

September 2025

# Monitoring the Implementation

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Queensland Family and Child  
Commission and Child Death  
Review Board

# Recommendations

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QUEENSLAND  
**Family & Child**  
Commission



# Executive Summary

The Queensland Family and Child Commission (the Commission) is a statutory body with responsibilities to provide oversight, advocacy, and advice on critical matters affecting children and families. Through its evidence-based and comprehensive approach, the Commission makes recommendations that are grounded in research and informed by lived experiences, quantitative data, case studies, and extensive stakeholder feedback. This approach provides for practical, realistic, and effective recommendations to government to address the complex challenges facing children and families.

Recommendations produced by the Commission are aimed at promoting lasting, meaningful change within systems, policies, and practices. While they serve as an important catalyst for systemic reform, it is essential to recognise that the value of recommendations made by any oversight entity lies in the outcomes for the end-user in the system – the experience for the children and families engaging with the child protection system.

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The role of monitoring is critical in transforming these recommendations from theoretical solutions into **tangible systemic change**. This goes beyond transactional confirmation of an agency completing a task as written in a recommendation – it is a **continuing dialogue between the Commission and government** to genuinely report on whether systems have improved, that families are better supported, and that children are safer.

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An outcomes-focused approach to monitoring the implementation of recommendations considers not only whether a recommendation has been actioned, but further whether the reform has resulted in the intended improvements in practice – to contribute to a transformation of how systems function, how professionals act, and how children experience care and protection.

Over the past decade, the Commission and the Child Death Review Board (the Board) have made 222 recommendations aimed at improving the child protection system in Queensland. This report provides a progress update on the status of implementation of these recommendations and considers the policy reform and practice changes that have come into effect as a result of findings and recommendations by the Commission and the Board.

**222 recommendations**

made by the Commission and Board

# Background

The Commission is charged with responsibilities to review and improve the systems designed to protect and safeguard Queensland's children. The Commission is governed by the *Family and Child Commission Act 2014* (FCC Act) and has specific functions under the legislation for the purposes of promoting the safety, wellbeing and best interests of children and young people and improving the child protection system. This includes to provide oversight of the child protection system, to analyse and evaluate, at a systemic level, policies and practices relevant to the child protection system and the performance of relevant agencies in delivering services, and to provide leadership and give expert advice to relevant agencies about laws, policies, practices and services.<sup>1</sup>

As part of its oversight of the child protection system, the Commission may make recommendations to the government that are based on oversight reviews, evidence gathering, and expert analysis, and are aimed at improving policies, practices, and outcomes for children and families in Queensland. Recommendations made by the Commission are intended to address identified systemic risks or challenges and serve as a tool for driving meaningful, sustainable improvements within the child protection system.

Recommendations delivered to government are subject to acceptance by the government of the day. Where government has accepted a recommendation, the Commission will maintain oversight of the actions undertaken to progress that recommendation and will evaluate the outcomes of the implementation action with consideration to the policy intent of the recommendation and the experience for the end-user engaging with the system.

The Commission undertook a full review of recommendations in 2024 to deliver a collated register of all recommendations delivered to government and ascertain a status update of the progress made to deliver on the policy intent suggested in the relevant oversight reports. This process involved targeted discussions with responsible Agencies, engagement with stakeholders, and analysis of the information provided to deliver a collated register of recommendations, a comprehensive summary of the status of recommendations, and to provide for continuous improvement for the Commission in how we consider and develop recommendations.

The 2024 review included a theming process to group the types of recommendations made in reviews and reports, which provides valuable understanding for the Commission and government alike, as to the types of recommendations being made, and providing nuance when considering the recommendations which remain outstanding.

## Child Death Review Board

The Commission hosts the Board and provides secretariat support. The purpose and function of the Board, as outlined in the FCC Act, is to carry out reviews relating to the child protection system following the death of a child connected to the system, to analyse data, and apply research, to identify patterns, trends and risk factors relevant to reviews of the Board, and to make recommendations about *"improvements to systems, policies and practices for implementation by government and non-government entities that provide service to, or otherwise interact with, children and their families"*.<sup>2</sup> The Board is required to monitor the implementation of any recommendations made through its functions. This is supported by the active monitoring conducted by the Commission.

## Active recommendation monitoring

The primary purpose of monitoring recommendations is to engage with government to promote meaningful, long-term change within the child protection system which improves outcomes for children and families. Monitoring

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<sup>1</sup> Queensland Legislation (2014). *Family and Child Commission Act* (2014). [Family and Child Commission Act 2014](#)

<sup>2</sup> Queensland Family and Child Commission (2025). *Child Death Review Board*. [Child Death Review Board | Queensland Family and Child Commission](#)

serves as a mechanism to track the progress of recommendations, ensuring that they are translated from conceptual solutions into actionable strategies, and measurable outcomes.

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## Intentional monitoring of recommendations fosters accountability and transparency.

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This accountability is not only crucial for ensuring the successful delivery of reforms but also for maintaining the trust of the public, stakeholders, and the communities that engage with the child protection system. By monitoring the progress of recommendations, the Commission can provide regular updates, share information on outcomes, and ensure that all stakeholders are aware of the status of ongoing reforms. This process promotes continuous improvement by creating a dynamic feedback loop. As reforms are implemented, the Commission can assess their effectiveness, identify any emerging gaps or unintended consequences, and make recommendations for further adjustments or improvements. This adaptive approach enables our engagement with the child protection system to remain responsive to the evolving needs of children and families in Queensland.

## Keeping pace with change through agile, system-wide recommendations

In alignment with our commitment to continuous improvement in our oversight functions, the Commission has evolved how recommendations are crafted and delivered to government, adopting a greater strategic focus in our approach.<sup>3</sup> Recommendations are developed through the integration of evidence, expert analysis, and stakeholder input to provide well-informed, feasible, and impactful actions with clear policy intent to improve outcomes for Queensland children and families.

In a dynamic policy landscape, recommendations in child protection must be agile. As societal values, political priorities, and research evolve, so too must the guidance provided to agencies and decision-makers. Recognising that recommendations are often borne out of a point-in-time systemic review based on actions, outcomes, or experiences which have already transpired, the Commission acknowledges the need for future-focused, strategic recommendations which move beyond transactional 'fixes' to identified system issues that have occurred and rather, brings the broader picture more clearly into view. This provides recommendations which aim to address the many moving parts of the system in a way that respects the interconnectedness of the system and the specific and particular functions they deliver.

This approach is reflected in contemporary recommendations by the Board and the Commission, which propose strategies to address gaps in interagency collaboration, legislative inadequacies, and structural capability deficits. These types of recommendations aim to address root causes, enabling long-term reforms that benefit not only those engaged with the child protection system, but all children and families in Queensland. By concentrating on system-wide reform, the Commission avoids the risk of contributing to excessive regulatory burden, which can overwhelm frontline workers and stifle flexibility. Overly prescriptive procedural guidance may unintentionally lead to a compliance-driven "checklist mentality," diverting attention from strategic reform and child-centred goals. In contrast, system-focused recommendations promote innovation, adaptability, and holistic improvement.

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<sup>3</sup> Queensland Family and Child Commission (2023). Oversight Framework: How the Queensland Family and Child Commission selects, designs and conducts reviews, audits and evaluations. [Queensland Family & Child Commission // 2023-2027 Oversight Framework](#)

## Aged recommendations

The December 2024 report raised the need to consider the applicability and relevance of aged recommendations and explore the suitability of continuing to monitor and action these recommendations.<sup>4</sup> The report identified that, at the time of publishing, 20 of the 37 recommendations reported as outstanding were delivered to government prior to 2022 - more than three years old:

- Keeping Queensland's children more than safe: Review of the Blue Card System (2017);
- A spotlight on vulnerable infants: Improving responses to red flags (2019); and,
- Looking beyond behaviours: Responding to vulnerable children with high-risk behaviours (2020).

The outstanding recommendations related to policy and procedure (13; 6.2% of all recommendations), program/service design (8; 3.8% of all recommendations) and legislation reform (7; 3.3% of all recommendations). At the time of 2024 review, the Commission received advice from government that some recommendations had been delayed due to machinery of government changes impacting responsible Agency clarity, and the extensive work required to enact recommendations which relate to legislative changes given the time taken to progress amendments through Parliament. It was also acknowledged that the policy and reform landscape has changed significantly over the past eight years, with a number of Inquiries, taskforce reports, oversight reviews and agency audits resulting in a comprehensive register of recommendations being held by the primary child protection portfolios.

In preparing this report, the Commission considered these aged recommendations in the context of current and upcoming reform and in consultation with responsible Agencies.

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<sup>4</sup> Queensland Family and Child Commission (2024). Monitoring of the implementation of recommendations made by the Queensland Family and Child Commission and the Child Death Review Board. [Monitoring of the implementation of recommendations report | Queensland Family and Child Commission](#)

## Keeping Queensland children more than safe: A review of the Blue Card System

Through a dedicated effort by government to progress the remaining 16 recommendations from *Keeping Queensland's children more than safe: Review of the Blue Card System* ('Blue Card report'), this report has been finalised.

It was identified that the majority of recommendations made in the Blue Card report related to *legislation reform* (38; 46.9%) and *policy and procedure* (30; 37.0%). With such a large number of recommendations seeking legislative changes and policy improvement, delays were experienced in the progression and realisation of the intent of the recommendations; some recommendations contained interdependencies relying on other actions prior to completion, or where finalisation was dependent on legislation change.

In July 2025, the Commission met with responsible Agencies to confirm the actions undertaken to progress the Blue Card report recommendations and supported the finalisation of all outstanding recommendations.

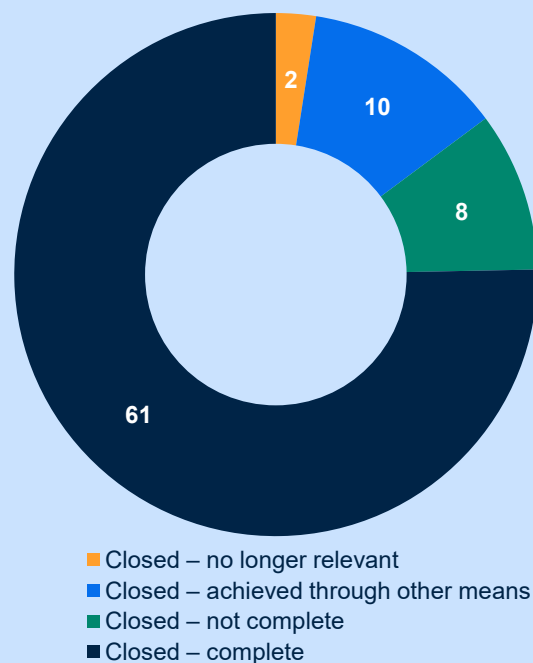
### A spotlight on vulnerable infants: Improving responses to red flags

At completion of the 2024 review, this report had two recommendations outstanding: Recommendation 2 (with four sub-parts) and Recommendation 5. These recommendations focused on improving decision-making by addressing assumptions and attitudes among frontline child protection staff. Through further engagement with the responsible Agencies, the Commission has supported the finalisation of the remaining recommendations acknowledging extensive work that has been undertaken in the five years since the recommendations were delivered, which satisfy the policy intent sought. Three of the five recommendations in this report (including Recommendation 2) focused on improved transparency, monitoring and reporting. Actions undertaken by responsible Agencies – including streamlining of information sharing between frontline services and ongoing workforce development to identify and respond to domestic and family violence risks – were aimed at incorporating these recommendations into existing and continuing reform activities to promote continuous improvement. The Commission supports the finalisation of this review report and related recommendations.

### Looking beyond behaviours: Responding to vulnerable children with high-risk behaviours


The 2020 review on high-risk behaviours included a single systemic recommendation now considered fulfilled through broader Commission-led reforms, including the Changing the Sentence report, the Youth Justice Oversight Program, and multi-agency roundtable activities undertaken in 2022, 2023 and 2024 to maintain focus on the needs of vulnerable children who display high-risk behaviours and promoting shared accountability across relevant portfolios for coordinated responses. The policy intent of this recommendation is reflected also in Recommendation 3 of the *Child Death Review Board Annual Report 2021-22*<sup>5</sup>, and further in Recommendation 3 of the *Child Death Review Board Annual Report 2023-24*<sup>6</sup>, to prioritise work on the continuity of care for children with complex needs. The Commission acknowledges the commitments by government including the establishment of a Secure Care Facility model and reinforces the Board's recommendation to nominate a lead agency within government to provide

Figure one: Reported status of recommendations from 2017 Blue Card report



<sup>5</sup> Child Death Review Board (2022). *Child Death Review Board Annual Report 2021-22*. [Child Death Review Board Annual Report 2021-22](#)

<sup>6</sup> Child Death Review Board (2024). *Child Death Review Board Annual Report 2023-24*. [Child Death Review Board: Annual Report 2023-24](#)



quarterly public reporting on the status of this work. Given the work being undertaken in response to other ongoing Recommendations, the Commission is supportive of this report being finalised as *Closed – not complete*, noting work is continuing under subsequent recommendations.

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In a dynamic policy landscape, recommendations in child protection must be agile. As societal values, political priorities, and research evolve, so too must the guidance provided to agencies and decision-makers.

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## Adequacy assessments

Following the 2024 review of recommendations, the Commission developed an assessment approach to provide meaningful oversight of the actions undertaken by government to progress the policy intent of recommendations made and provide commentary on the suitability of the implementation. This approach has been informed by the process utilised by the Office of the Independent Implementation Supervisor, which conducts adequacy assessments to evaluate whether the implementation of government responses to recommendations has been both sufficient and sustainable.<sup>7</sup>

The Commission's adequacy assessment tool considers evidence of implementation, potential for impact, and sustainability. Each of these criteria contributes to a comprehensive, system-level understanding of the value of actions undertaken in response to recommendations and providing an assessment of whether the strategies engaged provide for effective improvements in outcomes in the long term.

### Evidence of implementation

**This criterion assesses the extent to which a recommendation has been fully implemented. It examines whether there is:**

- **Minimal evidence of implementation** – only some components have been actioned
- **Moderate evidence of implementation** – most components have been actioned
- **Significant evidence of implementation** – all components have been actioned

### Potential for impact

**This considers the likely effect of the implementation on achieving meaningful and positive system change for Queensland children and families. Ratings:**

- **Minimal impact** – limited or no expected improvement
- **Moderate impact** – some expected improvements
- **Significant impact** – strong potential for positive system-wide change

### Sustainability

This assesses whether the changes made are embedded into systems and structures in a way that ensures their longevity. This includes evaluating: the likelihood that implementation will lead to sustainable system change; the degree to which resources, systems, and structures support ongoing delivery; and, whether continuous improvement in outcomes is likely over time. Ratings:

- **Minimal sustainability** – low likelihood of lasting change
- **Moderate sustainability** – some structures in place for ongoing impact
- **Significant sustainability** – high likelihood of durable system improvements

If the adequacy assessment identifies any inconsistencies or gaps in the implementation of a recommendation, the Commission will formally communicate these findings back to the responsible department for further work. During this time, the recommendation is considered 'open – in progress', to reflect that further action is required. Through these adequacy assessments, the Commission provides appropriate oversight that all completed recommendations are not only met from a transactional approach but are also functioning effectively and sustainably.

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<sup>7</sup> Office of the Independent Implementation Supervisor (2025). [Adequacy | Office of the Independent Implementation Supervisor](#)



**Figure two: The Commission's adequacy assessment tool**

# Methodology

In 2024, the Commission considered the internal processes for monitoring the implementation of recommendations. This review identified several opportunities to enhance consistency, transparency, and accountability, including the development of a comprehensive status classification schedule to provide greater nuance to the progress status of recommendations and a theming exercise to group recommendations made based upon the policy intent or actions required. This process also included the creation of an updated, fit-for-purpose central register to track active and closed recommendations and record progressive updates from responsible agencies.

## Greater nuance in status reporting

Since publishing the 2024 review, the Commission has continued active engagement with responsible agencies to maintain regular dialogue on the implementation of outstanding recommendations. In response, agencies have provided comprehensive updates which include qualitative summaries of the actions taken to progress each recommendation and have provided analysis of any further steps required to fully implement or meet the original intent of the recommendations. Feedback received from stakeholders has advised that the more nuanced approach to status reporting has provided for Agencies to more accurately reflect the progress of recommendations and provided for recommendations to be finalised where the policy intent has been met albeit through means other than stipulated in the original recommendation, or where alternative policy reform has been engaged.

Table one: Status classification schedule – as published in December 2024<sup>8</sup>

Status	Description
<b>Closed – completed</b>	The recommendation has been implemented completely as detailed. For example, the intent of the recommendation has been achieved through implementation of actions described in the recommendation.
<b>Closed – not completed</b>	The recommendation has been accepted but is unable to be completed. For example, the recommendation was accepted in-principle but unable to be implemented due to budget/ scope/ time/ resource.
<b>Closed – achieved through other means</b>	<p>The intent of the recommendation has been achieved through actions other than described in the recommendation. For example:</p> <ul style="list-style-type: none"><li>the intent of the recommendation has been achieved through existing strategy reform</li><li>the intent of the recommendation has been achieved through implementation of a different recommendation</li></ul> <p>that actions were undertaken other than what was described in the recommendation, which achieved the same intended reform.</p>

<sup>8</sup> Queensland Family and Child Commission (2024). Monitoring of the implementation of recommendations made by the Queensland Family and Child Commission and the Child Death Review Board. [Monitoring of the implementation of recommendations report.PDF](#)

	The matter which the recommendation sought to address has changed; or the reform landscape has changed; or the recommendation as it is worded no longer achieves the intention.
<b>Open – in progress</b>	
<b>Not Started</b>	

## Theming and grouping

The 2024 review engaged a theming exercise to group recommendations as to the policy intent or actions recommended to government. These six themes are:

- legislation reform,
- policy and procedure,
- training (including capacity building and community education),
- transparency/monitoring and reporting,
- resourcing, and
- program/service design.

Each theme reflects a distinct area of focus and forms the basis for understanding both the intent behind recommendations and the levers available for system-wide change.

Through the active monitoring of recommendations, the Commission has learned that while agencies are generally committed to action, the timeliness and feasibility of implementation can vary significantly depending on the nature of the recommendation. Recommendations involving legislative change, for example, often require longer lead times and political will, whereas those related to training or procedural updates may be achieved more rapidly but still require adequate resourcing and organisational readiness. This insight allows the Commission to calibrate the scope and design of recommendations, ensuring they are ambitious yet achievable, and backed by a clear implementation pathway.

Theming of recommendations made to government is a tool for analysis and a driver of continuous improvement. It enables the Commission to monitor systemic progress across key reform areas, track patterns of implementation over time, and identify where further focus or support may be needed. Strategically, it strengthens the Commission’s ability to advise government, influence systemic change, and fulfil its mandate to improve outcomes for children, young people and families in Queensland. A thorough understanding of the progress of recommendations based upon their theme analysis also supports the Commission to deliver meaningful and achievable recommendations following oversight review work and provides greater opportunity to work with government to seek impactful system improvement.

# New Recommendations

Since the publication of the *Monitoring of the Implementation of Recommendations* report in December 2024, the Commission and the Board have made a further 13 recommendations, bringing the total number issued by the Commission to 222 recommendations. The new recommendations include:

**Table two: New recommendations made since December 2024**

Child Death Review Board Annual report 2023 - 24	
No.	Recommendation
1	Department of the Premier and Cabinet (DPC) facilitate the publication of commitments from each portfolio Minister or Director-General regarding their commitment to children in state care. This public commitment to children in care should include commitments regarding the core business of the portfolio, as well as broader employment and training, economic and work placement opportunities.
2	Department of Child Safety, Seniors and Disability Services (Child Safety) and Queensland Health collaborate to revise and/or develop new practice guidance for child protection practitioners, foster carers and residential care providers on providing regular, effective, sensitive and contextual guidance to children in care to support and promote their sexual health and wellbeing. This must include topics of sexual and reproductive education, contraception, healthy relationships and consent.
3	Government prioritise its response to the Child Death Review Board 2021–22 Annual Report Recommendation 3: Continuity of care for children with complex needs, noting that cases reviewed by the Board in 2023–24 reinforced the need for flexible, specialised care models, particularly those who display violent and dysregulated behaviours or who are experiencing significant substance use or mental health concerns. Given the ongoing seriousness of this issue, government’s response to this recommendation should include nomination of a lead role who will produce quarterly public reporting on the status of this work.
4	<p><b>4.1</b> Take action to ensure that where a child in state care does not engage with a public mental health service, their referral is not closed until:</p> <ul style="list-style-type: none"> <li>the child’s case is discussed at a Suspected Child Abuse and Neglect (SCAN) meeting (or other equivalent multi-agency coordination mechanism); and,</li> <li>a multi-agency strategy to support engagement has been developed and enacted.</li> </ul> <p><b>4.2</b> Take action to ensure that where there is non-engagement of a young person in state care with a mental health service including Child and Youth Mental Health Services (CYMHS) or Evolve Therapeutic Services (ETS), this does not result in the closure of the referral and Queensland Health maintains responsibility and takes alternative action to respond to the mental health needs of the child.</p> <p><b>4.3</b> Improve access to mental health supports for children and young people by:</p> <ul style="list-style-type: none"> <li>improving staff awareness of Gillick competency and the ability for Gillick competent children and young people to access mental health services without parental consent; and,</li> <li>allowing young people who are Gillick competent to nominate any appropriate adult as their support person.</li> </ul>
5	Queensland Health take action to provide clear guidance that will support Child Safety to better assess the safety of children living with disabilities and/or chronic medical conditions with a specific focus on distinguishing between intentional parental neglect or maltreatment compared to

	deficits in the health literacy or competency of the parent that should be addressed through health and/or disability support services.
6	Queensland Health develop guidelines for clinicians to promote a family-centred approach to the provision of health services to children and young people, such that clinicians consider the wellbeing of siblings and can directly refer siblings into the health service, or to the clinician, if risks or health concerns are identified.
7	<p>Queensland Government continue to prioritise its response to the impact of family and domestic violence on Queensland children, and continue to implement the past recommendations of the Board and the following reviews:</p> <ul style="list-style-type: none"> <li>• Not Now, Not Ever report, the Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland</li> <li>• Hear Her Voice – Report Two – Women and girls’ experiences across the criminal justice system</li> <li>• Independent Commission of Inquiry into Queensland Police Service A Call for Change.</li> </ul>
8	<p><b>8.1</b> The Queensland Government invest in a public campaign to assist parents to understand childhood behaviour development, positive parenting techniques and the consequences of corporal punishment; and,</p> <p><b>8.2</b> All child protection entities (Child Safety, Queensland Health, Education, QPS and Youth Justice) enhance staff awareness of the additional vulnerabilities of young (under five years) and/or non-verbal children. This may include how to interpret and seek corroborating evidence in response to verbal and non-verbal disclosures.</p> <p>It is recommended that this includes:</p> <ul style="list-style-type: none"> <li>• consideration of implementing a bruising clinical decision rule, such as the Ten-4-Faces-P material, to ensure that it is captured in their current guidance on indicators of physical abuse to increase their capacity to identify non-accidental injuries;</li> <li>• consideration of the need to seek information from a broader range of sources who know the child than might otherwise be required for verbal children. This would include early childcare workers, support workers, neighbours and extended family; and,</li> <li>• improving how agencies facilitate and receive medical assessments of children including how they provide relevant context as to why the review has been requested, contact the medical practitioner prior to the review, and nominate an independent medical professional.</li> </ul>
9	Queensland Government outline the work it is doing to further embed the practice guidance it created in response to the Child Death Review Board 2022–23 Annual Report <i>Recommendation 5: Strengthening child safety practice in response to parental substance and methamphetamine use</i> , noting cases reviewed by the Board in 2023–24 confirmed the ongoing need to support frontline practitioners in their risk assessments of children whose parents’ substance use is problematic
<b>Regulation of home education: Insights paper</b>	
No.	Recommendation
1	<p>The Department of Education take immediate action to implement Recommendation 1 of the Child Death Review Board Annual Report 2022–23 report to:</p> <ul style="list-style-type: none"> <li>• Initiate a regular process of data sharing with QPS and DCSSDS to identify home-schooling students who may benefit from in-school support services.</li> </ul>

	<ul style="list-style-type: none"> <li>Pursues legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.</li> </ul>
2	The Home Education Unit (HEU) explores ways for children registered for home education to participate in decisions about their learning needs and have their views and wishes documented. The HEU could consider options such as those proposed by young people at the QFCC Youth Summit 2024 including online forums to hear from all students and meet their needs.

### Corporal punishment: Insights paper

No.	Recommendation
1	<p>The Commission recommends that the Queensland Government fund a public health campaign aimed at reducing the incidence of corporal punishment in Queensland families. At a minimum, this should include development and deployment of:</p> <ul style="list-style-type: none"> <li>resources for parents to raise awareness about the harmful impacts of physical discipline on children and promoting practical, non-violent, evidence-based disciplinary approaches, to be provided at key developmental milestones (such as vaccination appointments);</li> <li>resources for children and young people, to improve understanding of their rights to live free from violence, and awareness of how to access support services;</li> <li>specific and tailored resources and approaches for cohorts at higher risk of using physical discipline including First Nations families, families from culturally and linguistically diverse backgrounds, and parents and children that live with disability; and</li> <li>d) a multichannel communication strategy to increase the visibility of existing funded parenting supports.</li> </ul>

### Too Little, Too Late: The progress made against the Queensland Residential Care Roadmap

No.	Recommendation
1	<p><b>1.1</b> The new Minister for Child Safety revisit the Residential Care Roadmap and publish a new, integrated strategy for improving the life outcomes for Queensland children in Out of Home Care System. This new strategy should be produced by incorporating the relevant election commitments, Child Death Review Board recommendations, and the actions from the Residential Care Roadmap including my advice contained in this report.</p> <p><b>1.2</b> The introduction of improved public transparency on the performance of the system that is raising vulnerable Queensland children, noting that the internal culture of the Department must become more courageous.</p> <p><b>1.3</b> On at least a six-monthly basis the Minister for Child Safety should meet with a group of young people living in residential care with intent of hearing about the quality of care they are receiving, and the Minister should routinely visit residential care homes.</p> <p><b>1.4</b> The use of generic residential care contracts and service standards must cease immediately – with any new houses required by the Department to be created only as part of a strategic pilot program exploring new models of care with bespoke service standards fit for the children in the house</p> <p><b>1.5</b> The creation of a specific and detailed plan for the maintenance and improvement of the mental health of young people who enter and exit Queensland's residential care system</p> <p><b>1.6</b> Production of an initial residential care outcomes framework by 28 February 2025 (with the view that it can evolve as the reform matures); and</p>

	<b>1.7</b> The rapid implementation of the new government's commitment to a trial of 100 professional carers within the next 12 months, and subject to any major impediments it's exponential expansion in place of the residential care system over the next three years
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These new recommendations are considered in the comprehensive status update and analysis further in this report.

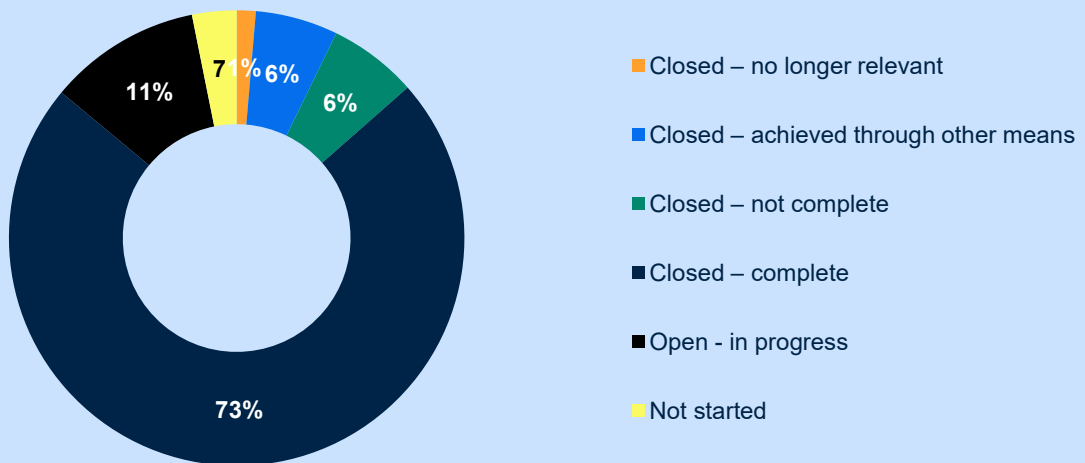
# Findings

The review of recommendations as undertaken in 2025 is informed by updates received from relevant responsible Agencies and stakeholders. The Commission acknowledges the large volume of recommendations delivered to government and the scope of reform which is already underway across multiple portfolios. The Commission acknowledges the work undertaken by relevant agencies to progress recommendations made by the Commission and the Board, with particular consideration to the intentional actions to progress aged recommendations which have been underway for many years.

**Table three: Status of recommendations as July 2025 review**

Reported Status	Total (Count)	Total (%)	2024 (Count)	2024 (%)
Closed – complete	161	72.5%	160	76.6%
Closed – not complete	14	6.3%	5	2.4%
Closed – achieved through other means	13	5.8%	5	2.4%
Closed – no longer relevant	3	1.4%	2	1.0%
<b>Total closed</b>	<b>191</b>	<b>86.0%</b>	<b>172</b>	<b>82.3%</b>
Open – in progress	24	10.8%	31	14.8%
Not started	7	3.2%	6	2.9%
<b>Grand total</b>	<b>222</b>	<b>100.0%</b>	<b>209</b>	<b>100%</b>

**Figure three: Implementation status of recommendations as at July 2025**



In a consideration of the investment required by responsible Agencies to implement recommendations, reviews such as the *Blue Card report (2017)* illustrate the scale and complexity of some reform areas. Whilst all recommendations are now finalised, as of July 2025, eight years have elapsed since the report was published, and recommendations were delivered to government. Importantly, assessment of the completion rate of these recommendations, noting the high proportion of recommendations relating to legislation reform, provides insights to the Commission on the ability for government to enact meaningful change in response to recommendations; appreciating the time investment required for amendments to be completed provides important considerations when preparing and developing recommendations.

Notably, recommendations from more recent reports such as the Queensland Paediatric Sepsis Mortality Study (2024; the Sepsis report) and the Who's responsible? Understanding why young people are being held longer in QLD watch houses (2023; the Watch House report) received rapid agency responsiveness. All five recommendations from the Sepsis report are already in progress, and 80 per cent of the Watch House report recommendations are underway. These examples suggest that where recommendations are well-targeted, timely, and aligned with clear system priorities, agencies are able to mobilise quickly to engage the policy improvements sought for in the oversight report.

Analysis of the completed recommendations as to their theme advises that of the total number of 222 recommendations delivered to government from the Commission and the Board, the greatest proportion of those recommendations relate to *policy and procedure* improvements, with a reasonable proportion (20.1 per cent) seeking *legislation reform*. This understanding, when considered in connection with the completion rates and timeliness of finalisation of recommendations, provides useful data to the Commission to guide the development of actionable, impactful recommendations in future reviews.

Table four: Theme summary of all recommendations

Themes	Closed				Total	Open			Grand Total
	Complete	Not complete	Achieved through other means	No longer relevant		In progress	Not started	Total	
<b>Legislation reform</b>	13.4%	2.7%	2.2%	0.9%	19.2%	0.4%	0.4%	0.8%	<b>20.1%</b>
<b>Policy and procedure</b>	36.2%	2.7%	1.3%	0.0%	40.2%	4.5%	0.9%	5.4%	<b>45.5%</b>
<b>Program / service design</b>	9.8%	0.4%	0.4%	0.4%	11.0%	2.2%	0.9%	3.1%	<b>14.3%</b>
<b>Resourcing</b>	2.7%	0.0%	0.4%	0.0%	3.1%	0.4%	0.4%	0.8%	<b>4.0%</b>
<b>Training</b>	2.2%	0.0%	0.4%	0.0%	2.6%	0.0%	0.0%	0.0%	<b>2.7%</b>
<b>Transparency / monitoring and reporting</b>	8.0%	0.0%	0.9%	0.4%	9.3%	3.6%	0.4%	4.0%	<b>13.4%</b>
<b>Grand Total</b>	<b>72.3%</b>	<b>5.8%</b>	<b>5.8%</b>	<b>1.8%</b>	<b>85.4%</b>	<b>11.2%</b>	<b>3.1%</b>	<b>14.1%</b>	<b>100.0%</b>

Smaller thematic areas such as *Resourcing* (4.1 per cent) and *Training* (2.7 per cent) represent more targeted, capacity-building measures. While fewer in number, these recommendations are essential enablers of broader reform and often underpin the success of other thematic areas. Importantly, the proportion of open and not started recommendations is more concentrated within themes which require greater time investment, have more interconnected dependencies, or relate to cross-portfolio coordination to deliver on the policy change.

## Recommendations closed since 2024

From the December 2024 report to present, a further 19 recommendations have been closed. Through active engagement with responsible Agencies since the 2024 review, the Commission was able to report more accurately on the implementation status of recommendations captured in the former report. This is reflected in the below register of recommendations closed in the 2025 review.

Each of these recommendations was adequately assessed during consultation with the responsible Agency. The closure of these recommendations reflects meaningful progress by responsible agencies in implementing systemic changes and responding to identified issues. The adequacy assessments ensured that closures were based on evidence of sustained action and impact, rather than activity alone, maintaining the integrity and accountability of the Commission's oversight responsibilities.

**Table five: 2025 Closed Recommendations**

<b>Closed – Achieved Through Other Means</b>	
Rec.	Publication
<b>A spotlight on vulnerable infants. Improving responses to red flags: A system review following the death of a baby (2019)</b>	
2	<p><b>2.1</b> The Dept. of the Premier and Cabinet designs and administers a scenario-based questionnaire for representative groups of frontline staff in the child and family support system to identify if assumptions and attitudes are having adverse effects on critical decisions for keeping children safe. This questionnaire will focus on assumptions and attitudes towards domestic and family violence and family law court involvement. It will also seek information on how attitudes are influenced when the family is involved with more than one agency. The attitudes towards domestic and family violence survey may be used to support the questionnaire.</p> <p><b>2.2</b> The Dept. of the Premier and Cabinet develops and implements an education tool to address the influence of assumptions and attitudes affecting decisions regarding a child’s safety. It should include specific examples of commonly-held assumptions that are not based on facts, and of occasions when assumptions have led to negative consequences for children.</p> <p><b>2.3</b> The Dept. of the Premier and Cabinet evaluates, after 12 months of implementation of the training tool, whether the influence of assumptions and attitudes have been mitigated in decision making.</p> <p><b>2.4</b> The Dept. of the Premier and Cabinet, once the evaluation is complete, uses the results to refine the education tool to support continuous improvement in decision making and to embed the tool within agencies.</p>
5	<p>We recommend the Dept. of Child Safety, Youth and Women develops and implements a standard of practice for staff that requires case escalation when multiple child concern reports are recorded for a family, including:</p> <ul style="list-style-type: none"> <li>• Allocating the case to an experienced and skilled officer</li> <li>• Allowing reasonable time to undertake a complete case review and assessment</li> <li>• Establishing consultation points with senior officers and other professional</li> <li>• Responding immediately to red flags for the child (<i>Recommendation 1</i>).</li> </ul>
<b>Keeping QLD’s Children More than Safe: Review of the Blue Card System (2017)</b>	
6	<p>It is recommended that the QLD Government undertakes a review of the resourcing requirements necessary to support organisations in building capacity to be child safe.</p>
8	<p>It is recommended that the Dept. of Justice and Attorney-General develops:</p> <ul style="list-style-type: none"> <li>• An annual sector-wide education and training strategy to build the capacity of organisations to become child safe. In doing so, it should consider whether BCS should provide the training or if government will fund non-government organisations to provide it.</li> <li>• An accreditation process for training providers, including a training program and resource materials, to ensure fee-for-service training organisations have knowledge and understanding of QLD law and the requirements of child safe standards and WWCCs.</li> <li>• A new suite of materials to support organisations in developing and implementing child safe standards. These should include sector-specific best practice guidelines on creating child safe standards – to build greater understanding in organisations and the broader community.</li> </ul>

9	<p>It is recommended that the Dept. of Justice and Attorney-General:</p> <ul style="list-style-type: none"> <li>• Develops an education and community awareness strategy for parents, carers and the community to: <ul style="list-style-type: none"> <li>○ Raise awareness about the role of the blue card system in keeping children safe</li> <li>○ Help parents and carers choose child safe organisations for their children</li> <li>○ Increase understanding about child safe standards and about the fact that the WWCC is only one component of a much broader strategy</li> </ul> </li> <li>• Improves access to information about the blue card system that highlights the roles of parents, carers and the community in keeping children safe – including WWCC requirements.</li> </ul>
10	<p>It is recommended that the Attorney-General and Minister for Training and Skills proposes amendments to the WWC Act to require organisations to publish or display information about how they are meeting their child safe standards obligations.</p>
43	<p>It is recommended that the Dept. of Justice and Attorney-General:</p> <ul style="list-style-type: none"> <li>• Appoints a multi-disciplinary panel of advisors, including an Aboriginal person and a Torres Strait Islander person, with relevant expertise to advise on complex cases and more generally</li> <li>• Establishes a complex case review committee to review proposed decisions and make recommendations. This should include appropriate representation to ensure the interests of Aboriginal and Torres Strait Islander peoples are heard and considered.</li> </ul>
57	<p>It is recommended that, once the Royal Commission releases its final recommendations, the QLD Government considers developing separate legislation to allow information sharing for the purpose of assessing and managing risks of harm to the safety, welfare or wellbeing of children.</p>
58	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce new information-sharing provisions to allow BCS and other relevant agencies to exchange information for the purposes of:</p> <ul style="list-style-type: none"> <li>• Completing a WWCC assessment or other screening process</li> <li>• Monitoring and enforcing compliance with child safe standards.</li> </ul> <p>Key features should include:</p> <ul style="list-style-type: none"> <li>• Allowing agencies to share information for specific purposes</li> <li>• Penalties for misuse of information or unauthorised disclosure</li> <li>• Protection from liability for individuals where information has been shared in good faith.</li> </ul>
<p><b>Keeping QLD's Children More than Safe: Review of the Foster Care System (2017)</b></p>	
7	<p>It is recommended that the Dept. of Communities, Child Safety and Disability Services includes in the operational performance framework (being developed through the new quality improvement program) strategies to:</p> <ul style="list-style-type: none"> <li>• Increase timeliness of and improve response to standard of care reviews and harm reports</li> <li>• Monitor and report on responses to these reviews and investigations</li> </ul> <p>The Dept. of Communities, Child Safety and Disability Services should continue working with entities in other jurisdictions and nationally to improve:</p> <ul style="list-style-type: none"> <li>• The quality and comparability of reporting of instances of and responses to harm to children in care</li> </ul>

	<ul style="list-style-type: none"> <li>The public reporting of this.</li> </ul>
<b>Closed – No longer relevant</b>	
Rec.	Publication
Keeping Queensland's Children More than Safe: Review of the Blue Card System (2017)	
81	It is recommended that the Dept. of Justice and Attorney-General engages an independent entity to plan for and evaluate the success of these reforms of the blue card system.

## Closed – Not complete

Rec.	Publication
<b>Keeping Queensland's Children More than Safe: Review of the Blue Card System (2017)</b>	
12	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to expand the scope of the blue card system in line with the recommendation by the Royal Commission by:</p> <ul style="list-style-type: none"> <li>• Including additional categories of child-related work</li> <li>• Allowing regulation to prescribe other activities that involve providing services primarily to children and that require contact with children.</li> </ul>
13	<p>It is recommended that the Dept. of Justice and Attorney-General works with the Dept. of Transport and Main Roads to:</p> <ul style="list-style-type: none"> <li>• Define the types of child-related transport services that will be within scope of the system to ensure they are only those targeted at children</li> </ul> <p>Consider ways to reduce duplication of effort, processes and costs for those people affected.</p>
14	<p>It is recommended that the QLD Government reviews the Child Employment Act 2006 to ensure that organisations employing children are required to meet child safe standards.</p>
24	<p>It is recommended that as part of the review of screening processes across government (<i>recommendation 1</i>), consideration is given as to whether removing the exemption for registered health practitioners and lawyers is the most effective way to achieve comparable screening for individuals providing child-related services.</p>
31	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to:</p> <ul style="list-style-type: none"> <li>• Require applicants to disclose if they have been convicted of a crime or any other offence, or charged with any offence in a country other than Australia</li> <li>• Require applicants to disclose if they have lived or worked in New Zealand for six months or more</li> <li>• Require BCS to obtain a New Zealand criminal history for applicants who disclose they have lived or worked in New Zealand for six months or more</li> <li>• Enable BCS to require applicants to provide criminal history records from the relevant country and/or further information in relation to their criminal history</li> <li>• Enable BCS to seek further information from applicants (including statutory declarations) where they have disclosed international criminal history or cannot provide information.</li> </ul>
47	<p>It is recommended that the Dept. of Justice and Attorney-General implements an internal review process and generally requires applicants to use it before applying to the QLD Civil and Administrative Tribunal. This process must be designed to:</p> <ul style="list-style-type: none"> <li>• Simplify the current appeal process</li> <li>• Provide an opportunity to ensure that the best decision is made at the earlier available opportunity</li> <li>• Promote early engagement by applicants before a formal appeal process</li> <li>• Promote consistency of decision-making.</li> </ul>

56	<p>It is recommended that the QLD Government reviews offences and penalties in the WWC Act to:</p> <ul style="list-style-type: none"> <li>• Make sure offences for non-compliance with child safe standards requirements are kept and strengthened, including increased penalties, to emphasize the critical importance of creating and maintaining child safe environments</li> <li>• Consider whether the remaining offences relate to one of the categories of offences recommended by the Royal Commission and if they remain necessary under the new regime. Current safeguards in QLD should not be reduced.</li> <li>• Create national consistency in relation to penalties where possible</li> <li>• Introduce new penalties to support the new compliance and enforcement model as required.</li> </ul>
77	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce a statutory review process. It should specify that:</p> <ul style="list-style-type: none"> <li>• The first review be completed within five years of commencement of the amendments arising from the recommendations in this report</li> <li>• The review must consider the results of the evaluation in recommendation 81</li> <li>• The report be released publicly.</li> </ul> <p>In preparation for the statutory review, the Dept. of Justice and Attorney-General should consider appointing a panel of key external stakeholders to meet regularly and consider:</p> <ul style="list-style-type: none"> <li>• How the blue card system is operating (based on analysis of available data, complaints, customer satisfaction measures and other information)</li> <li>• What improvements are needed, including in relation to legislation, systems, policies and practices, on an ongoing basis.</li> <li>• The panel should have appropriate representation on to ensure the interests of Aboriginal and Torres Strait Islander peoples are heard and considered.</li> </ul>
<p><b>Looking beyond behaviours. Responding to the needs of vulnerable children with high-risk behaviours. A system review following the death of a child (2020)</b></p>	
1	<p>We recommend that the Commission leads the development of a system-wide solution to address the gaps in services and supports for children with high-risk behaviours. This solution will focus on:</p> <ul style="list-style-type: none"> <li>• Intervening early when a child's high-risk behaviours first emerge, and sustaining intervention while they persist</li> <li>• Promoting the safety of the child, and considering the causes and effects of the child's high-risk behaviours</li> <li>• Deterring the child from crime by keeping them connected to school, culture, country and community</li> <li>• Recognising and responding to the influence of the child's peer and family networks</li> <li>• Self-determination of Aboriginal and Torres Strait Islander peoples in respect of the services and practices to assist families and communities to protect, care for, and educate their children</li> </ul> <p>The solution should include expanding:</p> <ul style="list-style-type: none"> <li>• Health-based services and supports</li> <li>• Pathways to respite to address a child's high-risk behaviours</li> <li>• Disciplinary options in schools to educate a child on their behaviours and to connect them to positive influences</li> </ul>

- Restorative justice processes to include the participation of the child's school to keep the child engaged in education (where appropriate)

To support the solution, the Commission will:

- Hold a multi-agency summit (Looking beyond behaviours) to determine a solution that keeps the needs of these children at the heart of system responses.
- Work with entities, particularly Aboriginal and Torres Strait Islander entities, to develop a coordinated plan to implement a culturally safe solution
- Provide the plan to Attorney-General and Minister for Justice within 12 months of this recommendation being accepted.

**Closed – complete**

Rec.	Publication
<b>Keeping Queensland's Children More than Safe: Review of the Blue Card System (2017)</b>	
4	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to:</p> <ul style="list-style-type: none"><li>• Remove reference to child and youth risk management strategies and instead introduce a requirement for organisations to meet child safe standards</li><li>• Remove the link between WWCC requirements and risk management strategy requirements so that child safe standards are the priority and the overarching mechanism for achieving safe service environments</li><li>• Reframe the current risk management strategy requirements to reflect the Royal Commission's 10 elements of child safe environments as simple standards</li><li>• Increase penalties for offences about child safe standards, to reflect each organisation's responsibility to keep children safe in service environments</li><li>• Require organisations to meet child safe standards before starting operation.</li></ul>
5	<p>It is recommended that the QLD Government considers:</p> <ul style="list-style-type: none"><li>• Whether there is merit in separating the administration of the functions related to child safe organisations and WWCCs</li><li>• The links between child safe standards and a reportable conduct scheme if the government introduces one in QLD.</li></ul>
7	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to include a specific function - for the agency responsible for regulating child safe standards - to develop the capacity of people and organisations to create child safe environments.</p>
11	<p>It is recommended that the QLD Government considers further reforms to include any recommendations of the Royal Commission to strengthen child safe standards.</p>
16	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow its agency's chief executive to issue legally binding advice declaring whether a service is regulated (for example, through a statutory instrument).</p>
17	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to require WWCCs for people who:</p> <ul style="list-style-type: none"><li>• Operate a regulated service and make decisions that could impact on the implementation of child safe standards in the organisation</li><li>• Provide regulated activities i.e.:<ul style="list-style-type: none"><li>○ Engaged by a regulated service for an overnight camp where they will have contact with children, and/or</li><li>○ Engaged by a regulated service to work or volunteer for more than seven days in a calendar year and are:</li><li>○ In a position where they will have contact with children</li></ul></li></ul>

	<ul style="list-style-type: none"> <li>○ In a specified child-related service while children are ordinarily present – this includes schools, boarding schools, long day care services or kindergarten services, residential facilities, child-related health services, child-related disability services and youth detention facilities</li> <li>○ Are in a specified role – an adult member of a household where foster or kinship care, family day care or home stay is provided.</li> </ul>
18	It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow its agency's chief executive to issue legally binding advice declaring whether a WWCC is required (for example, through a statutory instrument).
19	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to remove the requirement for a person to have an agreement to work with an organisation before applying for a WWCC.</p> <p>Consideration should be given to the following to make sure the system is sustainable and the focus remains on child-related activities:</p> <ul style="list-style-type: none"> <li>• Having an appropriate fee structure – with a new streamlined application process it may be possible to allow paid applications to be processed on a cost-recovery basis</li> <li>• Requiring volunteers to have an agreement with a regulated service in order to have an application processed free of charge</li> <li>• Allowing BCS to give a non-compliance notice to an organisation that does not provide regulated child-related services but is attempting to require employees or volunteers to obtain WWCCs rather than relying on alternative criminal history screening processes.</li> </ul>
34	<p>It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to:</p> <ul style="list-style-type: none"> <li>• Enable BCS to use information from a reportable conduct scheme, if introduced in QLD, for WWCCs</li> <li>• In the absence of a reportable conduct scheme, enable BCS to consider disciplinary information under the Public Service Act 2008 and other regulatory frameworks as part of the risk assessment process, including for: QLD Health employees, police officers, youth workers, child safety officers, Dept. of Education and Training employees, disability workers, health practitioners, corrective services officers.</li> </ul>
46	<p>It is recommended that the Dept. of Justice and Attorney-General:</p> <ul style="list-style-type: none"> <li>• Engages a consultant with relevant expertise to review the suite of materials the BCS currently uses to communicate with applicants during the risk assessment process to make them easier to understand and less legalistic</li> <li>• Make sure all risk assessment staff are adequately trained in communicating with applicants</li> <li>• Establishes a new process for requesting submissions, including giving applicants: <ul style="list-style-type: none"> <li>○ Advice about the process before sending requests for submissions</li> <li>○ Details of the types of information needed in submissions and referee reports</li> <li>○ Details of the risk factors they need to address</li> <li>○ Reasons for a proposed negative notice</li> <li>○ Enough time to make submissions and gather related information</li> <li>○ Ongoing support during the process, with the ability to make submissions orally</li> </ul> </li> </ul>

52	<p>It is recommended that the following should be considered as part of the statutory review (see <i>recommendation 77</i>):</p> <ul style="list-style-type: none"><li>• Introducing accreditation frameworks as potential ways to improve the levels of compliance across organisations</li><li>• Introducing a public register of non-compliant organisations</li></ul>
68	<p>It is recommended that the Dept. of Justice and Attorney-General reviews the risk assessment process to identify and implement ways to:</p> <ul style="list-style-type: none"><li>• Automate the process for less complex risk assessments</li><li>• Manage all risk assessment files electronically.</li></ul>