**Annual Report** on the

Queensland Child Death Case Review Panels

2018–19

The Honourable Di Farmer

Minister for Child Safety, Youth and Women

Minister for the Prevention of Domestic and Family Violence

Dear Minister

In accordance with section 246HL of the *Child Protection Act 1999* (the Act), I present the annual report about the work of Child Death Case Review Panels under Chapter 7A of the Act and departmental responses for the period 1 July 2018 to 30 June 2019.

Yours sincerely



Leigh Roach

**Acting Director-General**

**Department of Child Safety, Youth and Women**

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**Message from the Director-General**

This report summarises the operations of Child Death Case Review Panels and the actions taken by my department in response to panel reports in 2018–19.

The impact of the death or serious physical injury of a child is profound, not only to the child’s family, carers and staff but also to the broader community. Preventing the death or serious physical injury of a child, is one of the key priorities of the department, and the child protection system more broadly. In the event of a death or serious physical injury, it is an important part of our accountability that there is a comprehensive review of the work the department has undertaken with the child, young person, their family and carers. These reviews ensure a comprehensive analysis of the policy and practice to identify what worked and the areas of learning that need further attention.

Since 2004, Queensland has utilised a two-tiered system for reviewing involvement with children and young people known to the department who have died or were seriously physically injured in the twelve months prior. This two-tiered approach ensures a robust and independent examination of our systems and practice. The first process is an internal Systems and Practice Review undertaken by my department (and the Director of Child Protection Litigation in the Department of Justice and Attorney-General where required); and second, an external review of the department’s review by the independent Child Death Case Review Panel.

In response to the Queensland Family and Child Commission 2017’s published review report: *A systems review of individual agency findings following the death of a child*, the Government has given consideration to how to best establish a revised external and independent child death review model. It has been announced that Queensland Family and Child Commission will host a new and independent Child Death Review Board once legislative amendments have been passed. I am pleased that this new and independent Board will be established, and believe this will provide a valuable opportunity for cross-agency benefits, such as the identification of systemic issues and the strengthening of collaborative practice.

In 2018-19, the Child Death Case Review Panels considered 77 departmental Systems and Practice Review reports and five reports prepared by the Director of Child Protection Litigation. These dealt with 54 deaths and 18 serious physical injuries. Child Death Case Review Panels made a range of findings, conclusions and recommendations to the department as a result of their review and considerations. This report details key panel findings and insights as a result of their review process.

I thank all involved in the review processes, inclusive of departmental and other agency staff, the reviewers, and the panel members. Their time and expertise contribute to better child protection policies and practices in Queensland.

We will again share this report with child protection leaders within and beyond our agency to ensure the system and practice as a whole continues to improve.



Leigh Roach

**Acting Director-General**

**Department of Child Safety, Youth and Women**

Executive Summary

## Background

When a child who is known to the department dies or suffers a serious physical injury, a two-step review process is undertaken. The first is an internal Systems and Practice Review completed by the department. The second is a review of the department’s review by an independent Child Death Case Review Panel. The purpose of both reviews is to identify and ensure improvements in the provision of services by the department and promote accountability.

Children ‘known to the department’ encompasses all those children who come to the attention of the department in the twelve months preceding their death or serious physical injury. This may include through intake processes, when concerns about abuse or neglect are recorded and assessed or when ongoing intervention occurs with a child and their family, including when a child protection order is sought.

The Director of Child Protection Litigation must also undertake a review if, at the time of the child’s death or serious physical injury, or in the one year prior, the child was subject to a litigation function by the Director of Child Protection Litigation. In these instances, the Child Death Case Review Panel then considers the department’s review and the Director of Child Protection Litigation’s review for the child at the same time.

## Panel Operations

During the reporting period, the Panels considered 77 review reports, relating to 72 individual children/cases comprising 54 deaths and 18 serious physical injuries. For five children, the Panels considered the department’s Systems and Practice Review Report and the Director of Child Protection Litigation’s Review Report. Nineteen panels completed reviews during the reporting period.[[1]](#footnote-1)

Panels considered departmental involvement with children and young people occurring across a number of points on the child protection continuum — from Intakes, Investigation and Assessment, Intervention with Parental Agreement and those subject to Child Protection Orders. The children and young people were from diverse cultural, family and community backgrounds, and had many different life experiences, opportunities and challenges.

Each of the 19 panels produced a report outlining broad conclusions and recommendations relating to the cases reviewed and detailed conclusions and recommendations for each individual case. These conclusions and recommendations are aimed at systemic improvement based on the individual cases reviewed. The Panels identified examples of high quality service delivery by departmental staff. The Panels also identified key or recurring themes and a range of areas for improvement.

During the reporting period, the panels delivered 19 reports to the Director-General of the department, and five reports to the Director of Child Protection Litigation.

In 2017, the Queensland Family and Child Commission (QFCC) published a review report: *A systems review of individual agency findings following the death of a child*. One overarching recommendation was made that the Queensland Government redesign the independent model through which the deaths of children and young people known to the child protection system are considered, to promote a shared responsibility and accountability between the agencies involved in providing services for the child who has died.

Following the Government giving consideration to how best to establish a revised external oversight and independent child death review model, it was announced that QFCC will host a new and independent Child Death Review Board.

The initiative complements QFCC’s oversight role and the child death register function, and was announced on Tuesday 11 June 2019 as part of the Queensland Government’s delivery of the 2019/20 Budget.

The function will be transferred from the Department of Child Safety, Youth and Women, along with a new format for the Board. Staged arrangements will be made to transition the Child Death Review Board.

## Actions Taken

Each panel’s report is provided to the Director-General of the department, and considered by key divisions in the department. A departmental response is prepared for the Director-General with respect to each panel report, outlining the actions the department has taken, or intends to take, in response to the report’s conclusions and recommendations.

At the policy, practice and resourcing levels, the department is committed to responding to and acting on the conclusions and recommendations of panels throughout the year. Recommendations and responses actively inform departmental policy and practice reform and performance mechanisms. Departmental actions and initiatives that have occurred in response to panel conclusions and recommendations are detailed in Chapter 4 of this report.

Chapter 1

# The Review System

## Background

The Department of Child Safety, Youth and Women (the department) is the statutory child protection agency in Queensland. The department works closely with other government departments, non-government agencies and the community to support families or carers to keep children and young people safe from abuse and neglect.

Children ‘known to the department’ encompasses all those children who come to the attention of the department in the one year preceding their death or serious physical injury. This may include through intake processes, when concerns about abuse or neglect are recorded and assessed or when ongoing intervention occurs with a child and their family, including when a child protection order is sought.

As at 31 March 2019, over 89,000 Queensland children and young people were ‘known to the department’ in the previous 12 months.

## Review Framework

Since 2004, Queensland utilises a two-tiered system for reviewing involvement with children and young people known to the department who have died or are seriously physically injured.

The department undertakes Systems and Practice Reviews of its involvement following the death or serious physical injury of a child who is known to the department in the year prior to their injury or death. Systems and Practice Reviews are conducted in accordance with Chapter 7A of the *Child Protection Act 1999* (the Act), and focus on facilitating ongoing learning and improvement in the provision of services by the department and promoting the accountability of the department.

The Act includes provisions under Chapter 7A requiring the department to carry out a review of its involvement with any child who dies or is seriously physically injured if:

* at the time of the child’s death or serious physical injury, the child is in the Chief Executive’s custody or guardianship, or
* within one year before the child’s death or serious physical injury, the Chief Executive became aware of alleged harm or alleged risk of harm to the child in the course of performing functions under or relating to the administration of the Act, or
* within one year before the child’s death or serious physical injury, the Chief Executive took action under the Act in relation to the child, or
* the child was less than one year old at the time of death or serious physical injury and, before the child was born, the Chief Executive reasonably suspected the child might be in need of protection after he or she was born, or
* the Minister requests a review.

Systems and Practice Reviews may occur in addition to criminal investigations and proceedings, coronial investigations and inquests, and reviews by other agencies.

Child Death Case Review Panels were established on 1 July 2014 under the Act to replace the Child Death Case Review Committee (supported by the former Commission for Children and Young People and Child Guardian) in overseeing the department’s reviews as recommended by the Queensland Child Protection Commission of Inquiry.

As of 1 July 2016, pursuant to the Act, the Director of Child Protection Litigation (in the Department of Justice and Attorney-General) is required to conduct an internal review on matters where a child has died or suffered a serious physical injury and the Director of Child Protection Litigation had performed or was performing a litigation function in relation to the child within one year before, or at the time of, the child’s death or serious physical injury.[[2]](#footnote-2) The review by the Director of Child Protection Litigation is then reviewed together with the associated Systems and Practice Review by the Child Death Case Review Panels.

The Queensland Family and Child Commission, the Queensland Police Service and the Coroner may also undertake systemic reviews of particular child deaths.

## Tier 1: Internal Systems and Practice Reviews

The department takes the death and serious physical injury of any child or young person seriously and seeks, through its review process, to identify opportunities to improve child protection service delivery to Queensland’s children and young people. The department is responsible for undertaking an internal Systems and Practice Review of its involvement with children and young people who have died or suffered a serious physical injury. The department’s review is the first tier of Queensland’s two-tiered case review system.

The purpose of the review is to facilitate ongoing learning and improvement in the provision of services by the department and to promote the accountability of the department. A Systems and Practice Review seeks out learning and development opportunities for continuously improving the child protection system. To achieve this, the reviews are transparent, inclusive and constructively focused on systems and practice improvements for children.

The term of reference for Systems and Practice reviews in relation to the death of a child is to:

*Review Department of Child Safety, Youth and Women’s service delivery to the Subject Child under the Child Protection Act 1999 in the year prior to their death with a focus on ensuring continuous improvement of service delivery, public accountability and improved outcomes for children.*

For Systems and Practice Review’s conducted in relation to a serious physical injury, the term of reference is to:

*Review the injury event and analyse service delivery factors that may have helped to prevent the injury.*

Changes to the *Child Protection Act 1999* in 2018, introduced provisions to support the safe care and connection of Aboriginal and Torres Strait Islander peoples by recognising the importance of maintaining their connection to family, community and culture. In particular, the Aboriginal and Torres Strait Islander Child Placement Principle was embedded into the administration of the Act , and places a stronger focus on ensuring anyone who undertakes a function under the Act does so in alignment with the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle — prevention, partnership, placement, participation and connection. As such, for Aboriginal and Torres Strait Islander children, the Systems and Practice Review considers the Aboriginal and Torres Strait Islander Child Placement Principle and whether the child received services in a culturally appropriate manner.

The Systems and Practice Review Committee oversees Systems and Practice Review outcomes and has responsibility for identifying learnings and making recommendations in Systems and Practice Review reports. The committee considers all Systems and Practice Reviews prior to them being finalised and provided to the Child Death Case Review Panels Secretariat.

The committee is chaired by the Executive Director, Child and Family Practice, and has membership from across key departmental areas, including:

* Review
* Capability and Learning
* Quality Practice and Clinical Support
* Operational Policy
* Investment and Commissioning
* Violence Prevention Commissioning
* the relevant Regional Director/s for each review being discussed
* the relevant Regional and Aboriginal and Torres Strait Islander Practice Leaders for each review being discussed

Co-opted membership is afforded to a person with expertise in a specific service delivery area, including:

* the relevant Practice Leaders (Mental Health, Alcohol and Other Drugs, Domestic and Family Violence and Office of the Official Child and Family Solicitor) for each review being discussed
* Specialist Services (Disability)
* Youth Justice Policy Performance Programs and Practice[[3]](#footnote-3)

The Systems and Practice Review Committee uses the following terms of reference when considering Systems and Practice Reviews:

* whether there is a link between the department’s practice or decisions and the serious physical injury or death of the child
* the accountability of officers involved in the case and whether any identified practice issues amount to misconduct and require referral to Ethical Standards
* whether there are learnings identified that could be used to inform reform activities
* how any learnings from the Systems and Practice Review could be used to strengthen frontline practice
* whether there are opportunities identified to improve the child safety service system more broadly
* whether there are opportunities identified for enhancing internal and external collaboration
* whether there is high quality practice identified in the review that merits recognition.

In addition, for reviews relating to Aboriginal or Torres Strait Islander children, the committee considers whether the service delivery has occurred with key consideration of the elements of the Aboriginal and Torres Strait Islander Child Placement Principle.

As soon as practicable, and not more than six months after being notified of the death, serious physical injury or Minister’s request for a review, the department must:

* complete the review
* prepare a report about the review
* provide a copy of the report and any documents obtained by the Chief Executive, and used for the review, to the Child Death Case Review Panel.

## Tier 2: Child Death Case Review Panels

Child Death Case Review Panels are the second tier of Queensland’s case review system and provide important accountability and oversight of Queensland’s child protection system. The panel considers the departmental reviews of all child deaths and children who suffered serious physical injuries if they were in the department’s care or were known to the department in the one year prior to their death or serious physical injury.

The Act contains provisions for Child Death Case Review Panels in relation to:

* the purpose of reviews
* membership and panel formation
* the conduct of business by panels
* Child Death Case Review Panel reports
* annual reporting.

The Minister is required to have the Child Death Case Review Panel review departmental reviews for the purpose of facilitating ongoing learning and development in the provision of services by the department and to promote the accountability of the department.

Members of Child Death Case Review Panels are drawn from a pool of approved members. A person is eligible to be a member of the Child Death Case Review Panel if they have expertise in the field of paediatrics and child health, forensic pathology, mental health, investigations or child protection, or has expertise in litigation relating to child protection proceedings or proceedings of a similar nature. A person is also eligible for membership if, because of their qualifications, experience or membership of an entity, they are likely to make a valuable contribution to the work of the panel. A member of the pool can hold office for no longer than two years.

Each review panel must include:

* at least three people who are not public service employees who the Minister is satisfied have specialist experience in child protection issues
* at least one, and no more than three, departmental employees
* at least one public service officer who is employed as a senior officer or senior executive officer in a different department
* at least one panel member who is an Aboriginal or Torres Strait Islander person.

If the panel is established for reviewing a review by the Director of Child Protection Litigation, the panel must also include a member with expertise in litigation related to child protection proceedings or proceedings of a similar nature.

The Minister is responsible for approving the composition of a panel and the cases assigned to a panel for its consideration.[[4]](#footnote-4) A review panel may be allocated one or more reviews. The Child Death Case Review Panels Secretariat assists the Minister to allocate reviews and select members to convene a panel. Members are selected from the pool according to the themes and characteristics of the cases to be reviewed by the panel and the members’ areas of expertise.

A panel can conduct its business, including meetings, in any way it considers appropriate and is not subject to direction by the Minister about the way it performs its functions.[[5]](#footnote-5) Panels typically meet and discuss the allocated cases. The panel critically reflects on the department’s Systems and Practice Review, departmental involvement and the circumstances of the family leading up to the death or injury.

Child Death Case Review Panels must decide the extent and terms of reference for their review. When reviewing the department’s review, section 246DB(2) of the Act states that Child Death Case Review Panels may decide to consider:

* a matter within the terms of reference of the Chief Executive’s review
* ways of improving the department’s practices relating to the delivery of services to children and families
* ways of improving the relationship between the department and other entities with functions involving children and families
* whether disciplinary action should be taken against a public service employee of the department in relation to the department’s involvement with a child.

When reviewing the Director of Child Protection Litigation’s review, section 246DB(2) of the Act states that Child Death Case Review Panels may decide to consider:

* ways of improving the guidelines made by the Director of Child Protection Litigation under the *Director of Child Protection Litigation Act 2016*, section 39, and any other relevant policies
* ways of improving the relationship between the Office of the Director of Child Protection Litigation and the department
* whether disciplinary action should be taken against a member of the Director of Child Protection Litigation’s staff in relation to the staff member’s performance of a litigation function.

Following the panel meeting, a final report is prepared by the panel chair, with support from the Child Death Case Review Panels Secretariat, outlining the views, conclusions and recommendations of the panel. This report typically contains the panel’s consideration and conclusions for each departmental Systems and Practice Review. It also includes any broader overarching themes, conclusions and recommendations that may be identified by the panel.

Within six months of receiving the department’s review report, the Child Death Case Review Panel must complete its review, prepare a report and provide it to the Chief Executive of the department.[[6]](#footnote-6) If both the department and the Director of Child Protection Litigation are required to carry out a review, the panel must review both reviews at the same time, prepare its reports and deliver them to the Chief Executive and the Director of Child Protection Litigation within six months of receiving both reviews.[[7]](#footnote-7) *Figure 1* explains the Queensland case review system for those children known to the child protection system.

The Chief Executive of the department must give a copy of its report to the Minister if the review was initiated by a request from the Minister or if the Minister requests a copy. The Director of Child Protection Litigation must give a copy of its report to the Minister for Justice if requested.

The Chief Executive of the department and the Director of Child Protection Litigation may give copies of their respective reports to each other.



*Figure 1. The Queensland case review system for children known to the child protection system*

Chapter 2

# Profile of Children and Young People subject to Reviews

## Snapshot

In the 2018–19 reporting period, Child Death Case Review Panels completed reviews of cases involving 72 children and young people.[[8]](#footnote-8) Fifty-four (54) cases involved children or young people who had died and 18 cases related to a child or young person who had sustained a serious physical injury.

Of the 72 children and young people reviewed, 41 were male and 31 were female. Twenty-seven of the children and young people identified as Aboriginal (38 per cent), two identified as Torres Strait Islander (three per cent) and three identified as both Aboriginal and Torres Strait Islander (four per cent).

*Figure 2* shows the number of cases reviewed each year from 2014-15 to present. The present review system came into effect on 1 July 2014, requiring the department to review cases where the child was known to the department in the one year prior (previously the timeframe included children who were known to the department in the *three* years prior) and introducing the requirement to also conduct a review for children who sustained a serious physical injury. While the numbers of child deaths have remained relatively stable, the 2018–19 year has seen a significant increase in the numbers of children who have sustained serious physical injuries, generally from accidental causes.

Information about all children whose deaths were registered in the 2018–19 year is found in the Queensland Family and Child Commission Annual Report, *Deaths of children and young people, Queensland, 2018–19*.

***Figure 2. Number of cases subject to review by panels in Queensland since 2014***.

## Characteristics of Cases

**Serious physical injuries**

The most frequent circumstance of serious physical injury was accidental, accounting for 13 of the 18 cases (72 per cent). Five of these cases involved transport related injuries, while four cases involved burns.

The five serious physical injury cases that were not accidental consisted of three cases of assault and two cases of self-harm.

*Figure 3* shows the circumstances of serious physical injury in the cases reviewed in the 2018–19 reporting period.

Nine of the children/young people identified as Aboriginal.

The most common age category for cases reviewed were children in middle childhood aged 10-14 years (six cases), children in early childhood aged 1-4 years (five cases), and teenagers aged 15-17 years (four cases). Two of the children were aged 5-9 years, while one child was aged under one year.

**13**

**3**

**2**

**18**

***Figure 3. Circumstance of serious physical injury of children and young people in the 2018–19 reporting period***

**Deaths**

The most frequent circumstance of death was disease or morbid condition, accounting for 19 of the 54 cases (35 per cent). This category included children and young people who died due to disease, illness or disability.

Accident was the second-most frequent circumstance of death, consisting of 16 cases (30 per cent). Six of these cases involved drowning, four related to transport, three related to a house fire, and the remaining three were due to other circumstances.

Sudden and Unexpected Death in Infancy (SUDI) accounted for seven of the cases (13 per cent).

Suicide or self-harm accounted for 13 per cent of the deaths (seven children), and all were adolescent aged. Three of the youths were in the 10-14 age category, while the remaining four were in the 15-17 age category.

*Figure 4* shows the circumstances of death in the cases reviewed in the 2018–19 reporting period.

**5**

**7**

**7**

**16**

**19**

**54**

***Figure 4. Circumstance of death of children and young people in the 2018–19 reporting period***

Consistent with their higher levels of physical vulnerability, young children aged under one year were the highest represented, accounting for 21 of the cases (39 per cent). The second highest age category were young children aged 1-4 years, accounting for 13 cases (24 per cent).

*Figure 5* shows the age categories of deaths and serious physical injuries in the cases reviewed in the 2018–19 reporting period.

***Figure 5. Age categories of deaths and serious physical injuries in the 2018–19 reporting period***

**Children missing at the time of their death or serious physical injury**

For the 2018-19 reporting period there were five children identified as missing when advice was provided to the department of their death (four) and serious physical injury (one) respectively. In the 2017-18 reporting period there were zero.

Chapter 3

# Panel Operations in 2018–19

## Panel Composition

In July 2017, the department finalised a recruitment process that resulted in the appointment of four additional members to the Child Death Case Review Panels member pool by the Minister. In July 2017, 25 existing members of the pool were also extended for a further two years by the Minister.

In February 2019, one external member and five representatives from other government agencies were re-appointed to the pool for a further two-year term, until 31 January 2021.

Additionally, in February 2019, 21 senior executive officer positions from the department were appointed to the pool, including one Identified position. However, Machinery of Government changes in May 2019, resulted in two of these positions being re-allocated to another government agency.

There are presently 49 members in the panel pool. Membership is comprised of 20 external members, 19 positions from the department, and 10 senior officers from other government agencies.

*Figure 6* identifies the percentage breakdown of present panel pool membership. *Appendix B* includes the biographies of the external members and *Appendix C* identifies the membership of departmental and other government agency officers.

***Figure 6. Panel membership entity breakdown in 2018-19***

Three members identify as Aboriginal. Currently, there are no Torres Strait Islander members. Of the 30 members appointed to the pool by name, seven are male and 23 are female.

The 20 external members have a wide variety of expertise and experience, including health, social work, child protection practice, mental health, drug and alcohol abuse, accident prevention, domestic and family violence, and legal/litigation.

*Figure 7* identifies the rates of the main areas of expertise for the present external members of the pool.

***Figure 7. External members’ expertise breakdown in 2018-19***

The composition of members on each panel and the allocation of cases to panels were approved by the Minister, with assistance from the Child Death Case Review Panels Secretariat. Each panel was chaired by an external member. A large pool of members with diverse experience and expertise provided the opportunity for cases to be allocated to panels based on common themes and characteristics of the children and their families.

Multiple cases were allocated to panels with consideration of the child’s age, circumstances of the death or injury, type of departmental involvement at the time of death or injury, and family characteristics. Members were then selected based on their experience and expertise to review the themes and characteristics of the cases to be considered.

Each panel comprised at least three external members, one member from the department and one member from another government department. Each panel had at least one Aboriginal member, noting there are currently no Torres Strait Islander members in the pool. A litigation expert was a member of each panel that was required to consider a review by the Director of Child Protection Litigation.

##

## Panel Themes

During 2018–19, panels were convened around the following themes relating to service delivery to children and young people:

* with severe chronic or terminal medical conditions and disabilities
* whose circumstance of death was suicide or self-harm
* who were very young and vulnerable at the time of their death
* who were from remote and regional locations
* who had suffered a serious physical injury arising from an assault
* whose death was caused by accidental incidents
* who were adolescents at the time of their death.

*Appendix A* provides more detailed information on membership of each panel convened in 2018-19.

## Panel Outcomes

The 19 panels completed 77 reviews in the 2018–19 financial year. The Panels considered cases involving 54 children and young people who died and 18 children who sustained a serious physical injury. Five of the cases were also subject to a review by the Director of Child Protection Litigation. Panels considered departmental involvement with children and young people at a number of points on the child protection service delivery continuum.

These children and young people were from diverse cultural, family and community backgrounds, and had different life experiences and challenges.

The Panels produced reports outlining the conclusions and recommendations of their reviews, which were submitted to the Director-General of the department and the Director of Child Protection Litigation. The 19 panels offered a number of findings, conclusions and recommendations to the department for ongoing service delivery improvement. The five panels which considered reviews by the Director of Child Protection Litigation offered their findings, conclusions and recommendations to the Office of the Director of Child Protection Litigation for ongoing service delivery improvement.

The approach and nature of recommendations of the panels varied based on panel composition and the types of cases allocated. Each panel made recommendations aimed at systemic improvement based on the individual cases allocated to them. There were recurring themes and areas for improvement that appeared across multiple panels.

The final report of each panel was considered by key areas in the department and panel conclusions and recommendations have directly influenced key areas of reform and service improvement.

The department also made the recommendations from the Systems and Practice Review Committee and Child Death Case Review Panels available to departmental staff. Practice Connect, Capability and Learning, Regional Directors, the Regional Practice Leaders and Aboriginal and Torres Strait Islander Practice Leaders have collectively made these learnings more visible across the department to inform the ongoing strengthening of the child protection system and practice.

Departmental actions that have been taken in response to panel reports and Systems and Practice Review Committee reports are detailed in Chapter 4.

The Director of Child Protection Litigation’s actions that have been taken in response to panel reports will be detailed within the Director of Child Protection Litigation’s Annual Report, as per Section 40 of the *Director of Child Protection Litigation Act 2016*.

## Panel Conclusions and Recommendations

Panels identified areas of improvement in the systems and processes associated with the delivery of services to children, young people and their families. The Panels identified systems and practice learnings and proposed recommendations in a range of areas. The following seven key service delivery areas are highlighted:

**Domestic and Family Violence**

The Panels encouraged the department to continue to support ongoing practice to occur through a domestic and family violence lens. The Panels highlighted the importance of understanding risk factors of Domestic and Family Violence such as isolation, and excessive physical discipline. The Panels identified the need for collaborative responses to Domestic and Family Violence within the context of child protection, and to make use of partner agencies to strengthen these responses. The Panels further encouraged these responses to be modelled around the rights of children and young people. The Panels highlighted the Safe and Together model for practice as a positive tool for assessment of risk.

**Foster Carers**

The Panels highlighted the extraordinary commitment and dedication of foster carers to children and young people with complex disease and morbid conditions. The Panels identified the need for a review of resources and training provided to foster carers by the department and its partners to ensure foster carers are adequately prepared for providing care for a child, particularly in the context of trauma, and are aware of the department’s ongoing requirements.

**Information sharing with partner agencies**

The Panels encouraged the department to share the key learnings from reviews with partner agencies to support cross-agency communication, collaboration and information sharing. The Panels highlighted the need for ongoing and updated resources and information to be provided to departmental officers from partner agencies in order for effective advocacy for clients. The Panels highlighted that joint accountability, responsibility and commitment to best possible outcomes for children and families would be strengthened by ongoing interface between partner agencies. The Panels encouraged communication between partner agencies that clearly identifies roles and expectations of each agency when their engagement is relied upon as a protective factor. The Panels identified the benefits of Suspected Child Abuse and Neglect (SCAN)[[9]](#footnote-9), for information sharing, and meaningful cross-agency engagement and further highlighted that this process can influence the quality of child protection services.

**Improvements to Culturally and Linguistically Diverse practice and engagement**

The Panels encouraged the department to continue to develop staff understanding and awareness of the significance and importance of engaging with culturally and linguistically diverse children and families in a culturally appropriate manner and to ensure that services are provided in a collaborative, meaningful way. The Panels highlighted the need for appropriate cultural organisations to be connected to children and families for further support.

**Risk Assessments**

The Panels highlighted the need for training specific to parental intellectual impairment in the context of risk assessments. The Panels identified the need for strengthening the ability of departmental staff to accurately identify the strengths within families to improve risk assessments. The Panels highlighted the need to consider previous unsubstantiated outcomes, and new concerns soon after intervention closure in risk assessment processes. The Panels identified the need for training to occur to improve the quality of risk assessments.

**Structured Decision Making Tools**

The Panels highlighted the need for departmental staff to identify when they have made use of professional judgement by clearly documenting the rationale for use, and the corresponding decision made. The Panels encouraged the department to include cultural considerations within the Structured Decision Making tools. The Panels highlighted the importance of accurate completion of the Structured Decision Making tools, as per the department’s policy and procedures.

**Training and Development**

The Panels encouraged the continuation of meaningful and purposeful mentoring and supervision for departmental staff. The Panels highlighted the ongoing support of professional development for departmental staff, including promotion of reflection. The Panels highlighted the improved and increasing training resources for departmental staff. The Panels identified the need for ongoing training and resources to reflect emerging issues such as methamphetamine misuse, chronic neglect, fire safety, safe sleeping and legal principles (such as ‘least intrusive’).

## Future of Panels

Under the Queensland Family and Child Commission (QFCC) oversight provisions, as set out under the *Family and Child Commission Act 2014*, independent consideration was undertaken of the reviews conducted by the department, the Child Death Case Review Panel and Queensland Health into the death of Mason Lee. In 2017, QFCC published a review report: “*A systems review of individual agency findings following the death of a child*”.

The review focused on whether the internal and external review processes were robust and appropriately identified systemic issues within Queensland Health and the department. QFCC found the reviews undertaken by Child Safety Services, Queensland Health and the Child Death Case Review Panel in the Mason Lee case were timely and thorough.

One overarching recommendation was made, that the Queensland Government redesign the independent model through which the deaths of children and young people known to the child protection system are considered to promote a shared responsibility and accountability between the agencies involved in providing services for the child who has died.

The review recommended in part:

*That the Queensland government considers a revised external and independent model for reviewing the deaths of children ‘known to the child protection system’.*

*Amendments will be required to the Child Protection Act 1999 to transfer responsibility for the child death case review panel to an independent government agency.*

*Legislation will be required to compel nominated agencies who have provided service delivery to the child to undertake an internal review.*

Following the Government giving consideration to how best to establish a revised external and independent child death review model having regard to the recommendation and other reports which have recommended oversight bodies for vulnerable children and young people, it was announced that QFCC will host a new and independent Child Death Review Board.

The initiative complements QFCC’s oversight role and the child death register function, and was announced on Tuesday 11 June 2019 as part of the Queensland Government’s delivery of the 2019/20 Budget.

The function will be transferred from the Department of Child Safety, Youth and Women, along with a new format for the Board. Staged arrangements will be made to transition the Child Death Review Board.

# Chapter 4

# Actions taken in 2018-19

The department appreciates the depth and breadth of expertise of panel members and the insights they have provided into the department’s service delivery to children and families. The department is committed to ongoing learning and improvement in systems and practice and feedback from panels forms a key part of the continuous quality improvement process.

Chapter 4 provides a summary of actions taken by the department in response to the key areas derived from the findings and recommendations of the Panels detailed in Chapter 3.

## Domestic and Family Violence

**Integrated Service Response and High Risk Teams**

The department is leading work across government and the community to design, implement and test holistic and integrated approaches to improving the safety of Domestic and Family Violence (DFV) victims and their children while holding perpetrators to account for their violence. An integrated service response is an innovative approach which ensures coordination of services and supports across government, non-government services and other community organisations.

An integrated service response trial has been conducted in three locations:

* Logan/Beenleigh (urban location)
* Mount Isa/Gulf (regional city location)
* Cherbourg (discrete Indigenous community location).

The integrated service response trial focuses on how service systems can work together in a timely, structured and collaborative way to ensure people affected by domestic and family violence receive quality and consistent support.

Each location has engaged in a co-design process. For example, the Cherbourg response was co-designed to provide a culturally specific integrated response to domestic and family violence that is tailored to the needs of that community.

High Risk Teams (HRTs) are a core component of Queensland’s integrated service response approach. These teams are using common frameworks and tools to provide integrated, culturally-responsive risk assessment and safety management planning for victims and their children assessed to be at high risk of harm or death. The HRTs consist of core members from all agencies with a role in collaborating to keep victims safe and hold perpetrators to account — including police, health, court and corrections, housing, youth justice and domestic violence services.

High Risk Teams using Queensland’s first common risk assessment and safety management framework are currently operating in:

* Logan/Beenleigh
* Mount Isa/Gulf
* Cherbourg
* Brisbane
* Ipswich
* Cairns
* Mackay
* Caboolture

The roll out of integrated service responses to domestic and family violence in Queensland is a staged approach that started with the Logan/Beenleigh site in January 2017, followed by Mount Isa and Cherbourg in August 2017. The high risk teams in Brisbane, Ipswich, Cairns, Mackay and Caboolture have been progressively rolled-out between February 2018 and April 2019. This brings the total number of high risk teams using this common framework in Queensland to eight.

An independent evaluation of Queensland's trial of integrated responses to domestic violence, completed in July 2019 by the Griffith Criminology Institute, Griffith University, analysed integrated responses and high risk team practices and outcomes in the trial locations of Logan/Beenleigh, Mount Isa/Gulf and Cherbourg.

Evaluators highlighted many improvements including better information sharing (allowing for more informed decision making by agencies), enhanced accountability around service delivery across agencies, and there being more 'eyes' on perpetrators.

Most importantly, high risk teams were securing faster and more targeted help for victims at imminent risk of lethality or serious harm.

**Domestic and Family Violence Death Review and Advisory Board**

The Domestic and Family Violence Death Review and Advisory Board was established by the *Coroners Act 2003* to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board is required to identity common systemic failures, gaps or issues and make recommendations to improve systems, practice and procedures that aim to prevent future domestic and family violence deaths. The department provides a representative on the membership of the Board which reinforces and strengthens the government’s collective efforts to say ‘Not Now, Not Ever’ to domestic and family violence in Queensland.

**Children and Families Secretaries**

The bi-annual Children and Families Secretaries (CAFS) meeting was held in Adelaide in August 2019, providing an important opportunity to share insights and discuss common challenges across jurisdictional boundaries.

The intersection between domestic and family violence and child protection was an important focus of the meeting. As the 'National Framework for Protecting Australia’s Children 2009‑2020' comes to an end, CAFS members continued discussions about what the post-2020 national priorities should be to see real change, reduce the national prevalence of child abuse and neglect and improve child protection systems around the country.

**Safe and Together**

The department is continuing to partner with David Mandel’s United States-based Safe and Together Institute to strengthen the DFV informed child protection practice. The Safe and Together model highlights the relationship between child protection and dynamics of DFV, and is based on the concept that children are best served when the department works toward keeping them safe and together with the non-offending parent.

Safe and Together has been reviewed and supported by the Australian National Research Organisation for Women’s Safety (ANROWS). In the ANROWS research study ‘Invisible Practices’ Professor Cathy Humphreys from Melbourne University has described DFV informed CSSCs, like Caboolture and Caloundra, as ‘Centres of Excellence’ with regard to providing improved responses to children and their families affected by DFV. A two-year study was recently completed by the Domestic Violence Research Centre at Central Queensland University. The interim reports have been positive with Child Safety staff, partner agencies and a small sample of parents indicating that the Safe and Together way of working improves assessment and interventions with families.

The principles of the Safe and Together model emphasise:

* holding the parent, who uses violence as accountable
* assessing the impacts of the violent behaviour
* partnering with the non-offending parent (the adult domestic and family violence survivor)
* working with the offending parent to change violent behaviour
* working to ensure safer parenting choices.

Since late 2015, the department has partnered with the DFV sector to deliver Safe and Together training to 1,520 staff, and 353 non-government partners. This includes:

* 693 staff attending the four-day core face-to-face training and 827 staff attending the one-day overview training
* 215 non-government organisation partner attending the four-day core face-to-face training and 138 attending the one-day overview training
* Three face-to-face training (two days training) sessions with legal staff of the Office of the Child and Family Official Solicitor, with an opportunity extended to partner agencies; Office of the Director of Child Protection Litigation, Legal Aid Queensland and the Office of the Public Guardian.

To support the integration of Safe and Together’s principles in 2019/20, the department is engaging in the following:

* Integrating Safe and Together into the Child Safety Practice Manual
* Four face-to-face core training (four days training) sessions and one supervisor training (two days training) for front line staff
* Case reading training for those staff in roles which involve case analysis and quality assurance
* Three e-modules are available to child safety staff supported by group supervision
* Communities of Practice continue to be developed with five implemented to date
* The state-wide DFV Practice Leader role has been extended to end of 2019
* Child Safety continues to participate in research studies with the fourth to commence in 2019/20
* The Walking with Dads program continues in the Moreton region with a plan to offer internships to staff from other regions to experience hands on coaching in the model
* Placing specialist DFV and departmental workers in Family and Child Connect services, and specialist DFV workers in Intensive Family Support Services and some Aboriginal and Torres Strait Islander Family Wellbeing Services

## Foster Carers

The department has recognised the efforts of foster carers who provided a high level of care to children who passed away as a result of complex disease and morbid conditions.

In response to recommendations the department reviewed its resources and training provided to foster carers, the Foster and Kinship Carer Handbook was decommissioned and information for carers was transitioned to the Government website. This will ensure that information available to Foster and Kinship Carers is current as the new format will enable content to be more easily updated and managed.

Currently the Government website provides advice to carers about managing a critical incident and provides details about appropriate responses, such as who the incident should be reported to and a time frame for reporting. This includes contacting the Child Safety Service Centre or Afterhours Child Safety Service Centre and the Foster Care Agency or their on-call person. Carers are also advised that they can contact the Foster and Kinship Care Support Line for support or advice afterhours. To ensure staff and carers are aware of the right information these resources were promoted through Child Safety local carer networks.

In September 2018, the department released Carer Connect, which is a web and mobile friendly app that provides carers with improved and secure access to information and support. Carers can view relevant information and documentation to gain an understanding of how the needs of the children in their care can best be supported. Carer Connect has the functionality to support carers to upload pictures of their home and family, which can be shown to children before they come into their care and assist in making the transition for a child smoother. Another feature is the noticeboard which announces important information such as training and legislative amendments.

In 2017, in partnership with Foster Care Queensland, the department launched Partners in Care — an engagement project to hear directly from foster and kinship carers about their experiences and ideas for improving the care system. 17 face-to-face workshops were held in 11 locations across Queensland. The recommendations from the Partners in Care engagement workshops are well underway. As of June 2019, of the 37 recommendations accepted as a result of the forums, 21 are completed and 16 are underway.

The department is progressing a Foster and Kinship Care Strategy which recognises the invaluable contribution made by foster and kinship carers to the lives of children in care. The strategy aims to strengthen ways to support and empower foster and kinship carers to provide safety, security and opportunities to enable children to reach their full potential.

The strategy recognises that when making decisions for an Aboriginal or Torres Strait Islander child, the five elements of the Child Placement Principle are applied and that these principles hold significance for all decisions for all children.

Improving Child Safety’s work with foster and kinship carers, requires the development of policy and programs, looking at the investment, providing technology solutions, improving practice, and providing training and capability development. In order to realise the changes needed to the foster and kinship care system, strategic coordination and a deep commitment to action is required.

## Information Sharing with partner agencies

**Queensland Health**

The department shared a copy of a de-identified report with Queensland Health which highlighted the importance of consistent processes between departments in relation to medical consent. The department and Queensland Health staff held discussions examining the Child Safety Practice Manual guidance and form for consenting to operations as well as Queensland Health consent forms and the Queensland Health publication for their staff ‘Guide to information decision-making in health care’ with a view to incorporating improvements.

In March 2018, the Australian first ‘Navigate Your Health’ care model was established to give children and young people in care improved access to health checks, referrals and healthcare coordination support. The innovative two-year trial, delivers on one of the recommendations of the Queensland Child Protection Commission of Inquiry and has seen more than 500 referrals in the first 12 months. Navigate Your Health is being jointly delivered in Brisbane by the department, the Children’s Health Queensland Hospital and Health Service, and the Brisbane Aboriginal and Torres Strait Islander Community Health Service. Four dedicated ‘Health Navigators’ are monitoring participants in the trial and coordinating their care to ensure that they receive timely health and developmental assessments, and if needed referrals to appropriate health services. Navigate Your Health is an example of successful partnership, shared investment and information sharing between government agencies to improve outcomes for child in care. The joint Health and Child Safety Navigate Your Health team were awarded the Partnership award at the Children’s Health Queensland Excellence Awards. The Navigate Your Health pilot program is being expanded to two additional locations and will also service clients of the Department of Youth Justice.

**Department of Housing and Public Works**

The department has liaised with the Department of Housing and Public Works and has completed joint journey mapping in relation to housing support in Queensland and also specific measures assisting young people with a safety net of targeted early interventions, supportive social housing, and flexible packages of support and wrap-around services. Some of these include:

* the supports available to address immediate needs, assisting people experiencing homelessness to live with dignity, and building on existing investment in homelessness services, crisis accommodation and longer term supportive housing
* the supports across the housing continuum including emergency housing, community housing, RentConnect, Bond Loans and Rental Grants
* the actions under the Queensland Housing Strategy 2017–2027 to developing an Aboriginal and Torres Strait Islander Housing Action Plan to improve housing outcomes for Aboriginal and Torres Strait Islander Queenslanders
* initiatives to ensure that young people in public housing will have greater capacity to pursue education, training and employment opportunities, and social and economic participation
* measures ensuring that vulnerable young people exiting from out-of-home care and institutional settings will receive improved access to safe and secure housing options to support their transition to independence
* the Homelessness Social Benefit Bond – Youth CONNECT, delivering an integrated approach to young people who have exited, or are exiting, care or custody in Townsville, Logan and Ipswich
* a Young People Exiting Care project which will lead to improved housing pathways and solutions for highly vulnerable young people.

Guidance in the Child Safety Practice Manual is under review by the department to ensure officers have the latest resources available to assist them to respond to and support young people and their families experiencing housing crisis or vulnerability.

**Queensland Police Service**

In 2018-19 there was a Child Protection Joint Response Team trial consisting of three Joint Response teams operating across Queensland in Toowoomba, Townsville and the Gold Coast. The trial was delivered within existing funding and focused on Child Safety staff and Queensland Police Service staff using new processes to perform their day-to-day roles. The trial built on the existing process of joint investigations by Child Safety and the Queensland Police Service and included:

* the designation of ‘planning officers’ by both Child Safety and the Queensland Police Service
* daily briefings by the ‘planning officers’ to determine whether matters received by either agency met the criteria for a joint response, triaging matters that required a joint response and planning for the joint investigation
* the ability to respond to matters received by a Regional Intake Service when an urgent joint response is required
* the ability to share information between agencies while a joint response is occurring, without the need for a formal information request form.

An independent evaluation of the trial was undertaken by Griffith University and finalised in February 2019, making eight recommendations which included:

* updating the guidelines to clarify the definition of a joint investigation, including what constitutes the start and end of a joint investigation.
* Support for statewide implementation of the model
* Consideration of opportunities to support relationship building between staff of the partner agencies and consider co-location.

Statewide implementation is underway with Queensland Police Service. The rollout will occur in three stages from August 2019 and will be finalised in February 2020.

From October 2019, Child Safety staff will have access to criminal and domestic and family violence histories through the QPS developed, jointly funded, *Self Service of Document Retrieval* (SSoDR) system. SSoDR will provide information that is usually provided via a section 159N request under the *Child Protection Act 1999* (criminal history and DV history) not including occurrences recorded as ‘unfinalised matters’ or matters that will be redacted, such as youth justice matters.

## Improvements to Culturally and Linguistically Diverse practice and engagement

The department noted current practice resources available as links in the Child Safety Practice Manual, to assist staff working with families from culturally and linguistically diverse (CALD) backgrounds, including a practice paper, Working with people from culturally and linguistically diverse backgrounds. This practice paper directs Child Safety staff to engage interpreters in any situation where a child or family member has difficulty communicating in English. In addition, the practice resource, Planning the investigation and assessment, which outlines key actions to be considered when planning an investigation and assessment, also directs staff to arrange an interpreter for interviews with families from a CALD background. The resources also emphasise the importance of ensuring all interpreters are independent and accredited.

The department is reviewing the content available in the practice paper and resources and include relevant information in the Child Safety Practice Manual. The department does recognise there may be exceptional circumstances due to the urgency of the context and accessibility to interpreters (in person or by telephone) where staff may need to rely on family members. The department offers staff access to the SBS Cultural Competence program to enhance workforce-wide multicultural capability and assist staff to communicate with a range of cultures.

##

## Risk Assessments

The department, as part of their GRO learning and development program offer a course on Working with Intellectual Disability that was developed in conjunction with the Centre of Excellence. This course provides staff with the most current procedural information and practice guidance to help develop knowledge and understanding on how to best work with families where intellectual disability is present. Highlighted through this module is the safety, well-being and best interests of the child. Through the course, staff focus on these core areas:

* Understand: Explore concepts, terms and theoretical frameworks about Intellectual Disability.
* Assess: Conducting assessments where Intellectual Disability is a factor.
* Support: Consider effective communication strategies and support services to enhance best practice.

The departmental learning and development program – GRO – containing mandatory and non‑mandatory components provides a range of learning opportunities targeted at addressing this specific practice knowledge. New Child Safety Officers complete a range of workshops including but not limited to:

* Assessing Safety, Risk and Belonging in Child Protection
* Case Management in Child Protection and
* Engagement, Relationships and Participation in Child Protection.

Highlighted throughout the aforementioned workshops is the relationship between the framework for practice and professional judgement, in conjunction with the use of structured decision-making tools. Staff work through a case scenario which includes the use and implementation of relevant framework tools. This course involves completion of the Collaborative Assessment Planning Tool (CAP) which assists staff to accurately identify strengths within the family and assess the risk factors present. This scenario provides staff with a clear link between the tools and how they are utilised in recording information on relevant departmental and forms.

In addition, on 30–31 July 2018 a specific Framework for Practice conference was held – Celebrating Practice – to reflect back post implementation, share key learnings and stories arising from the journey.

To support implementation of the framework a program evaluation framework and project plan was developed which detailed a number of key information gathering activities to occur over a four year period from 2014 to 2018 including desktop reviews, focus groups, case reads and surveys. A final evaluation report was received in December 2018 which identified areas of strength and areas for continued growth and recommendations to support this.

A strengths based approach to child safety work needs to be carefully balanced with a continuous focus on safety, belonging and wellbeing. This is one of the practice principles of the Framework for Practice, and is a particular focus of the department’s agenda to strengthen capacity and skills in safety and risk assessment.

The Child Safety Capability Development (CSCD) team has strong and collaborative relationships with their Queensland Police Service (QPS) training colleagues, with whom they co-deliver forensic interviewing training to Child safety staff and police. The CSCD team were actively exploring how elements of QPS investigative skills practice knowledge could be further incorporated into strengthening the capability of frontline child protection staff in this complex area of practice as part of the shared commitment to ongoing and continuous quality improvement.

GRO is the learning and development program for Child Safety staff. This program contains a range of ongoing practice development training opportunities in both face-to-face and e‑Learning formats in key practice areas of child protection. As part of the Readiness for child protection practice component, this mandatory core learning area provides Child Safety Officers with job readiness skills and knowledge-building role capacity and confidence. Child Safety Officers are required to complete:

* Two-weeks of regionally-based (whenever possible) face-to-face training;
* a number of practice specific modules (e.g. parental mental health and defining domestic and family violence); and
* role specific module/s (including Intake and Investigation and Assessment).

The practice and role specific modules are e-Learning products available through iLearn, the departmental learning management system. Child Safety Officers can complete these courses in their workplace, before or after attending face-to-face training. As part of the department’s GRO learning and development program, Child Safety Training released a one-day face-to-face training workshop in early 2019 titled: Investigation and Assessment. This workshop is designed to build Child Safety Officers understanding of the skills and knowledge required to complete an Investigation and Assessment from end-to-end. This workshop covers a range of learning outcomes including, but not limited to: identification of the legislative requirements of an Investigation and Assessment Officer; practice planning, gathering information and making an assessment based on a case scenario; and developing an understanding of the Assessment and Service Connect response.

In regard to the existing training available to staff aimed at investigative practice and risk assessment the learnings from Panel reviews will additionally be incorporated into aspects of the training as case examples of the importance of agile skills in this area.

## Structured Decision Making Tools

The Structured Decision Making manual and tools are developed in conjunction with the Children’s Research Centre, the US-based centre that owns Structured Decision Making tools and therefore it was determined it is not appropriate to attach or add other checklists to the specific Structured Decision Making manual and resources. Links to other safety resources may be included in the Child Safety Practice Manual and this will be considered in the redesign and rewriting of the Child Safety Practice Manual occurring in 2019.

The Structured Decision Making manual was revised in relation to including cultural considerations and Versions 4.2 and 4.3 were released in October 2018 and May 2019 respectively. The department worked closely with the Children’s Research Centre and a range of Aboriginal and Torres Strait Islander staff and partners from across the state to update the Structured Decision Making cultural considerations. This consultation included a four day workshop with staff and partners, consultation with the Practice Leaders and staff from the Aboriginal and Torres Strait Islander Reforms area as well as consultation with Recognised Entity staff (prior to legislative amendments enacted in October 2018 removing references to Recognised Entities in the *Child Protection Act 1999*) and Queensland Aboriginal and Torres Strait Islander Child Protection Peak staff.

The Queensland First Children and Families Board was established to guide and oversee the *Our Way strategy: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017 – 2037* and all associated action plans including *Changing Tracks: An Action Plan for Aboriginal and Torres Strait Islander children and families 2017 -2019.* An outcome of the Board’s meeting on 5 – 6 March 2019, included an agreement that Board members be engaged in the review of the department’s Structured Decision Making tools[[10]](#footnote-10) together with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak.

The department determined that sufficient guidance is given to staff through the Structured Decision Making tools and existing training products, most notably risk assessment training. For example, the Family Risk Evaluation tool, which is part of the suite of Structured Decision Making tools, raises the risk score if there are four or more children who are living in the household. This not only flags higher risk in the family, but also prompts thinking by the assessing Child Safety Officer to consider what might sit behind this raised level of risk.

The department agreed that improving staff knowledge and skills in the use of Structured Decision Making tools is an area of continual attention and focus. Successful training in this area is a continuing, ever-evolving process. Much of the training is on-the-job, provided though coaching and supervision from experienced practitioners where staff are encouraged to clearly document how they reached their decisions.

The department provides a variety of training programs on Structured Decision Making and the various tools, which aids Child Safety staff in gaining an understanding of the core concepts and definitions of Structured Decision Making, and how to accurately apply these core concepts and definitions at critical decision points in the life of a case. This training also assists staff to make the best assessment possible at relevant decision points.

## Training and Development

**Leadership Development**

The department’s supervision and leadership frameworks are underpinned by the REACH model and associated training programs and resources. REACH Fundamentals and Advanced workshops introduce departmental staff to the concept of the REACH Leadership Framework, the process of facilitating professional supervision conversations and provides leaders the opportunity to learn more about the department’s REACH Leadership Framework. It explores the critical role leaders’ play when providing professional supervision.

The REACH Leadership Framework outlines the five core elements of successful leadership in the department. It encourages focused conversations that explore Relationships, Ethics, Acumen, Core Practice and Health, with the intent to grow and mature the leadership capacity of the whole organisation.

The department provides STEPS, an Emerging Leaders program that covers an introduction to Leadership and Management skills, as well as Mentor Connect, a mentoring program that connects staff at or above A06 classification to senior staff over a nine month period to share and develop learning from their experience. The REACH Leadership Framework, STEPS and Mentor Connect all complement the department’s Leadership Charter.

In August 2018, the department released its revised Leadership Charter which builds on previous versions developed a several years ago. The Leadership Charter outlines behaviours and actions expected of leaders in the department and is used to build engagement in leadership at all levels.

The NAVIGATE: Leading and Managing for High Performance program aims to develop and strengthen the management capabilities of leaders working in the department and supports the Quality Improvement Program. The program is comprised of blended learning with six e‑Learning modules, face to face workshops and follow up action learning groups, the NAVIGATE program has a focus on six capabilities:

* Action Learning
* Critical Thinking
* Improving Performance
* Communicating with Influence
* Strategic thinking
* Delivering Results

The NAVIGATE program is designed to complement the department’s existing REACH Leadership Framework, Leadership Charter, and suite of leadership and performance development programs. By the end of participation in the NAVIGATE program, it is anticipated participants will have grown action learning capabilities in the following areas:

* Critical and self-reflection – becoming aware of their strengths and identifying development areas
* Greater understanding of how they learn – being able to take self-reflection and new knowledge, make sense of it and apply it to work to develop performance
* Action orientation – being able to plan and implement actions that result in behavioural change

Participants will achieve these objectives by identifying action learning projects based on the results of a self-assessment aligned to the NAVIGATE program capabilities. Participants will meet regularly with other program participants in action learning set meetings and deepen their knowledge by completing six e-Modules and participating in four face-to-face workshops.

**Ongoing Training**

The department has a current suite of learning assets available for all new and existing staff. The learning and development program, which has been strengthened in recent years, provides a range of training options that can assist staff in the development of their practice skills relating to engaging confidently with fathers, particularly those with prejudicial histories involving violence, substance abuse and/or criminal behaviour.

The department, in conjunction with key internal and external experts in the Domestic and Family Violence (DFV) arena, including David Mandel (Safe and Together Institute) has developed a series of internal training modules to enhance and develop staff skills, knowledge and understanding of DFV.

This suite of learning assets includes some specific e-Learning non-mandatory modules available to all staff, ‘Recognise, Respond, Refer’ is included in the induction program. The ‘Engaging with Families where DFV is present’, module focuses on developing the skills and knowledge of staff in the areas of effectively engaging with people who have experienced violence and perpetrators. The ‘Domestic Violence and the Workplace - Advanced’ is a face‑to‑face program designed for Managers.

In relation to the mental health of young people, the department offers an Understand Suicide e-Learning course that aims to:

* develop a basic understanding of the key components of the Interpersonal Theory of Suicide (ITS) and frameworks for suicide prevention through:
	+ understanding primary, secondary, and tertiary suicide prevention
	+ identifying risk and protective factors, along with warning signs and situational precursors for various populations at risk of suicide and serious self-harm.
* articulate ways to contribute to the ongoing reduction of suicide risk through evidence‑based practice strategies and effective engagement with young people in a culturally aware, person-centred, and strengths-based way
* deepen understanding of applying structured professional judgement when assessing and responding to suicidal ideation and behaviours, in a crisis management context
* attain a clearer sense of how to apply tools from the Strengthening Families Protecting Young People Framework for Practice for assessing and responding to suicide risk when working with young people, along with applying the Aim4© conceptual model to your interventions
* articulate and apply self-care strategies when working with suicide and vicarious trauma.

The department also offers a mandatory e-Learning course for new and existing child safety staff, at all levels, on the topic of Introduction to Alcohol and Other Drugs. This training contains two topic areas relating to Understanding Substance Use and Working with Families respectively. The purpose of this e-Learning course is to provide staff with a functional understanding of substance use and assist staff in their practice with young people and families where substance use has been identified.

The department also offers an e-Learning course on Crystal Methamphetamines (Ice) open to all Child Safety staff. This module aims to assist staff in their assessments and interactions with clients who use crystal methamphetamine and includes an understanding on the issues associated with the use of ice in Australia, the impacts on parents and children, the relationship between ice and parenting, engagement strategies, clandestine laboratories, and worker safety.

## System Improvement Initiatives

A range of initiatives and projects are underway to support families earlier when they are experiencing risk and vulnerability and increase the safety and wellbeing of children and young people known to the department.

**Intake Review Project**

The Intake Review Project started in October 2018 as a targeted project to review Queensland’s child and family intake system. It is timely at the mid-point of the child and family reforms in 2019 to review the existing child and family intake system.

The project is looking at Intake services delivered by Family and Child Connect (FaCC) and the Child Safety Regional Intake Services (RIS) and consider the interface with Aboriginal and Torres Strait Islander Family Wellbeing Services (Family Wellbeing Services) and Intensive Family Support services, and other community services. The project is focused on:

* improving responses to children, young people, parents and families, particularly for Aboriginal and Torres Strait Islander people
* monitoring and coordinating Intake activities and initiatives across the department and other agencies
* making reporting and referral pathways clear and accessible
* reduced duplication and double handling of matters
* developing options for a contemporary Intake system.

**Investigation and Assessment**

The department is reviewing Investigation and Assessment policies and practices to make sure they remain relevant and in line with a strengths-based approach.

From 1 September 2019, Investigation and Assessments for five and ten day responses will start once a Child Safety Officer starts gathering and reviewing information about that case. The child must be sighted during the course of the Investigation and Assessment.

Changes to completion criteria enable Investigation and Assessments to be completed within 100 days of the notification being recorded, a change from the current 60 days.

These changes align Queensland's reporting with other Australian jurisdictions, and reflect the level of work undertaken by Child Safety to increase children's safety and strengthen families.

There will be no changes to commencement criteria for a 24 hour response timeframe. For all such matters, sighting and interviewing children must still occur. Maintaining this requirement will ensure Queensland's existing high standards are upheld.

**Placement Enhancement Project**

The Placement Enhancement Project (PEP) commenced in November 2018 and is a targeted project focused on increasing placement options for children and young people.

The PEP is focused on the following key areas:

* creating stable placements
* simplified budget processes
* accessing NDIS supports
* finding Kin
* increasing investment performance
* increase behaviour support knowledge.

**Unify**

The department has established a four-year program to implement a contemporary case and client management system to enable to best outcomes for children, young people and their families. This means the Unify Program will progressively implement a replacement for the Integrated Client Management System (ICMS).

Unify will support staff by streamlining processes and introducing more contemporary technology that enables greater engagement with children, young people, families and carers. At the heart of this multi-year program is the vision to implement a contemporary case and client management system that will enable the best outcomes for vulnerable children, young people and their families.

# Appendix A: Panel Compositions

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| --- | --- | --- |
| **Panel 55** | Theme:External members:Other government agency representatives:Departmental representative:Meeting date:Date report delivered to Director-General: | Deaths, aged 15-17 yearsShanna Quinn (Chair)Annabel TaylorSelwyn ButtonDonna LockyerMegan Giles 18 April 201813 July 2018 |
| **Panel 53** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Deaths, aged 0-4 years Shanna Quinn (Chair) Paul Colditz Raelene WardKaren Nankervis Glenn HoranBarbara Shaw1 May 201817 July 2018  |
| **Panel 51** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date reports delivered to Director-General and Director of Child Protection Litigation:  | Litigation matterClare Tilbury (Chair)Clinton SchultzGlenn HoranJulie Kinross24 May 20181 August 2018  |
| **Panel 57** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Aged 5-9 yearsAnnette Sheffield (Chair)Laurel DowneyBryan CookCindy ShannonChristopher HanselBernadette Harvey 5 June 201829 August 2018  |
| **Panel 58** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Aged 1-4 years, Disease or accidentClinton Schultz (Chair)Susan TeerdsKirsten VallmuurStephen StathisBernadette Harvey 21 June 201821 September 2018  |
| **Panel 59** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Aged < 1 Year, Deaths arising from disease or morbid conditionNicola Murdock (Chair)Jeanine YoungRaelene WardGraham KraakSusanne Le Boutillier 3 July 201816 October 2018  |
| **Panel 56** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | AdolescentsClinton Schultz (Chair)Kirsten VallmuurRosa AlatiDeborah WalshAnne EdwardsMegan Giles 9 August 20181 November 2018  |
| **Panel 60** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Deaths, aged 0-4 yearsGwenn Murray (Chair)Cindy ShannonRebecca Shearman Kirstine HarvieSusanne Le Boutillier 31 August 201812 November 2018  |
| **Panel 62** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Adolescents with serious physical injuries Annette Sheffield (Chair)Kirsten VallmuurRaelene WardAnne EdwardsSusanne Le Boutillier 3 October 20187 December 2018  |
| **Panel 61** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date reports delivered to Director-General and Director of Child Protection Litigation: | Accidents, aged 5-9 years Clinton Schultz (Chair)Kathryn McMillanSusan TeerdsHayley Stevenson Bernadette Harvey 13 September 201817 December 2018  |
| **Panel 63** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Adolescents Nicola Murdock (Chair) Rosa AlatiCindy ShannonBetty Taylor Glenn Horan Bernadette Harvey 18 October 2018 17 January 2019  |
| **Panel 64** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Aged 0–4 yearsAnnette Sheffield (Chair) Paul Colditz Jeanine Young Selwyn Button Bernadette Harvey 13 November 201825 February 2019  |
| **Panel 65**  | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Deaths from diseaseGwenn Murray (Chair) Cindy Shannon Margie KrugerStephen Stathis Susanne Le Boutillier 6 December 201829 March 2019  |
| **Panel 66** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date reports delivered to Director-General and Director of Child Protection Litigation: | Regional Aboriginal families Clinton Schultz (Chair) Rosa Alati Margie Kruger Karen Nankervis Barbara Shaw 15 January 2019 2 May 2019  |
| **Panel 70** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Adolescent deaths arising from self-harm/suicide Clinton Schultz (Chair) Rosa Alati Bryan Cook Hayley Stevenson Glen Knights 19 March 2019 3 May 2019  |
| **Panel 68** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date reports delivered to Director-General and Director of Child Protection Litigation: | Serious physical injury arising from assault Gwenn Murray (Chair) Cindy Shannon Betty Taylor Margie Kruger Nicole Duke Carina Muller 21 February 2019 7 May 2019  |
| **Panel 69** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date reports delivered to Director-General and Director of Child Protection Litigation: | Accidental Clare Tilbury (Chair) Kathryn McMillan Susan Teerds Raelene Ward Cindy Shannon Anne Edwards Andrea Lauchs 14 March 2019 27 May 2019  |
| **Panel 67** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | 0-4 years, deaths from disease/ Sudden and Unexpected Death in Infancy (SUDI)Annette Sheffield (Chair) Jeanine Young Raelene Ward Stephen Stathis Megan Giles 7 February 2019 5 June 2019  |
| **Panel 71** | Theme:External members:Other government agency representative:Departmental representative:Meeting date:Date report delivered to Director-General: | Aged 0-4 years, deaths from accidental/unknown/Sudden and Unexpected Death in Infancy (SUDI) Annette Sheffield (Chair) Cindy Shannon Susan Teerds Graham Kraak Arna Bronson 11 April 2019 18 June 2019  |

# Appendix B: External Members

**Professor Rosa Alati**

Professor Alati is of Italian background and located in Perth. Has a distinguished research background in life-course epidemiology of drug and alcohol use problems. She is the Head of School of Public Health at Curtin University as well as Honorary Professor at the Institute for Social Science Research at the University of Queensland. In the last 10 years, she has worked collaboratively with national and international teams in the fields of maternal substance use, offspring outcomes and related aspects of developmental and life-course epidemiology, particularly in relation to psychosocial health and wellbeing. She also has a background in Indigenous health research, with a focus on alcohol and drug studies in urban and remote Aboriginal communities.

**Professor Paul Colditz**

Professor Colditz is of Caucasian heritage and located in Brisbane. He is a practicing neonatal paediatrician with a Doctor of Philosophy in Medicine from the University of Oxford, UK. He is Professor of Perinatal Medicine at the University of Queensland (UQ), Director of the Perinatal Research Centre, and Head School of Clinical Medicine. He is currently President Paediatrics and Child Health Division, Royal Australasian College of Physicians and a board member of Red Nose. His research group focuses on clinically important perinatal health problems and translation to clinical practice that include investigations relating to seizure identification and prevention, brain injury and neuroprotection, parenting, and neural plasticity and pathways to improving neurodevelopmental outcomes.

**Mr Bryan Cook**

A consultant conducting and managing workplace investigations for state and local government authorities by undertaking complex investigations into suspected official misconduct, grievances (bullying and harassment) and complex workplace issues involving senior management as well as professional misconduct, particularly in the health sector. Previous work included being an Investigator/Reviewing Officer at the Crime and Misconduct Commission and investigating organised crime, child abuse and juvenile crime.

**Ms Laurel Downey**

Chief Executive Officer of Catalyst Child and Family Services, a not for profit organisation that provides clinical and out-of-home care services to children and their families involved with child protection services in far north Queensland. Catalyst currently runs three therapeutic residential services for young people with complex to extreme emotional and behavioural difficulties. Ms Downey is currently completing a PhD program with the La Trobe University, School of Allied Health, Social Work and Social Policy. This research project is designed to take the first steps towards an evidence base for the Spiral to Recovery, a practice framework for therapeutic care of children and young people. Ms Downey is from a regional area.

**Dr Kairi Kõlves**

Dr Kõlves is of Estonian heritage/culture and located in Brisbane. A Principal Research Fellow at the Australian Institute for Suicide Research and Prevention (AISRAP) and Co-Director of  the WHO Collaborating Centre for Research and Training in Suicide Prevention at Griffith University. She has been working in suicide research and prevention since 1998. Between 1999 and 2008, she worked at the Estonian-Swedish Mental Health and Suicidology Institute in Estonia and joined AISRAP team in 2008. She has been involved in different Australian, Estonian and international projects and has published over 100 peer reviewed papers, and several chapters and reports on suicide research and prevention. Dr Kõlves identifies as from a culturally and linguistically diverse background (being an Estonian).

**Ms Margie Kruger**

Member of the Queensland Law Society Family Law Committee, former President of the Child Protection Practitioners Association of Queensland, and former member of the Queensland Children Services Tribunal and the Queensland Law Society Children’s Committee. Ms Kruger worked in various child protection roles prior to commencing practice as a lawyer in 2000. Since this time she has practiced in the area of family law and child protection law and has been recognised as a recommended Queensland Family Lawyer.

**Ms Kathryn McMillan QC**

Ms McMillan is of Australian heritage and based in Brisbane. She practices as a Barrister specialising in administrative, civil and human rights, health law- including civil litigation and regulatory and coronial inquests along with an established practice in family and child protection law. She has appeared in 4 Commissions or Royal Commissions of Inquiry and was the Commissioner in the Youth Detention review. She is also an Adjunct Professor at the TB Beirne School of law, University of Queensland.

**Ms Gwenn Murray**

Ms Murray is a Member of the Queensland Civil and Administrative Tribunal (primarily hearing reviews of child protection decisions and blue card decisions) and previously a member of the Mental Health Review Tribunal. She has been a consultant criminologist in private practice for 20 years with specialist skills in child protection and youth justice. She was the Director of the Youth Advocacy Centre and Chair of the National Children’s and Youth Law Centre.  She has undertaken many reviews of child deaths, complex case reviews and large system audits and reviews across Australia. This includes the Qld Foster Care Audit during the CMC Enquiry into the Abuse of Children in Foster Care.  She won a child protection award for this work.

**Ms Shanna Quinn**

Ms Quinn is based between Brisbane and Hong Kong. Ms Quinn is a barrister working in the areas of family law, domestic violence and child protection. Before transitioning to law Ms Quinn worked for over 20 years as a forensic social worker providing family reports and expert evidence in family law proceedings. She is a mediator and has practised in Australia and Hong Kong for over 25 years. Ms Quinn has a well-developed appreciation of the significant impact culture, race, language and socio-economic context has on parenting, communication, conflict resolution and values.

**Mr Clinton Schultz** (identifies as Aboriginal)

A registered psychologist, currently employed by Griffith University School of Public Health as Lecturer of Aboriginal and Torres Strait Islander Health. Mr Schultz is a Lead Facilitator of the Australian Indigenous Psychologists Association's Cultural competence training for mental health practitioners. He is the author and facilitator of "Forming Culturally Responsive Practice", a Royal Australian College of General Practitioners’ accredited cultural competence training package. He has an honours degree in psychology.

**Professor Cindy Shannon** (identifies as Aboriginal)

Professor Shannon was formerly the Pro-Vice-Chancellor (Indigenous Education) at The University of Queensland and is also currently the Director of the Poche Centre for Indigenous Health (established in late 2014). Professor Shannon was previously the Director of the Centre for Indigenous Health at The University of Queensland and guided the development and implementation of Australia’s first degree level program that specifically targeted Aboriginal health workers. Professor Shannon has contributed to Indigenous health policy development and implementation nationally and undertaken a number of independent primary health care service reviews, including a major report for the 2003 interdepartmental review of primary health care service delivery to Aboriginal and Torres Strait Islander communities.

**Ms Annette Sheffield**

Ms Sheffield has previous experience as a frontline child protection officer, SCAN representative, and Registrar of the former child protection information system, and as Family Court Counsellor / Expert Witness and Child Health A/Senior Social Worker. Between 2003 and 2013, Ms Sheffield completed over 30 external case reviews for the former Department of Communities, Child Safety and Disability Services. She holds a Master of Social Administration and is currently an Ordinary Member (sessional) of the Queensland Civil and Administrative Tribunal.

**Professor Annabel Taylor**

Research Professor of Gendered Violence, Central Queensland University. Professor Taylor was the Former Director of the Queensland Domestic and Family Violence Research Centre, Central Queensland University and Former Director of the Te Awatea Violence Research Centre at the University of Canterbury, NZ. Prior to this, Professor Taylor had an extensive research and academic background in partnering with community and government sectors to support research needs and interests aimed at reducing violence and child abuse.

**Ms Elizabeth Taylor (Betty)**

An independent consultant who specialises in developing services, programs and training in the area of domestic violence and sexual assault. Ms Taylor is a board member of the Gold Coast Centre Against Sexual Violence, a founding member of the Domestic Violence Death Review Action Group and a member of the Queensland Domestic and Family Violence Research Advisory Committee.

**Ms Susan Teerds**

Ms Teerds is of Scottish heritage and is located on the Sunshine Coast, however works in Brisbane. The Chief Executive Officer of Kidsafe Queensland. Ms Teerds is the Chair of the Infant Sale Sleeping Working Group, a member of the Consumer Product Injury Research Advisory Group, member of the Australian Standards Committee CS-020 Prams and Strollers and CS-003 Infant Products and is also an advisor for the collaborative researching the development of a sustainable prospective data collection system to identify cases and risk factors for low speed vehicle run-over incidents. Key focus areas for Kidsafe include: Road Safety, Home Safety, School Safety, Playground Safety and Child Car Restraints for children with disabilities or medical conditions.

**Professor Clare Tilbury**

Professor Tilbury is of Anglo-Australian heritage and lives and works on the lands of the Yuggera, Turrbal, Yugarabul, Jagera and Yugambeh people. She is the Leneen Forde Chair of Child and Family Research in the School of Human Services and Social Work at Griffith University, with over 30 years’ experience as a social work practitioner, policy officer, researcher, and educator. Her research focuses on child protection systems, performance measurement, accountability, and racial disparities. She has led significant national child protection and family support research projects, publishes extensively in Australian and international scholarly journals, and disseminates her research widely within policy and practice networks. She serves on government advisory bodies and the boards of various community and professional organisations related to child and family wellbeing, socio-legal issues, and access and equity. She is a member of the Griffith Criminology Institute, Australasian Regional Editor for Child and Family Social Work, and an Editorial Advisor for Australian Social Work.

**Associate Professor Kirsten Vallmuur**

Associate Professor Kirsten Vallmuur is a Principal Research Fellow supported by a Motor Accident Insurance Commission funded research fellowship within the Australian Centre for Health Services Innovation at Queensland University of Technology.  She is currently leading the Queensland State-wide Trauma Data Warehouse development project in collaboration with Queensland Health and the Motor Accident Insurance Commission. She is a previous Australian Research Council Future Fellow where she worked in the Centre for Accident Research and Road Safety. She has expertise in the analysis and understanding of morbidity and mortality coded data sets, injury surveillance systems, trauma data linkage, health classifications and injury classifications. She has conducted numerous collaborative health data research projects with internal and external university based researchers, government and non-government agencies in the following areas: Consumer product safety injury surveillance, External cause of injury classifications, Injury surveillance using emergency department hospital and mortality data, Morbidity and mortality data quality, Child abuse documentation coding and reporting, Identification of occupational injury in health databases, Identification of alcohol-related injury in health databases.

**Dr Deborah Walsh**

A domestic and family violence specialist practitioner (social work) and researcher. She developed one of Australia’s first risk assessment frameworks for use in family violence work and continues to provide training and consultancy to the health and welfare sector in Australia. Dr Walsh conducted a landmark Australian study on the level, extent and nature of violence against women during pregnancy. She is currently a Lecturer at the School of Nursing, Midwifery and Social Work, Faculty of Health and Behavioural Sciences at the University of Queensland and has recently published a text book on working with domestic violence.

**Ms Raelene Ward** (identifies as Aboriginal)

Ms Ward is located in Toowoomba. Ms Ward has completed her PhD in Aboriginal suicide and is currently awaiting confirmation. She is a Registered Nurse, holds a Masters in Health and is a Lecturer in Indigenous Nursing and an Aboriginal Researcher with the School of Health, Nursing and Midwifery at the University of Southern Queensland. She is currently a community representative on the Darling Downs-West Moreton Human Research Ethics Committee. Ms Ward is an Aboriginal Researcher and Senior Lecturer in the School of Nursing at the University of Southern Queensland. She has a wealth of experience, knowledge and skills in undertaking research with Aboriginal people and communities bringing into these projects well established networks and rapport with many diverse communities. Ms Ward continues to establish a profile in suicide prevention in Aboriginal communities producing a number of publications, including peer-reviewed journal articles, opinion pieces in the Nursing Review, major reports, contributing chapters in several different nursing and education texts books within Australia.

**Professor Jeanine Young**

Professor Young was born in Innisfail, Queensland, is of Irish-British heritage and currently resides in Brisbane with her family. Professor Young is a Registered Nurse, Registered Midwife and qualified neonatal nurse who has worked in infant, paediatric and child health for over 25 years. She completed her PhD in infant care practices and their relationship with risk factors for Sudden Infant Death Syndrome (SIDS), Faculty of Medicine, University of Bristol. She has worked in Australia and the United Kingdom in neonatal intensive care, acute paediatrics and community child health. Professor Young has established a research program to investigate Queensland’s relatively high infant mortality rate, with a particular focus on developing evidence-based strategies and educational resources to assist health professionals in delivering Safe Sleeping messages to parents with young infants and to address Close the Gap targets to reduce Aboriginal and Torres Strait Islander infant mortality. She is a senior member of the Red Nose National Scientific Advisory Committee (Chair 2005-2013) and Australian College of Midwives Scientific Advisory Committee. The focus of her research is to ensure that safe sleeping public health recommendations are evidence-based.

# Appendix C: Public Service Members

**Departmental Members**

The following senior executive officer positions within the Department of Child Safety, Youth and Women are appointed to the pool of approved members:

* Executive Director, Strategy and Partnerships
* Executive Director, Strategic Policy and Legislation
* Executive Director, Investment and Commissioning
* Executive Director, Child and Family Operations, Service Delivery
* Executive Director, Indigenous Strategy and Partnerships, Strategy (Identified)
* Executive Director, Strategy and Delivery Performance, Strategy
* Regional Executive Director, South West Region
* Regional Executive Director, North Queensland Region
* Regional Executive Director, Central Queensland Region
* Regional Executive Director, Moreton Region
* Regional Executive Director, South East Region
* Child and Family Regional Director, North Queensland Region
* Child and Family Regional Director, Central Queensland Region
* Child and Family Regional Director (North Coast), Moreton Region
* Child and Family Regional Director (Brisbane), Moreton Region
* Child and Family Regional Director (Logan/Beaudesert), South East Region
* Child and Family Regional Director (Gold Coast/Bayside), South East Region
* Child and Family Regional Director (Darling Downs), South West Region
* Child and Family Regional Director (West Moreton), South West Region

**Government Members**

The following public service officers from other Queensland Government departments are appointed to the pool of approved members:

* Department of Communities, Disability Services and Seniors
* Ms Donna Lockyer, Regional Director, Disability and Community Services
* Ms Karen Nankervis, Professor and Centre Director, Centre of Excellence for Clinical Innovation and Behaviour Support
* Department of Housing and Public Works
* Ms Kirstine Harvie, Executive Director, Strategic Policy and Legislation
* Department of Justice and Attorney-General
* Ms Anne Edwards, Director, Queensland Sentencing Advisory Council.
* Queensland Corrective Services
* Ms Nicole Duke, Regional Manager, Probation and Parole
* Queensland Health
* Associate Professor Stephen Stathis, Medical Director, Child and Youth Mental Health Services
* Mr Graham Kraak, Director, Strategic Policy Priority Areas
* Department of Education and Training
* Ms Hayley Stevenson, Executive Director, Student Protection
* Mr Selwyn Button, Assistant Director-General, State Schools Indigenous Education (Identifies as Aboriginal)
* Queensland Police Service
* Detective Inspector Glenn Horan, Operations Manager, Corrective Services Investigation Unit, Homicide Group, State Crime Command
* Detective Senior Sergeant Christopher Hansel, Child Trauma and Sexual Crime Unit, State Crime Command
1. A completed review is defined as a panel which has submitted a completed report to the Director-General (and Director of Child Protection Litigation, if required) between 1 July 2018 and 30 June 2019. [↑](#footnote-ref-1)
2. Section 246AA *Child Protection Act 1999* (Qld) [↑](#footnote-ref-2)
3. Following establishment of the new standalone Department of Youth Justice, youth justice staff no longer participate as co-opted members given they are now external to the department. [↑](#footnote-ref-3)
4. Section 246HF *Child Protection Act 1999* [↑](#footnote-ref-4)
5. Section 246HG *Child Protection Act 1999* [↑](#footnote-ref-5)
6. Sections 246DB and 246DC *Child Protection Act 1999* [↑](#footnote-ref-6)
7. Sections 246DB, 246DC and 246DD *Child Protection Act 1999* [↑](#footnote-ref-7)
8. A completed review is defined as a panel which has submitted a completed report to the Director-General (and Director of Child Protection Litigation, if required) between 1 July 2018 and 30 June 2019. [↑](#footnote-ref-8)
9. In accordance with the *Child Protection Act 1999*, section 159I-159L, SCAN is an information coordination team, who provide a multi-agency response to children where statutory intervention is required to assess and meet their protection needs. Core member agencies include the Queensland Police Service, Queensland Health and the Department of Education. [↑](#footnote-ref-9)
10. Action 6.10 – Review child protection practices, including assessment and decision-making tools. *Changing Tracks: An Action Plan for Aboriginal and Torres Strait Islander children and families 2017 -2019* [↑](#footnote-ref-10)