

June 2024

# Operational Guidelines

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



Queensland  
Family & Child  
Commission



### Acknowledgement

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

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

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

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

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

### Copyright

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**1 July 2022**

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Version	Date	Description
1.0	28 May 2020	Endorsed by cross-agency working group
1.0	1 July 2020	Approved for release by Directors-General, Commissioner of Police and the litigation director
1.1	11 April 2022	Endorsed by cross-agency review group
1.1	1 July 2022	Approved for release by Principal Commissioner, QFCC
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# Introduction and overview

## Background

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

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

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

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

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

The Act established a new child death review model by:

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

The child death review model commenced on 1 July 2020.

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

## Purpose

Chapter 7A (Internal agency reviews following child deaths or injuries) of the *Child Protection Act 1999* (CP Act 1999) outlines the legislative responsibilities of agencies in carrying out reviews, including determining whether a service was provided to the child within the year prior to their death.<sup>2</sup>

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

## Agencies required to undertake reviews

These guidelines apply to agencies responsible for undertaking reviews under Chapter 7A of the CP Act 1999. These agencies<sup>3</sup> are:

- Child Safety
- Education
- Queensland Health (QH)
- the Queensland Police Service (QPS)
- Youth Justice
- the Director of Child Protection Litigation (DCPL).

### Definition



For the purposes of these guidelines:

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

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

Relevant agency	DCPL
If the agency has been involved with the child, the head of the relevant agency must undertake a review of the relevant agency's involvement with the child. <sup>4</sup>	If the DCPL has performed a litigation function in relation to the child, a review must be conducted of the Office of the Director of Child Protection Litigation's (ODCPL) involvement in the matter concerning the child. <sup>5</sup>

<sup>2</sup> In alignment with section s245C of the CP Act 1999, any reference in this document to providing a service to a child includes a reference to interacting with a child, or a member of a child's family, in relation to a matter relevant to the child's safety and wellbeing.

<sup>3</sup> Relevant agencies refer to the core service delivery area. Multiple service delivery areas may be coordinated by one Department.

<sup>4</sup> See sections 245H and 245I of the CP Act 1999 for details of requirements for reviews, and section 245K of the CP Act 1999 for further details on the scope of a relevant agency review.

<sup>5</sup> See section 245J of the CP Act 1999 for details of requirements for reviews and section 245L of the CP Act 1999 for further details on the scope of a litigation director review.

The review process set out in legislation is summarised below.  
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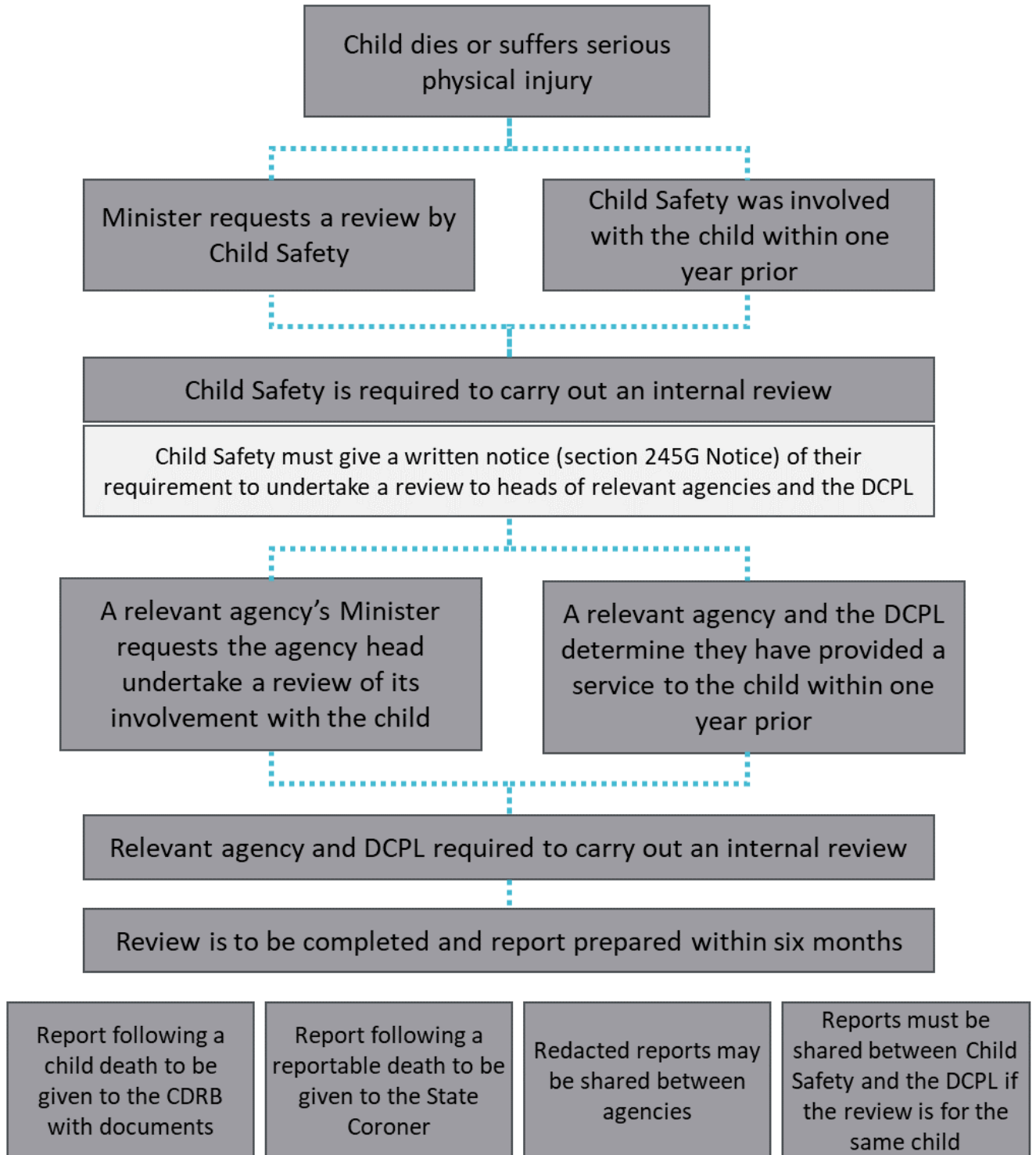


Figure 1 – Agency review process

## Guiding principles for agency review

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

### Purpose

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

#### Improve service delivery

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

#### Promote accountability

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

#### Joint learning

Target review reports to inform agency learnings, as well as systemic learnings by the Child Death Review Board.

### Values

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

#### Child-focused

The best interests of children are at the centre of all reviews and decisions.  
Agencies will acknowledge the child as an individual and consider the personal and environmental factors specific to that child.

#### Culturally inclusive

Agencies will include Aboriginal and Torres Strait Islander peoples to identify culturally relevant learnings.  
Agencies will consider the child's cultural identity when determining the adequacy and effectiveness of services provided to a child.

#### Responsive to diversity

Agencies will consider the individual needs of children in determining the adequacy and effectiveness of services provided to that child.

#### Transparent and accountable

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

#### Objective

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

#### Courageous

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

#### Respectful of staff knowledge

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

#### Non-adversarial

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

#### Support collaboration and joint learning

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

<p><b>Provide information in a timely way</b></p> <p>Agencies will put processes or delegative structures in place so that information can be shared in a timely way to support each other's reviews.</p>	<p><b>Share findings</b></p> <p>Agencies will share review outcomes with other relevant agencies who have undertaken a review on the same case.</p>	<p><b>Privacy and confidentiality</b></p> <p>Agencies will protect the confidentiality of information in accordance with the CP Act 1999 and use appropriate data controls when sharing sensitive information.</p>
<p><b>Process</b></p> <p>Applying flexible review processes will optimise agency efficiency, while having some consistent elements will support value across the broader review process</p>		
<p><b>Flexible</b></p> <p>Reviews may be undertaken in the manner most appropriate for the agency and the case being reviewed.</p>	<p><b>Terms of reference</b></p> <p>Each agency will determine its own terms of reference for a review by considering the nature and extent of its involvement with the child and their family.<sup>6</sup></p>	<p><b>Scope to reflect agency or public value</b></p> <p>The scope of an agency review will be determined by each agency and should allow greatest focus to be placed on matters that provide the greatest opportunity for learning and improvement to services.</p>
<p><b>Time period for review</b></p> <p>Relevant agencies can determine the terms of reference, scope and time period for a review; however, at a minimum, must review at least the 12 months prior to the child's death or serious physical injury.</p>	<p><b>Reflection on review process</b></p> <p>Agencies will reflect on review processes and look at ways to continuously improve them over time.</p>	

## Step 1 – Establish an agency co-ordination point

### Agency co-ordination point



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

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

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

<sup>6</sup> In alignment with section s245C of the CP Act 1999, any reference in this document to providing a service to a child includes a reference to interacting with a child, or a member of a child's family, in relation to a matter relevant to the child's safety and wellbeing.

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

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

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

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

Co ordinate the receipt and provision of information and advice about the requirement to undertake a review	
Responsibility	<p>Child Safety co-ordination point</p> <ul style="list-style-type: none"> <li>determine triggering event<sup>7</sup> as soon as practicable</li> <li>issue Section 245G Notice<sup>8</sup> and allocate case number</li> <li>allocate case number for agency reviews triggered by a request for a review by the Minister for Child Safety</li> </ul>
	<p>All co-ordination points (other than Child Safety) in response to a Section 245G Notice</p> <ul style="list-style-type: none"> <li>determine if a review is required as soon as practicable</li> <li>notify agencies if a review will be conducted and the date of the triggering event (and the CDRB when the matter relates to a child death) as soon as practicable</li> <li>notify agencies if no review is required (and the CDRB when the matter relates to a child death)</li> </ul>
	<p>Co-ordination points (other than Child Safety) in response to request for a review by a Minister</p> <ul style="list-style-type: none"> <li>notify Child Safety of triggering event and request case number from Child Safety</li> <li>notify other relevant agencies of triggering event and case number</li> <li>notify the CDRB when the matter relates to the death of a child</li> </ul>
<i>See Step 2—Determine the requirement for an agency review</i>	
Co ordinate information, advice and assistance for agencies planning a review	
Responsibility	<p>All co-ordination points</p> <ul style="list-style-type: none"> <li>request and provide information necessary to assist with determining the scope and time period for a review</li> <li>notify agencies of terms of reference or aspects of a review that have shared value or impact</li> <li>if requested, organise access to data, information, people and funded organisations within an agency’s remit</li> </ul>
<i>See Step 3—Plan for an agency review</i>	

<sup>7</sup> A ‘triggering event’ is defined at section 245M of the CP Act 1999. The triggering event happens at different points for relevant agencies. See Figure 2—Agency review flowchart.

<sup>8</sup> Child Safety provides the Section 245G Notice to the DCPL when it is performing, or has performed, a litigation function in relation to the child.

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

**Responsibility**

All co-ordination points

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

*See Step 4—Conduct an agency review*

**Co ordinate the provision of reports and review outcomes**

**Responsibility**

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

- identify and share outcomes relevant to other review agencies
- may provide the review report to relevant agencies or the DCPL which undertook a review on the same matter (the report must be redacted before sharing) (Child Safety and DCPL do not need to redact reports when sharing with each other)
- following a child death, provide a copy of the review report and any source documents to the CDRB
- following a reportable death under the *Coroners Act 2003*, provide a copy of the review report to the State Coroner

Child Safety and DCPL co-ordination points within six months of the triggering event

- provide the review report to each other

*See Step 5—Prepare a report about the review*  
*See Step 6—Share the review outcomes and provide a report*

## Step 2 – Determine the requirement for an agency review

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

**Triggering event**



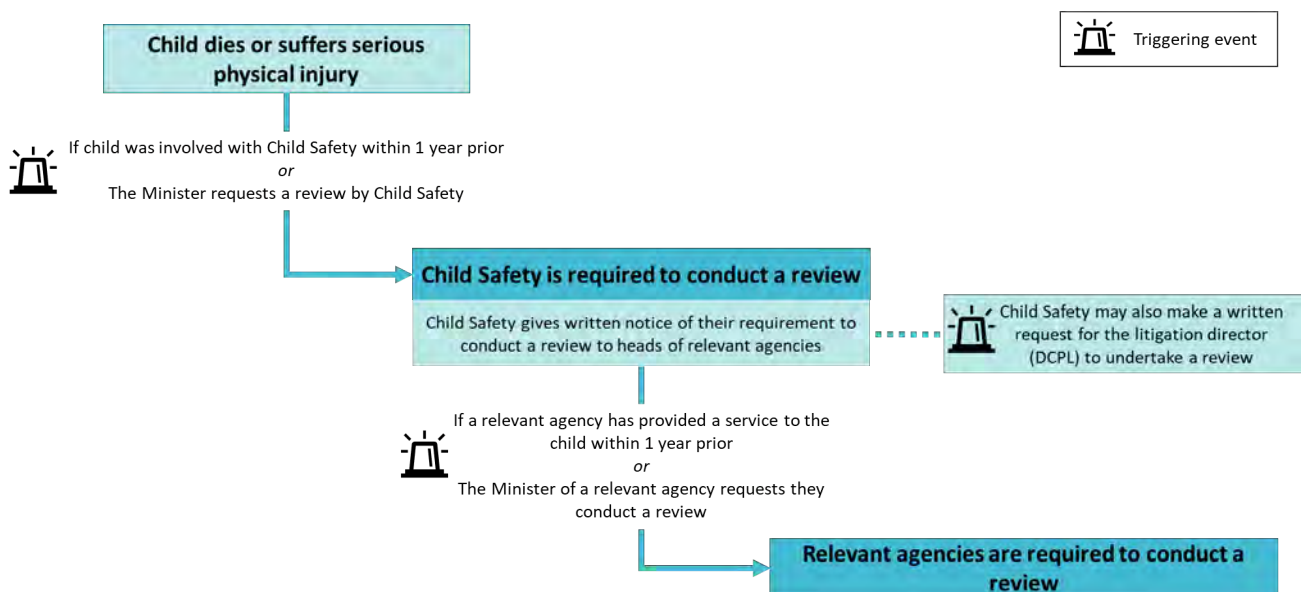
A **'triggering event'** is defined at section 245M of the CP Act 1999. The criteria for triggering events for a relevant agency are set out in section 245M(1). The criteria for a triggering event for the DCPL are set out in section 245(M)2. See Figure 2—Agency review flowchart.

Relevant agencies are the departments of:

- Child Safety
- Education
- Queensland Health (QH)
- Queensland Police Service (QPS)
- Youth Justice

For a relevant agency, the review is of the agency's involvement with the child.<sup>9</sup>

For the DCPL, the review is of the ODCPL's involvement in the matter concerning the child.<sup>10</sup>



**Figure 2**—Agency review flowchart

<sup>9</sup> See section 245K of the CP Act 1999 for further details on the scope of a relevant agency review.

<sup>10</sup> See section 245L of the CP Act 1999 for further details on the scope of a DCPL review.

## Issue a notice

Child Safety must give a written notice (using the standardised Section 245G Notice) of its requirement to undertake a review to heads of relevant agencies and the DCPL (or delegates).<sup>11</sup>

The Section 245G Notice must include:

- child's name
- an internal agency review case identifier generated by Child Safety (to be used by all agencies)
- the Integrated Client Management System (ICMS) number for the child
- child's date of birth
- child's date of death or serious physical injury<sup>12</sup>
- child's address, including previous known address within the review period
- indicative cause of death or serious physical injury, including a brief description of circumstances
- parent/carer name/s, including address of primary residence or last known
- current living arrangement (for example, their home address, a hospital or a residential care facility).

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

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

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

## Determine if a review is required

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

### Services provided to a child



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

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

The DCPL will confirm, as soon as practicable, whether the criteria<sup>13</sup> is met to undertake a review on receipt of the Section 245G Notice. If the DCPL is required to undertake a review, the date of the triggering event is the date that Notice is received from Child Safety.

<sup>11</sup> For Queensland Health, this is the Director-General of Queensland Health, and not the chief executive of a Hospital and Health Service.

<sup>12</sup> Serious physical injury means (a) the loss of a distinct part or an organ of the body; or (b) serious disfigurement; or (c) any bodily injury of a nature that, if left untreated, would endanger or be likely to endanger life, or cause or be likely to cause permanent injury to health.

<sup>13</sup> Section 245J of the CP Act 1999

## Notify other agencies

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

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

## If a Minister requests a review

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

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

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

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

# Step 3 – Plan for an agency review

## Determine if a review is required

### Terms of reference



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

The terms of reference for each review may vary and be focused on a particular issue, circumstance, aspect of service delivery or otherwise consider all services provided to the child. To determine these, each individual agency considers the type and extent of involvement with the child.

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

Each agency review must have terms of reference.

The terms of reference for a relevant agency may include any of the following matters:<sup>14</sup>

- a. determining whether the agency's involvement with the child complied with legislative requirements and the agency's policies

<sup>14</sup> Section 245K of the CP Act 1999

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

The terms of reference for a DCPL review may include any of the following matters:<sup>15</sup>

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

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

#### ***Other consideration in determining the terms of reference of a review***

Reviews relating to Aboriginal and/or Torres Strait Islander children should involve First Nations peoples. Agencies will consider their own Aboriginal and Torres Strait Islander frameworks and strategies to determine the appropriateness of responses and areas for improvement.

Agencies will acknowledge each child's heritage and understand their own unique cultural needs.

Review processes should also be responsive to a child's differing abilities and be inclusive of their diversity.

#### ***Determine the scope and time period for the review***

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

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<sup>15</sup> Section 245L of the CP Act 1999

### Scope and time period for review



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

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

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

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

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

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

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

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

### Consider opportunities for collaboration

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

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

Existing mechanisms between agencies will be used to share review outcomes with relevant agencies and the CDRB.

## Step 4 – Conduct an agency review

### Agencies to establish procedures for conducting a review

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

- undertake a review within 6 months of a triggering event
- facilitate ongoing learning and improvement in the provision of services
- promote accountability
- support collaboration and joint learning
- develop terms of reference that will be most appropriate for the case
- involve Aboriginal and/or Torres Strait Islander peoples when reviews relate to an Aboriginal and/or Torres Strait Islander child
- promote processes that are responsive to cultural and individual differences
- engage staff in the review, including holding non-confrontational and non-blaming discussions.

### Information sharing for purpose of agency reviews

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

- a relevant agency asking another for information relevant to a review<sup>16</sup>
- an entity giving confidential information to a relevant agency for the purpose of an internal agency review, whether the information was requested or not<sup>17</sup>
- relevant agencies sharing the outcomes of their internal review with each other<sup>18</sup>
- providing a copy of the review report (See *Step 6—Share the review outcomes and provide the report* for details).

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

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

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

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

### Sharing confidential information

Section 245S of the CP Act 1999 enables relevant agencies to share information to effectively carry out reviews.

<sup>16</sup> Section 245T(1) of the CP Act 1999

<sup>17</sup> Section 245T(2)–(3) of the CP Act 1999

<sup>18</sup> Section 245T(3) of the CP Act 1999

As per Section 197A of the CPA Act 1999, a person who honestly gives information for this purpose is not liable in any way and cannot be held to have breached any professional standards.<sup>19</sup>

### **Giving information to the CDRB**

As legislated under section 29P of the *Family and Child Commission Act 2014* (FCC Act 2014):

- the Chair of the CDRB may ask any entity for information for the purpose of the board's functions and
- any entity<sup>20</sup> may give confidential information to the Chair for the purpose of the board's functions, whether or not the Chair requested the information.

It is a principle underlying the information sharing provisions that public entities should give the information requested and a person acting honestly is protected from liability for giving the information.

To assist with information sharing, the CDRB and a public entity may form an information sharing agreement.<sup>21</sup> For example, there is a Memorandum of Understanding (MOU) between the CDRB and QFCC, and CDRB and Domestic and Family Violence Death Review Advisory Board. The MOU reduces duplication among reviews of same cases and enables learnings to be shared between the review entities.

Information should be shared with the CDRB in a collaborative and timely way.<sup>22</sup> Doing this will improve the quality of systemic findings and recommendations to improve the child protection system.

## **Step 5 – Prepare a report about the review**

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

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

### **Collaboration with other agencies**

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

#### **Example**



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

<sup>19</sup> Section 197A, Section 245V(2)–(4) of the CP Act 1999

<sup>20</sup> Sections 5 (dictionary in schedule 1), 29P and 29T of the FCC Act 2014 and section 245T(4) of the CP Act 1999

<sup>21</sup> Section 29R of the FCC Act 2014

<sup>22</sup> Section 290 of the FCC Act 2014

In writing a report, if an agency includes a recommendation or an action that is likely to impact another agency, consultation with that agency must occur prior to completing the report.<sup>23</sup>

### Example



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

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

At any stage of the review process, an agency may request to establish a working group with other agencies undertaking a review about the same matter. This allows agencies to share learnings and discuss and resolve issues in a timely way to improve service delivery to children.

### Report approval

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

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

## Step 6 – Share the review outcomes and provide the report

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

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<sup>23</sup> Note: Agencies will only be making recommendations for their own service provision and not for other agencies.

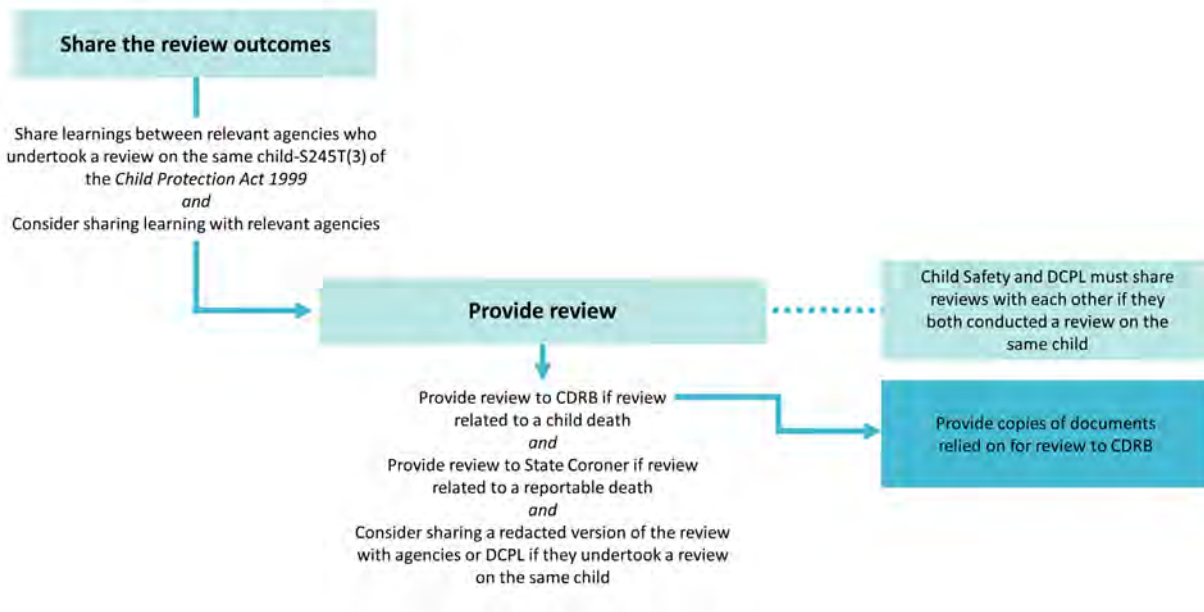


Figure 3—Providing reviews and review outcomes flowchart

### Identify whether review outcomes should be shared with relevant agencies who carried out an internal review

Section 245T(3) of the CP Act 1999 allows the head of a relevant agency to give confidential information to the head of another relevant agency for the purpose of sharing the outcomes of an internal agency review (the DCPL is unable to do so as it is not a relevant agency).<sup>24</sup>

Information will be shared through agency co-ordination points. The QH co-ordination point will be responsible for liaising with HHSs about sharing their learnings with other agencies.

### Requirement to provide reports to others

The DCPL and the chief executive of Child Safety must give a copy of their review report to the other if both have carried out a review for the same child.<sup>25</sup> Information does not need to be redacted where the DCPL and Child Safety share the report between each other following a review for the same child.

If the DCPL and the head of a relevant agency (other than Child Safety) are both required to carry out a review for the same child, each may give a **redacted** copy of the review report to the other.<sup>26</sup>

<sup>24</sup> As DCPL is not included in section 245T(3) of the CP Act 1999, it is unable to share a report with a relevant agency that has not conducted a review.

<sup>25</sup> Section 245Q of the CP Act 1999

<sup>26</sup> Section 245R(1) of the CP Act 1999

**Redacted**

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

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

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

**Reportable death**

**Reportable deaths** are deaths where:

- the person's identity is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a cause of death certificate hasn't been issued and isn't likely to be
- the death was related to health care
- the death occurred in care, custody or as the result of police operations.

Usually, a police officer or medical practitioner will report a death to the coroner and/or coronial registrar; however, everyone has an obligation to report a death if they suspect it has not been reported.<sup>27</sup>

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

**Documents relied on to prepare reports**

The Agency head or DCPL who carries out a review must give the CDRB a copy of the review report<sup>28</sup> and copies of any documents obtained by the agency or the DCPL and used for the review.<sup>29</sup> Copies of documents provided to the CDRB must be in accessible, digital form. These include documents obtained by the agency and used for the review, together with the report document.

**Step 7 – Share the review outcomes and provide the report****Monitor implementation of recommendations**

<sup>27</sup> Queensland Courts, available at <https://www.courts.qld.gov.au/courts/coroners-court/coroners-process/reportable-deaths>

<sup>28</sup> Section 2450(1) of the CP Act 1999

<sup>29</sup> Section 2450(1) of the CP Act 1999

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

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

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

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

### Consultation with agencies on CDRB recommendations

If the CDRB intends to recommend in a report that a certain agency take responsibility for a recommendation, it must consult on that recommendation before finalising the report.<sup>30</sup>

It must also provide agencies with a reasonable opportunity to make a submission about adverse information included in a report.<sup>31</sup>

Where the agency makes such a submission, the CDRB must:<sup>32</sup>

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

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

### Queensland child death register

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

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

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<sup>30</sup> Section 29L(3) of the FCC Act 2014

<sup>31</sup> Section 29L(1) of the FCC Act 2014

<sup>32</sup> Section 29L(2) of the FCC Act 2014

## Appendices

### Appendix 1—Template for Section 245G notice

#### Section 245G Notice

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

<b>Section under which this review is being carried out</b>	Section 245E <input type="checkbox"/> (Child Safety review following involvement with child) Section 245F <input type="checkbox"/> (Child Safety review at Minister's request)
<b>Case Review Number (assigned by Child Safety)</b>	
<b>Child's details</b>	
Family name	
Given names	
ICMS Client Number	
Date of birth	
Death or serious physical injury	Death <input type="checkbox"/> If Death, is it a reportable death? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Serious physical injury <input type="checkbox"/>
Date of death/serious physical injury	
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/>
Child's primary place of residence (address)	
Placement type	<input type="checkbox"/> In-home <input type="checkbox"/> Kinship <input type="checkbox"/> Foster <input type="checkbox"/> Residential <input type="checkbox"/> Other: _____
Previous known addresses of child	
Aboriginal or Torres Strait Islander status	Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/>

	Both Aboriginal and Torres Strait Islander <input type="checkbox"/>	Not stated <input type="checkbox"/>
<b>Death/serious physical injury incident</b>		
Date of triggering event (Child Safety)		
Circumstances of death/injury (brief description)		
Location of death/injury incident		
<b>Family details</b>		
Mother's name		
Mother's date of birth		
Father's name		
Father's date of birth		
Carers' name (if relevant)		
Carers' date of birth		
<b>Child protection status</b>		
Child protection status at time of death/injury		
Missing person at time of death/injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments		
<b>Form administration</b>		
Form completed by		
Date		

## Appendix 2—Example of notification to other agencies

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

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

### **Agency undertaking a review**

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

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

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

*Louise Black  
DoE Co-ordination point  
[contact details]*

### **Agency NOT undertaking a review**

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

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

*Louise Black  
Education Co-ordination point  
[contact details]*

### **Agency undertaking a review at request of own agency Minister**

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

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

*Date of Ministerial request: [DD/MM/YYYY]  
Child Safety to reply to email with the allocated Case Review Number for this matter.*

*Louise Black  
Education Co-ordination point  
[contact details]*

## Appendix 3—List of Amendments

Changes to the Operational Guidelines as agreed by the Cross-agency review group.

### 1 December 2021 commencement

Summary Reports discontinued.

Changes to the Section 245G template:

Removal of sibling identities.

### 1 June 2022

Changes to the Section 245G template:

Inclusion of child's previous known addresses

Inclusion of child's living arrangement at time of incident

Mother's, Father's and Carers' date of birth added.

Two new principles, "culturally inclusive" and "responsive to diversity", were added.

Guidance on developing terms of reference and review scope expanded to provide greater clarity.

Definition of reportable death added.

Department names updated.

Reference included to agencies being able to request the formation of a working group with other agencies undertaking reviews on the same case.

### 30 June 2024

Changes to:

- Page 7 (and related details in diagram on page 18), under the roles of responsibilities for agency coordination points, under the fourth heading **Co-ordinate the provision of reports and review outcomes**, in the first dot point of *identify and share outcomes relevant to other review agencies, whether or not they conducted a review on the same child* – **omit** *whether or not they conducted a review on the same child*.
  - Resulting text to be: *Identify and share outcomes relevant to the other review agencies.*
- Page 17, in **Step 5-Prepare a report about the review** in the text between the two diagrams which reads *In writing a report, if an agency includes a recommendation that is likely to impact another agency, consultation with that agency must occur prior to completing the report*– **insert** after 'recommendation' or an action.
  - Resulting text to be: *In writing a report, if an agency includes a recommendation or an action that is likely to impact another agency, consultation with that agency must occur prior to completing the report.*