Child Death Review Board

Queensland **Family & Child** Commission

Annual Report 2021–22

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

Queensland Government

About the Child Death Review Board and this report

The Child Death Review Board (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.

This report has been prepared under section 29J of the *Family and Child Commission Act 2014*. It describes the work of the Child Death Review Board (CDRB) in 2021–22 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*.

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Child Death
Review Board
Queensland **Family & Child** Commission

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28 October 2022

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 2021–22 Annual Report for the Queensland Child Death Review Board (CDRB).

In 2021–22 the CDRB reviewed the deaths of 55 children. This Annual Report details the key system issues identified in those child death reviews and offers the CDRB's insights and recommendations to improve the system.

The CDRB has focused on opportunities to strengthen service delivery in the areas of workforce reform, continuity of care for children with complex needs, domestic and family violence, infants and unborn children, and children with disability.

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

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Acknowledgements

The Queensland Child Death Review Board (CDRB) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people 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 Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

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.

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Every Queensland child has the right to be loved,
respected and have their rights upheld.

Each year, some children known to
the child protection system die.

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

Message from the Chair

Every Queensland child should be loved, safe and have their rights upheld. Sadly, for some Queensland children this is not always the case.

The Child Death Review Board (CDRB or the Board) is responsible for conducting system reviews following the death of a child known to the child protection system. The Board makes recommendations to improve the system and respond to gaps in child death prevention mechanisms.

The Queensland child death review model provides the opportunity to learn from the experiences of children and their families by considering the internal agency reviews undertaken by government agencies and applying a systemic lens to identify emerging issues, themes, and wider learnings across the entire human services system in Queensland.

Over the past year, the Board has reviewed the deaths of 55 children and young people. Each of these young lives was important and valuable, and the Board seeks to honour their life through our work.

This report provides details about the operations of the CDRB in the past year, including information about the children whose deaths were reviewed, and the complex issues experienced by them and their families. It examines the recurring service system issues that have been highlighted across the cases and presents the CDRB's findings and recommendations for the year.

In 2021–22 the CDRB has focused on opportunities to strengthen service delivery in the areas of children with disability; continuity of care for young people with high risk behaviours; workforce reform; domestic and family violence; and infants and unborn children. Six major recommendations have been made. The recommendations call for the Queensland Government to take specific actions regarding policies, procedures, and practices. They are deliberately broad and focus on improvements that will require cross-government reform with relevant agencies and stakeholders.

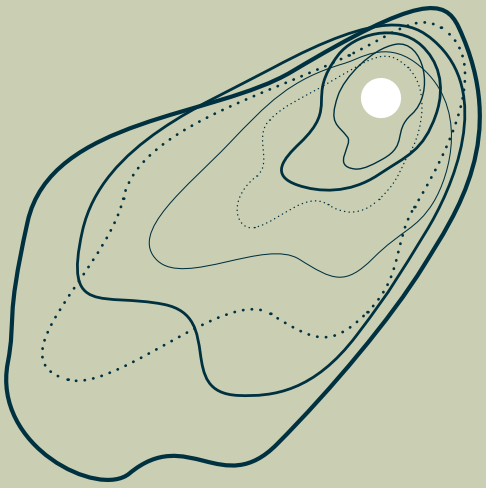
This is the second year of operation of the new child death model in Queensland, and my first year as Chair. It is a privilege to work with members of the Board and our partner agencies across government, non-government, and community sectors to strengthen the systems that help safeguard Queensland children and young people.

I would like to thank all those involved in the child death review processes, including the review agencies, our key stakeholders, CDRB members and the Secretariat staff. Together we have worked collaboratively to ensure the systems designed to protect children continue to improve and evolve to meet the needs of our most vulnerable Queenslanders.

Luke Twyford

Chair
Child Death Review Board

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.

Introduction

The Child Death Review Board (CDRB or the Board) is responsible for conducting system reviews following the death of a child known to the child protection system. It undertakes reviews to identify opportunities for system improvements and to make recommendations about the changes needed to keep children safe.

This is the CDRB's second annual report.

Chapter 1 — Examines in more detail the purpose of the CDRB, processes for child death review in Queensland and the membership and expertise of the CDRB.

Chapter 2 — Provides an overview of key characteristics of the 55 children and young people reviewed in the reporting period. It looks at the causes of death of the children, basic demographics, and Aboriginal and Torres Strait Islander status.

Chapter 3 — Discusses the key themes and service system issues identified by the CDRB in 2021–22. Relevant case studies and research projects undertaken by the CDRB are shared and the recommendations made by the CDRB for the reporting period are detailed.

Chapter 4 — Revisits the recommendations made in last year's annual report and provides an update on the implementation of these recommendations. The chapter presents a summary of key actions, practice reform and changes that have taken place following recommendations made in 2020–21, as reported by the responsible agencies.

Chapter 5 — Considers issues relating to the governance of the CDRB.

Summary of recommendations

Recommendation 1

Workforce reform to ensure service accessibility and delivery

The CDRB recommends: that the Queensland Government implements reform across the human services workforce to ensure it can meet the needs of children and families. This reform should:

- examine and address the shortages in core skills areas that are projected to become more pronounced over the coming decade, particularly in regional and remote areas
- recognise the overlap and competition that exists between departmental portfolios, and establish ways (such as exploring joint commissioning and pay parity) to help children, families and carers receive quality support
- promote place-based approaches, particularly in the early intervention and secondary services areas, to address local workforce issues
- include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers.

Recommendation 2

Workforce reform to ensure service accessibility and delivery

The CDRB recommends: that the Queensland Government implements reform across regional and remote communities of Queensland, particularly First Nations communities, to ensure there is a present human services workforce that can engage with the local community, particularly in culturally safe and engaging ways. This is to include:

- investigating how statutory roles can be redirected to local Community-Controlled Organisations to enable local employment and service delivery
- empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community-Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces
- investigating and repurposing unspent funding for long-term vacant positions to support place-based service design and delivery in regional and remote communities to address the departmental and portfolio silos that are impacting on the ability to delivery holistic family support and early intervention.

Recommendation 3

Continuity of care for children with complex needs

The CDRB recommends: that the Queensland Government develops a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours that recognises that multiple government departments come into contact with these young people, and there is no single responsible owner for the assessment and response required to address the complex needs. The model should:

Be informed by a study of child death, serious injury or other relevant cases where the children were identified to have complex needs manifesting in high-risk behaviours to establish:

- commonalities with their trajectory into tertiary systems
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model. (*Recommendation 3.1*)

Include an early intervention stream that provides a pathway for professionals working closely with children and families, such as schools, to trigger a case management response. The response should focus on:

- addressing the social, emotional, cultural and health and wellbeing needs of children and their families which contribute to their behaviours
- supporting the child's family and carers for the continuation of positive family functioning, behavioural guidance and treatment at home
- coordinating health-based assessments and treatments
- working with the child's school to ensure the child is engaged in education; and
- providing access to informal and formal respite for children and families. (*Recommendation 3.2*)

Include a tertiary stream that provides a specialised accommodation service for children that meets the underlying causes of high-risk behaviours that are a danger to themselves or others that is:

- underpinned by a culturally appropriate case management response addressing the social, emotional, health and wellbeing issues of children and their families contributing to the behaviours
- authorised by a clear and appropriate legal framework that clarifies if, when and how restrictive practices can be used, and how the system will be monitored with effective oversight to ensure decisions and actions are in the best interests of the young person; and
- integrates ongoing access for the child to family, culture and education. (*Recommendation 3.3*)

Recommendation 4

Responding to domestic and family violence

The CDRB recognises there is significant reform occurring in the area of domestic and family violence.

The CDRB recommends: that within this reform, the Queensland Government include a focus on:

- children as specific victims of domestic and family violence in their own right
- culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence
- the role of fathers and fathering, as promising points for behaviour change intervention.

Recommendation 5

Promoting the safety of infants and unborn children

The CDRB recommends: that the Queensland Government:

- extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to:
  - supporting and monitoring the wellbeing and development of an infant within the family home; and
  - addressing families' health and psychosocial needs and wellbeing as they arise.
- implements or expands initiatives to create safer sleep environments for all priority Queensland populations by:
  - supplementing home visiting with tiered support strategies using the family's existing resources
  - upscaling multimodal safe sleeping programs to provide an acceptable, feasible, safe, and culturally appropriate initiative for families
  - implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.

Recommendation 6

Promoting the safety of children with disability

The CDRB recommends: that the Queensland Government engages with the Commonwealth Government to improve access for vulnerable children and families to the NDIS by:

- demonstrating the cost benefit of establishing state-based positions across Queensland to help vulnerable children and parents with disability access the NDIS system and receive services – these positions need to be based in universal or secondary services with which children and parents engage
- improving the mechanisms by which children and parents with complex needs can enter and access the NDIS – including consideration of an appropriate agreement that allows prescribed state professionals to refer children and parents to the NDIS on their behalf.

The CDRB expects the outcomes of the engagement to be reported back to it by August 2023.

Chapter 1

Purpose, process and members

The Child Death Review process is designed to provide a contemporary and best practice child death review model that covers both government and non-government agencies to identify opportunities for improvements in systems legislation, policies and practices.

Purpose

The Child Death Review Board (CDRB or the Board) was established by the *Child Death Review Legislation Amendment Act 2020* and commenced on 1 July 2020. It is designed to provide a contemporary and best practice child death review model that covers both government and non-government agencies and has the power to make and monitor recommendations and publicly report on the outcomes of child death reviews.

Under the previous model, only Child Safety[2] and the Director of Child Protection Litigation were required to review their service provision to a child. Under the Child Death Review Board model, four additional agencies are required to review their service provision if they have provided services to a child in the 12 months prior to the child's death. These are the Department of Education, Youth Justice, Queensland Health, and the Queensland Police Service.

The Child Death Review Board is hosted by the Queensland Family and Child Commission and is 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; and
- mechanisms to help children and prevent deaths that may be avoidable.

Child death review process

Queensland's child death review process is two-tiered. Government agencies that were involved with a child in the 12 months prior to their death undertake a review of their service delivery to the child. This is known as an internal agency review. Each agency produces a report outlining its findings and recommendations which is provided to the CDRB for its consideration and to inform its recommendations about systemic improvements or preventative activities to reduce future child deaths.

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.[3,4]

2 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.

3 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.

4 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.

Child Death Review Board reviews

The CDRB receives and considers all internal agency review report findings and adopts a wide systems focus to identify improvements needed to help keep children safe and well. The focus and purpose of the CDRB's reviews is to identify opportunities for continuous improvement in systems, legislation, policies and practices; and mechanisms to help children and prevent deaths that may be avoidable.[5] It does not investigate the deaths of individual children or make findings about the actions of individuals.[6]

In 2021–22, the CDRB met five times to review trends and emerging system issues across 55 cases. For 11 of these cases, the CDRB conducted in-depth reviews (referred to as Level 3 reviews), where it was identified that children's experiences of the system provided the greatest opportunity for learnings and recommendations about improvements to systems, policies, practices and legislation.

For these reviews, the CDRB collates multiple agencies' information and findings to develop visual timelines of children's touchpoints with the system in the 12 months prior to their death. Timelines provide an objective and systemic view of the child's experiences and provoke discussions about systemic gaps or issues—rather than focusing on individual agencies or practices. Other cases (Level 1s and 2s) are reviewed by the CDRB to monitor and report on recurring issues and trends.

The fifth meeting included consolidating findings from CDRB reviews and preparing recommendations to address the system issues identified across these cases (described in Chapter 3). The five meetings were numbered 7 to 11. Meetings 1 to 6 were held in 2020–21.

CDRB members

The CDRB consist of a Chair and 11 members. Members include both government and non-government persons with a requirement that government members not constitute a majority.

Ms Cheryl Vardon fulfilled the role of CDRB Chair from the CDRB's commencement on 1 July 2020 until her retirement in December 2021. Mr Luke Twyford was appointed as Chair in March 2022.

Two new members, Ms Jody Currie and Ms Simone Jackson, were appointed to the CDRB in 2022 following the resignation of two members, including the Deputy Chair. Ms Currie was appointed as Deputy Chair.

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.[7] In 2021–22, CDRB members reflected expertise across child protection, family law, maternal, family and child health and mental health, education, justice systems and child advocacy.

Mr Luke Twyford *Chair meetings 9 to 11*

Mr Luke Twyford commenced as Principal Commissioner of the Queensland Family and Child Commission (QFCC) in January 2022. Luke is an experienced senior executive in the child and family sector. Luke was appointed as CDRB Chair in March 2022.

Luke's career spans more than 20 years across Commonwealth, New South Wales and Northern Territory governments in the areas of reform, research and evidence, integrity, audit, governance and complaints management. Prior to joining the QFCC, Luke worked for nine years with the Northern Territory Government, leading critical reform of the child protection and youth justice system and its legal frameworks.

Luke holds a Bachelor of Laws with Honours from the University of Wollongong. He has extensive experience providing evidence to courts, inquiries and commissions.

Luke's parents fostered a number of children throughout his childhood, with his own lived experience and those of his foster brothers and sisters profoundly shaping the perspective he brings to his work and his passion in advocating for the rights and wellbeing of children and young people.

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

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

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

Non-government members

Ms Jody Currie *Deputy Chair meetings 9 to 11*

Ms Jody Currie is a Yugambah person with traditional ties to the country between the Logan and Tweed Rivers. Since attaining her Bachelor of Arts (BA) in Gender Studies, Jody embarked on her career in health and human service delivery.

Jody has a particular focus in child protection and health, working in several senior positions in both the community and government sector.

Jody was most recently Chief Executive Officer of the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane. She established ATSICHS Brisbane as a Nationally Registered Early Childhood Education provider, a Nationally Registered Housing Provider, and a Registered National Disability Insurance Scheme Provider.

Ms Simone Jackson *meetings 9 to 11*

Ms Simone Jackson is a proud Kamilaroi woman from Southwest Queensland and an accomplished Government and now Non-Government Executive with over 20 years' experience as a public servant. Simone has worked in roles relating to justice and human services across Queensland and the Northern Territory. Over the past 11 years she has worked in significant senior Government roles.

Simone was appointed the Northern Territory's Chief Witness, for the Royal Commission into Institutional Child Sexual Abuse and presenter to the Senate Inquiry into Out of Home Care. In Queensland, she has been the Executive Director for the Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP). She drove the implementation of Youth Justice reforms for Department of Child Safety, Youth and Women, and is a member of the Queensland Parole Board.

Simone is committed to better outcomes for Aboriginal and Torres Strait Islander peoples, in particular, reducing the numbers of young people in the Child Protection and Youth Justice systems and the overrepresentation of Aboriginal and Torres Strait Islander adults in prisons.

Simone is the Chief Executive Officer, Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health) based at Ipswich, covering Ipswich and West Moreton region.

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 held the position of Chair and Deputy Chair of the Child Protection Practitioners Association of Queensland (CPPAQ) and, until the end of 2016, 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 a registered nurse, midwife, and neonatal nurse with over 30 years of experience in neonatal, maternal and child health, and paediatric care, in Australia and overseas. She holds a professorial appointment at the University of the Sunshine Coast. Jeanine has established a research program to investigate Queensland's infant mortality rate. A particular focus of interest is the development of individually tailored, community based, wrap-around care interventions to address the multiple disadvantages experienced by families with social vulnerabilities who experience the greatest burden of infant mortality.

This program includes evidence-based strategies and educational resources to assist health professionals and community workers in partnering with families with young infants to find innovative, evidence-based, culturally appropriate and practical solutions for keeping babies close and safe within sleep environments, including shared sleep environments. 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.

Government members

Government appointments to the Board are based on a position rather than the person. As different officers occupy the nominated Board position within an agency, they automatically become the agency's Board member.

Child Safety

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Child Safety) is the Chief Practitioner.

Dr Meegan Crawford was the Chief Practitioner and Child Safety's representative on the Board throughout 2021–22.

Dr Crawford commenced her career as a Child Safety Officer 30 years ago after graduating as a social worker. She has since 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.

Youth Justice

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Youth Justice) is held by the Assistant Chief Operating Officer, Youth Justice Statewide Services, Operations and Commissioning.

Mr Darren Hegarty held the role of Assistant Chief Operating Officer and the Youth Justice representative on the Board for meetings 7, 8, 10 and 11.

Mr Hegarty has led a number of positive and significant reforms for children and young people in both the youth justice and child protection systems. These include the Youth Justice Strategy and Action Plans, Out of Home Care Reinvestment program, including Queensland's first Mental Health Recovery Residential, improved service delivery frameworks within Child Safety, targeted outcomes for Aboriginal and Torres Strait Islander families, stronger engagement with community Elder groups and Aboriginal and Torres Strait Islander service providers, and the re-focused investment in Intensive Family Support for children and young people. Darren has extensive experience in providing innovative approaches to solving complex problems within the human services sector.

Mr Nicholas Dwyer held the role of Assistant Chief Operating Officer and was the Youth Justice representative on the Board for meeting 9.

Mr Dwyer has over 23 years' experience working in the human services sector across youth justice, child safety and communities. This includes over ten years in senior leadership roles, most recently working alongside Queensland Police on the Youth Justice Taskforce initiatives. Over the past four years he has worked in a variety of senior leadership roles that have directly contributed to the development and implementation of one of the most significant set of reforms and investment to have occurred in youth justice service delivery in Australia through the action plan, Youth Justice Task Force and numerous budget lead reforms. Nicholas is currently working on the organisational change emerging from the Bob Atkinson review of the Youth Justice Strategy Action Plan, the work of the Youth Justice Cabinet Committee and the taskforce, and how this will reshape service delivery for young people and their families across Queensland.

Queensland Health

The Board position within Queensland Health is held by the Medical Director of Child and Youth Mental Health Services, Children's Health Queensland.

Dr Stephen Stathis held the position of Medical Director of Child and Youth Mental Health Services, Children's Health Queensland and was the Queensland Health representative on the Board throughout 2021–22.

Dr Stathis obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child & Adolescent Psychiatry and Forensic Psychiatry. Besides being 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 paediatrics and psychiatry, mental health policy and strategic planning, gender dysphoria, consequences of early childhood trauma and abuse, and adolescent forensic psychiatry.

Department of Education

The Board position within the Department of Education is held by the Executive Director for Student Protection and Wellbeing.

Ms Hayley Stevenson held this position and was the Department of Education representative throughout 2020–21.

Ms Stevenson 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.

Ms Stevenson 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.

Queensland Police Service

The Board position within the Queensland Police Service is the Detective Superintendent Child Abuse and Sexual Crime Group.

Detective Acting Superintendent Mark White held this position and was the Queensland Police Service representative for meetings 7 and 8.

Detective Acting Superintendent 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, the State CPIU Coordinator and QPS Child Safety Director when the Detective Acting Superintendent at the Child Abuse & Sexual Crimes Group, Crime and Intelligence Command. 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.

Detective Inspector Stephen Blanchfield held the role of Detective Acting Superintendent and was the Queensland Police Service representative for meetings 9 to 11.

Detective Inspector Stephen Blanchfield has over 30 years' policing experience, with more than 20 years as an investigator. He has worked in regional two-person stations and in challenging urban areas. He commenced in the specialised field of child protection in 1991 and has worked in Homicide, Child Abuse and Sexual Assault and, Fraud and Cyber Crime. He was Investigations Leader into the murder of Daniel Morcombe.

Stephen was instrumental in implementing the QPS Investigative Interviewing Strategy, travelling to the UK in 2014 to undertake training and becoming one of the first QPS members to be an Interview Advisor.

In December 2015 he was promoted to Detective Inspector, Major and Organised Crime Squad, South Eastern Region. In October 2018 he returned to child protection as Operations Manager, Child Trauma and Sexual Crime Unit, Crime and Intelligence Command.

Members who retired or resigned in 2021–22

Ms Cheryl Vardon was Chair for meetings 7 and 8. Ms Vardon was the Chief Executive and Principal Commissioner of the QFCC from October 2015 to December 2021.

Ms Vardon 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.

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 was Deputy Chair for meeting 7. Dr 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*.

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

Mrs Hetty Johnston AM was a community member for meeting 7. Mrs 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.

Chapter 2

Overview of cases reviewed

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

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*, may not align with the number of child deaths reviewed by the CDRB in the same year. This is because the QFCC reports on child deaths registered[8] in the financial year, whereas CDRB numbers are based on reviewed cases.

8 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.

Figure 1: *CDRB 2021–22 review summary statistics*

In 2021–22, the Child Death Review Board (CDRB) reviewed the deaths of 55 children – equivalent to the reviews undertaken in 2020–21.

First Nations children continued to be over-represented, reflective of their over-representation across the child protection system.

The majority of children (48) were living with family or friends or independently at the time of their death.

Twenty-four deaths were from natural causes. The most frequent categories of external cause of death were suicide and drowning.

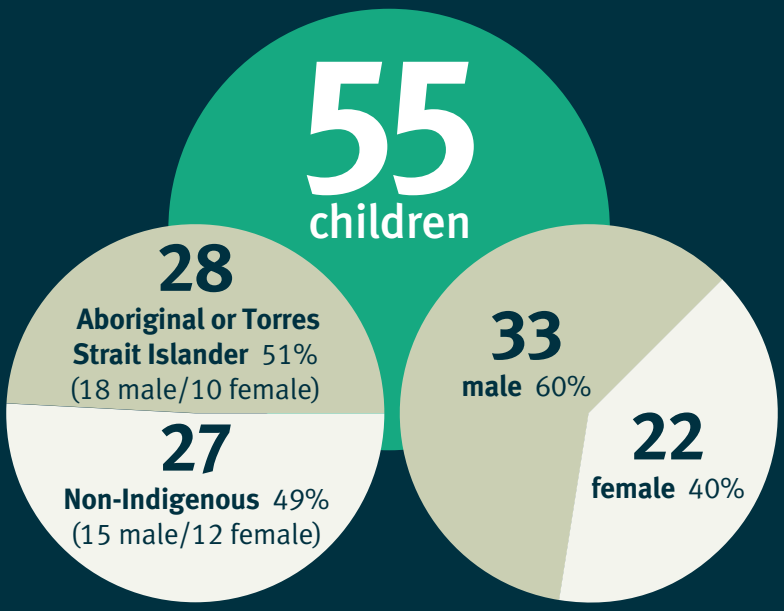
Eleven deaths were categorised as Sudden Unexpected Death In Infancy (SUDI). This is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause at the time of death.

More agency reviews were undertaken this year, 191, compared with 68 in 2020–21, and provided to the Board for its consideration. This increase was due to 2021–22 being the first full year that all agencies were required to undertake reviews if they had provided services to the child in the 12 months prior to their death.[9] The higher number of review reports from Queensland Health (compared to the number of child deaths) is reflective of multiple Hospital and Health Services undertaking reviews for some children.

9 In 2020–21, Queensland Health, the Department of Education, Youth Justice (which formed part of the Department of Children, Youth Justice and Multicultural Affairs) and the Queensland Police Service were only required to provide reviews to the CDRB from January 2021.

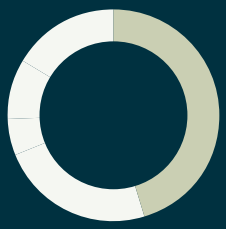
Demographics

In 2021–22, the CDRB considered the deaths of



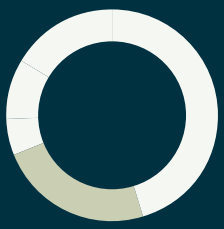
The number of deaths reviewed in each age grouping

under 1 year



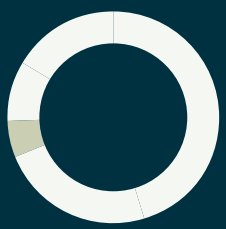
18 Aboriginal or Torres Strait Islander
7 Non-Indigenous

1–4 years



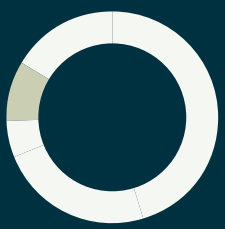
4 Aboriginal or Torres Strait Islander
9 Non-Indigenous

5–9 years



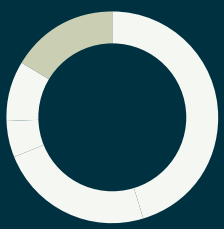
0 Aboriginal or Torres Strait Islander
3 Non-Indigenous

10–14 years



1 Aboriginal or Torres Strait Islander
4 Non-Indigenous

15–17 years



5 Aboriginal or Torres Strait Islander
4 Non-Indigenous

Category of deaths reviewed by the CDRB

24 were from **natural causes**

31 were from **external causes**

- **6** **suicide**
  5 male 83% / 1 female 17%
  1 aged 10–14 years
  5 aged 15–17 years
- **6** **drowning**
- **5** **unknown causes** with cause of death pending
- **5** unexplained (**SIDS** and **undetermined**)
- **5** other **non-intentional** injury
- **3** **fatal assault** and **neglect**
- **1** **transport related**

Care circumstances

48 were **living with family or friends** or **independently** at the time of their death

4 were in **foster** or **kinship care** or on a **permanent guardianship order**

2 were in **residential care**

1 in other **state-based custody**

Agency reviews considered by the CDRB

191

This included:

- **91** **Queensland Health**
- **55** **Child Safety**
- **21** **Queensland Police Service**
- **15** **Department of Education**
- **6** **Youth Justice**
- **3** **Director of Child Protection Litigation**

Sudden Unexpected Death in Infancy (SUDI)[10]

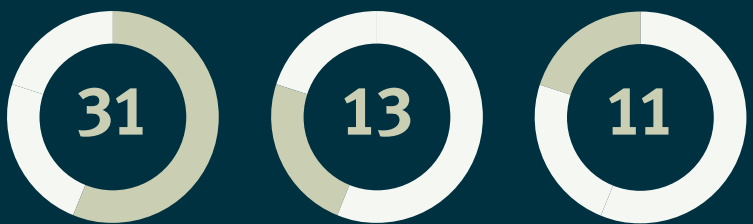
11 deaths fell within the **SUDI research classification**

- **7** **Aboriginal or Torres Strait Islander**
- **4** **Non-Indigenous**

10 This is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause at the time of death. Numbers may not total because SUDI is a double count category and may be counted under natural and external cause of death.

Categorisation of reviews

Upon receipt of agency review reports and supporting information, cases are categorised using a categorisation framework to determine the terms of reference and depth of analysis for each. The categorisation framework 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 and requiring in-depth review by the CDRB. Level 1 and 2 reviews consolidate agencies' information and findings from multiple child death reviews to identify and report on recurring issues and trends.



Chapter 3

Key themes and recommendations

The Child Death Review Board's (CDRB) reviews collate information from multiple agencies and services that interacted with children in the 12 months prior to their deaths. The CDRB uses this information to comment on issues or gaps occurring across the system—rather than focusing on individual agencies or practices in isolation.

This chapter outlines the key themes and systemic issues observed by the CDRB in its reviews of the child protection system's[11] responses to 55 children. It also includes recommendations for addressing some of the core issues.

Board members discussed trends and recurring systemic issues focused on:

1. Workforce reform to ensure service accessibility and delivery
2. Continuity of care for children with complex needs
3. Domestic and family violence
4. Promoting the safety of infants and unborn children
5. Promoting the safety of children with disability.

The CDRB made 6 recommendations to address these issues.

11 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'.

Theme

1 Workforce reform to ensure service accessibility and delivery

The findings and recommendations made in this report call for system and practice improvements across early intervention, targeted support, and statutory intervention. To enable this, there is a need to fundamentally shift how Queensland approaches workforce and service delivery issues.

The child protection system is large and diverse, comprising government and non-government sectors. Universal and secondary services share the responsibility for prevention and early intervention with children and their families experiencing multiple or complex needs. Where a child needs protection or cannot remain safely at home, tertiary child protection services hold the primary responsibility for coordinating necessary interventions and services.

To promote the safety and wellbeing of children, and timely delivery of services, Queensland needs to be able to attract, recruit and retain an appropriately skilled workforce.

Across Queensland, the demand for services is increasing:

- high numbers of families are being referred to family support services—including Family and Child Connect,[12] Intensive Family Support[13] and Family Wellbeing Services[14]
- increasing numbers of concerns about child protection issues are being reported to Child Safety[15]
- more young people are accessing mental health services[16]
- the NDIS National Workforce Plan 2021–25 identifies the need for 83,000 additional NDIS workers by 2024 (nationally)
- schools are experiencing demand from a growing student population[17]
- there is high demand for foster and kinship carers.[18]

While there has been much investment in staff resourcing and training within individual portfolios, the demand has outstripped the available supply of services and exacerbated workforce shortages. Among CDRB reviews, this was particularly evident across child protection, family support and health service delivery. The CDRB observed that agencies and services are competing for staff and the issue is compounded by disparities in remuneration and incentives and leave provisions across government and non-government sectors. This results in some sectors consistently losing trained staff to other areas.

In many cases, the CDRB and agencies have attributed oversights or critical practice errors to workforce and resourcing challenges—specifically, the cycle of high workloads and staff vacancies. In the cases reviewed this has impacted:

- the timeliness and quality of assessments and decisions about children's safety
- the ability of agencies to share and consider comprehensive information about children's circumstances to inform decisions and subsequent actions; and
- the ability to provide consistent or regular interventions to young people and families to address their needs.

Service delivery challenges are amplified in many First Nations and rural and remote communities due to additional geographical, climatic, and contextual barriers that impact the attraction, recruitment and retainment of a workforce.[19] Some communities are reliant on outreach models of service delivery which do not always meet the specific needs of children and families within that community and can reduce capacity for service delivery (for example, time spent travelling).

12 DCYJMA 2022, Our Performance: Who family support services work with. Family and Child Connect enquiries received by referral source, https://performance.cyjma.qld.gov.au/?domain=5mkrfftdokc0&subdomain=5e3uyemkkec0&tab=1rr2kadb4x34. Annual data extracted 26 August 2022.

13 DCYJMA 2022, Our Performance: Who family support services work with. Families referred to an Intensive Family Support service, https://performance.cyjma.qld.gov.au/?domain=5mkrfftdokc0&subdomain=5e3uyemkkec0&tab=1llsva5zu5pc#58rvxqph7mk0. Accessed 26 August 2022.

14 DCYJMA 2022, Our Performance: Who family support services work with. Families referred to a Family Wellbeing Service, https://performance.cyjma.qld.gov.au/?domain=5mkrfftdokc0&subdomain=5e3uyemkkec0&tab=2ljg0jbbn9g0. Accessed 26 August 2022.

15 Based on number of concerns (intakes) received by Child Safety from 30 June 2017 to 30 June 2021. Department of Children, Youth Justice and Multicultural Affairs 2022, Our Performance: Concerns received by Child Safety, https://performance.cyjma.qld.gov.au/?domain=3nu2zxmixre0&subdomain=5yorpqmnl4g0&tab=5kp2vj52afk0 Accessed 3 August 2022.

16 headspace 2019, Increasing demand in youth mental health: A rising tide of need, https://headspace.org.au/assets/Uploads/Increasing-demand-in-youth-mentalh-a-rising-tide-of-need.pdf; University of Queensland (Institute for Social Science Research) 2020, Final Report: National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries, https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf

17 Queensland Government Statistician's Office 2020, Schools and higher education: Full-time students by government and non-government sector, by school level, Queensland, 1993 to 2020. Accessed 26 August 2022. https://www.qgso.qld.gov.au/statistics/theme/society/education/schools-higher-education

18 DCYJMA 2022, Our Performance: Who family support services work with. Children entering care, https://performance.cyjma.qld.gov.au/?domain=6r87nygu3rk0&subdomain=275e3zcn1if4&tab=3cfgiunxt4c0. Accessed 26 August 2022.

19 Queensland Productivity Commission 2017, Service delivery in remote and discrete Aboriginal and Torres Strait Islander communities, https://s3.treasury.qld.gov.au/files/Service-delivery-Final-Report.pdf; Public Commission's Overview https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms-overview.pdf

Key theme 1
Workforce reform to ensure service accessibility and delivery

Case example

The CDRB reviewed a cluster of cases where agencies and support services were unable to successfully engage with Aboriginal children and families living in regional Queensland. These children had recurring contact with the system at times of crisis (such as when they were displaying suicidal ideation or using illicit substances), however agencies and services (government and non-government community services) were unable to sustain meaningful service engagement or address their social, emotional and wellbeing needs due to staff shortages, gaps and limited presence.

This was illustrated in the experiences of one Aboriginal young person and their family who came into contact with the system in relation to illicit substance use, offending, suicidal ideation and attempts and child protection concerns.

As illustrated in **Figure 2**, the system responded to incidents through Child Safety investigations, Queensland Police cautions, Queensland Health assessments and treatment and referrals to local support services. However, services were unable to sustain meaningful engagement. Multiple factors were considered to have influenced this—including referred services not being culturally appropriate, limited service choice and issues with access arising from the mode of service delivery.

Government and non-government agencies reported significant difficulties with attracting and retaining staff and addressing service gaps in these communities.

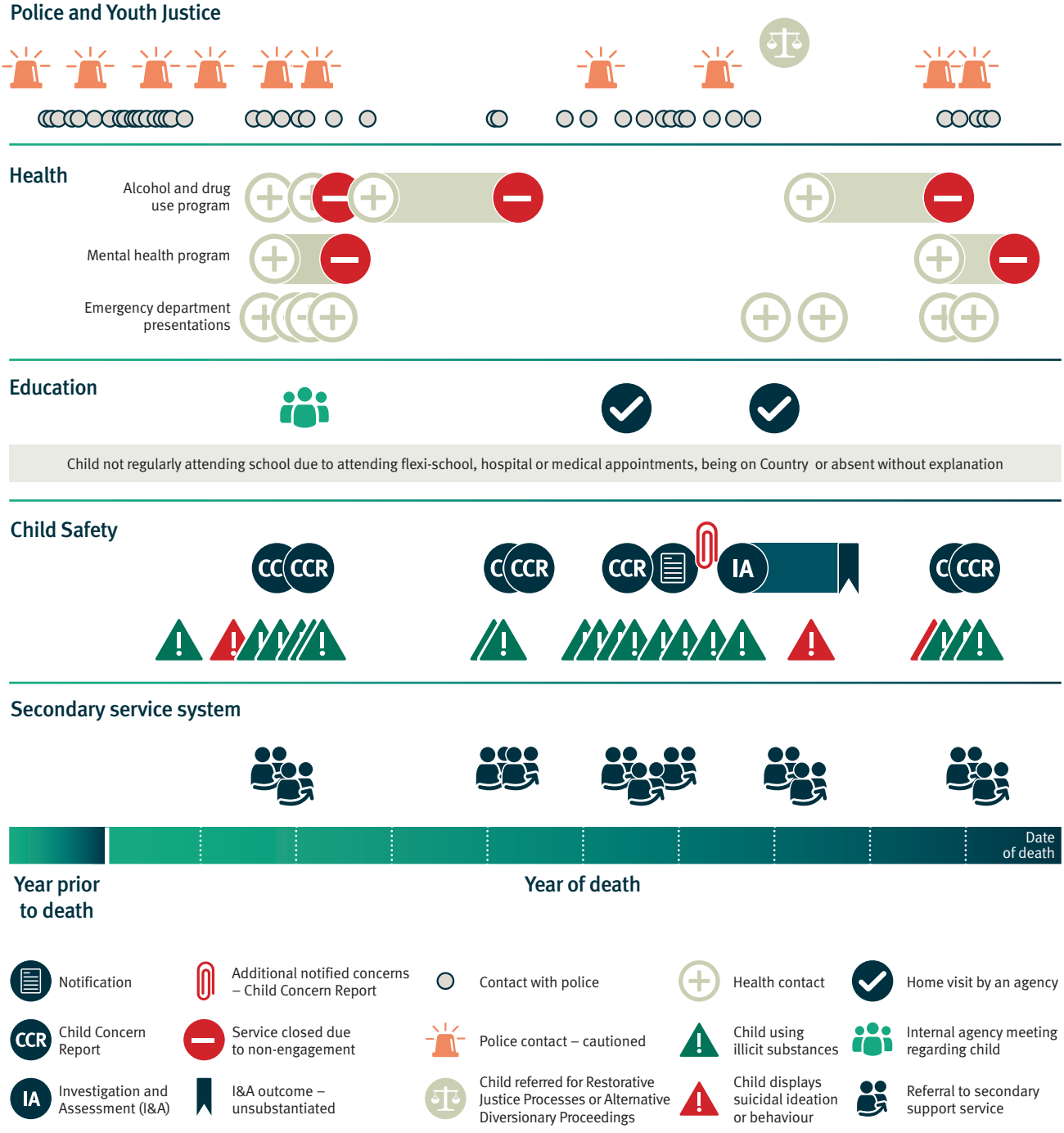
Specific issues were flagged with:

- the cycle of high staff turnover on high workloads and limited staff experience
- shortages of appropriately qualified staff
- the time and resource implications of outreach service delivery models resulting in concerns about children's safety not being responded to immediately
- challenges to attract local community members to fill vacant positions
- services having limited capacity to accommodate new clients, resulting in waiting lists or limited follow-up to engage with referred clients
- available service delivery models not being appropriately suited to community needs (such as delivery of tele-link services where rapport with families has not been built)
- gaps in suitable services and positions to promote children's social and emotional wellbeing and respond in periods of crisis.

The CDRB noted the impact of mistrust and disempowerment on meaningful service engagement. It considered that self-determined, locally run community services would be best positioned to engage children and families needing support.

Key theme 1
Workforce reform to ensure service accessibility and delivery

Figure 2: *An adolescent's experience of the system in the year prior to their death*



Key theme 1
Workforce reform to ensure service accessibility and delivery

Workforce and service delivery gaps are not new or unique to any one agency. Challenges relating to workloads and the strain on the workforce (both government and non-government), staff recruitment and retention, and service delivery have been highlighted in multiple inquiries over the years. Investment in solutions for service design and commissioning, workforce reform and future planning are consistently on the agenda for individual agencies at the State – and Commonwealth-levels. This portfolio, or sector-based approach, contributes to a fragmentation of the overall workforce strategy, and can lead to counterproductive competition.

The CDRB has noted multiple State and Commonwealth strategies underway with a focus on building workforce capacity. The *Safe and Supported: the National Framework for Protecting Australia's Children 2021–31*, includes actions to build a sustainable and skilled workforce across the child and family support sector. This includes building strong Community-Controlled sectors and an increased focus on cultural safety and Aboriginal and/or Torres Strait Islander-led early intervention.[20]

The *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037* (Our Way) outlines a framework for change and a commitment by the Queensland Government and First Nations communities to work together to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children and families in the child protection system. Workforce reform, capacity building and Aboriginal and Torres Strait Islander Community-Controlled Organisations leading change are key priorities of implementation.

The national peak body for Aboriginal and Torres Strait Islander children and the sector supporting these children—SNAICC (Secretariat of National Aboriginal and Islander Child Care) is also leading sector development. It works in partnership with Indigenous and non-Indigenous services, and Commonwealth and State Governments to grow and strengthen the sector's capacity to deliver high-quality and sustainable programs and services.[21]

The CDRB discussed initiatives led by individual Queensland Government agencies to transfer authority for decision-making and service delivery to First Nations communities and leaders to alleviate service delivery issues and improve outcomes for children and families, for example, the *Local Thriving Communities* reform. While these initiatives are a step in the right direction, broader commitment and coordination is needed to fundamentally shift the way communities and government design, fund and deliver services holistically, and free of portfolio and professional silos.

This may include examining opportunities to divert current positions or funding, consolidating existing services or investing in joint commissioning where this would align with communities' needs and preferences.

While it is not possible to capture the full extent of workforce reforms and initiatives underway, the CDRB acknowledges the breadth of this work and recognises that its findings and recommendations build on existing efforts. However, the ongoing workforce challenges and impacts on quality service delivery to children and families, which the CDRB has observed, necessitates a solution. The CDRB is concerned that the approach to workforce reform is typically siloed and does not sufficiently address the projected shortages of staff and skills across the human services industry. A coordinated, whole of sector approach is required to ensure a sustainable human services sector into the future.

Coinciding with this, investment in Community-Controlled Organisations and locally led service design must be strengthened in a way that recognises communities hold the knowledge and expertise in keeping their children safe. The CDRB considers that there is opportunity to transfer authority and investment to communities in a way that promotes ownership of responsibilities for decision-making and service provision for First Nations children and their families.

Agencies were consulted about the workforce issues identified by the CDRB and gave their support to the recommendation. Agencies recognised the strain on the workforce across all partners (government and non-government organisations) in the human services and disability support sectors. They also acknowledged that workforce challenges are particularly acute in regional and remote areas. The focus on issues of staff attraction, retention and pay disparity across the human services sector was welcomed.

20 Commonwealth of Australia (Department of Social Services) 2021, *Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031 (the National Framework)*, https://www.dss.gov.au/sites/default/files/documents/12_2021/dess5016-national-framework-protecting-childrenaccessible.pdf

21 https://www.snaicc.org.au/about/vision-and-purpose/strategic-plan/

Key theme 1

Workforce reform to ensure service accessibility and delivery

Concluding comments

Workforce challenges are well known. Stakeholders across government and non-government agencies are acutely aware of the impact that these challenges have on their timely and quality delivery of services to children and families. Individually, these agencies are leading solutions to address the current challenges and gaps, however a holistic picture is needed.

The CDRB observed:

- Children and families experiencing vulnerabilities have complex needs that can reach crisis at any time. In some cases, they have experienced poor outcomes due to workforce challenges and limited service availability.
- Workforce challenges are exacerbated in regional and remote areas with staff shortages in universal, secondary and statutory services. It is observable that communities with the highest need, are often those experiencing the greatest difficulty in filling vacancies and retaining staff.
- In regional and remote communities, particularly First Nations communities, there are unacceptable gaps in service delivery, caused by gaps in local employment and difficulties in recruiting to vacancies.
- There is a need for a broad approach to workforce reform in the human services industry.
- Carers for vulnerable children should be considered as part of any workforce reform as shortages in carers are impacting decision-making and outcomes for Queensland's children.
- To best fulfil local workforce needs, authority must be transferred to communities to design and deliver placed-based strategies.

Recommendation 1

The CDRB recommends: that the Queensland Government implements reform across the human services workforce to ensure it can meet the needs of children and families. This reform should:

- examine and address the shortages in core skills areas that are projected to become more pronounced over the coming decade, particularly in regional and remote areas
- recognise the overlap and competition that exists between departmental portfolios, and establish ways (such as exploring joint commissioning and pay parity) to help children, families and carers receive quality support
- promote place-based approaches, particularly in the early intervention and secondary services areas, to address local workforce issues
- include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers.

Recommendation 2

The CDRB recommends: that the Queensland Government implements reform across regional and remote communities of Queensland, particularly First Nations communities, to ensure there is a present human services workforce that can engage with the local community, particularly in culturally safe and engaging ways. This is to include:

- investigating how statutory roles can be redirected to local Community-Controlled Organisations to enable local employment and service delivery
- empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community-Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces
- investigating and repurposing unspent funding for long-term vacant positions to support place-based service design and delivery in regional and remote communities to address the departmental and portfolio silos that are impacting on the ability to delivery holistic family support and early intervention.

Theme

2 Continuity of care for children with complex needs

Many children known to Queensland's child protection system are exposed to, or have experienced, trauma. In most cases, these children receive the care and support they require from their families, communities and services. However, for some, the combination of untreated trauma and additional risks which accumulate throughout their childhood can manifest in significant and long-lasting psychological, emotional and behavioural impacts.

Across its reviews, the CDRB has observed recurring evidence of children and young people who displayed complex or challenging behaviours—often termed 'high-risk behaviours'. These behaviours frequently included substance use, disengagement from school and social environments, transient housing, use of violence, criminal offending, and suicidal ideation or attempts. The CDRB identified several common features in the life trajectories of a group of young people (aged 12 to 17 years) whose cases came before the Board. Of these children:

- all were not regularly attending, or had disengaged from, education
- all were reported to be using illicit substances (such as cannabis, methamphetamines or petrol sniffing)
- all had contact with the Queensland Police Service regarding offending behaviours with many also being known to Youth Justice Services
- many were not living at home with their families or were frequently leaving their family home
- all but one had significant child protection involvement from a young age, mostly due to reports about their families' experiences of domestic and family violence, parental substance use, physical harm or neglect
- while several had suspected or confirmed intellectual disabilities and mental illnesses by the time they became involved with statutory Child Safety and Youth Justice services, there were distinct gaps in assessments and service delivery when their behaviours first emerged in early childhood
- several of their deaths were associated with engagement in high-risk behaviours (such as transport incidents in stolen vehicles or suicides in the context of substance use).

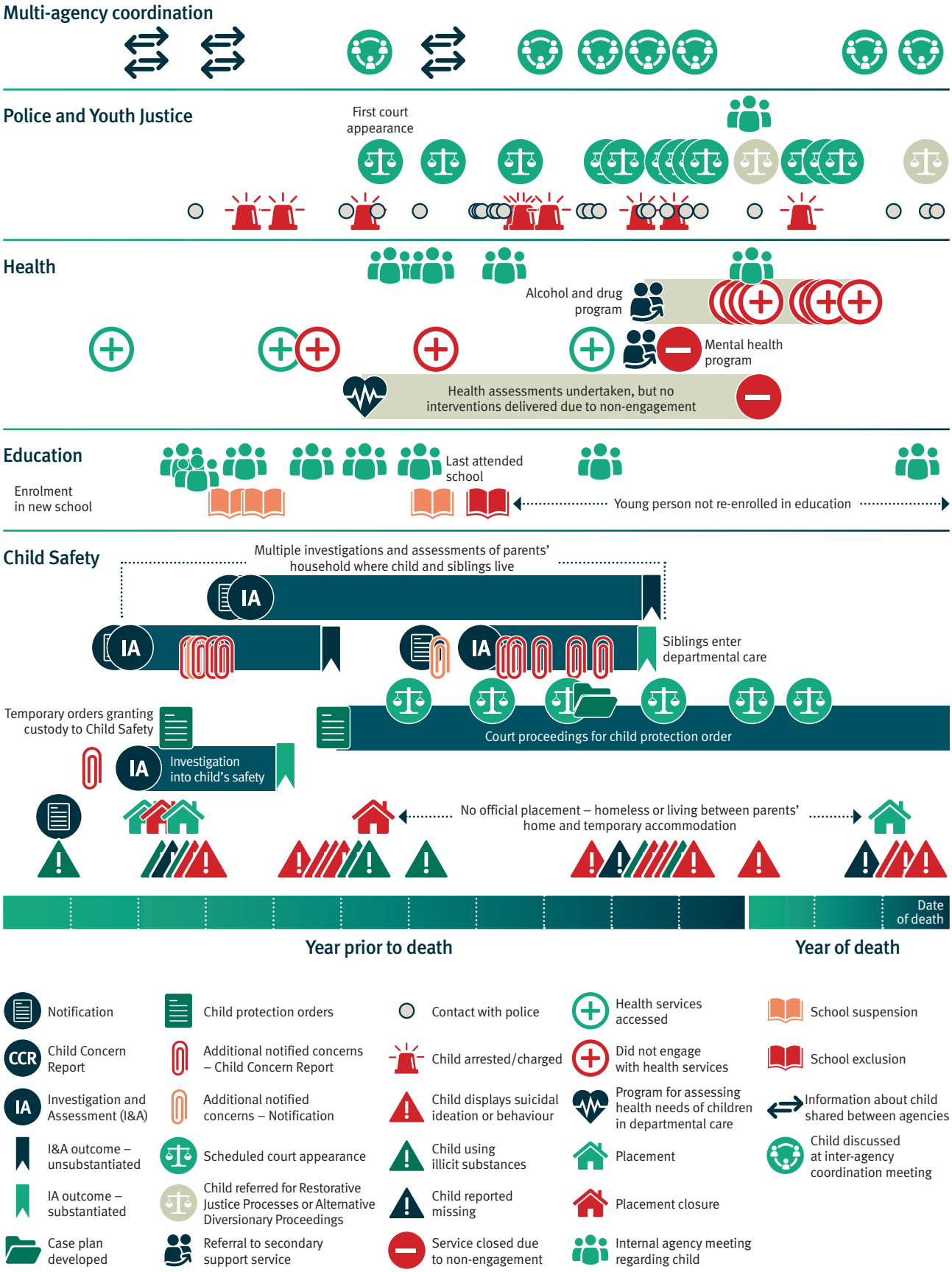
In a tragic cycle, their behaviours escalated and became branded as 'more challenging' as system responses became more reactive, punitive and withdrawn. Consequently, their trauma and behaviours were exacerbated by responses that isolated or excluded them from stability and support. In particular, they were suspended or excluded from schools, displaced from family and community, experienced unstable housing or multiple placement breakdowns, had increasing transactional contact with police and the youth justice system and were exited from support services when they were deemed to not attend or engage.

Case example

By the age of 12, a young person was subject to over 60 reports to Child Safety and multiple child protection orders. The reports raised a range of concerns including verbal and physical abuse, neglect, allegations of child sexual abuse, parental substance use, domestic and family violence and mental illness. During their adolescence, this young person engaged in violent and risk-taking behaviours (including illicit substance use, offending, violence against others and suicidal ideation and attempts). They were placed in multiple out-of-home care placements, in part due to challenges in managing their behaviours.

As illustrated in **Figure 3**, in the year prior to this young person's death, the system was unable to successfully intervene and engage them with the supports and services they needed. Agencies were aware of the school suspensions and exclusions, increasing contact with police and youth justice, closure of health services and erosion of stability and positive influences as the young person's placements closed and they returned to unsafe households and experienced periods of homelessness. While agencies shared information and met to discuss this young person's circumstances at critical points in time (such as when they were excluded from school, when their placement closed or when they first appeared in court), there was a lack of coordinated responsibility to meet the young person's safety, education, therapeutic, behavioural and health needs.

Figure 3: *An adolescent's experience of the system in the year prior to their death*



Key theme 2
Continuity of care for children with complex needs

This appears to be accepted as a common trajectory for some children and young people, with efforts to respond and divert them diminishing as their behaviours heighten. They are considered 'challenging' and 'unable to be engaged' and a tragic cycle occurs where less support is provided as the need intensifies.

For some children, their behaviours pose a danger to themselves or others—such as frequent suicidal and self-harming behaviours or significant violence. This cohort often requires more intensive support and intervention beyond that provided by early intervention responses due to a combination of factors such as school disengagement, entrenched substance use and limited safe family or support networks. However, the system struggles to undertake assessments and provide interventions to address the underlying causes of their behaviours due to a lack of safe and stable care options. For example:

- Children with diagnosed mental illnesses may be eligible for assessment and treatment in adolescent mental health units. However, these are intended to reduce clinical risk and develop an ongoing plan for recovery in a community-based setting. They are not suitable for providing longer-term care and support around children's social and behavioural needs. Children are excluded from receiving this form of care when they do not meet treatment criteria, or their behavioural and health needs are undiagnosed.
- Children in need of protection with complex support needs may receive intensive therapeutic care and support, coordinated through their residential, foster or kin care placement. However, the ability to undertake assessments and deliver interventions is impeded when children experience placement breakdowns or leave their placements and are uncontactable. Similarly, staff in residential care facilities do not hold the specialist skills for assessing and responding to behavioural support needs.

The CDRB is concerned that without intervention to stabilise children's care, assess their support needs, provide treatment and reintegrate them into stable and positive structures and influences (such as schools, culture, family and communities), their unmet needs (and behaviours) escalate without any one area of government being responsible for the de-escalation of risk.

Case example

By late adolescence, an Aboriginal young person was entrenched in the youth justice system, cycling between periods of detention and community supervision. Their behaviours were seen to have been shaped by early childhood trauma, chronic inhalant use and limited cognitive and emotional ability to regulate their behaviours.

This young person's early years featured multiple experiences of trauma, including familial and community suicides, domestic and family violence and physical and emotional harm. From the age of nine years, the effects of this trauma were evident—they were engaging in illicit substance use, offending and regularly absent from school for long periods of time. In the years that followed, they experienced multiple out-of-home care placement breakdowns, had increasing contact with the youth justice system and expressed suicidal thoughts and attempts. These suicidal thoughts were exacerbated by being away from family and community while the young person was in youth detention.

As this young person's behaviours continued, system responses became reactive—utilising punitive responses to their behaviours and focusing primarily on their immediate suicidal thoughts and plans. The system missed opportunities to provide meaningful and ongoing support to this young person in the context of their adverse early childhood experiences, health needs, intergenerational trauma, displacement from family, community and culture, school disengagement, continued youth justice involvement, recent familial deaths and ongoing deterioration in their mental health and wellbeing.

The CDRB noted the shared role of multiple agencies and services to coordinate responses to young people in these circumstances.

Key theme 2
Continuity of care for children with complex needs

Case example

A young person experienced homelessness following placement breakdowns resulting from carers' concerns about their violent and offending behaviours and being reported missing from their placement.

Simultaneously, their school lost sight of them after they were unenrolled, and they were exited from health services due to non-engagement. At times, agencies struggled to locate them and implement supports and strategies which would have upheld their safety, wellbeing and connections.

The CDRB recognises the significant reforms currently underway in Queensland to strengthen service delivery to children with backgrounds of trauma, in particular the commitments and actions under the *Every Life: The Queensland Suicide Prevention Plan 2019–2029* which include a dedicated focus on children known to the child protection system.

The CDRB also welcomes the recommendations made by the Mental Health Select Committee in its *Inquiry into the opportunities to improve mental health outcomes for Queenslanders* which focus on increased investment in early intervention, strengthened cross-sector strategies to address adverse childhood experiences, and improving the continuity of care to children across service delivery settings. Since the Committee's findings, the Queensland Government has committed $1.645 billion over five years for mental health services.[22] This will include programs and service delivery for young people.

To complement existing efforts to reduce adverse childhood experiences and provide responsive services to address the subsequent impacts of trauma, the CDRB considers that a dedicated whole-of-system model is required to respond to children displaying complex behaviours.

This model must:

- determine the critical points to intervene in children and young people's trajectories
- seek to assess and treat the underlying causes of their behaviours—including addressing their social, emotional, cultural, psychological and health needs
- facilitate children's connection to family, culture and community and involve family in planning and delivering responses wherever possible
- support continuation of, or reintegration into, stable and positive environments, such as school and housing
- be underpinned by cross-agency responsibility and action for responding to children with complex behaviours which recognises the complex and interlinked needs experienced by children (such as health, mental health, education, disability, child protection and youth justice services) during different stages of their development.

Agencies consulted on this recommendation were supportive of the need to holistically address the complex situation of service delivery to young people with complex behaviours. The proposed tertiary stream, particularly the creation of a legal framework for restrictive practices, is a contentious issue and will required detailed consultation and consideration to ensure that the legal framework provides clarity and has a strong monitoring framework to oversee and protect the safety and rights of children. One agency suggested that any proposal to allow restrictive practices should be the subject of an application that is judicially considered, made by an independent decision-maker, to provide the extra layer of oversight.

The Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships reported the authorisation framework for the use of restrictive practices with NDIS participants under the *Disability Services Act 2006* (Qld), is currently under review and includes the potential expansion of the framework to include the use of restrictive practices with NDIS participants who are children. The Board notes the legislative framework for the NDIS provides clarity on the decision and actions taken to use restrictive practices, as well as clear oversight and reporting functions that provide transparency about this practice.

22 Queensland Government, *State Budget 2022–23: Budget Measures (Budget Paper No. 4)*, https://s3.treasury.qld.gov.au/files/Budget_2022-23_BP4_Budget_Measures.pdf

Key theme 2
Continuity of care for children with complex needs

Concluding comments

Children and young people who display complex behaviours are often in contact with multiple agencies or services around their health, wellbeing, education and safety needs. While most agencies are aware of who these children and young people are, they experience specific challenges assessing and delivering responses that best meet the young person's needs, and coordinating cross-agency action that engages the young person and de-escalates their behaviour.

The CDRB observed:

- Children who display complex behaviours have often experienced significant trauma and multiple adverse life experiences, however they miss out on relevant support services unless they have a diagnosed mental health concern or disability.
- Rather than applying punitive responses that exclude the young person from treatment, there is a need to assess and treat the underlying causes of their behaviours.
- As these children often have touchpoints with multiple agencies or sectors, a cross-agency approach is needed which recognises the complex and often interlinked issues they experience.
- Responses to these children should seek to stabilise their care arrangements (within their families or in statutory out-of-home care) while assessments and supports focus on the child's needs (for example, family connection, health and wellbeing, housing and education).
- Staff shortages (for example, shortages of behavioural therapists) must be addressed as part of a broader workforce reform to support assessment and service delivery to children with complex behaviours.

Recommendation 3

The CDRB recommends: that the Queensland Government develops a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours that recognises that multiple government departments come into contact with these young people, and there is no single responsible owner for the assessment and response required to address the complex needs. The model should:

Be informed by a study of child death, serious injury or other relevant cases where the children were identified to have complex needs manifesting in high-risk behaviours to establish:

- commonalities with their trajectory into tertiary systems
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model. (*Recommendation 3.1*)

Include an early intervention stream that provides a pathway for professionals working closely with children and families, such as schools, to trigger a case management response. The response should focus on:

- addressing the social, emotional, cultural and health and wellbeing needs of children and their families which contribute to their behaviours
- supporting the child's family and carers for the continuation of positive family functioning, behavioural guidance and treatment at home
- coordinating health-based assessments and treatments
- working with the child's school to ensure the child is engaged in education; and
- providing access to informal and formal respite for children and families. (*Recommendation 3.2*)

Include a tertiary stream that provides a specialised accommodation service for children that meets the underlying causes of high-risk behaviours that are a danger to themselves or others that is:

- underpinned by a culturally appropriate case management response addressing the social, emotional, health and wellbeing issues of children and their families contributing to the behaviours
- authorised by a clear and appropriate legal framework that clarifies if, when and how restrictive practices can be used, and how the system will be monitored with effective oversight to ensure decisions and actions are in the best interests of the young person; and
- integrates ongoing access for the child to family, culture and education. (*Recommendation 3.3*)

Theme

3 Responding to domestic and family violence

Children's experiences of domestic and family violence can have profound and damaging short- and long-term impacts on their development, health, behaviour, and wellbeing.

Since it was established, the CDRB has observed a high prevalence of domestic and family violence across the cases it has reviewed. In most cases, domestic and family violence was not directly associated with, or did not immediately precede, the child's death. The impacts of domestic and family violence on family functioning and children's wellbeing were evident.

Case example

The CDRB reviewed several cases which included evidence of children and their siblings engaging in violent or aggressive behaviours in the context of ongoing reports of domestic and family violence within their families and households. In some cases, the CDRB reviewed evidence of young children displaying verbal and physical aggression and violence and self-harming behaviours. In other cases, older adolescents demonstrated violent behaviours towards their own partners following recurring reports of violence throughout their childhood.

The CDRB observed recurring issues with critical practice errors, limited engagement with perpetrator programs, service gaps for children and young people and gaps in staff knowledge and skills specific to responding to domestic and family violence. These impacted the quality and timeliness of responses provided to children and families.

Given the observed prevalence of domestic and family violence among cases, the CDRB undertook a review of system responses to 43 children and young people for the purpose of identifying recurring issues and areas for improvement within the child protection system. This review comprised an analysis of system and practice learnings identified by:

- agencies in their reviews of service delivery to children following their deaths; and
- the CDRB.

The CDRB also commissioned Dr Samara McPhedran to prepare a literature review on topic areas relating to service engagement (including engagement with perpetrator programs), comorbidity of risk factors with domestic and family violence and coordinated system responses to children and families who experience domestic and family violence.

This review provided insights from cases and contemporary research about system responses to children and families who experience domestic and family violence, and opportunities to improve practices and responses. The findings were grouped into the following key focus areas.

Assessing risk to children

Agencies' decisions and actions about children's safety did not always adequately identify and respond to lethality indicators or information about risk. Not all forms of domestic and family violence—particularly non-physical forms—or lethality indicators were recognised or understood by agencies, and therefore the associated risks to children were not clearly identified. At times, non-physical forms of violence were discounted when the system over-relied on evidence of physical violence (such as bruises to children or reports of physical violence to police).

Harm (or risks) to children was also missed or minimised, particularly where children were not interviewed appropriately, decisions about their safety were made based on incomplete information, or responses did not consider both the physical and emotional harm caused by violence within their family.

Key theme 3
Responding to domestic and family violence

Case example

The CDRB considered the case of an infant who resided with their parents and older siblings, all under the age of 10 years. The father was subject to a current Domestic Violence Order in relation to violence he had perpetrated against the infant's mother. The father was reported to use physical abuse (hitting, punching, choking, kicking), financial abuse (demanding mother give him her money to use at poker machines, not allowing mother to use her money to buy food), coercive control (isolating mother from family and friends, damaging her car to ensure she could not leave, locking her in the house) and emotional abuse (name-calling, belittling, telling her she was a bad mother, accusing her of having affairs).

In this case, the potential cumulative harm was not considered as the children had not overtly stated what they had witnessed or how it made them feel. Believing that children who present as well-dressed and 'happy' at the time of interview, and who do not disclose domestic and family violence, does not confirm they have not been impacted and are not at risk.

In reflecting on its service delivery to the infant, an agency review report recognised the difficulty of relying on observations from a brief interaction with a child as it minimised and failed to acknowledge the child was impacted or traumatised by their experience of living with domestic and family violence.

Responding to children and families

In most review cases, male caregivers (such as fathers, mothers' partners or stepfathers) were alleged to be the primary person responsible for violence in the household. The CDRB, did however, observe recurring examples of the system not successfully engaging them with interventions or involving them in responses. For example:

- offending parents were not included in investigations, ongoing interventions or referrals to secondary support services, despite their ongoing presence in the household and responsibility in caring for their children
- there was little or no follow-up with offending parents who had left the household or were not present when agencies responded to the incidents
- the system over-relied on offending parents agreeing to address violence, without interventions or supports put in place to facilitate or monitor this.

While agencies used referrals to secondary services for support with addressing domestic and family violence, uptake was low, with no evidence of offending parents successfully engaging with referred perpetrator programs or interventions. Several barriers were considered to have impacted service engagement, such as waitlists for services, fear that engagement would result in Child Safety involvement, lack of referrals to culturally appropriate services and relocation of families.

Case example

A father was supported to contact a men's behaviour change program. The program providers indicated that there would be a four-week wait until the next intake. Agencies disengaged from the family on the basis that the mother and father were engaging in several services, including the referred behaviour change program.

Subsequent information indicated that the father had not engaged with the program and the violence was escalating.

Key theme 3
Responding to domestic and family violence

Fatherhood may be a significant motivator for encouraging men to accept accountability for their actions and change their behaviour.[23] Their motivation to attend behaviour change programs often centres around improving their parenting and relationships with their children.[24] While research on fathers' engagement is relatively scarce, evidence suggests that tapping into a man's desire to be a better father may be an effective means through which to address his use of domestic and family violence.[25] Fathering practices, however, are not well embedded across men's behaviour change programs.

Children who have experienced domestic and family violence are at greater risk of using violent behaviours in their own relationships or being a victim of intimate partner violence as adults.[26] In the cases reviewed most referrals for support focused on parents. The CDRB identified a critical gap in system responses for children and young people who use, or who in the future may use, violence. In some cases, professionals said they received limited guidance or were not aware of services to respond to the needs of young people. This resulted in young people not receiving intervention or support, or assumptions that they could access support themselves if needed. The CDRB reflected on the need to address this gap and deliver responses that recognise the impact of intergenerational trauma among young people and support their healing.

Building capability

CDRB and agency reviews commented repeatedly about the capability of professionals to assess the risks domestic and family violence poses to children and to respond effectively. Oversights and practice errors were often seen to stem from limited staff capacity or gaps in staff skills and training. Reviews called for further rolling out of training and tools, embedding greater consideration of cultural protective factors in responses, and improving connections with Community-Controlled Organisations to facilitate solutions for working with First Nations families experiencing domestic and family violence.

Over recent years, Queensland has experienced significant investment and reform for improving awareness of, and responses to, domestic and family violence. Recommendations made in the *Not now, not ever* report set the vision and direction for Queensland's strategy to end domestic and family violence and ensure that those affected have access to safety and support, with the subsequent *Domestic and Family Violence Prevention Strategy 2016–2026* and action plans providing the roadmap for how this is to be achieved.[27]

One of the significant changes stemming from the *Not now, not ever* report was the establishment of the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB). The DFVDRAB is responsible for the systemic review of domestic and family violence deaths in Queensland and making recommendations to prevent or reduce the likelihood of these deaths. It has made wide-reaching recommendations to systems, policies and practices to reduce domestic and family violence and address contributing factors. This has included recommendations specific to agencies within the child protection system and focused on identifying risks to children.

23 Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work*, 23, 97–104.; Broady TR, Gray R, Gaffney I & Lewis P 2017, 'I miss my little one a lot': How father love motivates change in men who have used violence', *Child Abuse Review*, 26(5), 328–338.; Casey EA, Leek C, Tolman RM, Allen CT & Carlson JM 2017, Getting men in the room: Perceptions of effective strategies to initiate men's involvement in gender-based violence prevention in a global sample', *Culture, Health & Sexuality*, 19(9), 979–995.; Stanley N, Graham-Kevan N & Borthwick R 2012, 'Fathers and domestic violence: Building motivation for change through perpetrator programs'. *Child Abuse Review*, 21(4), 264–274.

24 Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work*, 23, 97–104; Pennell J, Rikard RV & Sanders-Rice T 2014, 'Family violence: Fathers assessing and managing their risk to children and women' *Children and Youth Services Review, 47*(1), 36–45; Stanley N, Fell B, Miller P, Thomson G & Watson J 2012, 'Men's talk: Men's understandings of violence against women and motivations for change', Violence Against Women, 18(11), 1300–1318.; Stanley N, Graham-Kevan N & Borthwick R 2012, 'Fathers and domestic violence: Building motivation for change through perpetrator programs'. *Child Abuse Review, 21*(4), 264–274.

25 Carlson J & Casey EA 2018, 'Perceptions of men who have perpetrated intimate partner violence on creating a transition to fatherhood program', *Journal of Family Violence, 33*(7), 457–468.; Humphreys C & Campo M 2017, *Fathers who use violence: Options for safe practice where there is ongoing contact with children*. Australian Institute of Family Studies: Melbourne.; Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work, 23*, 97–104.

26 Royal College of Psychiatrists, *Domestic violence and abuse – the impact on children and adolescents*, https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children

27 Queensland Government, *Domestic and Family Violence Prevention Strategy 2016–2026*, https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/008db60d-06e9-4702-bb87-48be367edf93/dfv-prevention-strategy.pdf?ETag=ef56a614ca32eedadca2acffc3f37578

Key theme 3
Responding to domestic and family violence

The DFVDRAB's findings and recommendations, alongside those of the Women's Safety and Justice Taskforce and recent Commission of Inquiry into Policing Responses, will significantly shape responses to families and children experiencing domestic and family violence.

The domestic and family violence reform agenda is ongoing, and more time is needed for many of the changes to be fully implemented and impacts for children and families to be realised. It is critical that the experiences and needs of children and young people continue to be at the forefront of this work. There are times that their voices and needs are lost when the system heavily focuses on responding to their parents.

The CDRB has shared findings from its system reviews with review agencies for the purpose of driving continuous improvements in system responses to Queensland children. The CDRB also has a memorandum of understanding (MOU) with the DFVDRAB for the purpose of sharing learnings arising from reviews.

The CDRB consulted with agencies about its findings relating to domestic and family violence and received support for the intent of the recommendation.

Agencies acknowledged the significant reform occurring in the area of domestic and family violence. The reform includes implementation by relevant agencies of recommendations from the Women's Safety and Justice Taskforce and the DFVDRAB, including initiatives to strengthen responses to children's experiences of domestic and family violence.

Concluding comments

Domestic and family violence is prevalent across most cases reviewed by the CDRB. While it was often not directly associated with the death incident, it impacted family functioning and the wellbeing of children.

The CDRB observed:

- Recurring practice or critical thinking errors in how the system assesses and responds to children's experiences of domestic and family violence. At times, harm to children was minimised when their voices were not sought or heard, decisions about them were based on incomplete information, and violence and lethality indicators were not well recognised or understood.
- There are individual and organisational challenges for successfully engaging families in domestic and family violence services or support. Providing services which include a focus on fatherhood and fathering practices may be an opportunity to engage with fathers who use violence.
- There are gaps in supports and system responses to children and young people who use violence or display problematic behaviours that recognises their experiences as both victims and perpetrators of domestic and family violence.

Recommendation 4

The CDRB recognises there is significant reform occurring in the area of domestic and family violence.

The CDRB recommends: that within this reform, the Queensland Government include a focus on:

- children as specific victims of domestic and family violence in their own right
- culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence
- the role of fathers and fathering, as promising points for behaviour change intervention.

Theme

4 Promoting the safety of infants and unborn children

Infants (under 1 year of age) can be vulnerable to abuse or neglect due to their complete reliance on others for survival, their physical immaturity, their undeveloped verbal communication, and their social invisibility. For the second year, the highest proportion of deaths reviewed by the CDRB related to infants (45% in 2021–22 and 33% in 2020–21)—the majority of whom were Aboriginal and/or Torres Strait Islander.

While this proportion is not dissimilar from the broader population of child deaths for the same age group in Queensland,[28] families known to the child protection system often experience multiple and complex needs that can contribute to an increased likelihood of harm to their infants.

Access to quality medical care and safe living conditions serve as protective factors for infants' safety and wellbeing. Over the year, the CDRB has observed the complexity of issues experienced by the families of many infants whose deaths it has reviewed—particularly the comorbidity of substance use (particularly methamphetamines), poor mental health, domestic and family violence and housing instability. Agencies were often aware of these issues and held concerns for the infant's safety and wellbeing prior to, and following, their birth.

Limited early intervention, joined-up assessments between Child Safety and Queensland Health, and timely case management resulted in missed opportunities to:

- assess and ensure a safe and supported home environment prior to health professionals discharging a newborn home when concerns were held for their safety and wellbeing
- promote uptake of antenatal, postnatal and infant health services
- provide education about creating a safer infant sleeping environment
- refer to services that enable families to create safer infant sleep environments in the presence of known risk factors
- connect parents with appropriate services for mental health concerns, substance use or domestic and family violence; and
- foster support networks around the infant and parents.

Queensland offers public health care to infants and their parents through maternal and child health services and general practitioners for ongoing checks and supports for the infant's health, growth and development. This system is challenged with creating visibility and delivering support for infants when their parents do not actively engage with services (including health-based services). Among infant deaths reviewed by the CDRB, there were examples of limited follow-up with families to address barriers to engagement, and delays in agencies or referred services contacting families.

Families in similar circumstances may benefit from longer-term health-based programs which help them to meet their infant's health and care needs.

The CDRB discussed the merits of extending health home visiting programs to support the health and wellbeing of infants, particularly when their families experience entrenched psychosocial issues that may present a risk of harm to them. Extended health home visiting programs start during pregnancy and can continue through to when the child is a few years old. Within these programs, health workers visit parents at home to deliver child health services and parenting support.

28 The Queensland Family and Child Commission reports on the deaths of all children in Queensland (not just those known to the child protection system). In 2020–21, the Queensland Family and Child Commission reported that the highest proportion of child deaths across Queensland related to infants (60%, n=239). Queensland Family and Child Commission 2022, *Child Death Register Key Findings 2020–21: Child deaths in Queensland*, https://www.qfcc.qld.gov.au/sites/default/files/2022-06/All%20child%20deaths%202020-21%20fact%20sheet.pdf

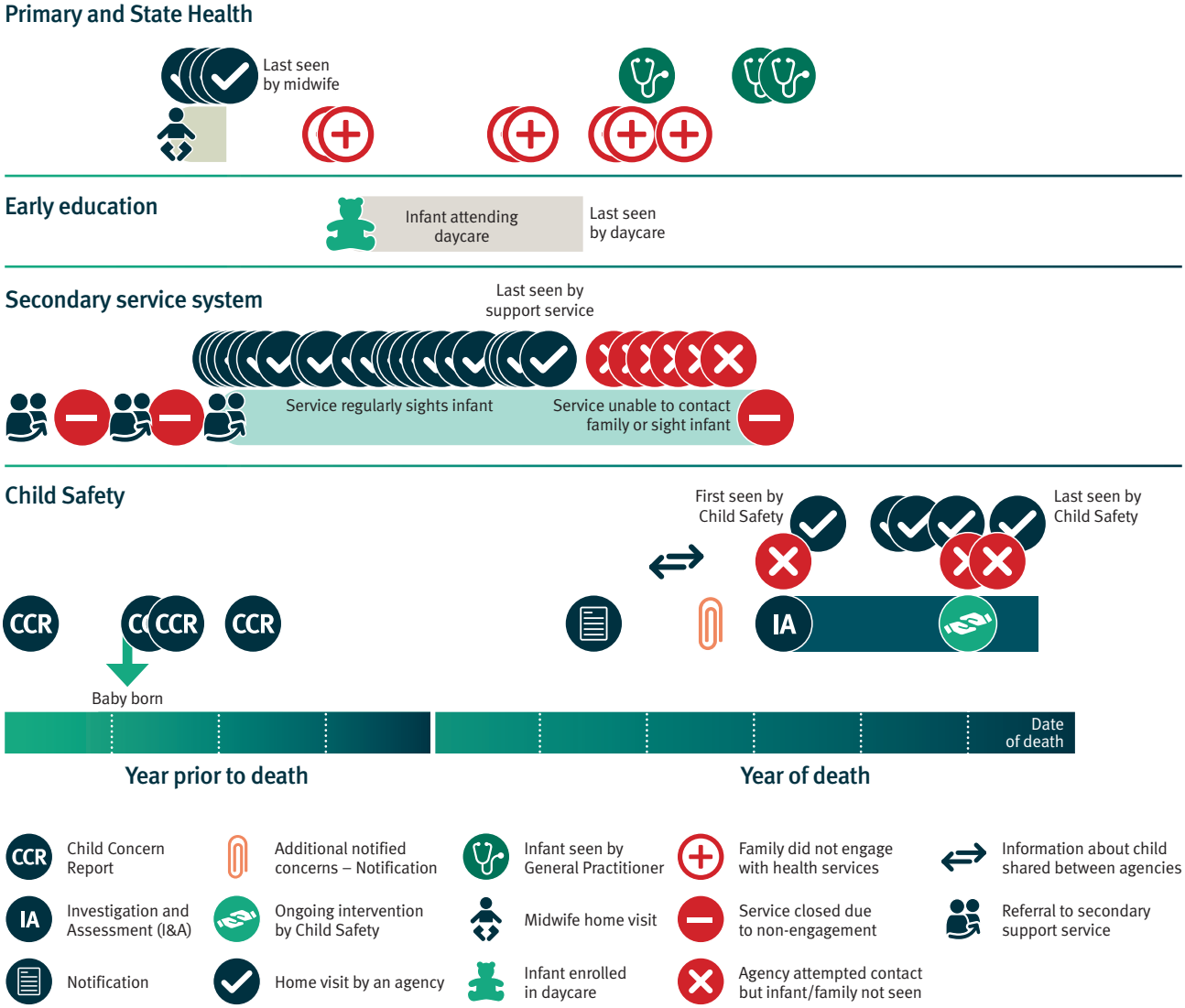
Key theme 4
Promoting the safety of infants and unborn children

Case example

The CDRB reviewed the experience of an infant born to a mother experiencing multiple and complex issues including methamphetamine addiction, untreated mental health issues, poverty and a lack of family and social supports. Agencies were aware that the infant's mother had a history of neglecting her children's basic needs due to drug use and untreated mental health issues.

In this case, concerns about the infant's safety in their mother's care continued. However, as illustrated in **Figure 4**, the system had limited visibility of the family in the weeks and months leading up to the infant's death. This was due to the family disengaging from daycare and health and support services, and delays in visiting the household to assess the infant's safety. During this time, the family was not receiving support to address their needs or to improve the infant's safety in their home.

Figure 4: *An infant's touchpoints with the system in the year prior to their death*



Key theme 4
Promoting the safety of infants and unborn children

The CDRB has previously discussed two existing programs—*right@home* and *Baby One Program*—however, considers that delivery of a home visiting model should be accessible, culturally responsive and relevant to individual infant's and family's needs.

Case study

The *right@home program* is an extended home-visiting program available for families living in the Logan, Beenleigh and Browns Plains, Pine Rivers and Caboolture areas. The program starts during pregnancy or soon after birth, continuing through until the child is two years old.[29] As part of the program, a child health nurse and social worker/psychologist visit parents at home and supports them with any child health and parenting concerns they may have.

The *Baby One Program* is an Aboriginal and Torres Strait Islander health worker-led home visiting program which supports a family-centred model of care. The program engages with women and families from pre-pregnancy until the baby is 1,000 days old. The program aims to improve the health of families, educate families on good health and making healthy choices, as well as providing pre-conceptual care for subsequent pregnancies.[30]

Joint home visitation between child safety officers and child and maternal health nurses may also offer opportunities for collaborative and child-focused practice, acknowledging the specific health expertise required in the assessment of infant wellbeing and enhanced opportunity to reinforce safer sleeping messaging. In December 2021, Child Safety and Queensland Health provided in-principle support to the CDRB's suggestion of joint visitation, but noted consultation and research was required to better understand feasibility and benefits. The agencies are working together to develop options during 2022.

Sudden Unexpected Deaths in Infancy

Infants known to the child protection system are also over-represented in deaths classified as Sudden Unexpected Death in Infancy (SUDI).[31] Just under half of the infant deaths in 2021–22 were classified as SUDI (11 cases), with many of these occurring in the infant's sleep environment. All SUDI events occurred in the child's home (rather than in out-of-home care), suggesting the need for strengthened support and education for families at home.

In recognition of this, the CDRB commissioned the Queensland Paediatric Quality Council (QPQC) to deliver a research report on risk factors for SUDI and to inform system improvements to reduce SUDI deaths among families known to the child protection system. Findings from the QPQC's research, together with information from its reviews, helped inform the CDRB's consideration of strategies to reduce infant deaths within the child protection population, particularly where parental smoking and shared sleep surfaces co-exist.

Research findings: Sudden unexpected death in infancy among vulnerable families in Queensland

The QPQC reviewed literature to provide insights into the risk factors associated with SUDI and components of a successful model for intervening with families known to the child protection system.

The research noted that the majority of SUDI in families known to the child protection system occurred in highly hazardous sleep environments, including sharing a sleep surface, particularly in the context of parental smoking and alcohol and other substance use. A range of other sociodemographic factors were also more frequently reported among this cohort—alcohol and substance use during pregnancy, experiencing domestic and family violence or poor mental health, intergenerational child protection involvement, criminal offending and limited social support.

The research considered that families experiencing social vulnerabilities have fallen behind in their uptake of safer infant care and safer sleep recommendations, and many experience barriers to implementing SUDI risk reduction strategies. However, effective strategies to increase uptake of safer sleep recommendations are lacking and research about how to achieve this specifically among families known to the child protection system is limited.

29 Children's Health Queensland, *right@home: Service detail*, https://www.childrens.health.qld.gov.au/service-right-at-home/

30 Queensland Health 2019, Growing Deadly Families: Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025.

31 Over the last five years, almost one-third of child deaths classified as SUDI have related to children known to the child protection system, see Queensland Family and Child Commission 2021, *Annual Report: Deaths of children and young people Queensland 2020–21*, https://documents.parliament.qld.gov.au/tp/2022/5722T41-FA1A.pdf

Key theme 4
Promoting the safety of infants and unborn children

Instead, research about families at high risk of SUDI and strategies for improving service engagement provides useful guidance on interventions for families known to the child protection system—such as programs that:

- address broader social and economic inequalities
- offer long-term face-to-face support
- establish strong collaborative relationships between services
- are tailored to families' individual circumstances
- involve whole-of-family/social network approaches; and
- incorporate multimodal interventions which provide a safe infant sleep space, coupled with a comprehensive education program.

The QPQC advised that any service likely to be effective in engaging families at high risk of SUDI experiencing social vulnerability must be underpinned by:

- a relationship-based continuity model of care, characterised by positive, trusting, non-stigmatising and non-judgemental partnerships, and continuity of care and carer
- a family-centred approach that recognises and builds on family strengths and competencies, responds to the wider needs and priorities of the family, and increases family participation and partnership through shared decision-making
- a harm reduction approach which empowers parents to make small incremental changes to reduce risk, while helping them to understand the importance of these changes.

The QPQC proposed three priority areas for the CDRB's consideration of system improvements:

- clear and timely multi-agency, bi-directional referral pathways for families with infants and young children experiencing multiple risk factors known to place infants at risk of SUDI and coexisting child protection concerns should be developed
- integration of infant sleep safety assessments and the provision of safer sleep advice into existing assessment and planning with families to reduce child protection concerns should be considered the responsibility of all services involved with these families
- explore statewide implementation of multimodal programs which provide a safe infant sleep space, coupled with comprehensive face-to-face education programs, to assist families to implement safer infant sleep practices.[32]

Importantly, efforts to reduce SUDI among families known to the child protection system should be flexible and tailored to acknowledge and address each family's circumstances. This includes the provision of culturally safe infant care models that meet the needs of Aboriginal and Torres Strait Islander women.

Infant and maternal health feature as priorities across multiple Queensland Government strategies, including the:

- *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*[33]
- *Growing Deadly Families: Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025*[34]
- *Every life: The Queensland Suicide Prevention Plan 2019–2029*[35]
- *Thriving Queensland Kids Partnership*.[36]

Currently there are multiple initiatives and programs underway relevant to infant safety and unborn children, including specialist perinatal and infant mental health services, midwifery group practice, midwife(nurse) navigator services, and development of clinical guidelines on Perinatal Mental Health and Safer Infant Sleep. Funding has also been allocated for the Better Care Together plan to enhance mental health, alcohol and other drug service delivery for new parents and their infants.

The CDRB's research and findings align with Government commitments to promote the best start in life for infants and build strong, resilient families. Individually, review agencies have also expressed a commitment to reviewing and refining practices relating to infants, unborn children and their families and undertaken specific actions accordingly.

32 Sudden unexpected death in infancy among vulnerable families in Queensland: A report prepared by the Queensland Paediatric Quality Council on behalf of the Child Death Review Board

33 Queensland Mental Health Commission, *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023* (October 2018) p. 23, https://www.qmhc.qld.gov.au/sites/default/files/qmhc_2018_strategic_plan.pdf

34 Queensland Health 2019, *Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025*, https://www.health.qld.gov.au/__data/assets/pdf_file/0030/932880/Growing-Deadly-Families-Strategy.pdf

35 Queensland Mental Health Commission 2019, *Every life: The Queensland Suicide Prevention Plan 2019–2029*, https://www.qmhc.qld.gov.au/sites/default/files/every_life_the_queensland_suicide_prevention_plan_2019-2029_web.pdf

36 The Thriving Queensland Kids Partnership is a systems leadership and change initiative led by a small core Queensland-based team with support from ARACY. https://www.aracy.org.au/the-nest-in-action/thriving-queensland-kids-partnership-tqkp

Key theme 4
Promoting the safety of infants and unborn children

For example, Child Safety considered whether guidance in the *Child Safety Practice Manual* could be enhanced to better assist staff take action before the birth of a child when it is reasonably suspected the child may be in need of protection after he or she is born. Queensland Police committed to increasing the awareness of frontline staff to recognise and report the signs of serious concerns for the wellbeing of unborn children. Queensland Health is currently evaluating the *right@home* program to understand how the program translates into local health services and community contexts, specifically within areas experiencing disproportionate levels of disadvantage and child developmental vulnerability.

The CDRB recognises that many families known to the child protection system experience comorbid risk factors, including substance use, mental health issues and domestic and family violence. The system must be alert to the needs of these families and provide additional support through pregnancy, birth and into early childhood. This will help to increase visibility of their infants and ensure parents have access to parenting support and consistent and accurate information about safer sleeping, particularly in circumstances where parental smoking and shared sleep surfaces co-exist.

Concluding comments

The system requires targeted investment in relevant health and social services to support families with infants and young children, particularly when they experience issues such as the co-occurrence of addiction, mental ill-health, housing instability and domestic and family violence.

The CDRB observed:

- During 2021–22, 45 per cent of all deaths reviewed by the CDRB related to the death of an infant (aged under 1 year), with just under half of these classified as Sudden Unexpected Death in Infancy (SUDI).
- Many families known to the child protection system experience comorbid risk factors, such as substance misuse, poor mental health, housing instability and domestic and family violence – a considerable proportion of the SUDI in families known to the child protection system occurred in the context of these factors.
- Inadequate antenatal care and unsafe infant sleep environments, particularly where parental smoking and shared sleep surfaces co-exist, are also risk factors in sudden infant deaths.
- Families known to the child protection system may experience barriers to implementing SUDI risk reduction strategies. Extended health home visiting programs should be offered to families experiencing psychosocial issues to increase opportunity to access relevant parenting support and infant health services. To improve engagement with families known to the child protection system such programs and services should involve:
  - longer term, face-to-face delivery with high-intensity family contact and collaborative working relationships between statutory agencies (i.e., health, child protection, housing) and non-government support services relationship-based, continuity models characterised by positive, trusting, non-stigmatising and non-judgement partnerships and continuity of both care and carer
  - family-centred approaches that acknowledge and build on family strengths and competencies, respond to the wider needs of and priorities of the family (including lack of resources, housing instability, and mental health), and increase family participation through shared decision making, and
  - strong reciprocal links with other relevant services (universal and specialist).

Recommendation 5

The CDRB recommends: that the Queensland Government:

- extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to:
  - supporting and monitoring the wellbeing and development of an infant within the family home; and
  - addressing families' health and psychosocial needs and wellbeing as they arise.
- implements or expands initiatives to create safer sleep environments for all priority Queensland populations by:
  - supplementing home visiting with tiered support strategies using the family's existing resources
  - upscaling multimodal safe sleeping programs to provide an acceptable, feasible, safe, and culturally appropriate initiative for families
  - implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.

Theme

5 Promoting the safety of children with disability

Most children with disability have their health, care and support needs met by their parents and carers who access and navigate services on their behalf. The CDRB reviewed cases where it was evident that some families experience complex issues or competing needs which impact their capacity to understand and navigate services, or they may be unwilling to do so for a variety of reasons. This means that without assistance, they and their children miss out on the critical supports and services to which they are entitled, and they may escalate to statutory services before assistance is provided.

Case study

The National Disability Insurance Scheme (NDIS) is a national scheme which provides *reasonable* and *necessary* disability supports for eligible people with intellectual, physical, sensory, cognitive or psychosocial disability.[37] The scheme places people with disability at the centre of decision-making by providing funding based on individual needs and allowing choice and control with how those funds are used.

The NDIS is administered by the National Disability Insurance Agency.

Assessment and delivery of disability supports to Queensland children and families is managed under the federal National Disability Insurance Scheme (NDIS).

The user-choice model of the NDIS requires that individuals understand and be proactive in seeking and navigating disability supports. For children, parents or carers must act on their behalf. However, both the CDRB and individual agencies have observed that this model does not work for all children. Agency and CDRB reviews identified examples of children not being connected with the NDIS when they should have been. Their families experienced complex issues, such as poor mental health, domestic and family violence or limited support networks. Parents with their own disability, and families with high levels of adversity experience significant challenges trying to navigate the NDIS. In some cases, access to the NDIS system and appropriate plan funding (for the child or their parent) would have prevented children from having contact with the statutory child protection system where concerns related to unmet disability support needs.

Across the system, agencies and organisations also encounter barriers to supporting families to access NDIS and secure adequate, and consistent, plan funding. Universal and secondary services—including schools, health services and family support services (such as Family and Child Connect, Intensive Family Support or Family Wellbeing Services)—are often aware of and working with children and families who experience complex issues. Services are limited, however, in their ability to refer or assist children and families to access the NDIS or engage with NDIS coordinators (such as Local Area Coordinators or Early Childhood Partners) due to conflicting legislative frameworks. Under the *Child Protection Act 1999* (Qld), certain professionals are permitted to share information about a child for the purpose of referring them to services which will decrease their likelihood of becoming in need of protection.[38] However, privacy and confidentiality requirements for sharing information about NDIS participants (or potential participants)[39] limit them from doing so unless parents' consent and engage.

Consequently, the CDRB has observed circumstances where families were reported to Child Safety, in part, due to concerns about parents' capacity to engage with the NDIS.

37 National Disability Insurance Scheme 2021, *What is the NDIS?*, https://www.ndis.gov.au/understanding/what-ndis

38 *Child Protection Act 1999* (Qld), s 159MD.

39 Outlined in the *National Disability Insurance Scheme Act 2013* (Cth) and NDIS Operating Guidelines.

Key theme 5
Promoting the safety of children with disability

Case example

The CDRB reviewed the system responses to a child who lived with, and was cared for, by their family. The family became known to the child protection system following concerns about the parents' mental health and ability to meet the child's medical and disability support needs with a limited support network.

The child had an NDIS plan, however agencies in contact with the family recognised that further supports were needed for the child and their siblings. As the child lived at home, their parents were expected to act on their behalf by seeking a review of their existing NDIS plan and applying for NDIS on behalf of the siblings.

Agencies and services involved with the family acknowledged that the parents were facing their own challenges and needed targeted support to achieve this, however no action was taken due to the parents' consent not being gained.

The parents' difficulties with accessing and navigating the NDIS on behalf of their children resulted in a lack of supports to meet the children's complex needs and significant caring responsibilities being shifted onto teenage siblings.

State and national inquiries and reviews have revealed widespread concerns about the complexity of NDIS access and coordination processes. Recent reviews have called for, among other things, greater equity in access to the NDIS through targeted outreach, access and planning processes that recognise the circumstances and experiences of different cohorts. For example, the Review of the *National Disability Insurance Scheme Act 2013* and *Inquiry into the NDIS market in Queensland* both supported the development of a national outreach strategy for engaging with certain cohorts of people with disability.[40]

In the 2022–23 State Budget, the Queensland Government invested $5.7 million to help children and young people with disability engage with the NDIS. This included funding to extend the Assessment and Referral Team (ART)[41] for a further 12 months, to provide case management to children and young people (aged 7 to 25 years) to assist with the NDIS application process, facilitate free clinical assessments when required, and liaise with specialists. This included targeting support to several cohorts of children and young people, including those who are engaged in, or at risk of entering, justice and child protection systems.[42]

State Government-funded positions have also been established within the Department of Children, Youth Justice and Multicultural Affairs to help ensure children's disability support needs are identified and their NDIS plans meet these needs.[43] These positions have had remarkable impact increasing the support services provided to children, however, children should not need to enter the statutory out-of-home care system to receive this level of support.

Continuing ART for a further 12 months is expected to provide critical support for children and families. However, there is a need for NDIS system design improvements to overcome inequitable access to, and usage of, NDIS disability support funding.

Access and navigation support must be easy for families who have complex lives and limited capacity to navigate government systems. Improvements needed include better enabling universal or secondary services to assist clients with whom they are already engaged and have developed a rapport. The voices of children with disability and their parents should be engaged and listened to in terms of the services required.

Professionals could also better assist those at risk of missing out on disability services if options existed to overcome complicated consent-based barriers and open referral pathways between State Government agencies and the NDIS.

40 Tune D 2019, *Review of the National Disability Insurance Scheme Act 2013: Removing red tape and implementing the NDIS participant service guarantee*, https://www.dss.gov.au/sites/default/files/documents/01_2020/ndis-act-review-final-accessibility-and-prepared-publishing1.pdf; Queensland Productivity Commission 2021, *The NDIS market in Queensland: Final Report*, https://s3.treasury.qld.gov.au/files/NDIS-final-report-volume-1.pdf

41 Assessment and Referral Teams provides an intensive case management approach to support eligible children and young people to access the NDIS. ART can individuals fill out application forms, talk with doctors or specialists, submit NDIS access applications and help track its progress. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, *Assessment and Referral Team*, https://qchub.dsdsatsip.qld.gov.au/art

42 Queensland Government, Funding to boost NDIS access in Queensland, Media Release, 30 June 2022. Available at: https://statements.qld.gov.au/statements/95580

43 Department of Children, Youth Justice and Multicultural Affairs, *Specialist Services*, https://www.cyjma.qld.gov.au/protecting-children/child-family-reform/specialist-services

Key theme 5
Promoting the safety of children with disability

Agencies consulted on the challenges of supporting children and their families to access and navigate NDIS services were generally in agreement with the recommendation, however one agency suggested that it should be amended to place the obligation on the Queensland Government to ensure that ongoing positions are in place to help vulnerable children and parents access the NDIS in complex cases where Commonwealth funded services do not meet their needs.

Some agencies provided examples of initiatives they have implemented to help address their clients interface with disability. For example, Queensland Health has funded seven permanent roles across seven Hospital and Health Services (HHSs) to support long-stay patients within the health system.

The Department of Education works with the NDIA to facilitate NDIS access clinics in areas where there is a need, and partners with the NDIA engagement team to build knowledge and understanding of school communities about NDIS access process and supports available through the NDIS.

Concluding comments

Families known to the child protection system often experience multiple or complex issues that place them at greater risk of experiencing inequitable access to supports and services. The CDRB has observed the significant burden placed on some children and families to access and navigate the NDIS. This has resulted in some families not being connected with the NDIS when they should have, receiving inadequate funding to meet their needs, or not accessing NDIS services under their plans.

The CDRB is of the view that:

- Implementing earlier support to assist this cohort of families to access and navigate the NDIS will promote equitable access and reduce the likelihood of their children having adverse outcomes. This is expected to alleviate the need for a resource and cost-intensive statutory response to unmet disability support needs.
- Some Queensland Government agencies have implemented specialist positions to connect clients to the NDIS. These positions have had an initial cost to the State but were seen to have resulted in greater access to disability support for children and families. The Queensland Government should determine the value of making similar positions easily accessible within universal or secondary services so that this work can benefit families experiencing multiple or complex issues before they enter statutory systems.
- The ability for state-based professionals to refer children and families for NDIS access support and navigation is complicated by legislative barriers for consent and information sharing. Overcoming these barriers will strengthen the role of professionals and help reduce the burden placed on families.

Recommendation 6

The CDRB recommends: that the Queensland Government engages with the Commonwealth Government to improve access for vulnerable children and families to the NDIS by:

- demonstrating the cost benefit of establishing state-based positions across Queensland to help vulnerable children and parents with disability access the NDIS system and receive services – these positions need to be based in universal or secondary services with which children and parents engage
- improving the mechanisms by which children and parents with complex needs can enter and access the NDIS – including consideration of an appropriate agreement that allows prescribed state professionals to refer children and parents to the NDIS on their behalf.

The CDRB expects the outcomes of the engagement to be reported back to it by August 2023.

Chapter 4

Monitoring recommendations

The Child Death Review Board (CDRB or the Board) monitors the implementation of the recommendations it has made in the previous year/s.[44] This includes the status of implementation efforts and nominated timeframes for completion.

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

The CDRB made 10 recommendations in 2020–21. These were tabled in Parliament in the Child Death Review Board Annual Report 2020–21, on 17 February 2022.

As part of the CDRB's monitoring functions the Chair wrote to the chief executives of agencies on 11 July 2022, requesting an update on the implementation of any recommendation on which they were identified as lead agency.

Agency responses in relation to the implementation status of the 10 recommendations from 2020–21 are provided here. The Board noted that out of the 10 recommendations, nine are in progress and one has been completed to the Board's satisfaction.

Recommendation (21) 1

The CDRB recommends: the Department of Children, Youth Justice and Multicultural Affairs strengthens its model 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, 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.

Actions taken by agency

Agency: Child Safety ***Status:*** In progress

Recommendation 1.1

Child Safety transitioned Intensive Family Support (IFS) services to an outcomes-focused performance framework on 1 July 2022. The new framework highlights factors to be considered when assessing the performance of funded IFS services and sets outcomes focused targets, including consent rates and achievement of family case plan goals.

The Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS) program was subject to an evaluation, completed in December 2021, incorporating feedback from 51 families who had used the services. They confirmed the services had helped them to feel more in control of their lives, and to develop strategies for raising their children and coping with their circumstances.

Funds have been identified to implement a workforce development strategy for the Aboriginal community-controlled organisation sector and the membership of a Governance Group to oversee its development and implementation is being finalised. Planning is under way for reform of the service model in remote communities.

Intensive Family Support Client Satisfaction Surveys provide direct information from families about their experiences of the IFS program. Families who have engaged with an IFS service are requested to complete the survey at the conclusion of the intervention. The results are collated and analysed by Child Safety on a six-monthly basis and presented to the Family and Child Connect (FaCC) and IFS Strategic Implementation Group.

The department continues to monitor and report on escalation, i.e., the proportion of families who receive support from IFS and FWS services who subsequently become the subject of an investigation by Child Safety.

Chapter 4 Monitoring recommendations

Recommendation (21) 1

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.

Actions taken by agency

Agency: Child Safety ***Status:*** In progress

Recommendation 1.2

The Queensland Government and Family Matters Queensland continues to work in partnership with communities and key stakeholders to implement *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037* to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children and families in the child protection system and close the gap in life outcomes by 2037.

The *Our Way* strategy and supporting actions are aligned with Family Matters Building Blocks, and Queensland Government commitments under Closing the Gap, Path to Treaty, Local Thriving Communities and priorities outlined in the National Framework for protecting Australia's children. This provides a framework for the work currently being undertaken in Investment and Commissioning to strengthen responses of the secondary sector.

Child Safety is continuing with IFS enhancements which includes strengthening cultural capability in IFS services through the Model and Guidelines and Investment Specifications. An emphasis on active implementation of the Aboriginal and Torres Strait Islander Child Placement Principle and providing culturally safe services with trauma-informed practices are key areas for strengthening.

As a result of the FWS evaluation, the service model for remote communities will be reformed to reflect the workforce profile in those communities. The revised model will be better able to respond to the complex needs of local residents. Work will also focus on expanding and skilling the workforce in the community-controlled sector to ensure an ongoing supply of staff with the skills required to respond to the challenges faced by families.

Recommendation 1.3

The current feedback mechanism (email) regarding family engagement, initially just to Child Safety regarding engagement, has been expanded to include both IFS and FaCC services providing feedback to Queensland Health and Department of Education referrals. Some services have established their own feedback mechanisms however a standard approach is being developed to ensure feedback is provided consistently across the system.

In addition, the Intake Program Improvement team (Statewide Operations), in partnership with Investment and Commissioning, is reviewing the services available to refer families subject to intake reports to ensure that families have access to early intervention.

Chapter 4 Monitoring recommendations

Recommendation (21) 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
- 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.

Actions taken by agency

Agency: Child Safety ***Status:*** In progress

Child Safety completed a Multiple Event Review trial focusing on intake responses to consecutive intake reports. The trial asked intake staff to consider four key questions on the third consecutive report in a 12-month period to assist in quality risk assessment, assessing impacts for children, understanding the effectiveness of any past referrals to the secondary sector and undertaking analysis of lengthy and complex child protection history.

The Multiple Event Review trial had a positive impact on intake child safety officers' ability to understand the cumulative impact of child protection history and improved confidence and capabilities in risk assessment.

Child Safety's Office of the Chief Practitioner continues work to embed the associated practice guidance and support. Ongoing work is also continuing with the Unify Program to explore how the new IT system can support the Multiple Event Review questions and improve visibility of child protection histories.

New child safety officers (CSOs) are offered mandatory training on Intake as a dedicated eLearning course where they are working in this role on the child protection continuum. This eLearning course is currently under review in collaboration with staff from the Intake Reform project. The processes involved in reviewing the child protection history and identifying patterns of harm and cumulative harm will be included in the updated version.

Chapter 4 Monitoring recommendations

Recommendation (21) 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; and
- 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.

Actions taken by agency

Agency: Child Safety ***Status:*** In progress

A paper on cumulative harm was prepared by the Intake Program Improvement Team in 2021 which provided operational, practice and procedural options for improvement. This paper is informing revisions to practice guidance and training resources.

Risk assessment practice guidance for staff has been updated in mid-2022 and includes strengthened content on cumulative harm in the practice guide *Assess harm and risk of harm*. Implementation activities across the state and in regions are making staff aware of the new practice guidance developed in the context of the removal of the Structured Decision Making risk related tools.

Content on cumulative harm is being updated in all training products:

- Training on cumulative harm is interwoven throughout mandatory 2-week face-to-face training for new CSOs, focused on the definition of cumulative harm and how it is assessed across all aspects of case work.
- A 2.5-day training on Assessing, Safety Risk Strengths and Belonging in mandatory face-to-face training has just been reviewed and as of 25 July 2022 an updated version will be released as a 3-day course
- A one-day face-to-face workshop on cumulative harm is delivered as required across the state.
- An eLearning course on cumulative harm is under development which will be released in August 2022.
- Cultivating Risk Assessment training was delivered to senior team leaders and senior practitioners in 2021–22 and is now being on delivered in all CSSCs for CSOs.

Chapter 4 Monitoring recommendations

Recommendation (21) 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 (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; and
- 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 Board and the QFCC's systemic review of intervention with parental agreements may be used to develop this training.

Actions taken by agency

Agency: Child Safety ***Status:*** In progress

Updates to the Child Safety Practice Manual have included significant changes to strengthen risk assessment, which includes assessment of whether a parent is able and willing.

All senior team leaders and senior practitioners have completed and all CSOs are currently undertaking Cultivating risk assessment learning circles to strengthen their risk assessment skills (to be completed by December 2022).

In addition to the previously mentioned updates to CSO training referred to in response to *Recommendations 2 and 3*:

- The one-day mandatory training for new CSOs on *Foundation Studies in Culture* was updated in April 2022 and has a strong focus on identifying culturally capable behaviours through an Aboriginal and Torres Strait Islander peoples cultural lens and has an enhanced focus on the cultural differences in parenting roles, family structures and child rearing practices.
- New training module: *Factors impacting decision making* was released in July 2022 and this course examines the factors which can impact decision making in assessments by unpacking cognitive biases, parental deception, and disguised compliance along with strategies to reduce their impact in child protection assessments.
- At the introductory level CSOs undertake training in domestic and family violence – the mandatory module is currently being updated and the 4 other modules have been updated in the last 12 months.
- Safe and Together training continues to be offered to practitioners to ensure DFV informed child protection practice which has a strong focus on perpetrator patterns of behaviour, perpetrator accountability, and partnering with victim survivors to protect children. Child Safety regions have trainers and the resources to train at least 240 staff statewide per year.

Ongoing updates are being made to CSO training including:

- The *Readiness for Child Protection Practice* two-week face-to-face program was reviewed as part of the Learning and Development project which concluded in February 2022. A revised version of this program is being launched on 25 July 2022 as version 5.
- From January 2023, version 6 of this program will include an extra week of face-to-face training.

From 2023 capability development will include one-to-one support from a Learning and Development Team with staff located in regions to support new CSOs in their first year of practice.

Chapter 4 Monitoring recommendations

Recommendation (21) 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 Board, 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; and
- 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 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; and
  - support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.

Actions taken by agency

Agency: Child Safety and Queensland Health

Status: In progress

Child Safety and Queensland Health have established cross-agency working groups to define, design and implement key activities that meet the intent of *Recommendation 5*.

To assist with determining priority focus areas for implementation, the cross-agency working groups have progressed a mapping exercise that captures the enablers and barriers to seeking, weighting and engaging expert advice from health professionals – spanning across Child Safety and Queensland Health services, systems and projects.

The mapping exercise and any future planned activities will be further refined through stakeholder engagement, which includes an upcoming co-agency workshop in September 2022, and consultation with Aboriginal and Torres Strait Islander community-controlled health services.

Chapter 4 Monitoring recommendations

Recommendation (21) 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 Board 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; and
- 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.

Actions taken by agency

Agency: Queensland Mental Health Commission ***Status:*** In progress

The Queensland Mental Health Commission continues to progress the coordination and oversight of whole-of-government suicide prevention priorities.

This includes the planning and collaborative renewal of *Shifting minds*, and development of phase two of *Every life: the Queensland Suicide Prevention Plan 2019–29*.

Youth suicide has been identified as an area of priority focus for further development under phase two of *Every life*. The renewal of *Shifting minds* and development of phase two of *Every life* will be informed by the evaluation of *Shifting minds* and review of *Every life* phase one that is currently underway, and this will involve comprehensive stakeholder engagement and consultation across government, non-government organisations, and people with lived experience.

Scoping and preliminary consultation has commenced to inform a project plan to support the cross-sectoral development of a targeted response to youth suicide prevention. This includes consideration of the research commissioned by the CDRB, *Highly vulnerable infants, children and young people: a joint child protection mental health response to prevent suicide*.

Concurrently work is in progress to address specific areas identified by the CDRB commissioned research. This includes scoping and development of a workforce competency framework for the human services and education workforce. A key aim of this work is to ensure that workforces and volunteers in the child safety, family services, youth justice, education and housing and homelessness services have competencies in recognising, responding to, and supporting the mental health, alcohol and other drugs, and suicide prevention needs of vulnerable young people. The development of this framework has included consultation with young people with a lived experience of out of home care, the Queensland Family and Child Commission (QFCC) Youth Advisory Council, the housing sector, non-government sector, as well as relevant peak body stakeholders through the Queensland Aboriginal and Islander Health Council (QAIHC) and Queensland Network of Alcohol and Other Drug Agencies (QNADA).

Chapter 4 Monitoring recommendations

Recommendation (21) 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; and
- 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.

Actions taken by agency

Agency: Child Safety and Youth Justice ***Status:*** In progress

Child Safety

Child Safety has progressed scoping and engagement with internal and external stakeholders regarding suicide prevention, including initial internal feedback regarding current policies and procedures.

A suicide prevention working group has been established to develop an action plan for Child Safety including review of policies and procedures.

Youth Justice

An independent audit of suicide risk management within the Youth Justice portfolio in 2020, and Systems and Practice Reviews (SPRs) tabled at the Youth Justice Systems and Practice Review Committee (SPRC), revealed significant practice opportunities existed to improve Youth Justice's response and management of suicide risk. Accordingly, recommendations included updates to Operational Policy/Procedures, development of supporting practice resources and enhancement of learning and development activities for all Youth Justice Staff.

A working party was formed in 2021 to assist this process, with a focus on aligning community and Youth Detention Centre procedures and practice, and on improving the transition process. Broad consultation was undertaken by the working party to inform this work, including frontline staff across the state and Queensland Health.

Key areas for review included:

- Clarifying timeframes for risk management plans completion.
- Clarification of staff responsible for completing medium to long-term plans for young people where a suicide risk alert is raised whilst a young person is in detention.
- Establishing processes to review and refer to already developed medium to long-term plans where multiple alerts have occurred within the same episode of detention and the existing medium to long-term plan is considered current and appropriate to address the risk.
- Developing improved information sharing processes, particularly between detention and community staff to ensure the accurate understanding of suicide risks (i.e., those identified within Suicide Risk Assessment Team processes) on transition between settings.
- Establishing consistent responses to the identification and management of suicide risks practice across all Youth Justice roles (i.e., Restorative Justice and Co-responder Team staff).
- The reviewed Operation Policy/Procedure was approved by the Assistant Chief Operation Officer of Youth Justice in October 2021.
- Development of supporting practice resources for staff and enhanced learning and development opportunities for staff.

Chapter 4 Monitoring recommendations

Recommendation (21) 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.

Actions taken by agency

Agency: Queensland Mental Health Commission and Queensland Family and Child Commission

Status: In progress

Given the nuances and complexities around children and young people's access to services without parental consent, and the need to develop safe and accurate messaging, the QFCC and QMHC agreed to separate the action into two parts – the delivery of youth friendly messages to raise awareness about mental health services and other supports, and a separate piece focussed on addressing the issue of parental consent.

The following implementation activities have been completed collaboratively by QFCC and QMHC:

- Awareness about mental health services and supports
  - Stakeholder consultation with the sector to identify key issues, existing youth friendly messages, best method of communicating messages and need to involve young people in project development.
  - QFCC contracted headspace to run a social media campaign on accessing and consent for young people to have their own Medicare card to support access to mental health services.
  - The campaign went live on digital and social platforms on 5 June. This resulted in:
    - over 1 million young people reached
    - 7,900 clicks through to the landing page to read the article.
  - A supporting QFCC digital media campaign from 1–28 June 2022. This resulted in:
    - over 548,000 young people reached
    - 43,000 clicks on the ad.
  - QFCC staff and youth advocates developed digital assets (animation videos) to raise awareness on mental health supports through a 'Let's have this convo, together' campaign
  - QFCC procured an external animator to develop the animation videos based on the storyboard and content developed by youth advocates and co-endorsed by QMHC.

  In progress:
  - Development of a QFCC media campaign across QFCC to promote and share the 'Let's have this convo, together' animations (second half of 2022). QMHC will also be able to use these animations, should they choose to run a campaign.
  - Development of assets that addresses consent to accessing and sharing information with mental health services.

  Not yet commenced:
  - Evaluation and future recommendation following media campaigns.
- Parental consent awareness
  - A third digital animation has been drafted addressing consent and parental access to information by mental health services providers. QFCC and QMHC are considering further development the strategies required to address the intent of the action.

Chapter 4 Monitoring recommendations

Recommendation (21) 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; and
- 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.

Actions taken by agency

Agency: Department of Education ***Status:*** Completed

The Department of Education completed an audit of 42 suicide postvention plans from schools across the state. Plans were considered against identified audit criterion. DoE is on track to incorporate findings of the audit into a report to be provided to the CDRB by August 2022.

Learnings from the audit will be used to inform DoE's resources (including the Student Learning and Wellbeing Framework and Supporting Students' Mental Health and Wellbeing procedure) and the support available to schools around the development and ongoing review and implementation of their plans. This will contribute to strengthening DoE's and school's approaches to responding to suicide events and, ultimately, will be associated with positive impacts for schools and students.

Recommendation (21) 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.

Actions taken by agency

Agency: Queensland Family and Child Commission ***Status:*** In progress

The Queensland Family and Child Commission is committed to working collaboratively with state- and non-state school sectors to progress recommendation 10 relating to extending its suicide notification process to non-state schools. It has identified, and is consulting, with officers from the Department of Education, the Queensland Catholic Education Commission and Independent Schools Queensland on the approach to implement this recommendation and the perceived benefits of the model for students in non-state schools.

Consultations are ongoing with these stakeholders about the legal, procedural and technological requirements to deliver this recommendation. Where barriers are identified, the QFCC will also consider other options to implement this recommendation which still meet its intent.

QFCC will also explore opportunities to notify other agencies with close links to families not enrolled in state or non-state schools.

Chapter 5

Board governance and operations

In 2021–21, the CDRB met five times. In addition to undertaking systemic reviews, meetings focused on reviewing and improving CDRB processes and engaging stakeholders to inform discussions about systemic improvements needed.

Meetings

The CDRB held five meetings in 2021–22. The Chair presided at all meetings.

A quorum[45] was present at all meetings except for Meeting 8. Conclusions from the discussion and actions arising out of Meeting 8 were ratified at the commencement of Meeting 9.

Meetings were:

- **Meeting 7:** Review meeting — 25 August 2021 at the QFCC Boardroom. At this meeting, the CDRB reviewed 14 cases.
- **Meeting 8:** Review meeting — 24 November 2021 at the QFCC Boardroom. Twelve cases were reviewed. As this meeting was held without a quorum present, minutes and actions were agreed to be ratified at the next meeting.
- **Meeting 9:** Review meeting — 23 March 2022 at the QFCC Boardroom. Thirteen cases were reviewed. The minutes and actions made at Meeting 8 were ratified. The CDRB Code of Conduct was endorsed by members for progression to the responsible minister for approval.
- **Meeting 10:** Review meeting — 18 May 2022 at the QFCC Boardroom. Fourteen cases were reviewed.
- **Meeting 11:** Annual meeting — 15 June 2022 at the QFCC Boardroom. Board members discussed the issues arising from their work over the past year and drafted the recommendations to be included in this report. Principles and approaches to making recommendations were confirmed. Two cases were reviewed.

Special presentations to the Board involved:

- **Meeting 7**
  - Professor Jeanine Young provided an overview of the *Pēpi-Pod*® program, highlighting that the program extends beyond the pod itself, to include the education, support and community that forms part of the larger program. *Pēpi-Pod* as a product are less effective than *Pēpi-Pod* rolled out as a program.
- **Meeting 8**
  - Deputy State Coroner Jane Bentley was invited to discuss the overlaps between the coroner's inquest process and the CDRB. Ms Bentley also spoke on the child death review system and how it has improved over time, particularly the increased collaboration between agencies.
  - Ms Susan Beattie, Manager, Domestic and Family Violence Death Review Unit, Coroner's Court of Queensland, was invited to participate in the review discussion of three Level 3 cases because of the domestic violence focus of the reviews. Ms Beattie discussed perpetrator intervention strategies and the challenging language around domestic and family violence.
  - Ms Georgina Richters, First Nations Advisory, was invited to attend the meeting and take part in the case discussions. Ms Richter is a senior Aboriginal professional, with over 25 years' experience in leadership roles and providing systemic and cultural advice. Ms Richter provided invaluable cultural and system insights.
  - Ms Penny Creamer, Executive Director Oversight, QFCC outlined to the CDRB outcomes of the Community Perspectives and Workforce Surveys. The surveys revealed confidence in the child protection system by community is holding steady but further increased system demand.
- **Meeting 10**
  - Mr Nigel Miller, Director of Child Protection Litigation, joined the meeting for the level 3 review discussion.

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

Attendance

		Meeting 7	Meeting 8	Meeting 9	Meeting 10	Meeting 11
		25 Aug 2021	24 Nov 2021	23 March 2022	18 May 2022	15 June 2022
Member	**Agency**	**Review meeting**	**Review meeting**	**Review meeting**	**Review meeting**	**Annual meeting**
Cheryl Vardon	QFCC (Chair)	●	●	Retired		
Luke Twyford		Yet to be appointed		●	●	●
Clinton Schultz	Non-government (Deputy Chair)	●	Resigned			
Jody Currie		Yet to be appointed		●	●	●
Hetty Johnston AM	Non-government	●	Resigned			
Simone Jackson	Non-government	Yet to be appointed		●	●	●
Bruce Morcombe OAM	Non-government	●	●	●	●	●
Jeanine Young AM	Non-government	●	●	●	●	●
Shanna Quinn	Non-government	●	○	●	○	●
Margaret Kruger	Non-government	○	●	○	○	●
Meegan Crawford	DCYJMA (Child Safety)	●	●	●	●	●
Hayley Stevenson	DoE	●	●	●	●	●
Stephen Stathis	QH	●	●	●	●	●
Darren Hegarty	DCYJMA (Youth Justice)	○	○	Not CDRB member	○	●
Nicholas Dwyer		Not CDRB member		●	Not CDRB member	
Mark White	QPS	●	●	Not CDRB member		
Stephen Blanchfield		Not CDRB member		●	○	●

● Present
○ Apology

Code of conduct

The *Public Sector Ethics Act 1994* requires the chief executive of a public sector entity to develop a code of conduct to govern the behaviour and responsibilities of individuals who will be bound by the code.

A draft code was developed and discussed with board members at Meeting 9 on 20 April 2022. After further amendments and out-of-session consultation it was sent to the Attorney-General for approval on 29 June 2022.

Implementation and process evaluation

In early 2022, the Secretariat, on behalf of the CDRB, undertook an implementation and process evaluation. The evaluation was designed to determine if the CDRB has been fully implemented as intended by the legislation and the CDRB's Procedural Guidelines, and to explore how well the processes supporting the new model of child death review are functioning, and to identify areas for improvement.

The scope of the implementation review included the implementation of the CDRB, but not the implementation of the internal agency review processes by relevant agencies.

Information underpinning the evaluation was obtained in April and May 2022 from a desktop review, and surveys of current and former CDRB members, current and former members of stakeholder agencies who had experience of CDRB processes, and current and former members of the Secretariat.

Responses were received from 14 current or former CDRB members, 11 current or former members of stakeholder agencies, and nine current or former members of the Secretariat.

The implementation review found that the CDRB had generally been implemented as intended with only three minor issues identified which are in the process of being addressed.

The process review identified many positive response areas, including governance matters, the diversity of CDRB member's experience, the quality of the commissioned research, and the Secretariat's support to the CDRB, including briefings, reports, research, recording meeting outcomes and preparation of draft recommendations.

The review highlighted opportunities for improvement in relation to strategies to maintain independence, representation of Aboriginal and Torres Strait Islander persons on the CDRB, and the volume of material CDRB members have to read and the caseload for each meeting.

Recruitment processes to replace CDRB members completing their three-year appointment at the end of June 2023 will include a focus on attracting interest in CDRB membership from Aboriginal and Torres Strait Islander persons. CDRB members in 2022–23 will discuss ways to reduce the workload at each meeting.

Conflicts of interest

CDRB members disclosed a personal interest relating to a review as required by legislation[46] on six occasions. Examples of interests disclosed include:

- volunteer community engagement bringing a member into limited contact with the case prior to being aware the case would be presented to CDRB
- having a senior role in an organisation that receives funding from Child Safety
- signing off on an internal agency review or having been involved in their department's service delivery to a child (government members)
- being a researcher and team member on programs considered for mention in a recommendation.

No members were asked to be absent from the case discussion for which they declared a potential conflict of interest, however, the Board agreed the researcher and team member would not engage in any discussions in the annual report meeting in which recommendations were being developed, relating to those programs.

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.

Action items

The CDRB assigned 21 action items in 2021–22, mostly to the Chair and Secretariat. Key actions included alerting relevant agencies to emerging matters as they arose. By the end of the financial year, 12 action items were completed. The remaining nine are in progress with seven scheduled to be completed by the first meeting in the new financial year. The six items incomplete from the 2020–21 financial year were also completed.

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

Stakeholder engagement and partnerships

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
- carried out similar review functions in other Australian jurisdictions
- are expected to be affected by or can assist in implementing system change recommended by the CDRB
- may assist in communicating the CDRB's key messages to a wider audience.

To support this, the Secretariat (on behalf of the CDRB) has 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 four media releases discussing areas of vulnerability and providing updates on milestones and data.

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 operational guidelines were revised in late 2021/early 2022, as proposed by the working group and drafted by the CDRB Secretariat.

The guidelines standardise agency internal review practices and guide information sharing between these agencies and the CDRB. This group comprises representatives from all review agencies,[47] 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 four times during 2021–22 to monitor the number of upcoming internal agency reviews and discuss the implementation of new child death review model processes and emerging issues.

Memoranda of understanding

The CDRB has 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. The main aim of the information sharing is 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 being finalised with agencies.

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 2022–23 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 2021–22, it commissioned one contract for this purpose. This was a literature review focused on system responses to domestic and family violence. An issues paper commissioned in the previous financial year relating to the prevalence of Sudden Unexpected Death in Infancy (SUDI) among families known to the child protection system was presented to the CDRB in 2021–22. These projects were undertaken in response to the number of child deaths where these issues were present and to support the CDRB to identify opportunities for system improvements.

Insights from these reports helped inform the recommendations in Chapter 3.

47 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.

Cultural integrity

In 2021–22, the CDRB considered the deaths of 28 First Nations children (51 per cent of the deaths it reviewed).

The Chair and Deputy Chair are working closely with Board members and relevant stakeholder to identify and address system issues that have a disproportionate effect on First Nations children, families and communities.

When considering the deaths of First Nations children, the Board will look at the active efforts of agencies to apply and uphold the Aboriginal and Torres Strait Islander Child Placement Principle and to provide culturally safe and responsive services.

Upholding the rights and best interests of First Nations children and their families will continue to be a focal point for the Board.

Risk management

The Secretariat, on behalf of the CDRB, has 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.

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Appendices

Appendix 1 Glossary of terms and acronyms
Appendix 2 Remuneration of the Child Death Review Board

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	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://cspm.csyw.qld.gov.au/glossary**	
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 **See https://cspm.csyw.qld.gov.au/glossary**	
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.
Intensive Family Support (IFS) programs	Intensive Family Support programs provide case management to families at risk of entering the statutory child protection system.
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.
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 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 met on five occasions in 2021–22, including one annual meeting. A total of 55 child deaths were reviewed in this period. One research project was commissioned and the report from a project commissioned in the previous year was received.
Financial reporting	The CDRB is audited as part of the Queensland Family and Child Commission. Accounts are published in the annual report.

Appendix 2
Remuneration of the Child Death Review Board

Remuneration

Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved sub-committee fees *if applicable*	Actual fees received
Chair (government)	Cheryl Vardon[48]	2	$0	N/A	$0
Chair (government)	Luke Twyford[49]	3	$0	N/A	$0
Deputy Chair (non-government)	Clinton Schultz[50]	1	$4,500	N/A	$1,125
Deputy Chair (non-government)	Jody Currie[51]	3	$4,500	N/A	$1,125
Member (non-government)	Simone Jackson[52]	3	$4,500	N/A	$1,125
Member (non-government)	Hetty Johnston AM[53]	1	$4,500	N/A	$1,125
Member (non-government)	Margaret Kruger	2	$4,500	N/A	$4,500
Member (non-government)	Bruce Morcombe OAM	5	$4,500	N/A	$4,500
Member (non-government)	Shanna Quinn	3	$4,500	N/A	$4,500
Member (non-government)	Jeanine Young AM	5	$4,500	N/A	$4,500
Member (government)	Meegan Crawford	5	$0	N/A	$0
Member (government)	Hayley Stevenson	5	$0	N/A	$0
Member (government)	Stephen Stathis	5	$0	N/A	$0
Member (government)	Darren Hegarty[54]	1	$0	N/A	$0
Member (government)	Nicholas Dwyer[55]	1	$0	N/A	$0
Member (government)	Mark White[56]	1	$0	N/A	$0
Member (government)	Stephen Blanchfield[57]	2	$0	N/A	$0
Number of scheduled meetings/sessions	5				
Total out-of-pocket expenses	$963 (accommodation, meal allowance and member taxi fares/parking)				

48 Cheryl Vardon ..... Chair for meetings 7 & 8.
49 Luke Twyford ..... Chair for meetings 9 to 11.
50 Clinton Schultz ..... Deputy Chair for meeting 7.
51 Jody Currie ..... Deputy Chair for meetings 9 to 11.
52 Simone Jackson ..... member for meetings 9 to 11.
53 Hetty Johnston ..... member for meeting 7.
54 Darren Hegarty ..... member for meetings 7, 8, 10 & 11.
55 Nicholas Dwyer ..... member for meeting 9.
56 Mark White ..... member for meetings 7 & 8.
57 Stephen Blanchfield ... member for meetings 9 to 11.

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Child Death
Review Board
Queensland **Family & Child** Commission

Queensland
Government