Child Death Review Board

Annual Report 2020–21

A report on the operations and systemic findings of the Queensland Child Death Review Board

Queensland Government

About this report

This report has been prepared under section 29J of the *Family and Child Commission Act 2014* (Qld). It describes the work of the Child Death Review Board (CDRB) in 2020–21 in carrying out its reviews and other functions under Part 3A of the *Family and Child Commission Act 2014* and the CDRB's Procedural Guidelines.

The CDRB is an independent board established on 1 July 2020 to carry out reviews of the child protection system following the deaths of children connected to it. These reviews aim to identify opportunities for improvement in systems, legislation, policies and practices and to identify mechanisms to help prevent deaths that may be avoidable.

Accessibility

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds.

If you have difficulty understanding this document, you can contact us on 07 3900 6000 and we will arrange an interpreter to effectively explain the report to you.

Contact for enquiries

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Attribution

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

Each year, some 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 who provided support
to the child and their family.

The Queensland Child Death Review Board
acknowledges the difficult and important work
of the government agencies that are 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 help prevent future deaths.

Acknowledgements

The Queensland Child Death Review Board (CDRB) acknowledges the Turrbal and Yugara peoples as the Traditional Custodians across the land on which the CDRB meets and works.

We recognise Aboriginal and Torres Strait Islander peoples as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to their Elders past, present and emerging.

The CDRB acknowledges the unique and diverse cultures of Aboriginal and Torres Strait Islander peoples and notes that, throughout this document, the terms Aboriginal and Torres Strait Islander and Indigenous have been used to collectively describe these two distinct groups of people.

The CDRB recognises these lands have raised generations of strong, thriving Aboriginal and Torres Strait Islander children for more than 60,000 years. We are committed to continually recognising the power and wisdom of Aboriginal and Torres Strait Islander families and their cultures and the important role they play within our community.

The CDRB also acknowledges the special rights of children, which are recorded in the *United Nations Convention on the Rights of the Child*[1] (UNCRC) and are guided by its four principles: the right of all children to survival and development; respect of the best interests of the child as a primary consideration in all decisions relating to children; the right of all children to express their views freely on all matters affecting them; and the right of all children to enjoy all rights of the UNCRC without discrimination of any kind.

The CDRB relies on the collective knowledge and contributions of government agencies and non-government organisations to inform its systemic reviews. It thanks these agencies and organisations and acknowledges their efforts in protecting Queensland children and assisting their families to care for them.

The CDRB also acknowledges the work of its Secretariat in analysing child death reports, gathering research, collating data, preparing reports and coordinating meetings.

Warning

This report may cause distress for some people.
If you need help or support,
please contact any of these services:

Lifeline ..... phone: 13 11 14

Beyond Blue ..... phone: 1300 22 4636

Kids Helpline *(for 5–25-year-olds)* ..... phone: 1800 55 1800

Aboriginal and Torres Strait Islander peoples
should be aware that this report contains data about
deceased children and information about systemic issues
facing Aboriginal and Torres Strait Islander peoples.

1 See United Nations Office of the High Commissioner for Human Rights 2002, *Convention on the Rights of the Child*, https://www.ohchr.org/EN/professionalinterest/pages/crc.aspx

Child Death
Review Board

cdrb.qld.gov.au

Reference: DOC21/2304

28 October 2021

The Honourable Shannon Fentiman MP
Attorney-General and Minister for Justice
Minister for Women and
Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29J of the *Family and Child Commission Act 2014*, I am pleased to provide for presentation to the Parliament the 2020-21 Annual Report for the Queensland Child Death Review Board, the inaugural annual report for this Board.

The report includes the recommendations from the Child Death Review Board based on the reviews undertaken in the period from 1 July 2020 to 30 June 2021.

I draw your attention to section 29J(3) of the *Family and Child Commission Act 2014* which requires you to table this report to Parliament within 14 sitting days.

Yours sincerely

Cheryl Vardon
Chair
Child Death Review Board

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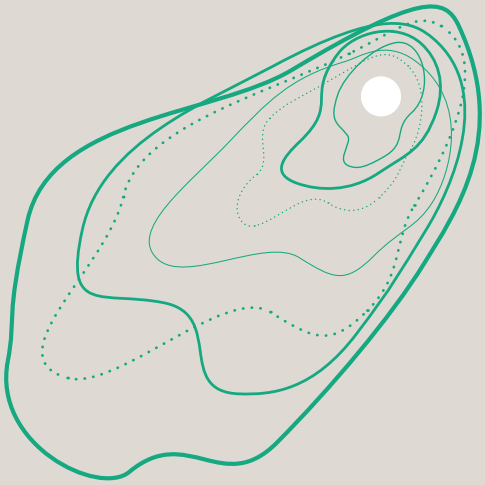
The Queensland Child Death Review Board's use of the pearl as its brand



The pearl represents the children. They are our central focus.

The oyster symbolises vulnerable children wrapped in protective layers, with the oyster shell representing the different entities that work together to form the child protection system.

The ripples emanating from the centre represent the impact of the death of a child and the efforts to learn from the loss and try to save other children.

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Message from the Chair

The death of a child or young person is a tragedy that sends ripples throughout the Queensland community. Every death raises questions about why it occurred and how it could have been prevented. When the child is known to the child protection system, the system must identify and apply better strategies to keep children safe.

Children known to the child protection system die at almost twice the rate of all Queensland children.[2] Some are placed in out-of-home care if their families are found to be unable to care for them, while others have had less serious contact. Some attend school, some receive health services, and some engage in behaviours that bring them to the attention of the police and the youth justice system. In most cases, there are many eyes on these children before they die, although some very young children remain at risk of becoming invisible.

Keeping them safe is not the responsibility of one agency alone, but of the whole child protection system. It is made up of universal services (available to everyone—such as health and education), secondary services (designed to intervene early to help families to address needs that could lead to their children requiring protection) and statutory services (provided to children in need of protection).

On 1 July 2020, Queensland strengthened its response to reviewing the deaths of children by establishing a contemporary, two-tiered model:

- requiring certain agencies to conduct a review of their service delivery to a child prior to their death and
- establishing the Child Death Review Board (CDRB) to review the system more broadly.

This is the CDRB's first annual report.

Over the past year, we have undertaken systemic reviews following the tragic deaths of 55 children. On behalf of the members of the CDRB, I acknowledge the grief and loss of those who knew these children, loved them, cared for them and worked with them. In most cases, it has been apparent that families, communities and professionals acted to support and protect these children.

In reviewing the child protection system following the death of a child, our role is neither to attribute blame nor to take disciplinary action against any individuals.[3] Instead, it is about learning and identifying opportunities for improvements to policies, procedures, legislation and systems to prevent avoidable deaths.

Each child's circumstances and experiences are unique, but we work to identify recurring systemic issues that have left children in unsafe environments and without the supports they needed. We then develop recommendations for changes to the system, to prevent and reduce future deaths. These recommendations are included in Chapter 5 of this report.

2 Queensland Family and Child Commission, *Child Death Register key findings 2019–2020: Children known to the child protection system*, https://www.qfcc.qld.gov.au/sites/default/files/2021-03/Children%20known%20to%20the%20child%20protection%20system%202019-20.PDF

3 *Family and Child Commission Act 2014*, s. 29H(5).

We developed the first year of recommendations with efficiency in mind. They focus on changes that can be carried out quickly and which will deliver effective results.

However, there are entrenched systemic issues that impact on the timeliness and quality of responses to children and families. They will take longer to address. We will investigate and work with partners to find solutions to them.

Concerningly, the overrepresentation of Aboriginal and Torres Strait Islander children—both within the child protection system and among children who have died—persists. We must do better. Our recommendations call for specific actions, but in implementing these, agencies must work with Aboriginal and Torres Strait Islander peoples and organisations to make sure actions are culturally responsive. I am also committed to ensuring Aboriginal and Torres Strait Islander peoples have meaningful involvement in review processes and in leading decisions about issues affecting their children.

We have observed the ongoing demand and strain experienced by the statutory child protection services that are designed to investigate concerns about children and protect those who are at risk of harm. Professionals are tasked with making complex and high-risk decisions while subject to workload pressures and resource constraints. Despite their efforts, these pressures are clearly affecting the quality and timeliness of services delivered.

Challenges in recruiting and retaining staff and carers are not new, and there are no easy fixes. Over the next 12 months, we will keep watch on this and on any strategies put in place. In the interim, we must make sure these professionals are equipped with the knowledge, skills and support to do what needs to be done.

I would like to recognise the significant contributions of our partners over the past year. Implementing a new model is never easy, and they have demonstrated strong commitment and willingness to adopt new processes and drive the necessary changes.

In particular, I thank the agencies who undertook internal reviews and provided information and advice to inform the CDRB's work. Because we only began receiving reports from most agencies in the latter part of the year, our findings this year largely focus on the Department of Children, Youth Justice and Multicultural Affairs. I anticipate that subsequent annual reports will cover issues across the broader child protection system.

I also acknowledge the work of the Department of Justice and Attorney-General and the Queensland Family and Child Commission in establishing the legislative and procedural foundations of the CDRB. I thank the Queensland Paediatric Quality Council and Professor Brett McDermott for working closely with the CDRB in its first year to provide contemporary research on best practice strategies to prevent child deaths.

Finally, I would like to thank the members of the CDRB. There is much value in undertaking these reviews, but it is difficult work. Members contributed important insights to help in identifying opportunities to enhance the system's responses to vulnerable children and their families. They serve as board members in addition to their daily workload, and I appreciate the effort and time they have generously dedicated.

While child death review processes have been used in Queensland for some time, the CDRB represents a significant shift in scope, functions and powers. I am honoured to have chaired it in its inaugural year and trust that the direction we have established will stand it in good stead in continuing to drive future improvements.

We need to learn from what happened to the children we have lost, so we can keep other children safe and well. In the course of my career, I believe this will be one of the most important things I have ever contributed to.

Cheryl Vardon

Chair
Child Death Review Board

Board members

Ms Cheryl Vardon
Chair

Ms Cheryl Vardon is the Chief Executive and Principal Commissioner of the Queensland Family and Child Commission (QFCC). She has held the role since October 2015.

She has had a distinguished career as an educator and is recognised for her leadership in the protection of vulnerable children and young people.

Since 2016, Cheryl has headed up a series of reviews for the Queensland Government, driving practical systems reform measures to keep vulnerable children more than safe. Reviews into system reforms still continue under Cheryl's leadership.

She is an experienced reviewer of systems, using case studies and stories to influence policy and establish reforms.

Cheryl's work in Indigenous education and services for Indigenous children and young people received a Prime Minister's Reconciliation Award.

She has held many leadership, board and statutory roles, as a director-general, chief executive, commissioner and adjunct professor in private, public and not-for-profit organisations, including education departments, children's services departments, consumer affairs, a national charity, universities and tribunals.

Cheryl is a Fellow of the Australian Institute of Managers and Leaders, a Fellow of the Australian College of Educators, a member of the Australian Institute of Company Directors and a member of the Women's Leadership Institute Australia. She was awarded an honorary doctorate (Doctor of the University) from Griffith University in 2018.

Dr Clinton Schultz
Deputy Chair

Dr Clinton Schultz is a Gamilaraay man and registered psychologist with a keen interest in holistic wellness, particularly the wellness of workers in health and community services. Clinton recently was awarded his PhD titled: *Winanga-li-gu* (Higher order listening), *Guwaa-li-gu* (higher order speaking), *Maruma-li-gu* (higher order healing). Factors of holistic wellbeing for members of the Aboriginal health and community workforce.

He was Assistant Professor with Bond University Medical School and is Director of Marumali Consultations and Owner of Sobah Beverages.

Mrs Hetty Johnston AM

Mrs Hetty Johnston AM founded Bravehearts Foundation Ltd in 1997 and is one of Australia's leading child protection advocates and consultants.

She was appointed as a Member of the Order of Australia in 2014 for her services to the community through a range of organisations that promote the welfare and rights of children.

In 2015, Hetty was recognised as Queensland's Australian of the Year for her ongoing work in highlighting the issues of child sexual assault and exploitation to media, families, schools and the general community, both nationally and internationally.

Hetty is the author of the book, *In the Best Interests of the Child*, and is currently a member of the Advisory Council to the Queensland Family and Child Commission.

Ms Margie Kruger

Ms Margaret (Margie) Kruger is a solicitor and practises in the area of family law and child protection law. She has worked in the area of child protection in service delivery to children and families, policy and the Court, both as a social worker and lawyer for 30 years. Margie was admitted to practice as a barrister of the Supreme Court of Queensland in May 2000 and was subsequently admitted to practice as a solicitor in October 2000. She is also admitted as a practitioner to the High Court of Australia.

Margie is the Deputy Chair of the Queensland Law Society Family Law Committee. She is a board member of the Child Protection Practitioners Association of Queensland (CPPAQ) and, until the end of 2016, held the position of President of CPPAQ. She has previously been a member of the Queensland Law Society Children's Committee.

Prior to commencing practice as a lawyer in 2000, Margie was a social worker with the Queensland Government working in the area of child safety. She worked in various roles including assessing notifications of harm, team leader, policy advisor and senior advisor in child protection in the Court Division of the department.

Mr Bruce Morcombe OAM

Mr Bruce Morcombe OAM is the co-founder of the Daniel Morcombe Foundation which he established with his wife, Denise, after the abduction and murder of their son in December 2003. The Foundation's vision is *Today we build a future where children are free from harm and abuse*.

The Morcombes advocate passionately for the education of children and young people on how to stay safe in both physical and online environments and for the support of young victims of crime.

They continue to drive to deliver child safety messages to as many Australian schools as possible. The Day for Daniel is held annually as a national day of action to educate children about personal safety.

In 2012, Bruce and Denise were recognised as Queensland's Australian of the Year nominations and both received Medals of the Order of Australia in 2013. In 2020, they were named as Queensland Greats for their tireless dedication to child safety advocacy.

Ms Shanna Quinn

Ms Shanna Quinn is a barrister, mediator and trainer with experience across Australia and Asia, specialising in family law. With extensive experience as a forensic social worker and counsellor, Shanna has focused her career around family law matters (parenting and property), domestic violence and child protection, including clients from diverse cultural, socio-economic and religious backgrounds.

Shanna's multi-disciplinary background provides a unique and integrated approach to all areas of her work. As a barrister and mediator, her background as a forensic social worker makes her particularly equipped to deal with sensitive and complex child-related matters.

Professor Jeanine Young AM

Professor Jeanine Young AM is the Deputy Head of School (Research) for the School of Nursing, Midwifery and Paramedicine at the University of the Sunshine Coast. She has worked in Australia and the United Kingdom in neonatal intensive care, paediatrics and community child health. Jeanine has a special interest in infant care practices, in particular breastfeeding and parent-infant bed-sharing, which formed the basis of her doctoral studies.

Jeanine has established a research program to investigate Queensland's infant mortality rate. It focuses on evidence-based strategies and educational resources to assist health professionals in delivering safe sleeping messages to families with young infants and to reduce Aboriginal and Torres Strait Islander infant mortality. Jeanine works in partnership with government, industry, safety and regulatory bodies and communities in translating evidence into practical advice for parents. Her efforts in reducing infant mortality by supporting the role of health professionals and health promotion within communities, have received state, national and international recognition.

Jeanine was made a Member of the Order of Australia for her work in June 2020.

Mr Phillip Brooks

Phillip Brooks is the Deputy Director-General of Youth Justice in the Queensland Department of Children, Youth Justice and Multicultural Affairs. He was formerly Commissioner at the Queensland Family and Child Commission.

Phillip is a descendant of the Bidjara Tribe (great grandfather), the Kairi Tribe (great grandmother), and the Ducabrook Clan located at Springsure Central Queensland.

Phillip has had a distinguished career in the child, youth and family support portfolio in Queensland across a range of roles including as Officer in Charge Queensland Police Service; Manager of Child Safety and Youth Justice Service Centres; and Director Government Coordination, Executive Director Strategy and Regional Director Child, Family and Community Services North Queensland.

Phillip completed the Executive Master of Public Administration with the Australia and New Zealand School of Government in 2020.

Phillip is the Youth Justice representative on the CDRB.

Detective Superintendent Denzil Clark

Detective Superintendent Denzil Clark commenced with the Queensland Police Service (QPS) in January 1988 and has served the past 30 years as a detective in various positions across the QPS. Denzil has worked as an investigator in regional child protection units, criminal investigation branches, various units within State Crime Command and at the Crime and Corruption Commission.

In 2018 Denzil was promoted to Detective Superintendent, Child Abuse and Sexual Crime Group which includes the key roles of State Child Protection and Investigation Unit (CPIU) Co-ordinator and QPS Child Safety Director.

Denzil has twice been awarded the Commissioner's Certificate and has also received a number of other operational and corporate awards in recognition of his contribution to policing.

In 2017, Denzil completed a Graduate Certificate in Applied Management.

Denzil was the QPS representative on the CDRB from 1 July 2020 to 15 June 2021.

Detective Acting Superintendent Mark White

Detective Acting Superintendent Mark White commenced with the Queensland Police Service (QPS) in April 1989 and has over 30 years' service as a detective in various positions across the QPS. Mark has predominately worked in regional Child Protection and Investigation Units (CPIU) and Criminal Investigation Branches (CIB) at Logan and the Gold Coast. This includes managing the CPIU and Domestic Family Violence and Vulnerable Persons Unit.

Mark has performed a range of senior roles including Regional Crime Coordinator, South Eastern Region; Crime & Support Services, Gold Coast; Assistant District Officer, Logan and his current role as the State CPIU Coordinator and QPS Child Safety Director. In 2018 Mark received an Exemplary Conduct Medal (Leadership) for managing the Tiahleigh Palmer murder investigation. Mark has received a number of commendations, including the Professional Government category of the Child Protection Week Awards. Mark has also attained post graduate qualifications including a Graduate Certificate in Applied Management in 2018 and a Master of Leadership & Management in 2021.

Mark is the QPS representative on the CDRB (from 16 June 2021 and ongoing).

Ms Bernadette Harvey

Ms Bernadette Harvey is the Regional Executive Director, South West for the Department of Children, Youth Justice and Multicultural Affairs (Child Safety). She has almost 30 years' experience working in government child protection and youth justice services.

Bernadette commenced her career with the former Department of Families in 1992 and spent 12 years in various front-line professional roles including case worker and team leader. From 2004, Bernadette was the Manager of the Rockhampton Youth Justice Service Centre. She held the position as Regional Director, Child and Family, Central Queensland Region with the Department of Child Safety, Youth and Women from 2009 to 2016. From October 2016 to April 2018, she was the Executive Director, Child and Family Operations before commencing in her current role.

Bernadette has formal qualifications in psychology, welfare studies, and law, and she holds an Executive Master of Public Administration.

Bernadette was the Child Safety representative on the CDRB from 1 July 2020 to 23 June 2021.

Dr Meegan Crawford

Dr Meegan Crawford is the Chief Practitioner for the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Child Safety). After graduating as a social worker, Meegan commenced her career 30 years ago as a Child Safety Officer.

Meegan has worked in a variety of roles in Child Safety including senior team leader, senior training officer, manager, director and executive director. She has also worked as an academic and research assistant for Griffith University.

As the Chief Practitioner, Meegan reports directly to the Director-General and has oversight of the teams responsible for child death and serious injury reviews, child safety complaints, child safety training, operational policy and practice development and guidance, and partnerships and projects.

Together these teams form the Office of the Chief Practitioner and lead reforms to improve safety, belonging, cultural and wellbeing outcomes for children, young people, parents and carers receiving child protection services.

Meegan is the Child Safety representative on the CDRB (from 24 June 2021 and ongoing).

Dr Stephen Stathis

Dr Stephen Stathis obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child & Adolescent Psychiatry and Forensic Psychiatry. Stephen is currently the Medical Director of Child and Youth Mental Health Services, Children's Health Queensland. He also acts as the clinical advisor to Queensland Health for child and youth mental health.

Stephen has extensive experience working among vulnerable and marginalised young people within the community. His clinical interests include 'bridging the gap' between paediatric and psychiatry, mental health policy and strategic planning, gender dysphoria, consequences of early childhood trauma and abuse, and adolescent forensic psychiatry.

Stephen is the Queensland Health representative on the CDRB.

Ms Hayley Stevenson

Ms Hayley Stevenson is the Executive Director for Student Protection and Wellbeing in the Queensland Department of Education.

Hayley leads the development and implementation of statewide policy in relation to child safety, domestic and family violence, suicide prevention, mental health, and student learning and wellbeing.

Hayley started her career working in a clinical mental health setting supporting adolescents with mental health concerns before joining a national Youth Suicide Prevention Strategy focusing on early intervention and building the resilience of young people.

This led Hayley to the Education sector where she has worked since 2002, with much of her work focusing on embedding support for student wellbeing into the everyday work of schools.

Hayley has experience working across a range of health and wellbeing policy areas impacting children, young people and their families and recognises the protective and supportive role education plays in improving the life outcomes of children.

Hayley is the Department of Education representative on the CDRB.

Executive summary

When a child known to the child protection system dies, the system must learn from the tragedy and make the necessary improvements to help prevent future deaths.

The child protection system (the system) is defined as the system of services provided by relevant agencies and other entities to children and young people in need of protection or at risk of harm. The system extends beyond the statutory child protection services to include preventative and support services to strengthen and support families and prevent harm to children and young people.[4]

For the purpose of a child death review, 'known to the child protection system' refers to children who were known to the Department of Children, Youth Justice and Multicultural Affairs (Child Safety) due to being subject to an intake[5], investigation and assessment or ongoing intervention in the 12 months prior to their death.

The Child Death Review Board (CDRB) was established on 1 July 2020 to carry out systems reviews following the deaths of children known to the child protection system.

Under section 29A of the *Family and Child Commission Act 2014* (Qld), the purposes of the CDRB's reviews are to:

- identify opportunities for continuous improvement in systems, legislation, policies and practices
- identify preventative mechanisms to help children and prevent deaths that may be avoidable.[6]

This report outlines the CDRB's activities and findings from the system reviews it conducted during its first year.

Establishing the board

Chapter 1 outlines the legislative and procedural arrangements that provide the foundation for the operation of the CDRB.

The Queensland Government established the CDRB to implement a revised independent model for reviewing the deaths of children known to the child protection system.

The government's commitment also required significant legislative change. Now, more agencies than before must conduct internal reviews of the service they provided to a child prior to the child's death. These agencies produce reports, which are used by the CDRB in its systemic reviews.

Board operations

Chapter 2 outlines key activities over the first 12 months of the CDRB's operation.

During this time, it prioritised working with partner agencies and stakeholders to develop and refine processes for sharing information and identifying systemic issues. This included:

- establishing memoranda of understanding with the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) and the Queensland Family and Child Commission (QFCC) to facilitate rapid information sharing in relation to child deaths and systemic issues
- commissioning two research projects with the Queensland Paediatric Quality Council (QPQC) and Professor Brett McDermott to analyse data and identify risk factors relating to sudden unexpected death in infants and to suicide
- commissioning a provider to develop a framework for strengthening the CDRB's cultural integrity and partnership
- inviting guest speakers to share their insights and expertise at CDRB meetings.

The Secretariat[7] also consulted with agencies responsible for conducting internal reviews to discuss and strengthen processes and met with stakeholders to share insights and learnings from interstate review models.

4 See *Family and Child Commission Act 2014*, sch 1, definition of 'child protection system'.

5 At intake, Child Safety receives, assesses and records child protection concerns from a notifier and decides how to respond. It is the first pointat which a decision is made about whether a child may be in need of protection.

6 *Family and Child Commission Act 2014*, s. 29A(4).

7 The Secretariat is a team made up of staff internal to the Queensland Family and Child Commission. It acts as the agent for the CDRB to help operationalise its functions, roles and responsibilities. The Secretariat operates under the direction of the CDRB Chair.

Analysing child deaths

Chapter 3 provides a statistical overview of the child deaths the CDRB reviewed in 2020–21.

During this period, the CDRB met six times (plus one out-of-session meeting to further consider some matters on a different day). Four of the meetings were to discuss the deaths of 55 children and young people who were known to the child protection system. One meeting was to establish procedures and processes, and one was to hold its annual meeting to discuss recurrent system issues and develop the recommendations.

+1 meeting held out of session

The CDRB considered demographic information and categories of death. This information highlighted several areas that need monitoring, including:

- overrepresentation of Aboriginal and Torres Strait Islander children in the deaths
- changing circumstances in youth suicide—including females using more lethal means[8] and younger children completing suicide
- multiple sudden unexpected deaths in infancy (SUDI).

As the CDRB builds its database capabilities and processes, it will undertake further analyses of trends and indicators of risk.

Commissioning research

When necessary, the CDRB engages experts to conduct research and provide information and advice on specific issues.

Chapter 4 provides an overview of two of the first three contracts the CDRB awarded in 2020–21 for this purpose. They analysed data and identified risk factors relating to suicide and SUDI, which accounted for 11 per cent and 16 per cent respectively of the deaths reviewed by the CDRB this year.

Professor Brett McDermott undertook the suicide research. The resulting report provides insights from recent research and clinical cases about how responses to young people known to the child protection system can be improved and how the system can work to lower the rate of suicide in this group. Professor McDermott presented his findings to the CDRB and guests in June 2021.

Researchers from the QPQC reviewed the existing literature regarding SUDI, with the aim of informing system improvements. The paper from this research is due to be presented to the CDRB in early 2021–22.

8 Lethal means refers to methods which have a high likelihood of resulting in a loss of life because there is little opportunity for someone to intervene or for the method to fail.

Identifying systemic issues and recommendations

Chapter 5 provides insights into recurring systemic issues and mechanisms to prevent child deaths observed by the CDRB across its reviews. In several cases, vulnerable children were left in unsafe environments without appropriate supports or did not receive the services they needed.

This chapter summarises the CDRB's findings across three areas:

1. engagement with targeted secondary services
2. accuracy and quality of child protection assessments
3. accessibility and availability of suicide prevention and postvention responses.

The CDRB makes 10 recommendations in response to these issues. They are detailed in Chapter 5, but the main points of focus include:

- how to ensure the secondary service model (intended to help families and keep them from becoming involved with Child Safety) is achieving its aims, and how to make the referral process to these services more effective
- how to ensure Child Safety, when making decisions about whether a child needs to be protected, thoroughly assesses historical information, indicators of harm to a child over time, patterns of parental behaviour, cultural factors, and health advice
- how a number of different organisations can contribute to the prevention of suicide. This includes targeted approaches from the Queensland Mental Health Commission on education and with Aboriginal and Torres Strait Islander communities; urgent work on suicide risk management plans, policies and procedures by Child Safety; the development of youth-friendly information by the Queensland Mental Health Commission and the QFCC; and different approaches with/for school students by the Department of Education and the QFCC.

In numerous reviews, the CDRB has observed the impact that entrenched systemic issues—such as workforce constraints and culturally unsafe practices—have had on the timeliness and quality of responses to children and families. It recognises that work is underway to address some of these issues. It also recognises these issues require further consideration before meaningful solutions can be identified.

One of the CDRB's functions is to monitor the implementation of its recommendations.[9] It will report on agencies' progress in implementing the recommendations in its 2021–22 annual report.

Looking forward (2021–22)

The final chapter, Chapter 6, sets out the future directions for the CDRB in 2021–22. As it will receive reports from all review agencies for the full year, it will be able to present a more balanced view of issues across the whole system.

Through cases reviewed to date, the CDRB has also identified several priority areas that it will keep watch of in the coming year to determine whether system improvements are required.

As part of its commitment to learning and reflection, the CDRB will also undertake an evaluation to review its implementation and explore how well processes of the new model of child death review are functioning. Board members and review agencies will be consulted as part of the evaluation.

9 *Family and Child Commission Act 2014*, s. 29D(e).

Chapter 1

The child death review process in Queensland

The Child Death Review Board was established on 1 July 2020 in accordance with the *Child Death Review Legislation Amendment Act 2020*. It was established to carry out systemic reviews following the deaths of children known to the child protection system. This chapter outlines the legislative and procedural arrangements which support delivery of its functions.

History

In 2016, following the death of a 22-month-old child, the Queensland Government requested that the Queensland Family and Child Commission (QFCC) oversee reviews completed by the then Department of Child Safety, Youth and Women and by Queensland Health.

In the following year, the QFCC released its review report: *A systems review of individual agency findings following the death of child*. The report included a single, overarching recommendation for the government ' ... to consider a revised external and independent model for reviewing the deaths of children known to the child protection system'.

The QFCC recommended that a new, contemporary and best practice child death review model be introduced with the following features:

- a scope that covers both government and non-government agencies
- extended powers and authority, including to make and monitor recommendations
- public reporting on the outcomes of child death reviews
- review of the panel (meaning the previous child death case review panel hosted by Child Safety) 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 interagency collaboration during the internal review process undertaken by review agencies.

The government accepted the QFCC recommendation and the Honourable Yvette D'Ath, then Attorney-General and Minister for Justice, introduced the *Child Death Review Legislation Amendment Bill 2019* to parliament on 18 September 2019. The Bill received royal assent on 13 February 2020 and became the *Child Death Review Legislation Amendment Act 2020*.

The Act established a new child death review model:

- requiring more agencies involved in providing services to the child protection system to conduct internal reviews of their service provision (previously only Child Safety[10] and the Director of Child Protection Litigation were required to review their service provision to a child)
- establishing a new, independent board (the 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
  - mechanisms to help children and prevent deaths that may be avoidable.

The QFCC was selected as the host agency for the CDRB due to synergies including the QFCC's management of the Child Death Register in Queensland and its existing child death prevention responsibilities.

While the CDRB is hosted by the QFCC for administrative purposes, its operational functions are not influenced by this administrative arrangement. It is not subject to direction by the responsible minister or anyone else about how it performs its functions. It has been established to act independently and in the public interest at all times.

The new child death review model commenced on 1 July 2020.

The child death review process

The child death review process is two-tiered. Each government agency that has been involved with a child in the 12 months prior to their death or serious physical injury undertakes a review of its service delivery to the child. This is known as an internal agency review. Each agency produces a report outlining its findings and recommendations.

If the matter relates to a child's death, each agency provides its internal agency review report to the CDRB for its consideration and to inform its recommendations about systemic improvements or preventative activities to reduce future child deaths. The CDRB does not routinely receive or consider internal agency review reports that relate to serious physical injuries.[11]

10 When the *Child Death Review Legislation Amendment Act 2020* commenced, Child Safety formed part of the Department of Child Safety, Youth and Women. As a result of government changes, Child Safety is now part of the Department of Children, Youth Justice and Multicultural Affairs.

11 The CDRB may, in exceptional circumstances, undertake a review following a serious physical injury at the request of the responsible minister. See *Family and Child Commission Act 2014*, s.29I.

Internal agency reviews

The purpose of internal agency reviews is to facilitate ongoing learning, promote accountability and improve services for children who come into contact with the child protection system. It is also intended to promote collaboration and joint learning across the reviewing agencies.

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

The agencies required to undertake reviews are:

- the Department of Education
- the Department of Children, Youth Justice and Multicultural Affairs (Child Safety)
- the Department of Children, Youth Justice and Multicultural Affairs (Youth Justice)
- Queensland Health (Hospital and Health Services)
- the Queensland Police Service
- the Director of Child Protection Litigation (DCPL). The reviews conducted by the DCPL have a different scope to those conducted by other review agencies.[12, 13]

Figure 1 illustrates the review process. Upon becoming aware of the death or serious physical injury of a child known to Child Safety in the 12 months prior, Child Safety must notify other agencies, which then determine whether they were also involved with the child in the 12 months prior to their death or serious physical injury. Each agency that provided services to the child, including Child Safety, must then conduct an internal review.

If the matter relates to the death of a child, on determining it is to undertake a review, an agency notifies the Secretariat of the CDRB. As soon as practicable (but not exceeding six months), each agency must then provide a copy of its report to the Secretariat and make accessible any documents obtained to inform its internal review.

Child Death Review Board reviews

As stated earlier, the CDRB carries out reviews of the child protection system following the death of a child connected to the system to identify:

- opportunities for continuous improvement in systems, legislation, policies and practices,
- mechanisms to help children and prevent deaths that may be avoidable.[14]

The CDRB does not investigate the deaths of individual children or make findings about the actions of individuals or assign disciplinary action against any person.[15]

Upon receipt of all the internal agency review reports, the CDRB Secretariat allocates the matter to a scheduled CDRB meeting, usually within six months of receiving the reports. At meetings, the CDRB reviews and considers these reports and other materials prepared by the Secretariat. Discussions focus on those deaths that provide the greatest opportunity for system learnings and recommendations about improvements to systems, policies, practices and legislation.

Figure 1: **Two-tiered review process**

12 See *Child Protection Act 1999*, ss. 245H and 245I for details of requirements for reviews, and s. 245K for further details on the scope of a relevant agency review.

13 See *Child Protection Act 1999*, s. 245J for details of requirements for the Director of Child Protection Litigation reviews and s. 245L for further details on the scope of those reviews.

14 *Family and Child Commission Act 2014*, s.29A.

15 *Family and Child Commission Act 2014*, ss.29A(3) and 29H(5).

Chapter 2

Board operations

This chapter outlines the key activities and operations of the Child Death Review Board (CDRB) in 2020–21. Beyond conducting systemic reviews and research in relation to child deaths, the CDRB has prioritised working with partner agencies and stakeholders to develop and refine processes for sharing information and identifying systemic issues.

Board membership

The CDRB was established with a Chair and 11 board members.

The *Family and Child Commission Act 2014* sets out requirements for the CDRB's composition, such as the appointment of an Aboriginal or Torres Strait Islander person as the Chair or Deputy Chair, and membership that reflects expertise in relevant fields.[16]

In 2020–21, the members of the board reflected expertise across child protection, family law, child health and mental health, education, justice systems and child advocacy.

Meetings

The CDRB held six formal meetings in 2020–21, with one meeting extended to consider some matters out of session.

A quorum[17] was present at all meetings except for the continuation of Meeting 5 out of session. This was resolved through follow-up conversations between the Chair and Deputy Chair to discuss findings.

The Chair presided at all meetings except for the later stages of Meeting 1, where the Deputy Chair presided.

Meetings were:

- **Introductory morning tea**—23 July 2020 at the Queensland Family and Child Commission (QFCC) Boardroom. Board members were introduced and provided with an information pack and signed confidentiality and other agreements.
- **Meeting 1—Induction meeting**—12 August 2020 at Room Three Sixty, Queensland University of Technology Gardens Point Campus. At this meeting, the CDRB discussed the procedural guidelines and the ways in which it would operate.
- **Meeting 2—Review meeting**—30 September 2020 at the QFCC Boardroom. Nine matters were reviewed.
- **Meeting 3—Review meeting**—25 November 2020 at the QFCC Boardroom. Twelve matters were reviewed.
- **Meeting 4—Review meeting**—3 March 2021 at the QFCC Boardroom. Sixteen matters were reviewed.
- **Meeting 5—Review meeting**—19 May 2021 at the QFCC Boardroom. Fourteen matters were reviewed.
- **Meeting 5 (out-of-session)**—16 June (online) continuation of Meeting 5. Four matters were reviewed.
- **Meeting 6—Annual meeting**—23 June 2021 at the Boardroom of the State Library of Queensland. Board members discussed the issues arising from their work over the past year and drafted the recommendations to be included in this report.

The CDRB invited special guests and stakeholders to attend several meetings to share their knowledge and expertise or facilitate joint learning. These included:

Meeting 2—a representative from Benestar (a workplace and employee wellness and wellbeing organisation) was invited to speak about board member's mental health and wellbeing, and about the availability of confidential support through Benestar.

Meeting 3—Mr Graham Murray, Assistant Director from the Office of the Director of Child Protection Litigation attended the discussion of one case to provide observations and commentary.

Meeting 5—Ms Tracy Linford, Deputy Commissioner (Crime, Counter Terrorism and Specialist Operations) Queensland Police Service, attended on behalf of Commissioner Katarina Carroll and addressed the CDRB. She spoke on several areas of focus, particularly relating to reoffending and disengagement amongst young people, responding to domestic and family violence and sexual offending, and the important role of Suspected Child Abuse and Neglect (SCAN) teams.

Meeting 6 (Annual meeting)

- Ms Natalie Lewis (Commissioner, QFCC) and Mr Mick Gooda (co-chair of the Queensland First Children and Families Board) shared views with the CDRB in its consideration of recommendations for the annual report
- Professor Brett McDermott presented on the suicide research he was commissioned to undertake by the CDRB. A range of special guests were invited to the presentation, but they did not participate in the CDRB discussions
- Dr Meegan Crawford (Chief Practitioner, Department of Children, Youth Justice and Multicultural Affairs) presented on Child Safety procedures and risk assessments and Ms Penny Creamer (Executive Director, QFCC) presented on the QFCC's oversight projects involving Child Safety risk assessments
- Ms Anna Moynihan attended as facilitator.

16 *Family and Child Commission Act 2014*, ss. 29W-29Y.

17 See *Family and Child Commission Act 2014*, s. 29ZF.

Attendance

		Meeting 1	Meeting 2	Meeting 3	Meeting 4	Meeting 5	Meeting 5 *continued out of session*	Meeting 6
		12 Aug 2020	30 Sept 2020	25 Nov 2020	3 March 2021	19 May 2021	16 June 2021	23 June 2021
Member	**Agency**	**Induction meeting**	**Review meeting**	**Review meeting**	**Review meeting**	**Review meeting**	**Review meeting**	**Annual meeting**
Cheryl Vardon	QFCC	●	●	●	●	●	●	●
Clinton Schultz	Non-government	●	●	●	●	●	○	●
Jeanine Young	Non-government	●	●	●	●	●	●	●
Bruce Morcombe	Non-government	●	●	●	●	●	●	●
Margaret Kruger	Non-government	●	●	●	●	○	●	●
Hetty Johnston	Non-government	●	● via Teams	●	●	●	●	●
Shanna Quinn	Non-government	●	●	●	● via Teams	○	○	○
Hayley Stevenson	DoE	●	●	●	●	●	●	●
Stephen Stathis	QH	●	○	●	●	●	●	● Proxy in attendance
Phillip Brooks	DCYJMA (Youth Justice)	●	● via Teams	○	○	○	● Proxy in attendance	● Proxy in attendance
Denzil Clark	QPS	●	● Proxy in attendance	●	●	●		
Mark White							●	●
Bernadette Harvey	DCYJMA (Child Safety)	●	●	●	● Proxy in attendance	● Proxy in attendance	● Proxy in attendance	● Proxy in attendance

● Present
○ Apology

Conflicts of interest

CDRB members disclosed a personal interest relating to a review as required by legislation[18] on eight occasions. Examples of interests disclosed include:

- receiving a phone call from the parent around the time of the child's death
- meeting a relative of a child at an event
- for government members, signing off on an internal agency review or having staff on their reporting team work with a child.

Two members were asked to be absent from the case discussion for which they declared a potential conflict of interest. In the other cases, the CDRB agreed that there was no conflict of interest arising in relation to the matter, and the member was able to participate.

The Chair sought guidance from the Queensland Integrity Commissioner, Dr Nikola Stepanov, to strengthen decisions made by the CDRB about potential conflicts of interest. Board members were provided with material developed by the Integrity Commissioner and the Secretariat providing guidance on navigating and resolving conflicts of interest.

Action items

The CDRB assigned 50 action items, mostly to the Chair and Secretariat, over the year. Key actions included alerting relevant agencies to emerging matters as they arose. By the end of the financial year, 25 action items were completed, and another 16 will be completed at the first meeting in 2021–22. The remaining nine action items are in progress.

Stakeholder engagement and partnerships

When the CDRB started operation, the Chair wrote to ministers, agencies, non-government organisations, peak bodies and other stakeholders, providing information about the CDRB's purpose, functions and operations.

Throughout the year, the CDRB developed and maintained professional relationships with a range of stakeholders to support the delivery of its functions. It worked with stakeholders who:

- provided insights into the experiences of individuals, families or communities or contributed expertise on matters that affect them
- contributed data, research or expertise to inform the CDRB's work
- undertook internal agency reviews and provided insights into relevant legislation, policies, procedures and practices
- are expected to be affected by or can assist in implementing system change recommended by the CDRB
- the CDRB considered would benefit from the patterns and trends it identified
- may assist in communicating the CDRB's key messages to a wider audience.

To support this, the Secretariat (on behalf of the CDRB) developed a stakeholder engagement strategy to guide and document the dissemination of information and engagement with stakeholders.

The CDRB also maintains a website at **www.cdrb.qld.gov.au**, which provides information about its structure, functions and work. The Chair issued two media releases discussing updates on milestones and data.

18 *Family and Child Commission Act 2014*, s. 29ZJ.

Engaging with review agencies and entities

A cross-agency working group was established in 2020 to develop operational guidelines for agency reviews following the death or serious physical injury of a child. The guidelines standardise agency internal review practices and guide information sharing between these agencies and the CDRB. This group was made up of representatives from all review agencies,[19] the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) Secretariat and an officer from the Department of Justice and Attorney-General.

Chaired by the CDRB Secretariat, the group met three times during 2020–21 to monitor the number of upcoming internal agency reviews and discuss the implementation of new child death review model processes and emerging issues.

The CDRB developed memoranda of understanding (MOUs) to facilitate information sharing with other entities. These describe the agreed processes and principles for sharing information, including confidential information relating to child deaths, to avoid duplication of activities across oversight entities. MOUs were established between the CDRB and the DFVDRAB, and between the CDRB and the Queensland Family and Child Commission. An additional tripartite MOU between the CDRB, the State Coroner and QFCC is under development.

The Secretariat also works closely with Queensland agencies and interstate entities to share information about the CDRB's operations and findings.

The Secretariat will continue to deliver information and presentations to relevant stakeholders in 2021–22 and engage with interstate entities through its membership on the Australian and New Zealand Child Death Review & Prevention Group.

Engaging with consultants and researchers

From time to time, the CDRB may engage experts to provide information to assist in the delivery of its functions. In 2020–21, it commissioned three contracts for this purpose.

Chapter 4 provides detail about the first two research projects, on suicide (Professor Brett McDermott) and sudden unexpected death in infants (the Queensland Paediatric Quality Council).

Cultural integrity framework

In 2020–21, the CDRB considered the deaths of 23 Aboriginal and Torres Strait Islander children (42 per cent of the deaths it reviewed). In several cases, it identified culturally unsafe practices and gaps in procedures for upholding the rights of Aboriginal and Torres Strait Islander children, families and communities.

The CDRB acknowledges that Aboriginal and Torres Strait Islander peoples need to be given more leadership in child death review processes, and also need to be able to share their insights. This will help to make sure discussions and recommendations accurately identify system issues experienced by Aboriginal and Torres Strait Islander children, families and communities and drive meaningful change.

The CDRB has commissioned a provider to develop an approach for strengthening its cultural integrity and pathways to involve Aboriginal and Torres Strait Islander organisations, communities and representatives in its discussions and recommendations.

This contract is expected to close in the first quarter of 2021–22, with the CDRB implementing necessary changes over the remainder of the year. This will be an ongoing piece of work, and the CDRB is committed to making improvements in consultation with relevant stakeholders.

Risk management

The Secretariat, on behalf of the CDRB, established a CDRB strategic risk register in compliance with the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*. These require that all accountable officers and statutory bodies establish and maintain appropriate systems of internal control and risk management.

The CDRB strategic risk register captures and monitors strategic and operational risks for the CDRB. For purposes of accountability, it is presented quarterly to the QFCC's Audit and Risk Management Committee.

19 Department of Children, Youth Justice and Multicultural Affairs—Child Safety and Youth Justice, the Office of the Director of Child Protection Litigation, the Department of Education, Queensland Health, and the Queensland Police Service.

Chapter 3

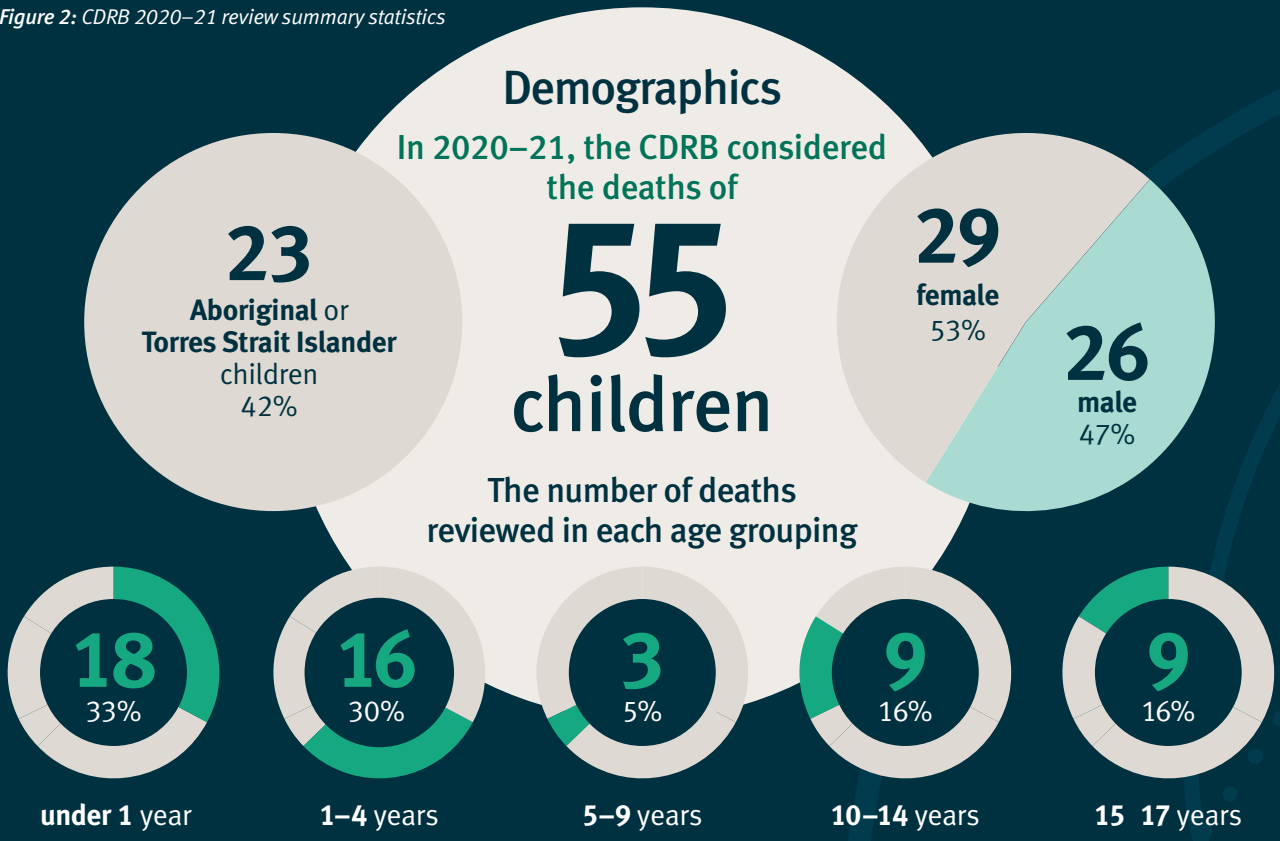
Analysis of child death reviews

This chapter provides a statistical overview of the deaths and key demographic characteristics considered by the Child Death Review Board (CDRB). This analysis helps the CDRB to identify trends in demographic characteristics and categories of death for its findings *(which are reported in **Chapter 5**)*.

The number of deaths of children known to the system that are reported in the Queensland Family and Child Commission's (QFCC) *Annual Report: Deaths of children and young people, Queensland, 2020–21* may not align with the number of child deaths reviewed by the CDRB in the same year and reported in this report. This is because the QFCC reports on child deaths registered[20] in the financial year, whereas CDRB numbers are based on a different timeframe.

The *Annual Report: Deaths of children and young people, Queensland* is the official statistical report on the deaths of all children in Queensland.

Figure 2: *CDRB 2020–21 review summary statistics*



Category of deaths reviewed by the CDRB

10 were from **natural causes**

45 were from **external causes**, including:

- **10** **fatal assault** and **neglect**
- **9** **transport-related** causes
- **9** **sudden unexpected deaths in infancy** (SUDI)
- **7** **unknown causes**, with cause of death pending
- **6** **suicide**
  67% female, 33% male
  4 aged 10–14 years,
  2 aged 15–17 years
- **2** **drowning**
- **2** other **non-intentional** injury.

20 The Queensland Child Death Register is based on death registrations recorded by the Queensland Registry of Births, Deaths and Marriages. Deaths in the *Annual Report: Deaths of children and young people, Queensland* are counted by date of death registration.

55
children

Child protection status at the time of death

4 were in **foster** or **kinship care**[21] or on a **permanent guardianship order**[22], and they were under four years of age at the time of their death.

51 were living with family or friends or independently at the time of their deaths.

Agency reviews considered by the CDRB

68 internal agency review reports in relation to the 55 child deaths.

This included:

- **55 Child Safety**
- **3 Director of Child Protection Litigation**
- **4 Queensland Health**
- **3 Department of Education**
- **3 Queensland Police Service**
- **0 Youth Justice**

Categorisation of reviews

As this is the first year of operation of the new child death review model, only Child Safety and the Director of Child Protection Litigation provided reports for the full year.

The four agencies newly required to undertake reviews—Queensland Health, the Department of Education, Youth Justice (which from 12 November 2020 formed part of the Department of Children, Youth Justice and Multicultural Affairs) and the Queensland Police Service—were only required to conduct reviews following the death or serious injury of a child after the new model was implemented on 1 July 2020.

The CDRB only received reports from these agencies from January 2021, due to the six-month timeframe for undertaking a review. Reports for the full year will be received from all agencies in 2021–22.

Upon receipt of internal agency review reports and supporting agency information, the CDRB Secretariat applies a review categorisation framework to determine the terms of reference and depth of analysis for each child death. The categorisation framework (levels 1–3) is based on the extent to which systemic learnings and opportunities can be identified from a case, with those categorised to a level 3 presenting the most significant opportunities for improvements.

The CDRB considers matters assigned to all levels at each meeting, and monitors trends or systemic issues across levels.

21 This is a form of out-of-home care where a person approved by Child Safety provides care in their own home for children and young people who have experienced harm or are at risk of harm. This may include a departmental foster carer or a member of the child's family.

22 Refers to a child protection order where a permanent guardian is legally appointed for a child.

Chapter 4

Research overview and findings

The Child Death Review Board (CDRB) commissioned two research projects to analyse data and identify risk factors relating to suicide and sudden unexpected deaths in infancy (SUDI). Professor Brett McDermott undertook the suicide research, and researchers from the Queensland Paediatric Quality Council conducted the SUDI research. Findings from the suicide research are used in Recommendation 6 in this report. Findings from the SUDI research will be considered by the CDRB in 2021–22.

Research into suicide prevention

The CDRB reviewed six suicide deaths of children in 2020–21. This represented 11 per cent of all the child deaths it reviewed. Three of the suicide deaths were Aboriginal and Torres Strait Islander children, four were in the 10–14-year age group, four were female and two were male.

The CDRB also considered the QFCC's report *Counting Lives, Changing Patterns: Findings from the Queensland Child Death Register 2004–2019*, which identified that youth suicide in Queensland has increased by an average of 2.6 per cent per year over the 16-year period.[23] Rates of suicides for young people aged 15–17 in particular showed a statistically significant change over this period, increasing by an average of 3.5 per cent per year.[24]

The purpose of the research

Given the observed increase in suicides since 2004 and the high rate of suicides of children known to the child protection system, the CDRB commissioned Professor McDermott to prepare a research paper on suicide. The paper was to:

- be based on the latest neurobiological and epidemiological evidence
- include a review of suicide deaths that had been or were to be reviewed by the CDRB
- identify the elements and interfaces a responsive child protection and mental health system should include to enable it to respond to the needs of highly vulnerable children.

The resulting report, *Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide* provides insights from recent research and clinical cases about how responses to suicidal young people known to the child protection system can be improved, and about how (ideally) to lower the rate of suicide in this group.

The report points out two compelling reasons why this topic is extremely important. The first is the very large numbers of children in contact with child protection services across Australia, a population with a high rate of suicide. In 2019–20, one in thirty-three Australian children were in contact with child protection services, equating to 174,700 children.

The second reason is that suicide is the leading cause of death in Australian 7–17-year-olds. It is responsible for approximately one third of deaths in that age group.

Contributing factors to suicides in children and young people

Mental illness is a significant contributor to suicide, with approximately one in 50 Australian youths experiencing at least one mental health disorder. High-risk groups include Indigenous Australians, where the suicide rate is four to twelve times higher than the non-Indigenous rate. Young people involved with the youth justice system are also at high risk, as are those who abuse alcohol or substances.

The report clearly details a significantly higher risk in children with an adverse childhood experience (ACE). ACEs include verbal, physical and sexual abuse, and physical and emotional neglect. The report details the complexity of some of these interactions. For example, there is a direct link between abuse and suicidal thinking, as well as an indirect link between abuse and disengagement with school, lower educational and employment outcomes, self-medication with drugs and alcohol, and cumulative stresses that lead to suicidal thinking.

When considering the relationship of any ACE with mental health, the report points out that there are very clear research findings relating psychological neglect or the experience of sexual abuse to depression. Other research has correlated abuse and neglect with post-traumatic stress disorder (PTSD) and psychotic symptoms.

In the suicide literature, there is a strong association between ACEs and suicide attempts before the age of 18, with one large study finding that a history of maltreatment was more influential on suicide behaviour than a lifetime history of mental illness.

Professor McDermott's report identified some research that suggests suicidal ideation is occurring at earlier ages and is now seen in primary school children. Two overarching risk factors have been identified—caregiver mental illness and caregiver experience of their own maltreatment.

Caregiver mental illness is more likely to be reported in mothers, mainly due to the absence of fathers in study samples and the lives of many children known to child protection services. Maternal mental illness more than doubles the likelihood of an allegation of maltreatment.

Caregiver experience of their own maltreatment has been found to increase mental illness in their offspring.

The report found that there is increasing evidence of changes in gene function due to the experience of ACEs such as abuse and neglect. These changes include alterations in an individual's response to stress, cognition, relationships (such as security of attachment) and addiction. Gene function changes have been correlated with psychopathology in adults, including depression and borderline personality disorder.

23 Queensland Family and Child Commission, *Counting lives, changing patterns: Findings from the Queensland Child Death Register, 2004–2019*, p. 20.

24 Queensland Family and Child Commission, *Counting lives, changing patterns: Findings from the Queensland Child Death Register, 2004–2019*, p. 28.

Also, there is now a substantial body of research linking ACEs to acute and chronic biological change. These changes can negatively affect health and lifespans. Because of the higher rates of ACEs experienced by Indigenous children (due to intergenerational trauma and the legacy of colonisation), the negative impact on health and lifespan is likely to be worse. Receiving warmth from a parent/caregiver may make a difference in terms of preventing these biological changes.

The report identified that brain imaging studies have consistently demonstrated abuse-related brain changes, with the most implicated functions being executive functioning, emotional regulation and impulse control. Some changes are very large. For instance, they can show a 12–18 per cent reduction in brain volume related to abuse. New findings show not only grey brain matter reduction but also changes in the white matter that connects brain regions. They also show evidence of increased impulsivity (the tendency to be swayed by emotional and other impulses).

Review of cases

Within his research, Professor McDermott reviewed the suicide deaths of eight young people. Six of these deaths have been reviewed by the CDRB, and two will be reviewed in upcoming meetings. Key findings were that there was an equal number of female and male deaths, which is unusual given the usual preponderance of deaths by suicide in males. Half of the cases were of Aboriginal or Torres Strait Islander young people, which is consistent with the increased suicide rate in that population.

Other characteristics that reflected the research findings included evidence of clear premeditation in several of the cases. All individuals ended their lives through highly lethal means, with seven out of the eight deaths being by hanging. All individuals also had:

- high to very high levels of ACEs that often began very early in life
- clear family histories of mental illness or substance abuse.

Several also had a family history of relatives who had died by suicide, often also by hanging.

It was likely that half of the group had a mental health diagnosis and were seen for mental health issues by either a general practitioner or by child and youth mental health services. A theme of these interactions was the difficulty in engaging the young person with the offered model of care.

Government policy and collaboration

As part of this study, Professor McDermott also considered 19 policies and procedures from Education, Youth Justice and Child Safety. He found that, almost without exception, these policies were well written and detailed clear expectations and responsibilities. Most, in the normal cycle of reviewing and re-issuing policies, would benefit from incorporating the understanding of cumulative suicide risk over time, and recent evidence about the psychological and biological implications of ACEs.

A general theme was that inter-sectoral collaboration (for example between child protection and health services) was not enshrined in these documents. This is despite inter-sectoral collaboration being clearly in the best interests of the child.

Given the increased understanding of the rates of mental illness in the child protection population, and links between child protection and mental health, there is a clear need for provision across physical and mental health services for these young people. A key problem so far has been the perception that child protection clients do not engage with current child and youth mental health services. Also, many of the range of mental health challenges in this group mean they are not always responsive to current mental health interventions.

The report noted, however, that in Queensland there have been considerable steps taken to remedy this, including the roll-out of Queensland Health's Evolve Therapeutic Services (which provide intensive mental health services for children and young people). There is increasing evidence that services specifically designed for children in care achieve positive outcomes.

Priority areas

The report concludes with seven priority areas to consider. These include—potentially for the first time in the world—developing a shared trauma-informed[25] framework across all services and departments that deal with young people including health (paediatrics and mental health), child protection, education and youth justice. This could be followed by a shared professional development program with different tiers, depending on the degree of clinical competence required by the practitioner.

Other priority areas include:

- effecting cultural change to increase inter-sectoral collaboration
- investing in data so services have rapid access to information about emerging risks and opportunities
- advocacy for a major expansion of services to parents and infants/preschool children
- engaging with Indigenous elders, parents, consumers and community members to create new service initiatives that will engage with this group of high-risk consumers.

Professor McDermott presented his findings to the board members and guests at the CDRB annual meeting in June 2021. The CDRB used these findings to develop recommendations (see Chapter 5, Recommendation 6).

The research report is available on the CDRB website.[26]

Research into sudden unexplained deaths in infancy

Sudden unexpected deaths in infancy (SUDI) are, as the name suggests, defined as the sudden and unexpected deaths of otherwise healthy infants, in which there are no immediately obvious causes of death.

These deaths occur predominantly in Queensland's most vulnerable populations. They include families known to the child protection system, Aboriginal and Torres Strait Islander families, and other families experiencing social disadvantage and multiple adversities.

In its first year of operation, the CDRB reviewed the deaths of 18 infants, nine of whom died suddenly and unexpectedly. This represented half of all infant deaths, and 16 per cent of the 55 cases reviewed this year.

The CDRB commissioned a review of the existing literature regarding SUDI within the child protection population with a view to informing system improvements in Queensland.

Researchers from the Queensland Paediatric Quality Council (QPQC), Dr Rebecca Shipstone, Dr Julie McEniery and Dr Diane Cruice, completed this work for the CDRB. The QPQC is responsible for analysing clinical information about paediatric mortality and morbidity in Queensland and making recommendations to improve the safety and quality of health services statewide. Its Infant Mortality Subcommittee focuses on reducing the rate of infant death in Queensland, including SUDI.

The paper from this research, scheduled for presentation to the CDRB in early 2021–22, will identify areas for system improvement for the CDRB to consider. They are likely to relate to:

- improving referral pathways for families experiencing multiple risk factors that place infants at risk of SUDI
- incorporating infant safe sleeping assessments and safe sleep advice across all services involved with families
- identifying opportunities for statewide programs that target safer infant sleep practices.

25 Trauma-informed approaches recognise the link between trauma and psychopathology, physical mobility, self-harm and suicide risk and understand how a person's trauma history affects the signs, symptoms and response to interventions of any given diagnosis. They accept that the prognosis for those who have experienced trauma is more guarded, the time required to make therapeutic gains is longer, engagement is more difficult, and the problems are more complex.

26 See www.cdrb.qld.gov.au

Analysis of sudden unexplained deaths of infants from 2014 to 2019

Concurrent with the commissioning of this research, and in response to a CDRB action item, the CDRB Secretariat undertook an analysis of SUDI deaths over a 16-year period from 2004 to 2019. This was based on the information in the Queensland Child Death Register, as reported in the Queensland Family and Child Commission publication, *Counting lives, Changing patterns: Findings from the Queensland Child Death Register 2004–2019*. The focus was to establish the number of these deaths that occurred amongst children from remote areas.

In addition, Queensland Health was consulted to identify what safe sleeping education is provided for families in remote areas.

The analysis found that the proportion occurring in each type of area—metropolitan, regional and remote—is similar for children who are known to Child Safety and those who are not. This suggests that children known to Child Safety who live in remote areas are not necessarily at greater risk of SUDI than other infants.

However, around seven per cent of the total deaths from SUDI occurring during the 16-year period were in remote or very remote areas. Only around 2.6 per cent of Queensland's total population resides in these areas.[27],[28] suggesting SUDI occurs more frequently in these areas than should be expected.

This is supported by findings of a 2013 review from QPQC, which reported four per cent of live births in 2013 were of infants from remote or very remote areas, while nine per cent of the deaths from SUDI occurred in those areas.[29]

A greater proportion of Aboriginal and Torres Strait Islanders live in remote areas of Queensland. Results of the 2016 Census show that 16.6 per cent of Indigenous Queenslanders live in remote areas, compared with only 2.1 per cent of the non-Indigenous population.[30] In line with this finding, the paper found that a greater proportion of sudden unexpected deaths of Indigenous infants occurred in remote areas. While less than three per cent of unexpected deaths of non-Indigenous infants occurred in remote areas, 18 per cent of the sudden unexpected deaths of Aboriginal and Torres Strait Islander infants were from remote or very remote areas.

Safe sleeping practices

Queensland Health provided information on its safe sleep education for this paper. This information stressed that child health professionals, in hospital and community health settings, are the cornerstones in providing expectant and new parents with education about safe sleeping. The expectations regarding safe sleeping education and information provided to parents are consistent across all Queensland Health facilities and service providers, regardless of location or remoteness.

27 As at 30 June 2016.

28 Australian Bureau of Statistics 2018, *Estimated resident Aboriginal and Torres Strait Islander and non-Indigenous population, states and territories, Remoteness Areas – June 2016*, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release

29 Queensland Paediatric Quality Council 2018, *Review of 2013 Queensland post-neonatal infant deaths*, https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/Review-of-2013-Queensland-Post-Neonatal-Infant-Deaths.pdf

30 Australian Bureau of Statistics 2018, *Estimated resident Aboriginal and Torres Strait Islander and non-Indigenous population, states and territories, Remoteness Areas – June 2016*, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release

Chapter 5

Systemic issues and recommendations

This chapter outlines the systemic issues observed by the Child Death Review Board (CDRB) in its reviews of the child protection system's responses to 55 children. It also includes recommendations for addressing many of them.

Focus areas

In addition to the internal agency review reports provided to the CDRB, government agencies and non-government organisations (including non-state schools and family support services) provided information about service delivery to children upon request.

Board members discussed trends and recurring systemic issues that sometimes left vulnerable children in unsafe environments or did not provide the supports they needed. This annual report focuses on the following three systemic issues:

1. Engagement with targeted secondary services.
2. Accuracy and quality of child protection assessments.
3. Availability and accessibility of suicide prevention and postvention supports.

The CDRB made 10 recommendations to address these issues. These were refined through consultation with review agencies, the Queensland Mental Health Commission and the Queensland Family and Child Commission (agencies responsible for leading the implementation of the recommendations). A summary of agency comments on CDRB findings and recommendations are in **Appendix 2**.

They were developed with efficiency in mind, acknowledging reforms already underway to address structural, policy and practice issues across the system[31]. Other operational and systemic issues observed by the CDRB but not subject to discrete recommendations are reported at the end of this chapter (see **Additional findings**).

The CDRB's recommendations call for agencies to take specific actions regarding policies, procedures and practices.

The CDRB encourages agencies to partner with Aboriginal and Torres Strait Islander people and organisations when implementing these recommendations. This is to ensure that changes are culturally safe and address policies or practices that contribute to the overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system and among the deaths.

The CDRB also observed several entrenched systemic issues that impacted on the timeliness and quality of responses to children and families. Internal agency review reports spoke of a system struggling to:

- establish a culturally safe and responsive system able to actively reduce the overrepresentation of Aboriginal and Torres Strait Islander children
- increase the availability of foster and kinship carers, especially Aboriginal and Torres Strait Islander carers
- manage the increasing demand on the system and have achievable workloads for staff including Child Safety cultural practice advisors[32]
- recruit and retain staff and provide them with initial and ongoing training
- know which agencies and services are involved with a family, and share information and deliver coordinated responses that work together well
- streamline—for children, families and professionals—the interface between state and federal systems such as child protection, the National Disability Insurance Scheme and the family law system.

As mentioned earlier, the CDRB is aware that agency- and system-level reforms are already underway to address some of these. It will remain vigilant to these issues over the coming year and continue to monitor their impact on vulnerable children. It will also watch the progress of existing reforms, with a view to identifying any necessary improvements.

31 The child protection system (the system) is defined as the system of services provided by relevant agencies and other entities to children and young people in need of protection or at risk of harm. It extends beyond statutory child protection services to include preventative and support services to strengthen and support families and prevent harm to children and young people. See *Family and Child Commission Act 2014*, sch 1 definition of 'child protection system'.

32 Cultural practice advisors are Aboriginal and Torres Strait Islander Child Safety positions that provide individualised and culturally appropriate casework support to children and families.

Focus area

1 Engagement with targeted secondary services

Child Safety funds non-government family support services, such as Family and Child Connect (FaCC), Intensive Family Support (IFS) and Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS), to offer support to families.

These services were established following the 2013 *Queensland Child Protection Commission of Inquiry* to assist families to access the right services at the right time and reduce the pressure on Child Safety.

Families may self-refer to these services or be referred by Child Safety and other government and non-government agencies (such as the Department of Education, the Queensland Police Service or Queensland Health).

The CDRB is concerned that the model of targeted secondary services may not be meeting its program intent. Of most concern is that the risk of a child needing Child Safety intervention may increase when funded services are not able to successfully engage families (that is, assisting the family to understand the service and consent to support) when they are first referred for support.

Each service has guidelines which include strategies for engaging with referred families.[33] In the January–March 2020 quarter, FaCC services were unable to engage with almost half of the families referred using these strategies (26.5 per cent refused support and 19.2 per cent were non-contactable).[34] This has been an ongoing trend since FaCC's full rollout in early 2017. IFS and FWS have a higher engagement rate, with approximately 60 per cent of families consenting to support, but they have not been able to successfully engage with 40 per cent of families.[35]

Consent rates for these services were most recently investigated by the Queensland Audit Office's 2020 performance audit into the child protection and family support system.[36] It recommended that Child Safety establishes minimum requirements for engaging families and for monitoring outcomes, increasing consent rates and improving the quality of data captured.[37]

The CDRB reached similar conclusions, and believes more should be done to find out what barriers exist from the perspectives of services, communities and families—and address them. Services should then be required and funded to demonstrate active efforts[38] as part of their engagement and intervention practices.

The CDRB considers a review is needed of the efficacy of these services and of how equitable access is to them. This could be informed by evaluations already completed by Child Safety and, more recently, the Queensland Family and Child Commission (QFCC).

Additionally, the CDRB observed some families being repeatedly referred to the same service they have previously (and sometimes recently) not engaged with. This has clearly become routine practice for both the referrers and the services, and more could be done to actively assist families to connect with the services and prevent them from having to be involved with Child Safety.

Under Queensland legislation, certain professionals (known as mandatory reporters) who work for Child Safety, the Department of Education, the Queensland Police Service and Queensland Health are required to report concerns for a child.[39] These agencies also have pathways to refer families to FaCC, IFS and FWS for support if their concerns do not meet the threshold for a report. The CDRB believes these agencies should be informed if a family they refer does not engage. Currently, only Child Safety is informed if a family it referred to secondary services did not engage.

33 Department of Children, Youth Justice and Multicultural Affairs (2020), *Family and Child Connect: Service model and guidelines*, https://www.cyjma.qld.gov.au/resources/dcsyw/about-us/funding-grants/specifications/facc-model-guidelines.pdf; Department of Children, Youth Justice and Multicultural Affairs (2020), *Intensive Family Support: Service model and guidelines*, https://www.cyjma.qld.gov.au/resources/dcsyw/about-us/funding-grants/specifications/ifs-model-guidelines.pdf; Department of Child Safety, Youth and Women (2019), *Aboriginal and Torres Strait Islander Family Wellbeing Services: Program guidelines*, https://familychildconnect.org.au/ARC/Program-Guidelines_ATSI-Family-Wellbeing-2017.pdf

34 Data provided to the Queensland Family and Child Commission (QFCC) by the (then) Department of Child Safety, Youth and Women on 6 July 2020. This was provided for a QFCC system review that was subsequently referred to the Child Death Review Board.

35 Queensland Audit Office (2020), *Family support and child protection system: Report 1 (2020–21)*, https://www.qao.qld.gov.au/reports-resources/reports-parliament/family-support-child-protection-system

36 Queensland Audit Office (2020), *Family support and child protection system: Report 1 (2020–21)*, https://www.qao.qld.gov.au/reports-resources/reports-parliament/family-support-child-protection-system

37 Queensland Audit Office (2020), *Family support and child protection system: Report 1 (2020–21)*, https://www.qao.qld.gov.au/reports-resources/reports-parliament/family-support-child-protection-system

38 Refer to SNAICC (2019), *The Aboriginal and Torres Strait Islander Child Placement Principle: A guide to support implementation*, https://www.snaicc.org.au/wp-content/uploads/2019/06/928_SNAICC-ATSICPP-resource-June2019.pdf

39 Referred to as mandatory reporters, certain professionals must make a report to Child Safety if they form a reasonable suspicion that a child has suffered, is suffering or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse, and may not have a parent able and willing to protect them. Mandatory reporters should also report to Child Safety a reasonable suspicion that a child is in need of protection caused by any other form of abuse or neglect.

Focus area 1
Engagement with targeted secondary services

To support this, these agencies must also decide what other action should occur to assist the family to receive support. They should receive guidance about strategies to help families overcome barriers to accepting support and when a report to Child Safety may be needed if a family is actively avoiding help.

Recommendation 1.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs strengthens its model of funded secondary services. This is to:

1.1 determine whether the model meets the needs of referred children and families by reviewing the:

- efficacy of services in terms of improving outcomes for children and families and diverting them away from needing Child Safety intervention
- equity of access for the families who are intended to benefit from these services.

To do this, the perspectives of children, families and communities should be gathered and used to inform findings. For example, in implementing recommendations 1 and 2 of the Queensland Audit Office's report,[40] this can be done by speaking with communities and Aboriginal and Torres Strait Islander peoples to identify barriers and enablers to equitable access and active efforts (such as cultural safety and practical supports) to help families to participate.

Findings from the agency's evaluations of these services and the Queensland Family and Child Commission's evaluations of the reform program could also inform this work.

The CDRB also recommends the Department of Children, Youth Justice and Multicultural Affairs:

1.2 develops and implements best practice and culturally responsive strategies to improve outcomes for children and families

1.3 supports and strengthens referral and reporting pathways for professional and mandatory notifiers by:

- developing guidance for relevant agencies and services about responding to concerns for a child if a referred family is not successfully engaged by these services
- requiring a referrer from a mandatory reporting agency to be advised by these services of case closure because of a family's non-engagement.

40 Recommendations 1 and 2 require the establishment of minimum contact requirements and collaboration with family support services to monitor outcomes, increase consent rates and capture data.

Focus area

2 Accuracy and quality of child protection assessments

Child Safety has responsibility under the *Child Protection Act 1999* to respond to information received that a child may be in need of protection or an unborn child may be in need of protection after they are born. The purpose of intake is to receive, assess and record child protection concerns from a notifier and decide how to respond. It is the first point at which a decision is made about whether a child may be in need of protection.

Reviewing child protection history at intake

A Child Safety intake officer is responsible for reviewing a family's child protection history (information recorded about the child's or family's previous contact with Child Safety) and collecting relevant information for their assessment of child protection concerns (either a child concern report[41] or a notification[42]).

Sometimes, a decision can be reached quickly, for example, if the concerns are so serious further information is not needed, or if the concerns are very low level and easily resolved. Other times, the correct course of action may not be so obvious, and Child Safety will need to carefully review the child protection history to consider whether intervention is warranted. If histories are not reviewed accurately, children could continue to live in unsafe home environments, or a notification could be recorded when intervention is not warranted or cultural factors have not been properly considered.

Analysing child protection histories is an important step in helping practitioners understand the extent, nature and outcomes of previous involvement with a family. It also assists in identifying cumulative harm,[43] patterns of behaviours, ongoing or escalating concerns and the presence of risk factors. Doing this can be challenging, and the time it takes depends on how much information is recorded on the system.

The decision is also time-sensitive. Within 48 hours of concerns being received, officers must gather and consider a range of information including child protection, domestic and family violence and criminal histories, professional expertise and cultural advice. They then need to consult and apply decision tools and assess whether a notification will be recorded.[44] Complicating this is the fact that practitioners respond to several intakes at the same time.

The CDRB observed that continuing workload pressures result in shortcuts being adopted during intake decisions. It believes these shortcuts to be most prominent in the process of reviewing child protection history. In several matters it reviewed, errors were made, obvious patterns of harm were missed, and incorrect recordings were made about the family's history, which persisted over multiple records for the family.

The CDRB considers this process needs to be revisited to make sure information about a family's child protection history is properly reviewed, analysed and considered when decisions are being made, and that staff have the necessary time and support to do this well.

Recommendation 2.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs improves its ability to undertake effective child protection history reviews at intake to support decisions about whether a child is suspected to be in need of protection.

This must include strengthened intake processes to make sure staff are able to give proper consideration to:

- complex or lengthy child protection histories (information about a family recorded on the data system)
- indicators of cumulative harm (refer Recommendation 3), particularly when frequent child concern reports are recorded[45]
- patterns of parental behaviour (acts or omissions—refer Recommendations 3 and 4)
- cultural factors.

To support this, Child Safety's *Workload Management Manual* should include guidance on reasonable workloads for intake.

41 A child concern report is an intake decision recorded when concerns are received by the department that do not meet the threshold for a notification.

42 A notification is an intake decision recorded when there is a reasonable suspicion that a child is in need of protection—a child has been significantly harmed, is being significantly harmed, or is at risk of significant harm, and does not have a parent able and willing to protect them.

43 'Cumulative harm' is a term used to describe the cumulative impact on a child from abuse and neglect over time. However only physical, emotional and psychological harm are recognised as official harm types. This means any cumulative impact on a child from ongoing emotional, physical or sexual abuse or neglect would be recorded as substantiated physical, emotional and/or psychological harm.

44 Department of Child Safety Youth and Women (2020), *Child Safety Practice Manual: Assess the information and decide the response*, https://cspm.csyw.qld.gov.au/procedures/receive-and-respond-at-intake-1/assess-the-information-and-decide-the-response

45 Child Safety is already developing options for responding to multiple child concern reports recorded about a family in order to better recognise cumulative harm.

Focus area 2
Accuracy and quality of child protection assessments

Identifying and assessing cumulative harm

The cumulative impact of multiple adverse experiences over the course of a child's life often goes unrecognised, or is not given enough importance, when assessing whether a child is in need of protection. This results in children who are at risk of harm repeatedly coming to the attention of the child protection system, without any ongoing intervention to address the underlying concerns.

Cumulative harm can lead to children experiencing complex trauma, the effects of which can include disruptions to brain development and associated emotional and behavioural issues.[46, 47]

Identifying cumulative harm can be challenging, as it is not always immediately obvious. Child protection policies, which ordinarily require quick responses to physical and sexual abuse (such as mandatory reporting requirements) may unintentionally result in a lower priority being given to cumulative harm (for example from neglect or emotional abuse) because it is not as visible.[48]

Some of the issues causing cumulative harm to be missed are:

- considering reports as discrete pieces of information rather than as parts of the whole picture
- making assumptions that previous concerns that have been raised have been resolved
- failing to scrutinise (because of resourcing and practice issues) the child protection history to identify harmful patterns of behaviour.

The CDRB is concerned that in almost a quarter of the children's cases it reviewed, cumulative harm was not recognised when it should have been or was not responded to appropriately. This finding is similar to those made in other inquiries which have recognised the impact of high-pressure environments and demand on workloads and quality of assessments.[49]

The CDRB acknowledges that Child Safety is developing a new information technology platform. It believes this will make child protection information more accessible to officers and alleviate some of the challenges associated with identifying cumulative harm. While technology plays an important role, it does not replace the need for staff to have the knowledge, skills and tools to recognise and respond to cumulative harm.

Recommendation 3.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs develops additional guidance for assessing cumulative harm.

This is intended to:

- assist staff to decide whether a notification should be recorded on the basis of cumulative harm
- make sure screening and response priority decision-making tools adequately reference indicators of cumulative harm
- be used in developing information technology platforms.

This work should take into account the reviews by Child Safety and interstate jurisdictions on decision tools and cumulative harm. Any updates to decision tools must take into account intergenerational trauma for Aboriginal and Torres Strait Islander families as a result of past policies and the legacy of colonisation.

46 Goldsmith SK, Pellmar TC, Kleinmann AM & Bunney W (2002), *Reducing suicide: A national imperative*, Institute of Medicine National Academies Press; Washington.

47 O'Connor D (2018, January 9), 'How we discovered the link between childhood trauma, a faulty stress response and suicide risk in later life', *The Conversation*, https://theconversation.com/how-we-discovered-the-link-between-childhood-trauma-a-faulty-stress-response-and-suicide-risk-in-later-life-88838

48 Scott D (2014), *Understanding child neglect* (CFCA Paper No. 20 2014), Victoria, Australia: Australian Institute of Family Studies.

49 Queensland Audit Office (2020), *Family support and child protection system: Report 1 (2020–21)*, https://www.qao.qld.gov.au/reports-resources/reports-parliament/family-support-child-protection-system

Focus area 2
Accuracy and quality of child protection assessments

Assessing a parent as able and willing

Child Safety's decision making, once harm or risk of harm to a child has been established, centres on an assessment of whether the child has a parent (defined broadly as a person acting as a parent for the child) who is able and willing to protect them from harm.

The term 'able and willing' appears multiple times in the *Child Protection Act 1999* but is not defined. The assessment is made at various decision points throughout the child protection continuum:

- at intake, when deciding whether to record concerns about harm to a child as a notification (there must be reasonable suspicion that the child is in need of protection to record a notification)
- at the investigation and assessment stage, where harm is investigated, and an assessment is made about whether the child is in need of protection
- during ongoing interventions, to determine whether a child's case should remain open or close, or whether a child can remain safely at home to open an intervention with parental agreement.[50]

CDRB members frequently questioned how a parent could have been considered able and willing to protect a child from harm, given the description of their behaviours and circumstances. This included cases involving ongoing domestic and family violence, chronic crystal methamphetamine (ice) use, untreated severe and persistent mental illness, active avoidance of a secondary service, or other circumstances that indicated their unwillingness or inability to protect their child from harm.

The CDRB is concerned misunderstandings and subjective decision making are leading to a misapplication of the legislative tests around the term 'able and willing' across decision points. Staff require further support to make better informed and objective decisions.

Recommendation 4.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs builds the capability of child safety officers on assessing whether a parent is 'able and willing', as it applies to making decisions about whether a parent can keep their child safe. This is to:

- build understanding about cultural differences in parenting, family structures and child-rearing practices
- promote consistency in its application across decision points at intake, during investigation and assessment, and for interventions with parental agreement
- address how to identify and respond to patterns of concerning parental behaviour (acts or omissions—that is, continuing to act in a way that harms a child, or not taking reasonable action to protect a child)
- address ongoing practice issues with failing to apply perpetrator pattern-centred domestic and family violence practice[51] (including by misidentifying victims of violence as failing to protect their child)
- (separately to parents who actively avoid or disengage from services) strengthen assessments of, and responses to, parents who do not engage with services due to:
  - limited supply of, and timely access to, supports and services in regional and remote areas
  - (for Aboriginal and/or Torres Strait Islander families) a lack of cultural safety within services or lack of active efforts taken by services to help families overcome barriers to their participation
- recognise the importance of children's views about the safety of their home environment and their parents' willingness and ability to meet their needs.

The findings of the CDRB and the Queensland Family and Child Commission's systemic review of intervention with parental agreements may be used to develop this training.

50 An intervention with parental agreement refers to a Child Safety intervention in which the child's parents agree to work cooperatively with Child Safety to keep the child safe, and are able and willing to work actively to reduce the level of risk in the home. This type of intervention does not require a court order.

51 The mapping, recording and understanding of patterns of domestic and family violence perpetrator behaviour to manage risk, plan for safety and deliver casework.

Focus area 2
Accuracy and quality of child protection assessments

Seeking advice from health professionals and recognising its importance

Some children and families experience specific health or mental health concerns and would benefit from expert advice from health professionals—in particular children with disability and children of parents with severe and persistent mental illness.

The *Child Protection Act 1999* and Child Safety's *Information Sharing Guidelines*[52] enable agencies (and other entities) to share information—including facts or professional opinions—to identify and assess concerns and to coordinate responses to children at risk of harm or subject to Child Safety interventions. While the complexity of the child protection system means there will always be some gaps in information sharing and service coordination between agencies, the CDRB observed gaps to be most prominent between Child Safety and Queensland Health.

In 2017, Child Safety established several specialist Child Safety positions in major hospitals to strengthen information sharing and enable rapid responses when doctors have concerns about a child's safety. This followed a review into the death of 22-month-old Mason Jet Lee, which found information and concerns from treating doctors about the child's injuries required further consideration by Child Safety.[53, 54]

Known as Child Safety Officers (Health Liaison), these positions act as a conduit between Queensland Health and Child Safety Service Centres and are responsible for:

- improving cross-agency knowledge of relevant policies and procedures
- supporting information-sharing processes between Child Safety and Queensland Health
- attending multidisciplinary case discussions to assist with the coordination of support services
- building relationships with health staff, including Queensland Health's Child Protection Liaison Officers, who are the primary health and hospital contacts for child protection matters and conduits for liaising with other health professionals in the district.[55]

Despite the existence of these positions, the CDRB reviewed several cases in which Child Safety did not seek, or give adequate weight to, advice from health experts relevant to the concerns being assessed and intervention being delivered. It considers that these agencies should work together to identify the structural and relational barriers and enablers in order to improve decisions about the protection and care needs of children and the coordination of services delivered to them.

Recommendation 5.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs and Queensland Health address the ongoing barriers and enablers to seeking, weighting and engaging expert advice from health professionals (including Aboriginal and Torres Strait Islander community-controlled health services).

This is to include:

- mapping the structural and relational barriers and enablers. This will be informed by discussions with frontline workers and findings from the CDRB, Queensland Health and Child Safety internal agency review reports and other sources of external review
- developing actions to address the findings and act on opportunities to improve inter-agency coordination more broadly
- increasing the capacity of the Child Safety Officer (Health Liaison) positions to:
  - facilitate access to expertise from health professionals about the health needs of children and the impact of parental mental illness on a child's safety
  - work with Child Safety regional intake services[56] to educate staff on health systems and to facilitate local relationships with hospital and health services and Aboriginal and Torres Strait Islander community-controlled health services
  - support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.

52 Department of Child Safety, Youth and Women (2018), *Information sharing guidelines: To meet the protection and care needs and promote the wellbeing of children*, https://www.cyjma.qld.gov.au/resources/dcsyw/child-family/child-family-reform/information-sharing-guideline.pdf

53 Department of Communities, Child Safety and Disability Services (2016), *Detailed Systems and Practice Review Report*, https://www.parliament.qld.gov.au/documents/TableOffice/TabledPapers/2020/5620T848.pdf

54 Department of Children, Youth Justice and Multicultural Affairs (2021), Queensland Government response to the death of Mason Jet Lee, https://www.cyjma.qld.gov.au/about-us/reviews-inquiries/queensland-government-response-death-mason-jet-lee

55 Information provided to the Queensland Family and Child Commission (QFCC) by the (then) Department of Child Safety, Youth and Women on 24 March 2020. This information was provided for a QFCC system review that was subsequently referred to the Child Death Review Board.

56 Regional intake services receive information and reports of child protection concerns from community members, government and non-government agencies. The services review, gather and analyse information, speak with experts and apply decision-making tools to determine whether or not a child is suspected to be in need of protection .

Focus area

3 Availability and accessibility of suicide prevention and postvention supports

Data from the Queensland Child Death Register between 2004 and 2019 shows that youth suicide in Queensland has increased by an average of 2.6 per cent per year over this 16-year period.[57]

The Queensland Family and Child Commission's *Annual Report: Deaths of children and young people, Queensland, 2019–20* reports:

> Youth suicide remains an area of deep concern. Analysis indicates a slow increasing trend in suicide over time. Adverse life experiences in childhood can contribute to increased vulnerability to poor mental health, and multiple family stressors including family violence were commonly present for young people who have taken their own lives.[58]

The CDRB is concerned about the disproportionate representation of Aboriginal and Torres Strait Islander children in suicide deaths. These children accounted for about eight per cent of the Queensland child population but 32 per cent of all suicides by children in Queensland between 2015 and 2019[59] and for half of the suicide deaths considered by the CDRB.

The CDRB is also concerned that the circumstances of suicide appear to be changing. It observed children committing suicide at a younger age (four of the six children who died by suicide were aged between 10 and 14 years) and girls using more lethal means (all four girls died from hanging).

Suicide prevention responses

The report prepared by Professor Brett McDermott (see **Chapter 4**) on behalf of the CDRB highlighted several findings for further consideration, including the need for better coordination between agencies working with vulnerable children and young people. The research findings need to be reviewed by a cross-agency group with authority to develop and implement actions to address them. Specific research[60] on suicide prevention for Aboriginal and Torres Strait Islander children should also be considered when developing actions.

The Queensland Mental Health Commission's *Shifting minds* Strategic Leadership Group (SLG) is a senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland. The CDRB considers it to be the appropriate body to develop and drive the changes needed, acknowledging the Queensland Suicide Prevention Network (once formed) can assist with this work.

At present, Child Safety and Youth Justice policies and procedures for assessing and responding to suicide risk require staff to raise a suicide risk alert and develop suicide risk management plans with children and their families. Staff are often required to assess suicide risk without the benefit of specialist expertise and cultural advice, and agency guidelines do not always cover the range of circumstances that can increase suicide risk.

CDRB members identified that suicide risk alert processes are not always followed by agencies, and the response is not always as effective and culturally responsive as it could be. Youth Justice data also indicates a high proportion of children requiring longer-term management of suicide risk do not have a plan in place. The CDRB acknowledges that Youth Justice has already begun investigating this issue.

In addition, the CDRB noted that young people report they do not know how to access mental health services or believe they cannot access them without parental consent. The QFCC and the Queensland Mental Health Commission both play a role in educating the community. If they work together to develop and deliver youth-friendly messaging, they will help to clarify the availability and accessibility of mental health services for young people, including their right to consent to their own treatment without the need for parental consent.

57 Queensland Family and Child Commission (2020), *Counting Lives, Changing Patterns: Findings from the Queensland Child Death Register 2004–2019*, https://www.qfcc.qld.gov.au/sites/default/files/2021-05/QFCC%2016%20Year%20Review%20-Web%20Version.pdf

58 Queensland Family and Child Commission (2020), *Annual Report: Deaths of children and young people, Queensland, 2019–20*, p. 5, https://www.qfcc.qld.gov.au/sites/default/files/2021-03/2019-20%20CD%20Annual%20Report%20FINAL.PDF

59 Queensland Family and Child Commission (2020), *Counting Lives, Changing Patterns: Findings from the Queensland Child Death Register 2004–2019*, https://www.qfcc.qld.gov.au/sites/default/files/2021-05/QFCC%2016%20Year%20Review%20-Web%20Version.pdf

60 See, for example, the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.

Focus area 3
Availability and accessibility of suicide prevention and postvention supports

Recommendation 6.

The CDRB recommends: the Queensland Mental Health Commission's *Shifting minds* Strategic Leadership Group (SLG), as the senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland, develops a targeted response to youth suicide.

This group, with the support of the Queensland Suicide Prevention Network (once formed), should consider the findings of the research commissioned by the CDRB into suicide prevention and effective child protection and mental health systems, specifically to:

- establish a shared professional development program on the acute and long-term effects of adverse childhood experiences
- provide Queensland data that can be rapidly given to agencies
- map pathways to services to identify structural barriers to delivering an accessible, comprehensive and integrated continuum of care
- identify the need for new investment to expand services for infants and pre-school children with mental health presentations (and their carers)
- promote service models designed by Aboriginal and Torres Strait Islander communities to effectively engage Aboriginal and Torres Strait Islander children and their families
- investigate multisystemic therapy (MST) for consumers who currently do not have their needs met by child and adolescent mental health services or Evolve Therapeutic services
- undertake routine reviews of policies and procedures of agencies providing services to children to make sure they promote inter-sectoral collaboration and consistency in responses.

Recommendation 7.

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs:

7.1 immediately examines why almost 60 per cent of young people under community supervision by Youth Justice considered eligible for a medium- to long-term suicide risk management plan have not had one developed

7.2 reviews its suicide risk management policies and procedures to:

- address barriers to developing and implementing medium- to long-term culturally responsive suicide risk management plans (examining the results from 7.1)
- establish mechanisms similar to the Suicide Risk Assessment Team approach used in youth detention centres to assist Child Safety and Youth Justice community supervision staff to better identify and respond to suicide risk. This is intended to provide staff with expert, multidisciplinary support when responding to a young person at risk of suicide
- ensure the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide, and that culturally responsive supports are provided to children who experience the suicide of a person known to them.

Recommendation 8.

The CDRB recommends: the Queensland Mental Health Commission and the Queensland Family and Child Commission develop and deliver youth-friendly messages to raise awareness about mental health services for children and young people, and about their right and ability to consent to and access these.

Focus area 3
Availability and accessibility of suicide prevention and postvention supports

Suicide postvention responses

Supporting a child or young person after the suicide of someone known to them (a postvention response) is critical in allowing them to process the death. It can also help to reduce the risk of suicide contagion. This is the process by which exposure to suicides increases the likelihood of other suicides in the community and it is thought to contribute to up to 60 per cent of youth suicides.[61] This is particularly relevant for Aboriginal and Torres Strait Islander young people, where imitation, normalisation and glamorisation of suicidal behaviours plays a big role.[62]

The QFCC currently notifies the Department of Education when a child dies by suicide so it can notify the school where the child was enrolled. This triggers the delivery of school-based postvention supports to the child's peer groups. This process should be extended to non-state schools. Education-based postvention responses should also be checked to make sure they are culturally responsive and based on expert advice.

Recommendation 9.

The CDRB recommends: the Department of Education undertakes an audit of a sample of schools to make sure:

- suicide postvention plans are up to date and comply with departmental policy, part of which is having an Emergency Response Team that includes a representative from the local mental health service
- plans are tailored to meet the specific cultural needs of the individual school community
- the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide and culturally responsive supports are provided to children who experience the suicide of a person known to them.

Recommendation 10.

The CDRB recommends: the Queensland Family and Child Commission extends its suicide notification process about children enrolled (or previously enrolled) in state schools to also include children enrolled in Catholic or independent schools. This will require consultation with, and the support of, the non-state schooling sector.

For children not enrolled in either a state or non-state school, opportunities to notify the agency most closely linked with the family should also be explored as part of this work.

61 Baldwin G, Helen B, Hannaway M and headspace School Support (2017), *Delivering effective suicide postvention in Australian school communities*, Victoria, Australia: headspace National Youth Mental Health Foundation.

62 Dudgeon P, Calma T, Milroy, J, McPhee R, Darwin L, Von Helle S and Holland C (2018), *Indigenous governance for suicide prevention in Aboriginal and Torres Strait Islander communities—A guide for primary health networks*, https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/designed-final-cultural-framework-guide-v4.pdf

Additional findings

While the CDRB did not make a discrete recommendation about every single issue it observed, it regularly shared its findings with relevant agencies and asked for action to be taken in response. This included opportunities to:

- strengthen oversight mechanisms for children subject to forensic orders (disability).[63] At the request of the CDRB, Queensland Health also undertook an audit of children subject to these orders to make sure they were safe, had supports in place, and were connected to family, community and culture
- align the legislative principles in the *Mental Health Act 2016* (Qld) with the Aboriginal and Torres Strait Islander Child Placement Principle[64] to uphold the rights of Aboriginal and Torres Strait Islander children when decisions are being made that impact on their connection to family, community and culture
- improve safeguards for children subject to interventions with parental agreement
- promote awareness of the strain placed on the whole child protection system when there are limited numbers of carers for children living in out-of-home care
- provide clarity around responsibilities for pool safety and other mandatory household safety issues for children living in out-of-home care
- provide appropriate responses to children of children living in out-of-home care, by improving data collection and developing practice guidance
- monitor the prevalence and impact of volatile substance misuse in remote communities to improve system approaches to deterring children
- meet the health needs of children subject to Child Safety intervention through follow up on outstanding medical tests, treatments and vaccinations to reduce the likelihood of preventable deaths
- improve system responses to filicide (the killing of a child by a parent) risk factors, in collaboration with partner agencies.

Monitoring recommendations

One of the functions of the CDRB is to monitor the implementation of the recommendations it has made in the previous year/s.[65] This includes identifying if the government accepted recommendations and nominated timeframes to finish addressing them, and the status of implementation efforts.

The CDRB will select certain recommendations to monitor in more detail. The monitoring may include:

- speaking with children, families, communities and frontline professionals about the changes they see
- establishing reporting requirements and collecting operational data
- reviewing the implementation and monitoring practices of agencies to check changes were:
  - planned well
  - informed by the perspectives of stakeholders
  - co-designed with Aboriginal and Torres Strait Islander peoples
  - evaluated.

As this is the inaugural year of operation, there are no recommendations to monitor at this time. The CDRB will begin reporting against its monitoring function in its 2021–22 annual report.

63 Forensic orders are mainly made by the Mental Health Court for people who are charged with a serious offence and are found to have been of unsound mind at the time of an alleged offence or are unfit for trial: Queensland Health (n.d.), *Forensic Orders – Mental Health Act 2016 Fact Sheet*, https://www.health.qld.gov.au/__data/assets/pdf_file/0035/635498/forensic-order-fs.pdf

64 The Child Placement Principle aims to keep Aboriginal and Torres Strait Islander children connected to their families, communities, culture and country and to ensure the participation of Aboriginal and Torres Strait Islander peoples in decisions about their children's care and protection.

65 *Family and Child Commission Act 2014*, s. 29D(e).

Chapter 6

Strategic priorities in 2021–22

This chapter outlines the strategic priorities of the Child Death Review Board (CDRB) for 2021–22. This will be the first year in which it will receive a full year of reports from review agencies, which will help it to consider the service delivery, procedures and practices of all relevant agencies and will lead to the introduction of additional priority areas in 2021–22.

System issues for ongoing focus

The CDRB will keep watch over several system issues that emerged in 2020–21. Some of these are likely to be selected for more in-depth analysis, and others will stay on the 'keep watch' list. These issues include the following:

- **Staff recruitment, retention and experience:** The CDRB will explore the prevalence of oversights reported by agencies to be a direct result of the strain on statutory services and lack of resources. This may include child protection, criminal justice and health services designed to protect and provide support to children at risk of harm.
- **Culturally safe and responsive practices:** When considering the deaths of Aboriginal and Torres Strait Islander children, the CDRB will focus on practices and procedures that contribute to the involvement of these cohorts in the child protection system and their overrepresentation in child deaths. This will include consideration of how the Aboriginal and Torres Strait Islander Child Placement Principle is implemented. The CDRB will also consider culturally safe and responsive practices when reviewing the deaths of children from culturally and linguistically diverse backgrounds.
- **Breaking the cycle:** The CDRB will focus on the role that intervention in infancy or early childhood could have played in the lives of children, regardless of the age at which they died. This may include exploring the supports provided to young parents, particularly those in, or who have just left, out-of-home care.
- **School attendance and disengagement:** Issues for exploration include children who disengage early from school and their trajectory into the youth justice system, children with poor school attendance rates, children who do not transition to secondary school after leaving primary school, children in residential facilities, and the effectiveness of Youth Engagement Hubs.[66]
- **Safer infant sleeping:** Issues for exploration include the overrepresentation in sudden unexpected deaths in infancy (SUDI) incidences of children known to Child Safety, using information obtained from SUDI and infant care practice research to inform policy, guidelines, education, professional practice and parent advice, and the messaging around safer infant sleeping for vulnerable families.
- **Investigation and assessment policy:** The revised investigation and commencement strategy (implemented September 2019) may be explored further in relation to unintended consequences of the changes.
- **Domestic and family violence:** Issues for further exploration may include how risk is assessed in households in which children reside and domestic and family violence occurs. The CDRB will consult with the Domestic and Family Violence Death Review and Advisory Board on this issue.
- **Data monitoring:** The CDRB will continue to monitor data on:
  - the frequency of persons alleged to be responsible for sexual offences being in close proximity to a child
  - Family Court involvement in cases
  - methamphetamine use.

Evaluation of child death review board implementation and processes

In early 2022, the Secretariat (on behalf of the CDRB) will undertake an implementation and process evaluation. This is to determine if the CDRB has been fully implemented as intended by the legislation and to explore how well the processes supporting the new model of child death review are functioning.

The evaluation will identify what is working well, as well as areas for improvement. CDRB members and review agencies will be consulted as part of the process.

Appendices

Appendix

1 Glossary of terms and acronyms

Term or acronym	Meaning
Agencies and organisations	
Board members/ members	Members of the Child Death Review Board
CDRB	Child Death Review Board
DCYJMA/Child Safety	Department of Children, Youth Justice and Multicultural Affairs
DoE	Department of Education
ODCPL	Office of the Director of Child Protection Litigation. The ODCPL supports the functions of the Director of Child Protection Litigation (DCPL) including by conducting the child death and serious physical injury reviews.
QAO	Queensland Audit Office
QFCC	Queensland Family and Child Commission
QH	Queensland Health
QMHC	Queensland Mental Health Commission
QPQC	Queensland Paediatric Quality Council
QPS	Queensland Police Service
Review agencies	These are the agencies required to undertake reviews following the death or serious physical injury of a child as defined in section 245B – see *relevant agency* – of the *Child Protection Act 1999*. These are: the Department of Education (DoE), the Department of Children, Youth Justice and Multicultural Affairs (Child Safety), the Department of Children, Youth Justice and Multicultural Affairs (Youth Justice), Queensland Health (hospital and health services) and the Queensland Police Service. The term review agencies also includes the Director of Child Protection Litigation defined in section 245J of the *Child Protection Act 1999* (noting its review scope is different to that of the other review agencies).
Youth Justice	Previously the Department of Youth Justice—now part of the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA. For clarity, Youth Justice is sometimes included in parenthesis after the Department of Children, Youth Justice and Multicultural Affairs.

Appendix 1
Glossary of terms and acronyms

Term or acronym	Meaning
Child protection terms See https://www.csyw.qld.gov.au/childsafety/child-safety-practice-manual/quicklinks/glossary-terms	
Child concern report (CCR)	A child concern report is a record of child protection concerns received by Child Safety that does not meet the threshold for a notification.
Child in need of protection	This is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering from harm, and does not have a parent able and willing to protect the child from the harm (*Child Protection Act 1999*, section 10).
Aboriginal and Torres Strait Islander Child Placement Principle	The Aboriginal and Torres Strait Islander Child Placement Principle aims to keep children connected to their families, communities, culture and country and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children's care and protection. The Principle centres on five elements: prevention, partnership, participation, placement and connection.
Child safety officer (CSO)	A child safety officer is authorised, under the *Child Protection Act 1999*, to: • deliver statutory child protection services, such as investigating and assessing allegations of suspected child abuse and neglect • intervene to ensure the safety and wellbeing of children subject to ongoing intervention, in accordance with legislation, policies and procedures.
Cumulative harm	This refers to harm to a child caused by a series or combination of acts, omissions or circumstances that may have a cumulative effect on the child's safety and wellbeing. The acts, omissions or circumstances may apply at a particular point in time or over an extended period, or the same acts, omissions or circumstance may be repeated over time.
Domestic and family violence	Domestic and family violence is behaviour by a person towards another person with whom the person is in a relevant relationship. It includes behaviour that is: physically or sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the other person and causes them to fear for their safety or wellbeing or that of someone else.
Family and Child Connect (FaCC) service	Family and Child Connect is an easily accessible referral point for agencies working with families who may need support. Families can also contact FaCC services directly for advice and help. A principal child protection practitioner is based at each FaCC service to identify and respond to serious concerns that may need Child Safety intervention. A specialist domestic and family violence practitioner also works with each FaCC service to advise on and assist with domestic and family violence matters.
Family Wellbeing Service (FWS)	The Aboriginal and Torres Strait Islander Family Wellbeing Service is a program co-designed with the community-controlled sector and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak. Family Wellbeing Services are designed to make it easier for Aboriginal and Torres Strait Islander families across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and to build their capacity to safely care for and protect their children.
Harm	In this context, harm refers to any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation. Harm can be caused by a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances (*Child Protection Act 1999*, section 9).

Appendix 1
Glossary of terms and acronyms

Term or acronym	Meaning
Child protection terms *(continued)*	
Intake	Intake is the first phase of the child protection continuum and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child or unborn child, or when a request for departmental assistance is made.
Intake enquiry	An intake enquiry may be a request for information or relate to child wellbeing issues or child protection concerns. It is one type of departmental response to information received at the intake phase.
Intensive Family Support (IFS) programs	Intensive Family Support programs provide case management to families at risk of entering the statutory child protection system.
Intervention with parental agreement (IPA)	This refers to ongoing intervention with a child who is considered in need of protection, based on the agreement of the child's parent/s to work with the department to meet the child's safety and protection needs.
Investigation and assessment	Investigation and assessment is the second phase of the child protection continuum. An investigation and assessment is the departmental response to all notifications, and is the process of assessing the child's need for protection where there are allegations of harm or risk of harm to a child (*Child Protection Act 1999*, section 14).
Non-government organisation	In this context, this refers to a not-for-profit organisation that receives government funding specifically for the purpose of providing community support services.
Notification	A notification is recorded when information is received about a child who may be harmed or at risk of harm that requires an investigation and assessment response. A notification is also recorded on an unborn child if there is reasonable suspicion that they will be at risk of harm after they are born.
Out-of-home care	This refers to placements of children, subject to statutory child protection intervention, using the authority of the *Child Protection Act 1999*, section 82(1). Out-of-home care includes placements with a licensed care service, an approved or kinship carer, or another entity.
Parent able and willing	This refers to a parent who has both the ability and willingness to protect their child from harm (*Child Protection Act 1999*, section 10). A parent may be willing to protect a child, but not have the means or capacity to do so. For example, a parent with a diagnosed mental illness may express a willingness to protect their child; however, due to factors related to the mental illness, may not be able to do so. Alternatively, a parent may have the means and capacity to protect a child but may not do so. A child safety officer must clearly assess the parent's motivation and ability to protect the child. In circumstances where a child resides across two households, the ability and willingness of both parents to protect the child needs to be assessed.
Placement	This refers to when a child is placed in an out-of-home care living arrangement due to intervention by the department.
Regional intake service	This is the contact point for reporting concerns about a child. There are seven regional intake service locations across Queensland. They receive incoming calls and reports, assess the information and decide how to respond.

Appendix 1
Glossary of terms and acronyms

Term or acronym	Meaning
Other	
Adverse childhood experience (ACE)	Adverse childhood experiences can include abuse, neglect and household dysfunction. 'Adverse childhood experience' is generally seen as a mental health term, where the more a child experiences, the greater the likelihood of negative impacts on the child's physical and mental health. These include negative impacts on gene function and brain structure.
Child Death Register	The Queensland Child Death Register records the deaths of all children and young people who die in Queensland. It is maintained by the QFCC.
Post-traumatic stress disorder (PTSD)	Post-traumatic stress disorder is a treatable anxiety disorder that occurs when fear, anxiety and memories of a traumatic event remain and interfere with how people cope with everyday life.
Sudden unexpected death in infancy (SUDI)	Sudden unexpected death in infancy is a category of death where an infant dies suddenly, usually during sleep, and with no immediately obvious cause.

Appendix

2 Agency comments on findings and recommendations

In accordance with section 29L of the *Family and Child Commission Act 2014*, the Chair of the Child Death Review Board (CDRB) wrote to the chief executives of lead agencies on 6 September 2021 providing a copy of Chapter 5 and requesting feedback on the proposed recommendations. Following is a summary of their responses.

Recommendation 1.

Engagement with targeted secondary services

Lead agency: Department of Children, Youth Justice and Multicultural Affairs (DCYJMA)

Summary of responses

The DCYJMA requested changes to this recommendation. It requested that the requirement to review the efficacy of services and equity of access to them be removed, and some of the measures to strengthen reporting and referral pathways also be removed.

Other agencies likely to be affected by this recommendation, that is, Queensland Health (QH), the Department of Education (DoE) and the Queensland Police Service (QPS) indicated support for the measures to strengthen reporting and referral pathways.

CDRB position

Some of the changes requested by the DCYJMA were made. However, the intent of the recommendation—to review the efficacy and equity of access—was retained. The need for a service to advise a professional when a family they referred was not successfully engaged was also retained.

Relevant agency work in this area

DCYJMA is already progressing work relevant to this recommendation. Over the next two years DCYJMA will focus on priority reforms to deliver improved outcomes, informed by the Queensland Audit Office's (QAO) report and the Queensland Family and Child Commission's (QFCC) evaluations of the reform program.

DCYJMA also advised that its Intake Reform Project includes strategies to increase the number of intake referrals for Aboriginal and Torres Strait Islander families to Family Wellbeing Services (FWS). It is also reviewing referral criteria to a number of services so that families are appropriately referred to either early intervention services or more targeted intervention.

DCYJMA is working with Intensive Family Support and FWS providers on various strategies, including an outcome focused approach to contracting.

DCYJMA also reported it is working to identify opportunities to support enhanced referral and reporting pathways for all professional and mandatory reporters.

Recommendation 2.

Reviewing child protection history at intake

Lead agency: DCYJMA

Summary of responses

DCYJMA requested minor amendments.

CDRB position

Edits were made as requested.

Relevant agency work in this area

DCYJMA advised that a key component of improving the accuracy and quality of child protection assessments is improved presentation of information to assist intake staff to undertake reviews. It said that the findings from the Intake Reform Project will be used to inform the design of its new database, with an emphasis on improved presentation of child protection history. It will also look to make child protection histories display more interactively to help officers identify patterns of cumulative harm, abuse and neglect.

DCYJMA advised that functionality in its new database will have an improved focus on considering cultural factors, prompting and recording active efforts for the five elements of the Aboriginal and Torres Strait Islander child placement principle.

Appendix 2
Agency comments on findings and recommendations

Recommendation 3.

Identifying and assessing cumulative harm

Lead agency: DCYJMA

Summary of responses

DCYJMA did not request any edits to this recommendation.

Relevant agency work in this area

DCYJMA advised that it is progressing activities which will strengthen the assessment of cumulative harm, including by developing a paper to provide options for improving intake responses and reviewing the Structured Decision Making suite of tools.

A trial is also planned to respond to multiple intakes recorded about a child, with attention on the impact of surveillance bias for Aboriginal and Torres Strait Islander families.

Recommendation 4.

Assessing a parent as able and willing

Lead agency: DCYJMA

Summary of responses

The DCYJMA requested changes to this recommendation. It requested that the need to develop and deliver training about 'able and willing' be removed. It requested this be replaced with the need to 'explore ways to build the capability' of child safety officers.

CDRB position

The reference to training was replaced with the need to build the capability of staff in this area. 'Exploring ways to build capability' was not considered strong enough to deliver the intent of the recommendation.

Relevant agency work in this area

DCYJMA advised that the Office of the Chief Practitioner has commenced a review of mandatory child safety officer training and will examine methods to build practitioner capability, understanding and application of 'able and willing'.

Recommendation 5.

Seeking advice from health professionals and recognising its importance

Lead agency: DCYJMA and Queensland Health (QH)

Summary of responses

DCYJMA requested minor wording changes and removing some prescriptive details about what to consider when reviewing the Child Safety Officer–Health Liaison positions. It also requested the inclusion of a sub-point to explore ways to increase the capacity of these positions in building relationships with hospital and health services.

QH did not request any edits and indicated it will work collaboratively with the DCYJMA to improve interagency coordination and responses to vulnerable children and their families.

CDRB position

Editorial requests from DCYJMA were actioned, and prescriptive detail was edited to make it more succinct, but not removed entirely.

Relevant agency work in this area

DCYJMA advised that supporting child safety staff to appropriately consider advice from health practitioners has been a focus of the Intake Reform Project and other work.

It advised of a recent agreement between DCYJMA and QH on a process for medical officers to escalate concerns about Child Safety's decision making in relation to the immediate safety of a child upon discharge from a hospital.

Appendix 2
Agency comments on findings and recommendations

Recommendation 6.

Suicide prevention responses

Lead agency: Queensland Mental Health Commission (QMHC)

Summary of responses

QMHC did not request any edits to this recommendation.

DCYJMA advised that while it is not the lead on this recommendation, decisions based on research findings may impact on it.

QH advised that although it is not the lead on this recommendation, decisions made in this area will likely impact on it.

QH is supportive of a subgroup of the Queensland Suicide Prevention Network (once formed) being the most appropriate group to consider these findings.

QH cautioned that the value of data that can be rapidly provided to agencies should be considered, particularly within the context of complexities of data sharing and legislative provisions. It also advised that while there is strong evidence in support of Multisystemic therapy (MST) with young people with antisocial behaviours, a review of the evidence of the model's effectiveness in relation to young people with suicidality would need to be undertaken. MST is an expensive, intensive service model for a small number of young people.

QH cautioned that using a cross agency governance group to undertake reviews of agency policies and procedures may not result in the desired effect of promoting greater intersectoral collaboration. It acknowledged the systemic implementation of policies and procedures to be the challenge.

Relevant agency work in this area

QMHC advised that this recommendation aligns with the priority focus on children and young people identified for the *Shifting minds* Strategic Leadership Group (SLG) and the Queensland Suicide Prevention Network (pending formation).

QH identified that there is a schedule in the Evolve Therapeutic Services (ETS) 2019–2024 Memorandum of Understanding relating to developing a new therapeutic service delivery model for adolescents who exhibit high risk behaviors and who are not suitable for the ETS program. DCYJMA is to lead this work with Queensland Health supporting. This work is yet to commence.

Recommendation 7.

Suicide prevention responses

Lead agency: DCYJMA

Summary of responses

DCYJMA did not request any edits to this recommendation.

Relevant agency work in this area

DCYJMA advised of a number of activities that Youth Justice is undertaking in relation to young people at risk. This includes an internal Youth Justice review of suicide risk management procedure, currently underway, which will explore some issues associated with its responses to moderate and lower risk cases, identified through a Youth Justice initiated independent audit in 2020.

Youth Justice has included a case review of suicide risk management plans as part of the data gathering and reporting undertaken for the Youth Justice quality assurance program. Through this, suicide risk management plans will be reviewed for each service and detention centre across the state. Youth Detention Centres are also undertaking a review of operational procedures regarding suicide risk.

Youth Justice has a strong focus on enhancing staff learning and development opportunities regarding suicide risk management through a range of training and learning strategies.

DCYJMA advised that a Levels of Response document is being developed to be used alongside the Suicide Prevention Toolkit to clearly outline the response required for different levels of suicide risk.

DCYJMA advised that the Unify program is working with both Child Safety and Youth Justice practice areas to review the use of alerts, including suicide risk alerts, to improve functionality and use, and to ensure they are considered and used at all stages of the Child Safety and Youth Justice continuum.

DCYJMA cautioned that Youth Justice is not positioned to lead community responses to mental health or specifically manage suicide risk in the community. When Youth Justice becomes aware of peer risks or circumstances it ensures this information is provided to QH and the local health services to ensure a prompt service from the local experts.

Appendix 2
Agency comments on findings and recommendations

Recommendation 8.

Suicide prevention responses

Lead agency: QMHC and Queensland Family and Child Commission (QFCC)

Summary of responses

Neither QMHC nor QFCC requested any edits to this recommendation.

QMHC advised that early intervention, and empowering children and young people to access supports and services, are both critical and offer the greatest potential for reducing the risk of suicide and self-harm, improving health and wellbeing, and current/future social and economic outcomes.

Understanding individual rights, including consent, is an essential aspect of positive engagement with supports and services across the continuum of responses and interventions. QMHC supports the co-development of appropriate strategies to improve the understanding and ability of relevant stakeholders including young people and parents.

QFCC commented that young people have a right to participate in decisions that impact them, and that genuine youth participation will ensure that this recommendation is implemented effectively.

Recommendation 9.

Suicide postvention responses

Lead agency: Department of Education (DoE)

Summary of responses

DoE did not request any edits to this recommendation.

DoE advised that it places the highest priority on supporting the mental health and wellbeing of all Queensland state school students and reducing suicide and its impact in school communities.

It advised that it welcomes the recommendation to conduct an audit of suicide postvention plans in a sample of schools to ensure that Queensland state schools are taking an evidence-based, tailored approach to the management and response of suicide risk and events.

Relevant agency work in this area

DoE advised of a range of existing strategies that contribute to a coordinated approach to reducing suicide and its impact in Queensland state schools.

These include access to the support of the Regional Principal Advisors—Mental Health and Be You (the National Education Initiative) for all schools with secondary-aged students to have an up-to-date suicide postvention plan, a partnership with headspace to deliver suicide prevention and postvention training to guidance officers working in secondary schools, and an arrangement with the QFCC to alert the DoE when there is a suspected suicide of a child or young person in Queensland.

The alert from QFCC triggers a process whereby, if the child or young person is a Queensland state school student, the relevant region is informed. This process ensures that appropriate and timely support is provided to the school and young people who will be impacted by the suicide.

Recommendation 10.

Suicide postvention responses

Lead agency: QFCC

Summary of responses

QFCC did not request any amendments.

DoE commented that while it is not the lead on this recommendation, it can assist the QFCC to connect and partner with non-state school providers to extend its suicide notification system.

Appendix

3 Remuneration of the Child Death Review Board

Child Death Review Board (CDRB)

Act or instrument	*Family and Child Commission Act 2014*
Functions	Undertake systemic reviews following the deaths of children connected to the child protection system and make recommendations to improve the child protection system and to prevent the deaths of children.
Achievements	The CDRB commenced in 2020–21 and met on six occasions, including one induction meeting, four case review meetings and one facilitated annual meeting. A total of fifty-five child deaths were reviewed in this period. Two research projects were commissioned, and the CDRB started developing a cultural integrity framework.
Financial reporting	The CDRB is audited as part of the Queensland Family and Child Commission. Accounts are published in the annual report.

Remuneration

Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved sub-committee fees *if applicable*	Actual fees received
Chair (government)	Cheryl Vardon	6	$0	N/A	$0
Deputy Chair (non-government)	Clinton Schultz	6	$4500	N/A	$4500
Member (non-government)	Jeanine Young AM	6	$4500	N/A	$4500
Member (non-government)	Bruce Morcombe OAM	6	$4500	N/A	$4500
Member (non-government)	Margaret Kruger	4	$4500	N/A	$4500
Member (non-government)	Hetty Johnston AM	6	$4500	N/A	$4500
Member (non-government)	Shanna Quinn	4	$4500	N/A	$4500
Member (government)	Hayley Stevenson	6	$0	N/A	$0
Member (government)	Stephen Stathis	4	$0	N/A	$0
Member (government)	Phillip Brooks	2	$0	N/A	$0
Member (government)	Denzil Clark[1]	4	$0	N/A	$0
Member (government)	Mark White[2]	1	$0	N/A	$0
Member (government)	Bernadette Harvey[3]	3	$0	N/A	$0
Member (government)	Meegan Crawford[4]	0	$0	N/A	$0
Number of scheduled meetings/sessions	6[5]				
Total out-of-pocket expenses	$758 (accommodation, meal allowance and member taxi fares/parking)				

1 Denzil Clark was a member until 15 June 2021.
2 Mark White was a member from 16 June 2021.
3 Bernadette Harvey's position with the CDRB ended 23 June 2021.
4 Meegan Crawford was appointed to the CDRB on 24 June 2021 but attended several meetings as a proxy before this.
5 In addition to the six scheduled CDRB meetings, a 45-minute out-of-session meeting occurred on 16 June 2021 to discuss an agenda item remaining from the previous meeting. This meeting has not been reflected in this table.

Child Death
Review Board

Queensland
Government