The reasons for high staff turnover include comparative wages with other sectors, overtime and burnout.
- Learning and development needs (including supervision, support and mentoring) are unmet. This will not sustain a contemporary workforce.

We will continue to support peak bodies and sector leaders as they develop the future child and family workforce and will include workforce in our ongoing oversight work.

Rights, Voices, Stories

The QFCC engaged 11 youth researchers with lived experience and/or understanding of the out-of-home care system to work on our *Rights, Voices, Stories* project. This project focuses on listening to children and young people who rely on the child protection system to stay safe and well. The project hears their perspectives, finds out about their experiences, and identifies the sorts of outcomes they believe should be measured.

The youth researchers participated in a three-day workshop in March 2021 to:

- identify the outcomes that matter to children and young people in care (these will be monitored by the QFCC)
- undertake some research ethics and focus group facilitation skills training to support qualitative data collection (due to commence later in 2021).

A report describing this process and the outcomes identified by young people will be released later in 2021.

Review of interventions with parental agreement

The QFCC began a review of interventions with parental agreement (IPA) that will highlight areas of good practice and identify opportunities for system improvements to protect and keep children safe at home.

The core objective of this review is to determine:

- if children are safe when subject to an intervention with parental agreement
- if children subject to an intervention with parental agreement are at the centre of the intervention (rather than their parents or others), with their rights upheld and prioritised.

The review will focus at a system level and will include both qualitative and quantitative data to provide a picture of intervention with parental agreement practice as it is occurring in Queensland.

The review is due to be completed by mid-2022, with a report published soon after that.

4 An identified position means a job where the employer identifies that it is to be filled by a person with a particular attribute, such as cultural background or gender.

Principle focus—Systemic accountability for the safety and wellbeing of Queensland's First Nations children: a child-rights approach

Significant commitments have been made in Queensland to implement systemic reforms (to legislation, policy, programs, processes and practice) that give effect to each of the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle—prevention, partnership, placement, participation and connection.

The *Principle focus* program seeks to increase system-level awareness, accountability and advocacy for the rights of Aboriginal and Torres Strait Islander children by monitoring, evaluating and reviewing the effective application of the Aboriginal and Torres Strait Islander Child Placement Principle.

This program will help the QFCC exercise its statutory oversight functions regarding the improvement of the child protection system. It will also increase the likelihood that the Aboriginal and Torres Strait Islander Child Placement Principle will deliver the intended outcomes of:

- significantly reducing the rate of over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system
- improving the rights, safety and wellbeing of Aboriginal and Torres Strait Islander children and young people.

The program will also highlight areas of good practice and identify opportunities for system improvements to protect children.

Oversight groups

The QFCC chairs two oversight groups with child protection stakeholders, the Reviews Strategic Advisory Group and the Strategic Cross-agency Oversight Group.

The Reviews Strategic Advisory Group

The Reviews Strategic Oversight Group meets quarterly and is chaired by the QFCC Executive Director, Oversight. Its role is to help enable the implementation of government-accepted recommendations from reviews for which the QFCC is the delegated oversight agency.

Membership includes senior officers from across government agencies that have contributed to the implementation of these reviews.

The Strategic Cross-Agency Oversight Group

The Principal Commissioner chairs the Strategic Cross-Agency Oversight Group, which meets quarterly. Its purpose is to discuss sector-wide trends and issues, with a focus on systemic and cross-agency oversight. It is made up of representatives from the following agencies:

- QFCC
- Office of the Queensland Ombudsman
- Queensland Human Rights Commission
- Crime and Corruption Commission
- Queensland Mental Health Commission
- Queensland Office of the Health Ombudsman
- Office of the Health Ombudsman
- Queensland Civil and Administrative Tribunal
- Coroners Court of Queensland
- Office of the Public Guardian
- Queensland Integrity Commission
- Office of Child Protection Litigation
- Queensland Magistrates Courts Service.

In 2020–21, the QFCC was also responsible for:

Performance of the Queensland child protection system

Section 40 of the *Family and Child Commission Act 2014* requires the QFCC to report on:

- the performance of Queensland's child protection system in achieving state and national goals
- Queensland's child protection system's performance over time in comparison to other jurisdictions
- Queensland's progress in reducing the number of, and improving the outcomes for, Aboriginal and Torres Strait Islander children and young people in the child protection system.

More detailed information on Queensland's performance is available at ***Appendix D***.

Evaluation

The QFCC has legislative responsibility for analysing and evaluating, at a systems level, the:

- policies and practices relevant to the child protection system
- performance of relevant agencies in delivering services.

We conduct annual data collection activities to support this evaluation work, including surveys of the community and the frontline child protection and family support sector workforce. We also design and conduct system-level evaluations.

The QFCC has lead responsibility for evaluating the child protection reforms being implemented in response to the recommendations of the 2013 Queensland Child Protection Commission of Inquiry report. This has been/is being done at three milestones over the 10-year reform program.

These evaluations assess how well the reform program has been implemented and its outcomes and impacts.

Outcomes evaluation

This evaluation examined the first five years of the reforms in the child protection and family support sector and the outcomes as they relate to the strategic directions of the *Supporting Families Changing Futures* reform program.

However, as data collection began in late 2019 and continued throughout 2020, some of the insights shared by stakeholders reflect progress in more recent years, as well as the impact of COVID-19 on service provision.

While the evaluation report is being finalised, the preliminary findings show:

- There is a need to measure what matters to children and young people in the system.
- The workforce (and the services it delivers) is stretched and demand is increasing across the system.
- The over-representation of Aboriginal and Torres Strait Islander children is not decreasing.
- There are mixed views about the extent to which responsibility, risk and accountability are being shared.
- Governance of the reform program could be more strategic.

The final report will be released in late 2021.

Workforce survey

The workforce survey measures the perspectives of frontline workers and service providers in the child protection and family support sector on a variety of issues. It has been conducted in 2018, 2019, 2020 and 2021.

We received 761 responses in 2020, which was more than double the sample sizes achieved in the previous surveys. The 2020 survey results were published on the QFCC website in August 2020.[5]

Findings included:

- Survey respondents' perceptions about their roles and organisations were generally more positive than their perceptions about the broader child protection and family support system.
- Respondents working for non-government organisations were often more positive than those from government agencies.
- Compared with the 2019 survey results, the 2020 survey shows some improvements in perceptions:
  - that work/caseloads are manageable
  - that organisations have a positive culture
  - about the performance of the system
  - that reforms are improving outcomes
  - regarding access to high-quality learning and development opportunities.

The 2021 survey, which closed in May 2021, received 763 responses. Analysis and reporting of the results is underway, and findings will be shared on the QFCC website later in 2021.

Community perspectives survey

The community perspectives survey measures the community's confidence in the Queensland child protection sector and in its ability to keep children safe. It also measures the community's awareness of the child protection system and how it operates.

It has been conducted in 2017, 2019, 2020 and 2021.

In 2020, we received 2,530 responses. The results were published on the QFCC website in August 2020.

Public confidence and trust in the Queensland child protection system was found to be holding steady. More respondents agreed (56 per cent) than disagreed (44 per cent) they had confidence and trust in the Queensland child protection system (excluding respondents who didn't know or had no opinion). This is consistent with the 2017 and 2019 results (where 56 per cent agreed in both).

The 2021 survey received 2,520 responses. Analysis and reporting of the results is underway, and findings will be shared on the QFCC website later in 2021.

5 Market & Communications Research (for Queensland Family & Child Commission) 2020, *Workforce Survey 2020: FINAL Research Report*, https://www.qfcc.qld.gov.au/sites/default/files/2020-08/2020%20Workforce%20Survey%20report.PDF

Prevention of child deaths

The QFCC maintains the Queensland Child Death Register. The QFCC analyses information from the register and produces an annual report on the deaths of all children in Queensland. This helps to improve understanding of risk factors and supports the development of new policies and practices to reduce child deaths.

The register contains records of over 7,700 children whose deaths were registered with the Registry of Births, Deaths and Marriages between 1 January 2004 and 30 June 2021.

It provides a valuable evidence base that is used to:

- develop activities for safety and for the prevention of injury
- monitor the effectiveness of prevention activities
- provide detailed child death data to researchers and government agencies.

Supporting efforts to prevent child deaths

One way the QFCC contributes to the prevention of child death and injury is to make data held in the register available for research, public education, policy development and program design. Access to the comprehensive dataset is available at no cost to researchers.

In 2020–21, we responded to 25 requests from researchers and government agencies for detailed data from the register.

We have continued to monitor and support prevention of suicide deaths of children and young people by promoting mental wellbeing tips through our social media channels.

Participation in state and national advisory groups

The QFCC's child death prevention staff participated on several advisory bodies, such as the:

- Consumer Product Injury Research Advisory Group
- Queensland Government Births and Deaths Working Group
- Interim Queensland Suicide Prevention Network
- Queensland Paediatric Quality Council Steering Committee
- Infant Mortality Sub-committee
- Road Safety Research Network
- Australian and New Zealand Child Death Review and Prevention Group
- Multi-agency Advisory Group.

The Office of the State Coroner has initiated a 9-month pilot of a multi-agency advisory meeting for recent sudden unexpected death in infancy (SUDI) deaths.

The initiative was prompted by advocacy by the Queensland Paediatric Quality Council and the QFCC. The purpose of the multi-agency advisory meeting process is to provide advice and recommendations to the investigating coroner on sudden unexpected infancy deaths.

Improved collection of information on child deaths

The QFCC launched its new Child Death Register—Coda—on 12 March 2021. Coda brought new functionality and, with the migration of the full dataset of the previous 17 years of child death data, created greater opportunity to capture and use data in a more structured way.

These features will better support future research and child death prevention initiatives to help keep Queensland's children and young people safe.

Further enhancements and refinements of the system and its reporting tool will be made in the future.

Annual report on child deaths in Queensland

The QFCC's *Annual Report: Deaths of children and young people, Queensland 2019–20* was tabled in the Queensland Parliament on 17 March 2021.

The report found there has been a gradual decline in child mortality rates from natural causes (diseases and morbid conditions). However, deaths from natural causes still accounted for the majority of deaths of children (249 deaths or 66 per cent) while external (non-natural) causes of death accounted for 75 deaths (20 per cent).

Transport was the leading external cause of death, with 21 deaths. Suicide was the second leading cause of external deaths, with 20 deaths, a marked decrease from 37 suicide deaths in 2018–19.

Despite this, suicide remains the leading cause of death in young people aged 15–17 years over the last five years (37 per cent) and a leading cause for the 10–14 years age group (18 per cent).

For a summary of main findings, refer to the *Child deaths in Queensland* fact sheet, which is available on the QFCC website.[6] Additional fact sheets provide summary findings for children known to the child protection system and for Aboriginal and Torres Strait Islander children.

The annual reports on child deaths, 16-year data tables and the latest statistics on child deaths in Australian states and territories and New Zealand are also available on the QFCC website.[7]

16-year review of child death data

The Queensland Child Death Register captures valuable data about children's lives, including where they lived, the families in which they were raised, their cultural backgrounds, any vulnerabilities they may have experienced, and the circumstances and causes of their deaths.

During 2020–21, the QFCC undertook a high-level overview of the information held within the register for deaths occurring between 2004 and 2019, aiming to identify patterns and trends in child mortality over time.

By analysing all deaths occurring during the 16-year period, we were able to identify patterns and conduct complex statistical analysis to generate new insights into risk and protective factors for particular causes of death.

Over this 16-year period, a total of 7,175 children lost their lives in Queensland. The vast majority of these deaths (72.5 per cent) were due to natural causes.

6 Queensland Family & Child Commission 2020, *Child death register key findings 2019–20: Child deaths in Queensland*, https://www.qfcc.qld.gov.au/sites/default/files/2021-03/All%20child%20deaths%202019-20%20fact%20sheet_0.PDF

7 Queensland Family and Child Commission 2014–21, *Home page*, qfcc.qld.gov.au

The review identified several significant trends:

- The overall rate of child mortality in Queensland has decreased by an average of 3 per cent per year.
- Unexplained infant deaths have decreased by an average of 13.2 per cent per year since 2011, with the rate of sudden infant death syndrome, in particular, falling by 17.4 per cent per year, on average, between 2011 and 2019.
- External cause deaths have decreased by an average of 4.1 per cent per year. There has been a strong downward trend in the number of transport deaths specifically, which have decreased since 2004, on average, by 7.9 per cent per year. This is largely due to a decrease in the rate of on-road incidents involving young people aged 15–17 years that has occurred since the introduction of a graduated licensing system in Queensland in 2007.
- The rate of youth suicide, however, has increased by an average of 2.6 per cent per year, primarily concentrated among young people aged 15–17 years.
- Aboriginal and Torres Strait Islander children continue to be over-represented in child mortality statistics, dying at around twice the rate of non-Indigenous children. There has, however, been an encouraging downward trend in the annual rate of death for Aboriginal and Torres Strait Islander children over time, decreasing by an average of 2.3 per cent per year.
- Infant mortality—a key marker of population health—has declined for both Aboriginal and Torres Strait Islander and non-Indigenous children, with an annual average decrease of 4.7 and 2.6 per cent per year respectively.
- Children known to the child protection system are also over-represented in child death statistics, dying at a higher rate than those in the general child population in Queensland. For the period 2015–2019, children known to the child protection system died at a rate of 58.6 per 100,000 children compared with 34.4 per 100,000 for all Queensland children.

Collectively, the findings have established some encouraging trends but identified room for improvement. More work needs to be done to learn from these deaths, to reduce the over-representation of Aboriginal and Torres Strait Islander children in mortality statistics and to reduce the number of deaths of children known to the child protection system.

The *Counting lives, changing patterns: Findings from the Queensland Child Death Register 2004–2019* report was tabled in Queensland Parliament on 13 May 2021.

The findings of this review will influence the ongoing work program of the QFCC and inform broader research, policy and program development.

A copy of the report is available on the QFCC website.[8]

Red flags for filicide

A system review completed following the death of the child prompted the QFCC to explore the concept of 'red flags' to identify children who are at risk of fatal assault or neglect by a parent—an act known as filicide. A red flag is an act or intention (such as injury, threats of harm or death) or accumulation of risk factors likely to adversely affect a child's immediate safety.

During 2020–21, the QFCC worked with researchers from the University of Queensland to develop an evidence base for red flags using data from the Queensland Child Death Register. This project identified several risk factors that, when occurring together, may indicate a child is at increased risk of filicide.

A system-wide resource highlighting the red flags that professionals must be aware of when working with families has been developed. The sector will be further consulted in the first quarter of 2021–22 with an expected release date to be scheduled in the second quarter.

8 Queensland Family and Child Commission 2021, *Counting lives, changing patterns: Findings from the Queensland Child Death Register 2004–2019*, https://www.qfcc.qld.gov.au/keeping-kids-more-safe/preventing-child-injury-death/16-year-trend-review

Child death prevention strategy

The QFCC is developing a child death prevention strategy with a focus on using the research and analysis of Queensland's child death data to influence child death prevention practices and policy changes. A draft strategy will be circulated for consultation within the next year.

Child Death Review Board

On 1 July 2020, amendments to the *Family and Child Commission Act 2014* were enacted to establish the independent Child Death Review Board (the Board).

The amendments were brought about by the QFCC report: *A systems review of individual agency findings following the death of a child*. The report recommended that the Queensland Government ' ... consider a revised external and independent model for reviewing the deaths of children known to the child protection system'.

The new child death review model includes:

- a two-tier approach, with more agencies responsible for conducting internal system reviews following the death or serious physical injury of a child known to the child protection system
- the Board sitting outside of these agencies to identify opportunities for policy, practice and system improvements
- the Board being hosted by the QFCC for administrative purposes.

The Board conducts systemic reviews following the death of a child connected to the child protection system, to identify opportunities to improve the child protection system and prevent future deaths. It does not investigate the deaths of individual children.

It held its first meeting on 23 July 2020. It is made up of 12 members with relevant experience and skills and includes 50 per cent non-government members and two Aboriginal and/or Torres Strait Islander members. It is chaired by Cheryl Vardon, Principal Commissioner of the QFCC.

In 2020–21, with the support of the QFCC secretariat team, the Board:

- developed procedural guidelines, an evaluation framework and information-sharing agreements with review entities
- held six meetings, including one special meeting for the development of the first annual report and planning of future initiatives
- reviewed and analysed systemic issues arising from agency reviews of the deaths of 55 children
- requested information from several government and non-government agencies
- partnered with experts and commissioned research into sudden unexpected death in infancy and suicide prevention to identify patterns, trends and risk factors
- continued to lead the Cross-Agency Reviews Group in identifying emerging issues and sharing learnings from the new child death review model
- continued work on developing a cultural integrity approach for the Board.

Remuneration information for the Board will be reported in the Child Death Review Board Annual Report 2020–21.

Systems reviews following the deaths of children

In 2020–21, the QFCC delivered several system review reports to the responsible minister following the deaths and serious neglect of children.

We consulted with multiple agencies to inform the findings of the reviews, which identified gaps in the system responses intended to keep vulnerable children safe.

We continue to work with the Attorney-General and government agencies to implement the necessary changes.

Update of the Child Death Review Board database

The QFCC's new Child Death Register was enhanced in June 2021 to include separate role profiles for the Board Secretariat to enter relevant information from agency reviews.

This reduced the manual recording of data and will assist in developing future reporting of the Board.

The year ahead

In 2021–22, the QFCC will:

- use the findings from the *Changing the Sentence* report to continue monitoring the impact of Queensland's youth justice reforms on children
- release the findings from the outcomes evaluation examining the child protection reform environment
- strengthen its oversight focus on issues that disproportionately and adversely impact on the lives of Aboriginal and Torres Strait Islander young people in Queensland
- maintain and update the QFCC online Knowledge and Resource Hub (which provides easy access to important research papers and reports)
- hold agencies to account by reporting on the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle
- finalise the systemic review into interventions with parental agreement
- begin reporting on the outcomes that matter to children who relied on the out-of-home care system for their safety and wellbeing
- share the findings from the 2021 frontline workforce survey and community perspectives survey and undertake the 2022 surveys
- start a post-implementation review of the Queensland Government's implementation of the *Recommendation 28 Supplementary Review: A report on information sharing to enhance the safety of children in regulated home-based services*
- develop a roadmap for future phases of the new Child Death Register
- complete and publish the *Child death prevention strategy*
- continue to research factors that contribute to the injury and death of children and young people and, in conjunction with key partners, identify system responses to deal with them
- deliver the inaugural annual report on the operations of the Child Death Review Board.