When a Child is Missing

Post-Implementation Review

Queensland
Family & Child
Commission

Queensland
Government

EXECUTIVE SUMMARY

In 2016, the Queensland Family and Child Commission (QFCC) released *When a child is missing: Remembering Tiahleigh – A report into Queensland's children missing from out-of-home care (When a child is missing* report). The report made 29 recommendations to achieve whole-of-government system improvements in responding to children missing or absent from their out-of-home care placement.

As at 29 March 2017, the Department of Premier and Cabinet advised all recommendations arising from the *When a child is missing* report were implemented and had been transitioned to business-as-usual.

The QFCC has undertaken a post-implementation review (PIR) to assess how changes arising from the report recommendations have improved outcomes for children. As part of the review, six discussion papers were prepared to support dialogue between QFCC and each key agency responsible for recommendations. This is a summary of PIR findings. The summary considers four broad themes that have arisen from the PIR and from the findings of the six discussion papers.

The QFCC's PIR has determined the recommendations of the *When a child is missing* report have generally been implemented by the responsible agencies. In particular, the policy and procedural changes required by each recommendation were promptly dealt with. In some cases though, the response has yet to be fully embedded in normal business and there is insufficient evidence of an improved outcome for children. The PIR identified some opportunities for implementation of those policies and procedures to be strengthened to better meet the intended outcomes of the *When a child is missing* recommendations. This feedback has been individually provided to each agency, through the discussion papers, for their consideration and action.

A self-assessment audit of 12 cases of children living in out-of-home care was completed by each key agency between September 2016 and June 2017. Alongside more recent data supplied by the QPS, and other surveys and reports prepared since 2016, ongoing issues with responding to children who go missing from residential care placements have been highlighted. These matters require additional focussed action and response from agencies.

They include:

- connection between residential care services and children reported missing to police
- cultural change and staff training in residential care services around the distinction between a child who is absent from placement and one who is missing
- safety planning for children which is regularly reviewed and includes key stakeholders
- the ability for multiple agencies to share information quickly, easily, and securely, including data about a child's education history.

The self-assessment audit also indicated a majority of children in the sample were not attending school for periods of time during the nine months of the audit.

The Department of Child Safety, Youth and Women has advised QFCC it is continuing to work on improvements to information-sharing and safety planning processes. The QFCC considers there is scope for development of an oversight program to support improved outcomes for children living in the residential care system, particularly relating to operationalisation of recommendations by residential care services and links between school engagement and placement stability.

METHODOLOGY

Post-implementation review process

The review process involved establishing a working group of representatives from state government agencies responsible for responding to the recommendations of the *When a child is missing* report. The working group member agencies were:

- Department of Child Safety, Youth and Women (DCSYW)
- Queensland Police Service (QPS)
- Department of Education (DoE)
- Office of the Public Guardian (OPG)
- Queensland Health (QH)
- Queensland Family and Child Commission (QFCC).

The review included:

- a desktop review of relevant policy and procedure documents
- a small literature review of research into why children go missing from residential care placements
- interviews with agency representatives to understand policy application in practice
- working collaboratively with agencies to conduct a self-assessment audit of responses to children reported missing from out-of-home care
- preparation of six discussion papers, one for each of the six agencies listed above.

Self-assessment audit

A self-assessment audit was completed by DCSYW, DoE, OPG, QPS, QH and the Queensland Ambulance Service (QAS). While QAS did not receive any recommendations from the original review, their crucial role in the health system as first responders results in them holding data about children reported missing who then require transport to hospital. QAS volunteered relevant data to QFCC to inform the audit. The self-assessment audit required partner agencies to review their contact with a child during the period they were reported missing to QPS. Each agency was asked to respond to a set of questions about this contact.

The audit consisted of a sample of 12 children who had been reported missing to QPS. A total of 221 missing persons' reports were lodged for this cohort between October 2016 and June 2017. The audit sample included:

- eight (67%) males and four females (33%)
- an age range between 7 and 17 years
- seven (58%) Aboriginal children or Torres Strait Islander children
- children living in DCSYW's Moreton, South-East, South-West and North Queensland regional areas
- ten children (83%) in residential care.

The information provided was used to understand a child's interactions with government agencies between September 2016 and June 2017. The information was also used to identify whether changes to policy and practice in response to the *When a child is missing* report recommendations have led to improvements in the timeliness and effectiveness of those interactions. Case notes provided by five agencies (QAS is part of QH) provided a rich sample from which it was possible to derive a detailed narrative of a child's experiences and interactions with government agencies over the nine-month period. QFCC is grateful to the participating agencies for providing these data and acknowledges the considerable manual effort required to provide the information.

QPS has provided more recent high-level data, from 2018 and the first half of 2019, indicating the number of children being reported missing from out-of-home care has not declined.

Definition of missing

The definition of 'missing' referred to in this summary and the discussion papers is from the DCSYW guidelines used by carers when responding to a child missing from out-of-home care.

- A missing child is any child whose location is unknown and there are fears for the safety or concern for the welfare of that child.
- An absent child is a child who is absent for a short period without permission, and where the child's location is known or can be quickly established.[1]

The connection between missing children reports and residential care services

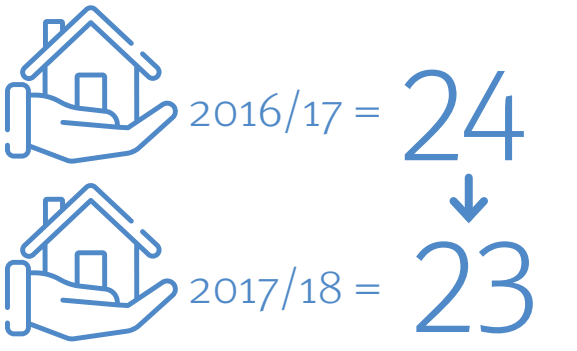
Of the 221 missing reports in the self-assessment audit, 213 (96 per cent) applied to children in residential care.

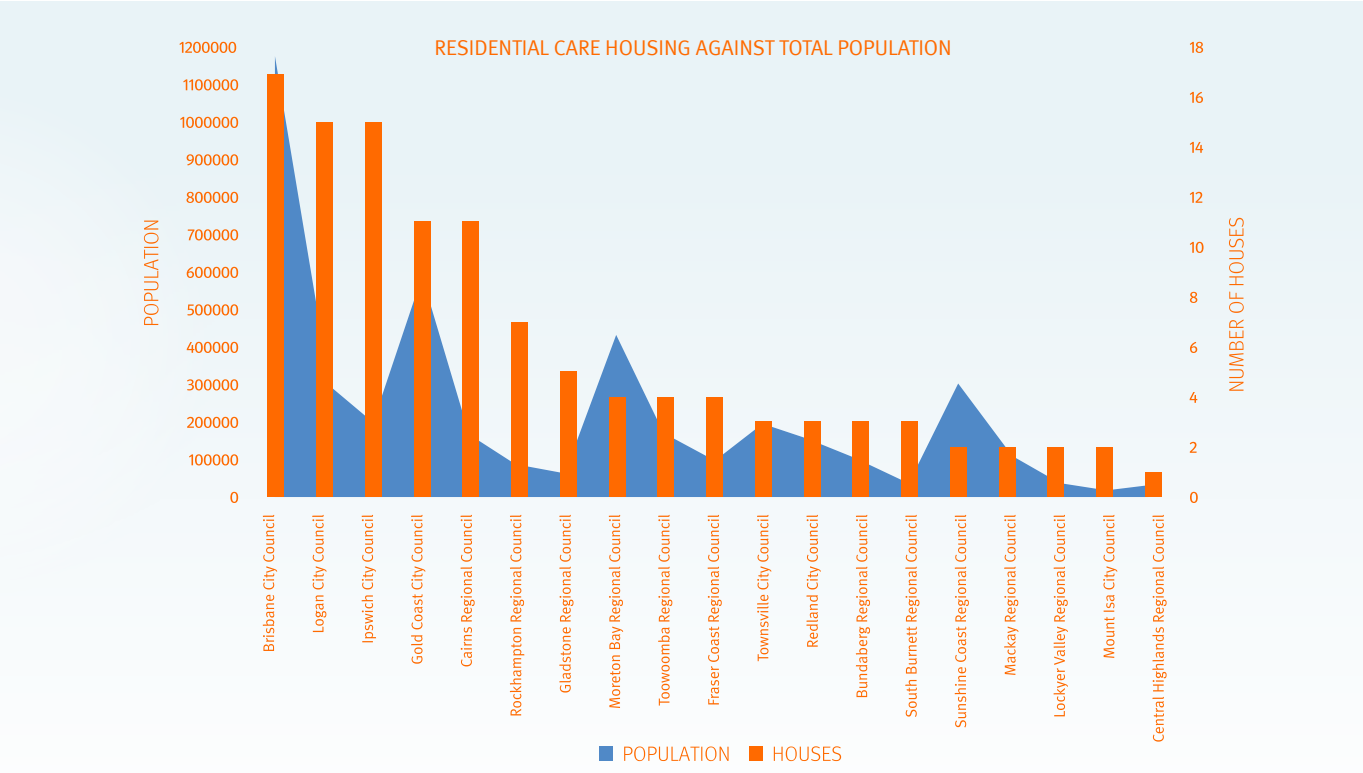
For the 2016/17 period, 9,107 Queensland children or young people lived in out-of-home care, of which 817 (nine per cent) were in residential care.[2]

In 2016, QFCC found children living in out-of-home care accounted for up to 30 per cent of all children reported missing to the QPS.[3] Within this group of out-of-home care missing reports, it appeared the majority came from residential care. This pattern was also highlighted in the *When a child is missing* review[4], leading to recommendations regarding use of appropriate terminology and better training for residential care workers (Recommendations 6 and 27).

- 9,107 children in OOHC compared with 1,277,609 total children in Queensland equates to 0.7 per cent of children.
- 817 children are in residential care which equates to 8.97% of the total children in OOHC.
- When compared to the overall number of children in Queensland, only 0.06 per cent of children are in residential care.
- 353 children in residential care (43 per cent) identify as of Aboriginal and/or Torres Strait Islander heritage. This is slightly higher than the 42 per cent (3,832 children) in out-of-home care.
- When compared to the total number of children in Queensland, the proportion of Aboriginal and Torres Strait Islander children in residential care is 0.02 per cent.

817 children and young people were placed in 117 different houses administered by 23 providers. Houses are available in 19 Local Government Areas (LGAs), with the majority located in the LGAs of Brisbane City, Gold Coast City, Logan City, Ipswich City and Cairns regional councils.[5]





Furthermore, in July 2017, the QPS advised QFCC it considered more than 50 per cent of police call-outs to residential care services about missing children to be unnecessary. In most cases, children reported 'missing' from their placement were simply not present in the residential care service when they were expected to be (not actually missing but absent from placement).[6]

The QFCC identified numerous instances in the self-assessment audit where children were reported missing even though:

- few or no attempts had been made to locate them before contacting police
- carers stated they held no concerns for the child's safety or their welfare
- carers were in regular contact with the child by phone during their absence and were able to identify they were not in immediate danger
- carers had sighted the child but were unable to convince them to return to the placement.

In some cases, carers advised they were 'required' to report the child missing after a prescribed period of absence.

> A 15 year old child living in a residential care facility was reported missing to police despite case notes recorded by the Youth Worker indicating they knew the child was at a local park, although without the permission of the Youth Worker. There were no concerns held by the Youth Worker for the child's wellbeing.

In October and November 2017, the QFCC spoke with young adults about their experiences in residential care and police involvement. The majority stated that when they lived in residential care, they felt police were called unnecessarily in certain situations.[7]

The practice of reporting children missing, when a child is maintaining contact and there are no welfare concerns, is resulting in a significant operational burden on the police and diverting resources from its core business of stopping crime and keeping the community safe. It is the responsibility of carers, Youth Workers, Child Safety Officers or other relevant officers to endeavour to locate the child as a 'responsible parent' would and develop behaviour management strategies for when house rules are broken.

Training and resourcing in residential care

The PIR indicated that while policy and procedural changes clearly define the difference between when a child is absent or missing from out-of-home care, translation into business-as-usual practice has yet to occur.

Missing person reports continue to be raised with police despite a child maintaining contact with the carer and there being no recorded concerns for the child's wellbeing.

Youth Workers need appropriate training and support to make determinations on vulnerability and their impact on deciding whether to make a missing person report to police.

Residential care services need to be adequately resourced to allow Youth Workers to take reasonable steps to locate a child who is absent.

Self-assessment audit

September 2016-June 2017 (9 months)

- 12 children, 221 Missing children reports (18.5 missing reports per child)
- 2 children went missing around 60 times each.
- 10 out of 12 in residential care.

QPS data

1 July 2017 – 31 January 2018 (7 months)

- 1407 Missing children reports to QPS representing 400 + children
- Approximately 200 reports a month
- approx. 3.5 missing reports per child
- 1 child reported missing 28 times
- Indicative advice that approximately 90% reported missing were from Residential care placements[8].

1 January 2019 to 30 June 2019 (6 months)

- 1,622 Missing children reports representing 457 individual children
- Approx. 270 reports/month
- Approx. 3.5 missing reports per child
- One child was reported missing 45 times, with others also in the 30s and 40s.
- 9 children were reported missing 10 or more times in a single month (April, May and June mainly).

A wide range of agency policies and procedures for missing or absent children from out-of-home care have been updated since 2016, in fulfilment of Recommendation 8 of the *When a child is missing* review. They now provide clearer and more consistent definitions across agencies and include guidance on immediate and longer-term actions to support the child. QFCC has been advised that further re-writing of the Child Safety Practice Manual, to make it easier to use, is being planned. However, the translation of policy and procedural amendments into practice, particularly in residential care services, requires further attention to embed the required cultural change. Confusion remains about the appropriate response for a child who is absent, opposed to a child who is missing from out-of-home care.

The Child Safety Practice Manual provides definitions of missing, absent, frequency and vulnerable, and describes factors which may increase a child's vulnerability while they are absent from their placement. How a Youth Worker or Child Safety Officer is to consider these factors when deciding whether to proceed to report a child missing is not explored.

Self-assessment audit findings

In 78 (35 per cent) of the 221 instances, a child reported missing returned to the placement, contacted a carer, or presented themselves to a police station, of their own accord. In just 24 (11 per cent) of the 221 instances reviewed, the child was missing in terms of the formal definition of missing or absent used by DCSYW and applied by QFCC when analysing the self-assessment audit data. In a further 26 cases, not enough information was available for QFCC to make a determination, leaving 161 instances, 73 per cent, where a missing persons' report appears to have been unnecessarily lodged with the QPS.

The case files reviewed for the self-assessment audit indicate several circumstances where it could be determined that reasonable steps to locate the child were not taken.

- A Community Visitor was told by a carer they were directed by a Child Safety Officer to not follow a child (who is routinely absent) but to just call police and make a missing person report; the Community Visitor further reported that the police were not happy with this approach.
- A Youth Worker advised Child Safety's After Hours Service Centre they would attempt to contact the child by phone and if they didn't return by a set time they would call the police.
- A missing person report was lodged for a child after "they failed to make contact with the carer".

Consultation with services and agencies in recent years and case notes reviewed in the self-assessment audit provide indications about why reasonable steps to locate a child might not be taken by a Youth Worker. They include the need for more support and training to determine and assess the vulnerabilities of children who are absent and circumstances where a Youth Worker/ Carer is the only staff member in a facility that also houses other children.

- Police would either bring the young person home, or we would go to the police station or we would go to the hospital. I would have to go everywhere with the youth worker. I would have liked to not have to go. I would get woken up in the night to go.[9]
- There is a reason they [young people] are running away. They have tried to have their voices, opinion heard and weren't so they remove themselves from the situation.[10]

QFCC notes the improvements to training opportunities and requirements for residential care staff, in fulfilment of Recommendation 27 of the *When a child is missing* review, including implementation of the *Hope and Healing – Queensland Framework for working with children and young people living in residential care*.[11] This is a trauma-informed therapeutic framework for caring and supporting children throughout their journey in residential care. Since 1 January 2019 all residential care staff must either be enrolled, working towards or hold a relevant qualification (ideally a Certificate IV in Child, Youth and Family Intervention (Residential and Out-of-Home Care).

Training and adequate resourcing of residential care services will demand a targeted response and commitment from both the residential care service providers and the DCSYW. The operation of the system means there will be natural variation in the ways different residential care services require Youth Workers to respond to instances of children being absent or missing and varying levels of expertise of Youth Workers to identify and evaluate the unique vulnerabilities of children. Inconsistent responses to a child absenting themselves and inconsistent record-keeping may reduce QPS's ability to locate a genuinely missing and vulnerable young person.[12]

Opportunities to encourage greater consistency and information-sharing across residential services providers, should be seized by DCSYW and by providers. QFCC notes that since April 2019 the *Health Services Quality Framework*, used to assess residential care facilities, has required residential care services to comply with the *Joint Agency Protocol to reduce preventable police call-outs to residential care services,* developed by QFCC and other stakeholders in 2018.

Collaborative safety planning

Of the 12 children whose cases were reviewed as part of the self-assessment audit, eight were noted to have had a safety plan or crisis management plan in place at some point during the nine-month period. Representatives of the child's support network (in this case a Child Safety Officer, service representatives and carers) were recorded as being involved in the safety planning process for just one of the eight children. Case notes showed safety plans for three children were updated after they returned from being reported missing.

It is well established that children living in out-of-home care have difficulty adjusting to structured living arrangements.[13] This may be particularly so for residential care facilities which may impose strict rules and curfews. Being routinely absent can be an expression of feelings for someone who struggles to regulate their emotions.[14] The *When a child is missing* report discusses the need for holistic assessments which explore the underlying risks and circumstances surrounding a child who is missing or absent.[15] The report also discusses cross-agency collaboration to develop a safety plan with a child after a period of absence or being missing, which considers prevention, education and support to minimise recurring events.

DCSYW techniques applied in safety and support planning for families of children at risk have been adapted for use with children who are frequently missing or absent from their placement.

The *Practice Resource: safety and support planning for young people who are frequently absent or missing from their placement* (the Practice Resource) encourages carers to work with children and their networks to:

- develop a safety plan and discuss their motivations for leaving
- consider the impact being absent has on people in their networks
- raise awareness of the risks, and
- reach an agreement about how the child can let their carers know where they are if they leave their placement.[16]

The DCSYW was also responsible for coordinating the development of the *Queensland Government Protocol for Joint Agency Response When a Child in Care is Missing*[17] to outline the roles and responsibilities of each agency for responding to missing and absent children from out-of-home care. Step eight requires:

> following the child being safely located, a safety and support plan will be developed by a joint agency care team to address issues that have led to the child going missing.

Self-assessment audit findings

Where safety plans were in place, they did not appear effective in preventing children from continuing to be absent or missing from placement and may not be developed in the way intended by the *When a Child is Missing* review. Where safety plans were discussed in the case notes provided with the audit, they sometimes involved rules for the child about the time they were to return home. For example, in one case carers' notes stated "under their safety plan if they have not returned by 9pm curfew they are to be reported missing. This has been done with…Police". Based on the information provided to the QFCC, the safety plans did not appear to document a child's reasons for leaving a placement, where they were likely to go, or what actions the child could take to keep themselves safe, as outlined in Recommendation 9.[18]

A child left their placement to visit their Aunt's place and was given a curfew by the Youth Worker. The child had a history of being absent from their placement and had a safety plan in place. Case notes showed the safety plan included allowing the child to sleep at a nominated relative's house.

On speaking with the nominated relative, the Youth Worker determined the child wasn't at the address at their appointed curfew and so a missing person's report was made to police. The police located the child at the nominated relative's house very soon after curfew.

The child asserted they had told the carers/youth workers where they were and when they would need to be collected. Police officers returned the child to their placement.

There were very few instances in which a safety plan was noted to have been developed in consultation with stakeholders and plans also did not appear to have been reviewed and updated after a child had been missing or absent. Of particular concern was the use of 'safety planning' as an action the child was required to undertake prior to leaving the placement. There were some instances of language such as the young person "was safety planned" before leaving the house. This suggests safety plans are not being used as a long-term approach.

Contextual information provided through the self-assessment audit suggested that safety plans often comprised of a series of rules for the child about the time they were to return home and the consequences if they failed to do so.

- The safety plan includes sighting the child every three hours if her address is known and contacting her every hour by phone. On a different incident the child left the placement simply because they didn't want to have to abide by the conditions imposed by the safety plan.
- Missing person report was made when the child's 10pm curfew wasn't made; additional notes provided by QPS stated, "missing person is a recidivist missing person who has no regard for … curfew".
- The Community Visitor escalated concerns about the risk and appropriateness of the DCSYW's response to the support needs of the child, particularly a clear safety plan when the child is missing or absent.
- Missing person did not make a safety plan before they left the house.
- Missing person didn't tell the carer when they would be returning and didn't make a safety plan before they left.

From the information provided to the QFCC, the safety plans developed did not appear to document a child's reasons for leaving placement, where they are likely to go, or what actions the child could take to keep themselves safe. There were very few instances in which a safety plan was noted to have been developed in consultation with stakeholders, and these plans also do not appear to have been reviewed and updated after each instance in which the child had been missing or absent.

The *Joint Agency Protocol to reduce preventable police call-outs to residential care services* emphasises the role of the police is to stop crime and make the community safer.[19] What we have observed through the post-implementation review is multiple instances of children not even meeting the definition of missing, let alone engaging in criminal behaviour, prior to police being called.

The application and use of safety and support plans is not applied consistently or purposefully as an opportunity to respond to the unique needs and behaviours of each individual.

Information-sharing

Difficulties sharing information and accurately reporting data across government agencies were identified by the *When a child is missing report* (Recommendation 19) and remains challenging, as evidenced by the self-assessment audit and a recent Queensland Audit Office report.[20] The self-assessment audit showed there were discrepancies in data provided by agencies about the same issue, including transfers to hospitals and school enrolments. Continuous improvement to data collection and standards should be a priority for ongoing collaboration between all prescribed agencies. This will support robust information about a child reported missing to be quickly shared in the interests of their safety. DCSYW's Our Child multi-agency information-sharing platform was launched in March 2018, has been fully operational since March 2019 and is expected to assist this process. Specific data from existing systems owned by the key agencies of QH, DoE, OPG, DCSYW, and Youth Justice is pulled automatically into a combined data base that can be accessed by police officers and certain child safety staff if a child from out-of-home care is reported missing. Between March 2018 and June 2019, 2,331 searches were conducted.[21]

Consistent engagement with formal education

Information-sharing between education providers, a child's carers and DCSYW about school progress and enrolment continuity of individual children living in out-of-home care appears to need strengthening. All parties should proactively participate in improving this process. This should include discussions about alternative schooling options, where it is considered these may help the child engage better with learning and the education system.

Eight of the twelve children in the self-assessment audit experienced a significant disruption to their education during the nine-month period of the audit. Four of the 12 children were not enrolled in any school for a period; in two cases this appears to have included several weeks of school term. Four children were suspended from school, for periods ranging from two weeks to two months and one child was marked absent for 175 of 193 school days in 2016. Five children moved schools at least once during the review period. Education was not significantly disrupted for four children, two of whom were in foster care and two in residential care.

It is known that consistent systems and approaches, important for all children, are crucial if they are living in out-of-home care.

Also, a disruption to school enrollment creates periods of time during which a child may lack boundaries or be not engaged in meaningful activity– two of the antecedents to running away.[22] Two-way communication between schools and carers is an important aspect of a successful education experience for any child.

CONCLUSION

Agencies have responded to all recommendations from the *When a child is missing report*. However, some of the responses have not created the impact expected or required.

This PIR suggests current management of children who are absent rather than missing from their placement may be an outcome of underlying issues related to training, resourcing and information exchange in residential care facilities. Residential care services have been the topic of multiple surveys and reports, often on specific aspects of the service provided. All note that residential care has a reputation for being the placement of last resort and that young people in residential placements can be some of the most disadvantaged, vulnerable and challenging young people in the out-of-home care system.[23] However,

"Evidence tells us that care placements for children are more likely to be effective when carers have skills in areas such as communication, coping skills, parenting, understanding trauma, valuing learning and connection to the birth family. Helping carers build their capacity in these areas is a direct investment in the children they're caring for.

Doing this can also help us reshape the narrative around out-of-home care and those who need it; not as an end-of-the-line solution for damaged people – but as a critical second chance for children with potential who have the same goals and aspirations as everyone else."[24]

The QFCC continues to maintain oversight of implementation of its recommendations through a Reviews Strategic Oversight group. The QFCC considers there is scope for development of an oversight program to support improved outcomes for children living in the residential care system. A future QFCC program of oversight would focus on:

- how the recommendations from the *When a child is missing report* have been operationalised by residential care workers and the auspicing agencies
- the link between school engagement and placement stability for young people placed in residential care.

APPENDIX ONE

When a child is missing: Recommendations[25]

This is a list of the recommendations from the 2016 report of *When a child is missing – Remembering Tiahleigh - a report into Queensland's children missing from out-of-home care*.

1. The Director-General of the Department of Premier and Cabinet (DPC), in consultation with the Director-General of the Department of Communities, Child Safety and Disability Services (D-G, DCCSDS), leads a discussion through the Directors–General Leadership Board on agency cultural change needed to promote a whole-of-government approach to vulnerable children living in out-of-home care.
2. The Government establishes a Missing Children Pilot Governance Model – 'Our Child'.
3. Child Safety Services develops an overarching media strategy.
4. The QPS publishes a missing child media release (including an Amber Alert) immediately when required.
5. The QPS revises the interim protocol introduced following the death of Tiahleigh Palmer and incorporate into the QPS Operational Procedures Manual, 'Chapter 12 – Missing Persons'.
6. All agencies cease using the term 'abscond' as it relates to children missing from out-of-home care and adopt a single standard definition in all policies and procedures using the terms 'missing' and 'absent from placement'.
7. The Government develops and implements a joint agency protocol for responding when a child is missing from out-of-home care.
8. Child Safety Services updates or creates relevant internal policies, procedures, guidelines and resources to align with the joint agency protocol and revised definitions of 'missing', 'vulnerable' and 'absent from placement'.
9. Child Safety Officers develop a safety plan for children who are frequently absent from their placement.
10. The QPS updates its Operational Procedures Manual, 'Chapter 12 – Missing Persons' to provide clearer guidance around processes involving children from out-of-home care and align with the joint agency protocol.
11. The DET implements a state-wide, same day notification procedure in State, non-state and Independent schools (where feasible), advising parents/carers when a child is absent from school.
12. The QPS amend the School Based Policing Program, Memorandum of Understanding and staff induction booklet to clearly outline the role and responsibilities of School-based Police Officers during missing children investigations and supporting initiatives for children identified as at risk.
13. The DET, Queensland Catholic Education Commission and Independent Schools Queensland review and achieve consistency for all policies and procedures for children living in out-of-home care, including processes for monitoring continuity of enrolment for children who move placements.
14. The DET nominates a central after hours contact number the QPS can call to obtain necessary information about a missing child's school attendance record, their networks, or other relevant information to assist in the QPS investigation.
15. The Office of the Public Guardian (OPG) makes certain children living in out-of-home care who have previously been reported as missing to the QPS or are frequently absent from their placement are visited by community visitors on a regular basis.

16. Child Safety Services amends the SCAN team system to reflect required responses to missing children from out-of-home care.
17. Government agencies nominate a person to be contacted when local contacts are unavailable to expedite information and assist the QPS with its investigations when a child is reported missing. The nominated contact is required to have strategic oversight and decision making authority.
18. QHealth provides a greater focus on advocating for the sharing of information regarding children from out-of-home care, particularly those children who may present to a hospital during the time they are reported as missing or absent from their placement.
19. Government establishes a process for collecting data on missing children from out-of-home care and reports information annually.
20. Child Safety Services regularly and proactively provides information to the QPS when a child is missing from out-of-home care as required by revised missing children's guidelines, forms and checklists.
21. The QPS updates the 'Form 1' to include whether a child in out-of-home care is reported missing.
22. Child Safety Services comply with the use of the Missing Persons Alert in the Integrated Client Management System (ICMS).
23. Child Safety Services collects data via the System and Practice Reviews on any significant injuries or death of children during the period of time they are missing and reports information annually.
24. QFCC updates the Child Death Register to enable recording of whether a child is reported as missing at their time of death.
25. Training be provided immediately to key QPS staff on Amber Alerts and how these differ from the previous Child Abduction Alerts to ensure staff are aware of the criteria for issuing the alert. This training should be extended to other relevant agencies as required.
26. Training is provided to all relevant Child Safety Services' staff, foster/kinship carers, care service providers and relevant agencies to incorporate procedures and processes for responding to a child who is absent from placement or missing.
27. The QFCC's action plan for the Strengthening the Sector Strategy includes appropriate training and guidance for residential care workers when children are absent from their placement or are reported as missing.
28. The QFCC to review legislation, policies and practices relating to information sharing between all parties, particularly the QPS, Child Safety Services and DET as responsible agencies for undertaking internal risk assessments and decision-making about the safety for all children in regulated service environments.
29. The QFCC establishes a governance group to provide strategic oversight for monitoring the implementation of recommendations from the review.

Endnotes

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