

Annual Report on the

Queensland Child Death Case Review Panels
2016–17



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families futures





Queensland Child Death Case Review Panels
Annual Report 2016–17

The Honourable Shannon Fentiman MP
Minister for Communities, Women and Youth
Minister for Child Safety
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 2016 to 30 June 2017.

Yours sincerely

Michael Hogan
Director-General
Department of Communities, Child Safety and Disability Services



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Message from the Director-General

This report summarises the operations of Child Death Case Review Panels and the actions taken in response to panel reports in 2016–17.

As indicated in previous reports, the subject matter of the work of the panels is very difficult. One of the toughest things we deal with as a department, and as a child protection system more broadly, is the death of a child known to us. We are very mindful that a young life has tragically been lost. I acknowledge the devastating grief and loss experienced by the family, carers and close community, and by those who worked directly or indirectly with the child. Serious injuries to children also are accompanied by hurt and grief.

In such situations, we are committed to the thorough review of our work with the child and their family or carers. This is part of our accountability. By investing in a robust two-tiered review system, we identify strengths and weaknesses as well as learnings that come from going back over the department's involvement in a child's life. We act on those insights through departmental responses at both practice and systems levels.

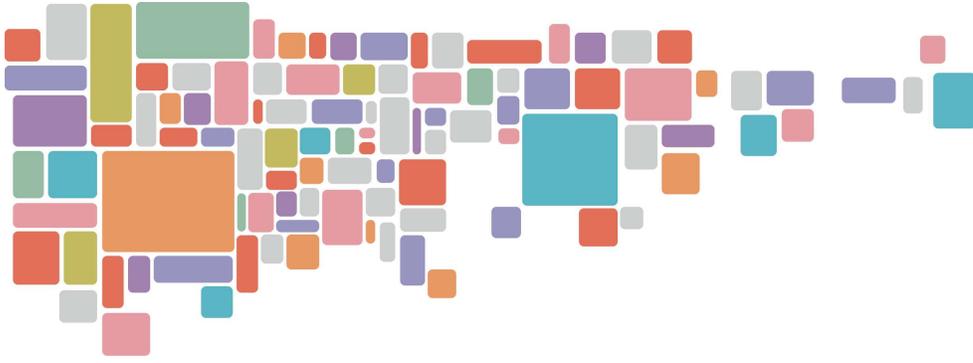
The department operates within strict statutory limits on the disclosure of information that can identify our involvement with a child and their siblings and family, or the notifiers of abuse or neglect. This constrains how much information can be available to the public. The parliament has enacted these requirements due the critical need for confidentiality and integrity in the Child Protection system.

The public interest in the deaths of children known to the department is also served by the statutory provisions for internal and external reviews. The department is also accountable through coronial processes and through misconduct investigations. The department will also assist police in criminal investigations and any subsequent proceedings where appropriate. The system is oversighted by the Queensland Family and Child Commission.

I again thank the reviewers and panel members for their time, diligence, expertise and investment in these cases, and for their contributions to better child protection in Queensland. I thank departmental and other agency staff for their participation. This is very demanding and often distressing work.

I encourage all those engaged in child protection to reflect on this report and use it to further improve practices and systems for services to children and families. We also again will share this knowledge with our agency staff, and with the government's Inter-departmental CEOs Committee, the Reform Leaders Group and Regional Child and Family committees, to ensure the system as a whole continues to improve.

Michael Hogan
Director-General
Department of Communities, Child Safety and Disability Services



Executive summary

Background

When a child who is known to the Department of Communities, Child Safety and Disability Services (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 conducted 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 encourage improvements in the provision of services by the department and promote accountability.

Children 'known to the department' encompass all those children who come to the attention of the department in the 12 months preceding their death or serious injury, through an intake, an Investigation and Assessment, are subject to an Intervention with Parental Agreement (IPA) or on a Child Protection Order. Around 80,000 Queensland children are 'known' to the department across any one year.

Panel operations

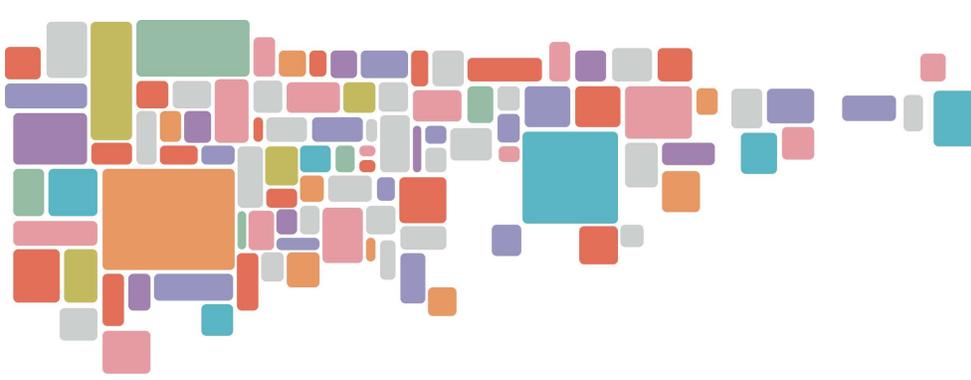
During the reporting period, the panels considered 57 review reports, relating to 56 individual children/cases. For one child, the panels considered the original Systems and Practice Review Report together with the Director of Child Protection Litigation Review Report. Fourteen panels completed reviews during the reporting period.

Panels considered departmental involvement with children and young people at a number of points on the child protection continuum — from intakes, Investigation and Assessment, IPA and on 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 14 panels produced a report outlining broad findings relating to the cases reviewed and detailed findings for each individual case. Each panel made findings 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.

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*". The QFCC found that the department's internal review and the external review were timely and thorough and in accord with the legislation. The QFCC did find that the system could be made more robust by extending the scope and strengthening the independence of external reviews.

The QFCC made one overarching recommendation 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 recommendation was accepted by Government and is being implemented by the QFCC with support from relevant agencies, including the department.



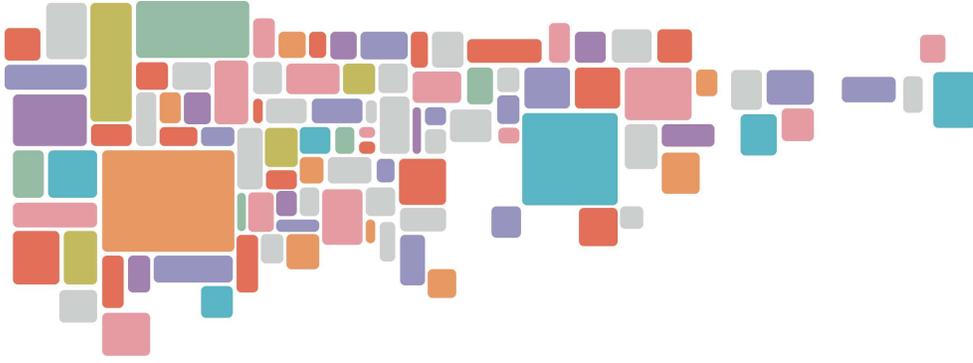
Actions taken

Each panel's report is provided to the Director-General of the department, and considered by key divisions in the department. A report is prepared for the Director-General on each report, outlining the actions the department has taken, or intends to take, in response to the findings.

At the policy, practice and resourcing levels, the department has responded to and acted on the findings of panels throughout the year. In particular, the findings have been used to address and improve practice and policies in relation to:

- training and information sharing
- domestic and family violence
- pressures from growing demand and complexity
- Aboriginal and Torres Strait Islander disproportionate representation and cultural capability
- cross-agency coordination
- parental drug use.

Findings and responses have also been considered through departmental reform and performance mechanisms.



Chapter 1

The review system

Background

The Department of Communities, Child Safety and Disability Services (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 through an intake or the subject of 'child concern reports' received by the department, an Investigation and Assessment, subject to an IPA or on a Child Protection Order.

Review framework

Since 2004, Queensland has utilised a two-tiered system for reviewing involvement with children and young people known to the department who have died.

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 Part 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.



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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 injury and the Director of Child Protection Litigation has performed a litigation function in relation to the child within one year before the child's death or serious injury¹. 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.

Tier 1: Internal Systems and Practice Reviews

The department takes the death and serious physical injury of any child or young person very 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 reviews is to:

Review Department of Communities, Child Safety and Disability Services' service delivery to the Subject Child under the Child Protection Act 1999 in the year prior to the child's injury or death with a focus on ensuring continuous improvement of service delivery, public accountability and improved outcomes for children.

For Aboriginal and Torres Strait Islander children, the Systems and Practice Review will also consider whether the child received services in a culturally appropriate manner.

The Systems and Practice Review Committee (SPRC) oversees Systems and Practice Review outcomes and has responsibility for making findings and 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 Panel Secretariat.

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

- Workforce Capability
- Complex Case Advice and Practice Support
- Case Review Unit
- Child Protection and Adoption Design and Commissioning
- Aboriginal and Torres Strait Islander Child Family and Community Services Programs
- Disability Services, Clinical Governance
- Domestic Violence Reforms

¹ Section 246AA *Child Protection Act 1999* (Qld)



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- the Regional Director/s for each review being discussed.

The SPRC 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 ensured that the child received services in a culturally appropriate manner.

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 12 months prior to their death.

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

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

The Minister is required to have the Child Death Case Review Panel, or an existing 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; or because of their qualifications, experience or membership of an entity are likely to make



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a valuable contribution to the work of the panel. A member of the pool can be appointed to 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.

The Minister is responsible for approving the composition of a panel and the cases assigned to a panel for its consideration². Cases were grouped into themes and allocated to members according to their 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 functions³. 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. Section 246DB (3) 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.

Following the panel meeting, a final report is prepared by the panel chair, with support from the Child Death Case Review Panel Secretariat, outlining the views and findings of the panel. This report typically contains the panel's consideration and findings for each departmental Systems and Practice Review. It also includes any collective themes and findings identified by the panel considering the cases allocated to them.

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 executive⁴. The chief executive must give a copy of the report to the Minister if the review was initiated by a request from the Minister or if the Minister requests a copy.

² Section 246HF *Child Protection Act 1999*

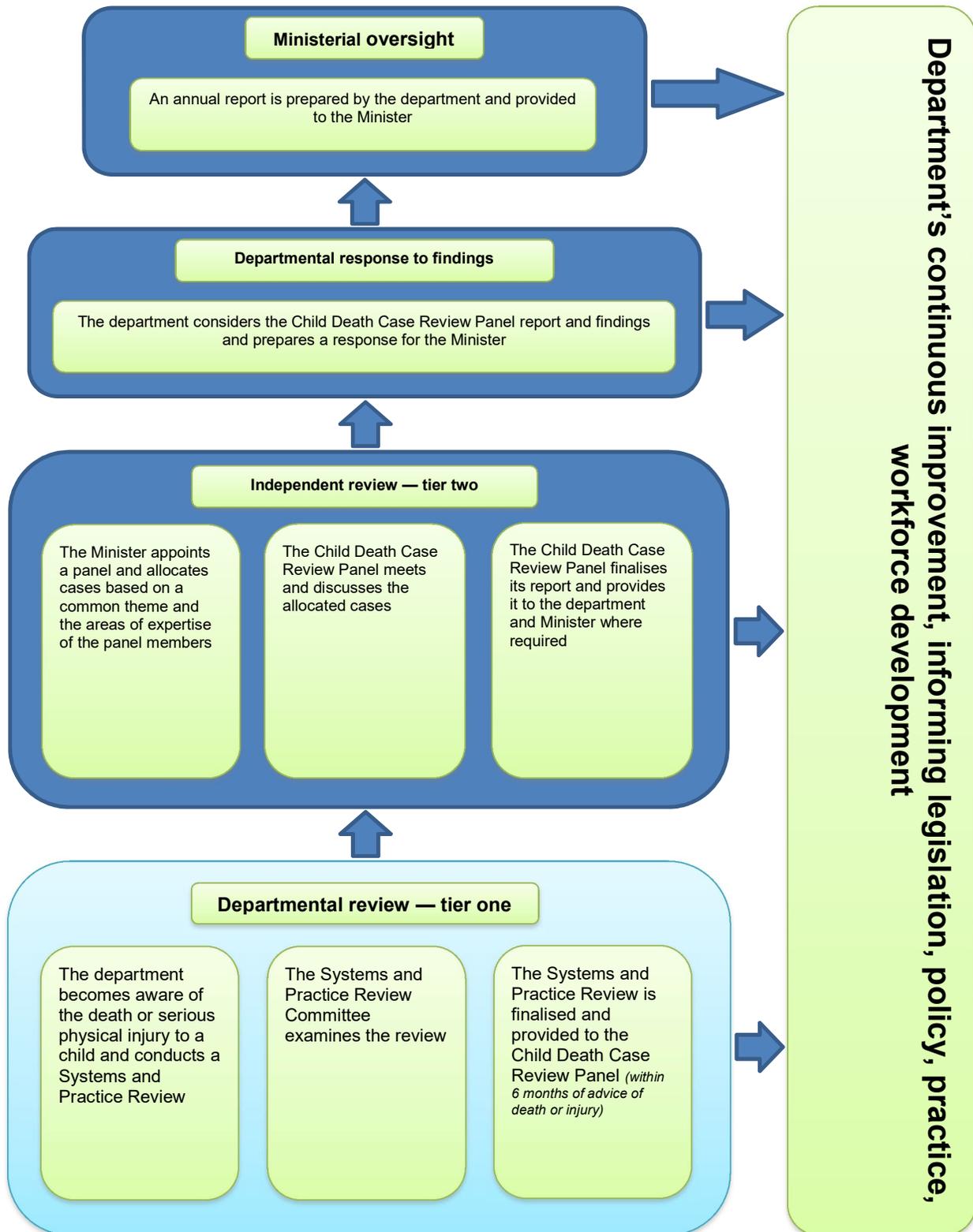
³ Section 246HG *Child Protection Act 1999*

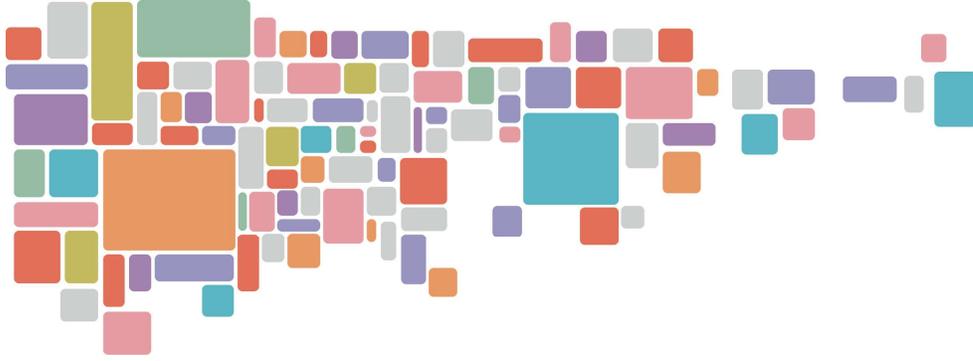
⁴ Section 246DC *Child Protection Act 1999*



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Figure 1. The Queensland Child Death Case Review system





Chapter 2

Profile of children and young people subject to reviews

Snapshot

In the 2016–17 reporting period, Child Death Case Review Panels completed reviews of cases involving 56 children and young people⁵. Fifty cases involved children or young people who had died and six cases involved serious physical injury.

Information about all children who died in the 2016–17 year is found in *The Annual Report: Deaths of children and young people, Queensland, 2016–17*, prepared by the Queensland Family and Child Commission (QFCC).

Of the 56 children and young people reviewed, 34 were male and 22 were female. Fourteen of the children and young people identified as Aboriginal (25 per cent), three identified as Torres Strait Islander (five per cent) and two identified as Aboriginal and Torres Strait Islander (three per cent). One related to children or young people of culturally and linguistically diverse backgrounds.

Figure 2 shows the number of cases reviewed each year from 2009–10 to 2016–17. It should be noted that legislative changes came into effect on 1 July 2014, reducing the timeframe for cases requiring review from three years to one year, and including the serious physical injury cohort.

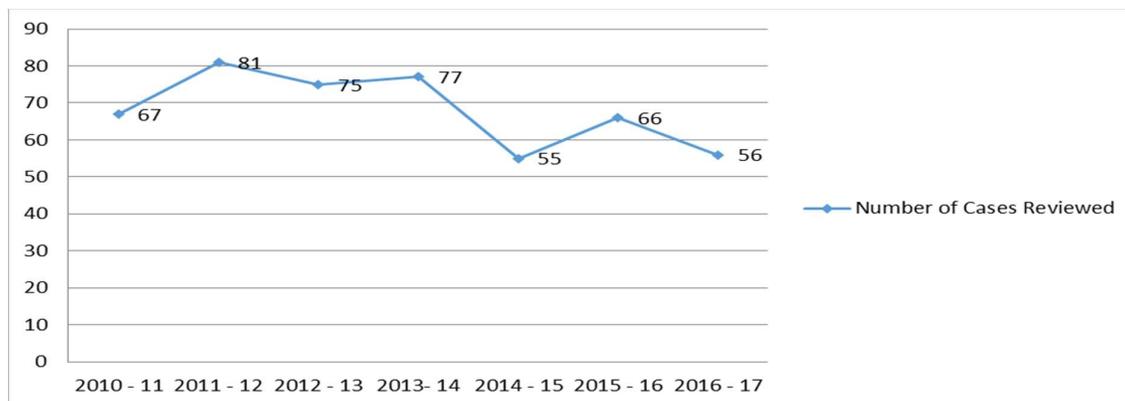


Figure 2. Number of cases subject to review in Queensland.

⁵ A completed review is defined as a panel which has submitted a completed report to the Director-General between 1 July 2016 and 30 June 2017.



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Characteristics of cases

The most frequent cause of serious physical injury was accidental, accounting for three of the six cases (50 per cent). Two of these were as a result of fire and one as a result of a motor vehicle accident. One case related to unknown causes, one case related to self-harm and one case was as a result of an assault. Two cases (33 per cent) related to children aged between one and four years and two cases (33 per cent) related to children aged between 15 and 17.

Figure 3 shows the causes of death in the cases reviewed in the 2016–17 reporting period.

The leading cause of death was disease and morbid conditions accounting for 23 of the 50 child death cases reviewed (46 per cent). This category includes children and young people who died due to disease or illness, disability or prematurity.

Suicide, accounted for six of the 50 child death cases reviewed (12 per cent)⁶. All six suicides related to males. Three children aged between 10 and 14, and three young persons aged between 15 and 17, were represented in suicide cases.

At the time of reporting, seven cases were categorised as unknown or pending. In these cases, the cause of death remains subject to finding by the Coroner and, therefore, unable to be classified. One cause of death was unable to be determined.

Children under the age of one were the highest represented group in child death cases, accounting for 32 per cent of cases reviewed. Children aged between one and four were the next highest representation (30 per cent), followed by young people aged between 10 and 14 (16 per cent).

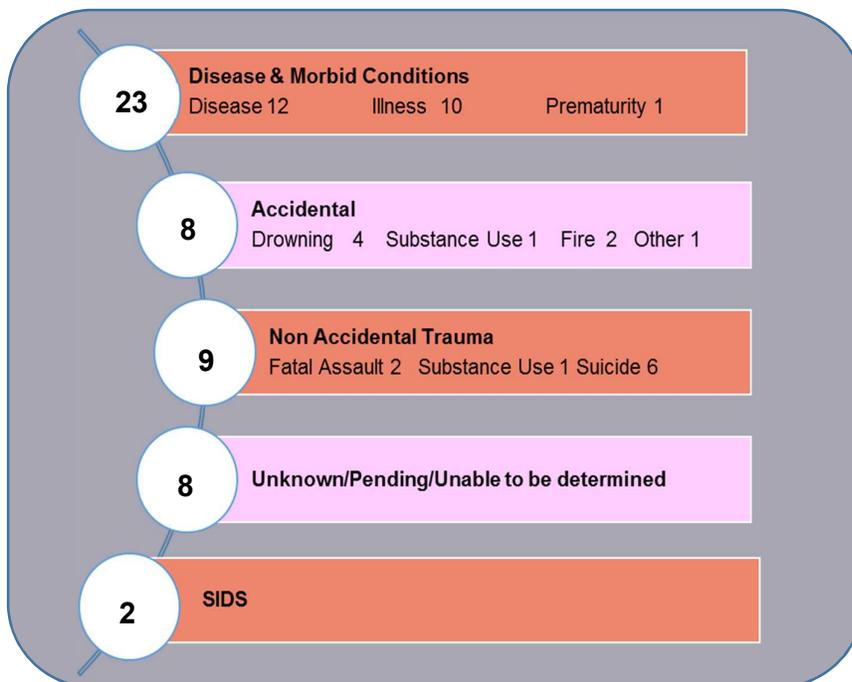
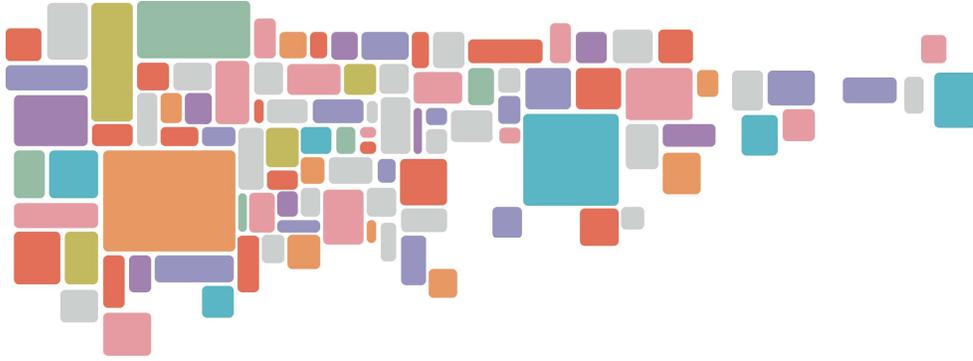


Figure 3. Cause of death of children and young people in the 2016–17 reporting period.

⁶ The department has categorised causes of death based on the known circumstances of the child or young person's death and available findings from Coroners. Some cases were still under the consideration of a Coroner at the time of compiling this report.



Chapter 3

Panel operations in 2016–17

Panel composition

In July 2015, the department coordinated a recruitment process that resulted in the Minister appointing a pool of 38 members to the Child Death Case Review Panels for a period of two years. One member resigned in 2016. In late-2016, a further recruitment process was conducted that resulted in the Minister appointing a further 12 members to the pool which included the appointment of a permanent Chair and Deputy-Chair.

Twenty-seven members are external to government, 12 are senior officers of other government agencies, and 10 are departmental representatives. Ten members had previously been appointed to the pool of members for the 2014–15 reporting period. Five members are Aboriginal. Currently, there are no Torres Strait Islander members. Thirty six of the 49 members are female.

The composition of each panel and the allocation of cases to panels were approved by the Minister, with assistance from the Child Death Case Review Panel Secretariat. Each panel was chaired by an external member. The use of a pool of members with diverse expertise provided the opportunity for cases to be themed and allocated to a panel with relevant expertise.

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. Appendix A provides more detailed information on the members of each panel.

Panel themes

During 2016–17, 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 cause of death was suicide
- who were very young and vulnerable at the time of their death
- whose cause of death was due to injuries caused by accidental incidents
- whose cause of death was non-accidental or unknown
- who were adolescents at the time of their death.

Panel findings

The 14 panels (Panels 23 – 36) completed 56 reviews in the 2016–17 financial year. They considered cases involving 50 children and young people who died and six children who sustained a serious physical injury. Panels considered departmental involvement with children and young people at a number of points on the child protection continuum.



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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 findings of their reviews, which were submitted to the Director-General of the department. The approach and nature of findings of the panels varied based on panel composition and the types of cases allocated. Each panel made findings 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.

Panels identified areas of improvement in the delivery of services to children, young people and their families, and interagency coordination. Panels acknowledged the reforms underway to strengthen practice and service delivery, arising from the implementation of the Child Protection Commission of Inquiry, *Not Now, Not Ever* Report and reviews led through the QFCC. The panels noted that benefits may not be manifest at the time of the child death or injury or during the review process.

The final report of each panel was considered by key areas in the department and a further report was provided to the Director-General outlining the action the department has taken, or intends to take, to address the findings in each panel's report.

The department also made the findings from the SPRC and Child Death Case Review Panels available to departmental staff. The Practice Connect team, Workforce Capability, Regional Directors, the Regional Practice Leaders and Aboriginal and Torres Strait Islander Practice Leaders are making these learnings more visible across the department to inform the ongoing strengthening of the system and practice.

Future of Panels

Under the 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, the 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. The 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. The QFCC also found that the system could be made even more robust by extending the scope and strengthening the independence of external panels.

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.

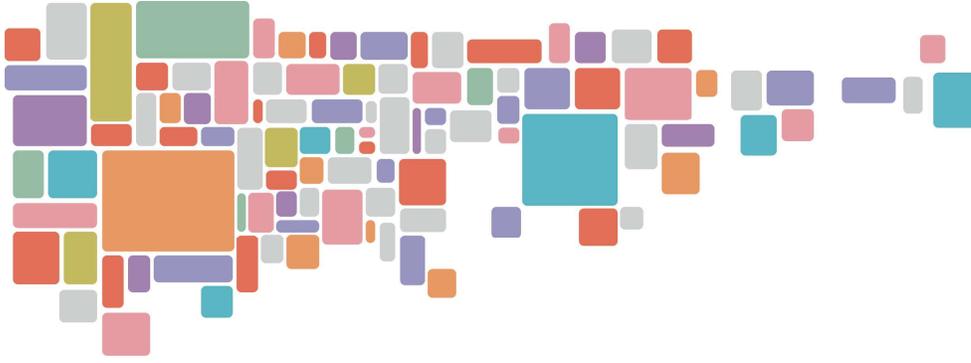
The review recommended in part:

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.

The recommendation was accepted by Government and is being implemented by the QFCC with support from relevant agencies. It is anticipated these changes will be advanced in 2017-18.



Chapter 4

Actions taken in 2016-17

Throughout the 2016–17 reporting period, a number of common issues were considered by the panels: domestic and family violence, complexity and workload pressures, Aboriginal and Torres Strait Islander over-representation and parental drug use. This chapter provides a summary of actions taken by the department in response to these themes. Information is also provided about responding to missing children.

Domestic and family violence

Domestic and family violence (DFV) is a significant cause of harm to children and young people and the impacts can be severe and long lasting. As outlined in the 2015-16 annual report, the department had commenced a suite of initiatives to improve domestic and family violence, family support and child safety services, and to strengthen the interface between these and other services.

The department is playing a key role in the roll-out of both the Queensland Government's Domestic and Family Violence Strategy and its Response to the Taskforce report *Not Now Not Ever - Putting an End to Domestic and Family Violence in Queensland*, as well the *Supporting Families Changing Futures* reforms in response to the Queensland Commission of Inquiry into Child Protection.

In particular, in 2016–17 the department has undertaken a range of actions in response to DFV continuing to be a theme identified by child death case review panels.

Integrated Service Response Trial and High Risk Teams

The trials are looking at how service systems can work better together in a structured, collaborative way to ensure people affected by domestic and family violence receive quality and consistent support.

High Risk Teams comprise staff from key agencies with a role in keeping victims safe and holding perpetrators to account, including Child Safety, Police, Health, Corrections and domestic violence support services. The teams provide integrated, culturally appropriate responses to victims and their children assessed to be at high risk of serious harm or death and are a key feature of the Queensland Government's integrated service responses to domestic and family violence.

Trials have been established in one urban site, one regional site and a discrete Indigenous community. The trial sites are Logan/Beenleigh, Mount Isa and Cherbourg. The Queensland Centre for Domestic and Family Violence Research has been commissioned to evaluate each of the three integrated service response trials.

Supported by learnings from the trial sites, an additional five High Risk Teams will be rolled out in:

- Cairns Region (2017–18)
- Brisbane (2017–18)
- Ipswich (2017–18)
- Mackay/Whitsunday (2018–19)
- Caboolture/Moreton Bay (2018–19).



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Child Safety Training

The department has worked with the Safe and Together Institute, an international expert in domestic and family violence, to develop five eLearning training resources that help staff identify, understand and assess domestic and family violence, and work with families, including Aboriginal and Torres Strait Islander children. A further two training modules will also be made available to staff in the near future.

In addition, since July 2016, more than 150 Child Safety staff and community DFV practitioners have attended the face-to-face training provided by the Safe and Together Institute. Training evaluation shows that practitioners feel more confident and competent with their DFV risk assessment and safety planning.

Working with Fathers who commit domestic and family violence

The department's *Walking with Dads* initiative has been launched in Moreton Bay, Mount Isa and the Sunshine Coast. The model targets fathers known to Child Safety who have exposed their children to domestic and family violence.

Walking with Dads involves a dedicated Child Safety Officer (CSO) who proactively engages fathers, supports them to take responsibility for their behaviour and assists them to access support services, including domestic violence behaviour change programs.

In addition, the department is trialling the *Caring Dads* program in Sunshine Coast/Moreton Bay and Ipswich/Toowoomba. This program, pioneered in Canada, is specifically tailored to fathers who commit domestic violence.

Other initiatives to strengthen links between domestic and family violence and Child Safety services

Other elements advanced in 2016-17 to strengthen the interface between domestic and family violence, family support and child safety services include:

- updating the tools assessing the risks and impacts of domestic and family violence as part of the *Strengthening Families Protecting Children* Framework for Practice
- deploying specialist non-government DFV workers along with Principal Child Protection Practitioners in each of the 20 Family and Child Connect services rolled out state-wide over 2016 and 2017
- deploying a Single Case Plan tool being used by non-government organisations providing intensive family services
- trialling the placement of DFV workers in Child Safety Service Centres, which is now being rolled-out in other CSSCs through the Assessment and Service Connect initiative (see more below)
- involving DFV services in Regional Child and Family Committees and Local Services Alliances set up under the *Strengthening Families Changing Futures* reforms
- making available the training on DFV developed for Child Safety officers to the non-government sector
- funding additional DFV services
- participating in the State Coroner's DFVD Death Review Board, and
- participating in the Australian National Research Organisation on Women's Safety (ANROWS) key research project on collaboration between child safety and domestic and family violence services.



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Responding to complexity and demand pressures

A common theme in cases reviewed was the complexity of cases and staff workloads. In 2016–17, the department has undertaken a range of actions in response.

Additional staff

In response to demand pressures, there were 129 new Child Safety positions created in the department during 2016-17. New positions were allocated using demand modelling to ensure the department responds to the areas of high need and workload. In addition, some 250 extra positions were created in the non-government sector

The Queensland Government also announced in June 2017 the allocation of an additional \$200 million over four years for an extra 292 Child Safety positions, to be appointed in 2017–18 and 2018-19. This includes 218 new child safety frontline and frontline support positions to be located in child safety service centres across Queensland – including 118 CSOs, 40 Child Safety Support Officers, 20 Senior Team Leaders and 40 Administrative Officers.

Further frontline and frontline support positions include a 20 person Child Safety Relief Pool, the Child Safety Quality Improvement Program, including 7 in a mobile specialist support team, dedicated 12 CSOs to work with Hospital and Health Services, 4 dedicated CSOs to work with QPS on joint investigations and information exchange, 5 additional positions for Child Safety After Hours Service Centre and 13 additional positions for a new Service Centre at Morayfield in the North Coast region.

Allocation of these additional positions has been targeted to areas of need, accounted for workload and complexity of caseloads and prioritised IPA cases and Investigation and Assessment matters. Using simulation modelling, these positions will also contribute to meeting future demand forecasts in these areas.

The 118 new PO4 and PO3 child safety officer positions provide career progression opportunities for CSOs, to improve staff retention and enable experienced staff to continue to work directly with children, young people and families. Sixty-one of the 118 CSOs will work with children subject to a Child Protection Order or IPA. This will bring down caseloads to under 18 over the next two years. The remaining 57 CSOs will undertake investigations and assessments to help alleviate pressures from the increasing complexity of families and growing demand.

Twelve extra CSOs will work with Hospital and Health Services (HHS) across the state focussing on collaboration and coordination between the health sector and child protection sector:

- CSOs will be supervised by a Senior Team Leader from a local Child Safety Service Centre (CSSC), be based in and work across a HHS catchment
- they will be the point of liaison and act as a conduit between Queensland Health and CSSC staff to support earlier and effective responses, intervention and case work activities with children and families who are known to the child protection system.

Given particular pressures in the North Coast and South East regions, in 2016-17 the department also split the regions into two Child Safety districts each with a Regional Director.

New Child Safety Quality Improvement Program

A key initiative in 2016-17 was the development of a new Child Safety Quality Improvement Program. This was part of the Government's Response to the reviews into the death of Mason Lee.

The Child Safety Quality Improvement Program will drive continuous improvement in practice, supervision, operations, management and leadership across the department's 7 regions and 50 Child Safety Service Centres. This includes developing and benchmarking quality standards, assessing casework and decision-making, reviewing performance, and advising local, regional and central managers on targeted or systemic improvement initiatives.



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The Quality Improvement team includes central and regionally-based positions which will implement a Continuous Quality Improvement (CQI) framework. The team will work in closely with regions and service centres to:

- ensure that the child safety services provided by the department are of a consistent high standard
- support the continuous improvement and development of practice
- influence the development of policies and procedures to support staff in delivering effective practice.

Specialist Practice Leader (Alcohol and Other Drugs) and Practice Leader (Mental Health) positions have also been created to work with regions and central office units to strengthen departmental skills, resources and knowledge in these areas within the context of child protection practice.

Other actions in 2016-17 that arose from reviews of child death reviews focused on driving continuous improvement in quality included:

- strengthening local SCAN support and operational arrangements
- implementing revised policies, procedures, guides and systems for responses and information exchange when children are missing from family-based or residential care, as recommended by the QFCC (see below)
- re-assessment of a number of matters the subject of Intervention with Parental Agreement, and
- renewal of practice and procedure expectations for supervision and handovers.

In one matter, the conduct of 12 officers was referred to Ethical Standards for assessment into possible breaches of standards. As at 30 June 2017, investigations proceeded in relation to nine staff. Three staff have left the department and disciplinary processes have been completed or are being finalised.

Assessment and Service Connect initiative

In addition the department is strengthening capacity to work with families with complex needs and provide a dual pathway for families referred to Child Safety for investigation, as recommended by the Queensland Commission of Inquiry into Child Protection.

In 2016-17, implementation commenced of a new working partnership between Child Safety and specialist non-government organizations through a co-responder model, known as Assessment and Service Connect (ASC).

The ASC model aims to foster a shared responsibility for supporting families and children across government and community sectors. This approach is seeing Child Safety, other government and non-government organisations working closely together to provide services to children and families at the first point of contact with Child Safety.

Responses are tailored to individual children and families. These include culturally safe responses for Aboriginal and Torres Strait Islander families, families from culturally and linguistically diverse backgrounds, as well as strengthened responses to domestic and family violence.

These co-responder services have been funded and are now operating in Gold Coast, Toowoomba, Roma/Charleville, Ipswich, Maryborough/Bundaberg, and Cairns and surrounds. Work is currently underway to roll out ASC across the rest of the state (Brisbane, North Coast and North Queensland, remainder of Central Queensland and remainder of South East Region).



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Other initiatives

Other initiatives advanced in 2016-17 to strengthen the department's capacity to address complexity and facilitate more integrated service responses include:

- continuing learning and development in foundational training, leading practice, intensive practice, Ice, DFV and family-led decision-making, aligned to the *Strengthening Families Protecting Children* Framework for Practice
- implementing the Hope and Healing Framework in conjunction with Peak Care, the representative organisation for non-government child safety services. The Framework is a trauma-informed therapeutic framework specifically for residential care services and aims to ensure that the support children receive helps them to overcome trauma they may have experienced
- engaging with the Queensland Mental Health Commission and Queensland Health in the development and implementation of adolescent mental health and suicide prevention plans and strategies
- engaging with Lady Cilento Hospital and Statewide Children's Hospital and Health Service to develop improved arrangements for health assessments, health passports and health services for children and young people in care
- instigating a review being conducted by the Queensland Family and Child Commission on ways to improve the operation of the multi-agency Suspected Child and Neglect (SCAN) teams
- piloting a Queensland Outcomes Framework for Children and Young People in Care
- facilitating inter-agency Complex Case panels for highly vulnerable young people, and supporting the development of Queensland Youth Engagement Charter, and
- facilitating assessments and preparations for children with disabilities in care to participate in the National Disability Insurance Scheme as it rolls out across Queensland over the three years from 2016-17.

Aboriginal and Torres Strait Islander over-representation

The panels again noted the complexities and need for greater cultural capability in cases involving Aboriginal and Torres Strait Islander children and young people.

In 2016–17, the department has undertaken a range of actions in response.

***Our Way* Strategy and *Changing Tracks* Action Plan**

The *Our Way* Strategy and *Changing Tracks* Action Plan for Aboriginal and Torres Strait Islander children and families were announced in May 2017. The Government has worked with Queensland Family Matters on the Strategy and Action Plan which provides a comprehensive and concerted plan to eliminate the over-representation of Aboriginal and Torres Strait Islander children and families in the child protection system over a generation.

The Action Plan seeks to work across six priority areas:

- Meeting the needs of Aboriginal and Torres Strait Islander young women under 25 years, and their partners, before and during pregnancy and parenting, especially during the first 1000 days.
- Increasing access to, and involvement in, early years, health and disability programs for Aboriginal and Torres Strait Islander children aged two to five years.



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- Providing Aboriginal and Torres Strait Islander families who have complex needs and children at risk with the right service.
- Enabling Aboriginal and Torres Strait Islander children and young people in out-of-home care to thrive, and re-engaging those disconnected from family and kin.
- Enabling Aboriginal and Torres Strait Islander children and young people aged 15 to 21 years in or leaving out-of-home care to learn and earn, and stay safe and well.
- Changing Tracks for services and systems with initiatives that will see governments and community organisations focus more on the child and how to enable families, respect cultural knowledge and authority, partner better and shift investment, innovate and learn and be more accountable.

The department also advanced work during 2016-17 through the review of the *Child Protection Act* to develop proposals to strengthen legislative provisions that embed the Aboriginal and Torres Strait Islander Child Placement Principle into child safety policy and practice.

Aboriginal and Torres Strait Islander Family Well-being Services

In 2016-17, the department partnered with community-controlled organisations to establish 20 Aboriginal and Torres Strait Islander Family Well-being Services across Queensland, following a Government commitment of \$150 million over five years, including \$60 million additional funds. These services will assist Aboriginal and Torres Strait Islander families experiencing vulnerability accessible, culturally-safe, integrated, healing-based and trauma-informed programs. By June 2017, 14 were operational and the remainder were either in procurement or preparing to undertake procurement.

In addition, eight Aboriginal and Torres Strait Islander Family Wellbeing services are being funded to engage Early Childhood Development Coordinators (ECDC) on a part-time basis to improve the engagement of Aboriginal and Torres Strait Islander families with the early childhood education and care system. The work undertaken by these roles will include:

- Working with families to promote the importance of their children's early learning for making a successful transition to formal education
- Enhancing the skills and knowledge of Family Wellbeing workers to address early learning needs
- Engaging directly with families to assist them with access to early learning services, and
- Fostering strong relationships with early childhood education providers within a service's area.

Each service will receive funding of \$125,000 for a two year period. The services that will engage ECDC are in Townsville, Mackay, Moreton Bay, Gold Coast, Ipswich, Logan, Cairns and Rockhampton.

Early childhood education programs provide critical physical and mental development for children including social and emotional growth. They help prepare children for school, provide health and wellbeing skills and monitoring, and important attachment to other adults. Promoting families' investment in their children's early learning is critical to ensuring that children make a successful transition to formal education, with long term benefits for their social and economic security.

Family-led decision making

In 2016–17, new Aboriginal and Torres Strait Islander family-led decision making and shared practice models were trialled in Ipswich, Mount Isa, Cairns and Torres Strait Islands. The learnings and evaluations are informing the future delivery of collaborative family led decision making processes across the system.



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Recognised Entity Review

The department is collaborating with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) to undertake a review of the Recognised Entity (RE) program. The review is being guided by a high level steering committee of diverse stakeholders, and has involved a statewide consultation process and a strategic design workshop involving department and Aboriginal and Torres Strait Islander stakeholders. The review has fed into proposed legislative amendments that would see the services independently facilitating family participation in statutory decision making.

The RE reform has been heavily informed by the evaluation of the Aboriginal and Torres Strait Islander Family Led Decision Making trials which have tested increased RE participation in case planning and provided an indication of the capacity and workforce requirements for transition to a new model.

Aboriginal and Torres Strait Islander Cultural Capability

A number of panels pointed to the need for the department to continue to improve cultural capability. In May 2015, the department released a comprehensive Aboriginal and Torres Strait Islander Cultural Capability Action Plan - *Respectfully Journey Together*. In 2016-17, implementation of the Action Plan continued through a range of initiatives, including:

- A revamped Aboriginal and Torres Strait Islander Workforce Strategy
- A revamped online cultural induction training course: *Starting the Journey*
- development of the *Valuing Aboriginal and Torres Strait Islander Peoples' Knowledge Lens* and User Guide and the *Respectful Language Guide*,
- establishment of the 'Yarn and Grow' Aboriginal and Torres Strait Islander Mentoring Program, and
- local initiatives to strengthen engagement with Aboriginal and Torres Strait Islander staff, elders and organisations.

Parental drug use

In a number of cases considered by the panels, drugs had a devastating impact on parents' ability to care for their children. This is a huge challenge for police, health, community services, child safety and obviously families and communities.

In 2016–17, the department has undertaken a range of actions in response.

Drug testing policy for Intervention with Parental Agreement (IPA) cases

In November 2016, a revised drug testing policy for parents working with the department under an IPA where drug use is an issue was announced. The Child Safety Practice Manual was updated to reflect this policy and to provide guidance for staff working with families affected by drug use.

Parents entering IPAs are required to show they are willing to engage in safety planning and work with the department to address child protection concerns, including agreeing to drug testing where drug misuse is an identified issue. Children are only allowed to stay with their parents when it is safe to do so under an IPA, and may still be placed in either foster care or with other family members.

Should a parent refuse to engage in drug testing, or if a positive result is returned, reassessment of the child's safety and the Safety Plan is undertaken, and a more intrusive intervention is sought. Where an IPA is no longer assessed as a suitable intervention to meet the needs of a child, the department will seek a Child Protection Order.



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Training

Child Safety Training has developed specialised online Ice training resources for frontline workers, including Child Safety, and Housing and Public Works employees, with the potential for rollout to domestic and family violence support providers. This online training module aims to increase staff skills and knowledge of Ice's attributes and effects, and assist them to recognise and respond to the signs of Ice use in the community.

342 staff have completed the current Crystal Methamphetamine module, and 352 staff have their course completion in progress. Child Safety Training refreshed this module, which was released in July 2017. In addition, the regions have engaged and facilitated community agency information sessions on this topic.

The department also committed to work with PeakCare and QATSICPP to organise a cross-sectoral forum on Methamphetamines (Ice), bringing together experts and practitioners from the drug and alcohol, family support, mental health and child safety sectors, which was held in August 2017.

Responding to missing children

The Queensland Family and Child Commission (QFCC) undertook a whole-of-government systems review into the arrangements in place for responding to children missing from out-of-home care, following the death of Tiahleigh Palmer in 2015. The QFCC released the report on 11 July 2016 which contained 29 recommendations for the Queensland Government. All recommendations were accepted.

The department released updated Missing Children Guidelines for approved carers and care services, revisions to the Foster and Kinship Carer Handbook and the Child Safety Practice Manual. The guidelines clarify what staff, carers and agencies can and should do when a child in out-of-home care is missing and are in line with the recommendations of the QFCC's report.

The guidelines have been promoted through CREATE, PeakCare and Foster Care Queensland to help carers understand what they do when a child in their care goes missing. There are also new delegations to ensure the department can quickly respond to requests from the Queensland Police Service for approval to identify a child as being a child in out-of-home care. The department has made changes to ICT systems, to enable the collection of data on children missing from out-of-home.

Information sessions, incorporating procedures and processes for responding to a child who is absent from a placement or missing, have been developed and provided to Child Safety staff and funded organisations in the sector. Training material has also been developed and provided to support information sessions with direct carers and staff in foster and kinship services.

The QFCC recommended that the government establishes a Missing Children Pilot Governance Model called 'Our Child', with the department as the lead agency. The primary role of the project is to improve communication between agencies and develop better operational responses to the management of occurrences for children missing from out-of-home care.

In 2016-17, the department has instigated the 'Our Child' project, working closely with the Queensland Police Service, Queensland Health, Department of Education and Training, Queensland Aboriginal and Torres Strait Islander Child Protection Peak, the QFCC, the Office of the Public Guardian, Foster Care Queensland and the CREATE Foundation.

The department will deliver an ICT system that will assist appropriate officers in various agencies to connect, communicate, share and collaborate to reduce the time taken to react to missing children, and to initiate a multi-agency response, including sending out media releases and amber alerts, where necessary. It will take approximately two years for the system to be rolled out in full, with the first stage scheduled to go live by end March 2018.



Appendix A

Panel themes and composition

Panel 23	Theme: Accidental External members: Professor Clare Tilbury (Chair) Associate Professor Kirsten Vallmuur Dr Anne Pattel-Gray Other government agency: Ms Natalie Parker Departmental officer: Ms Barbara Shaw Meeting date: 7 July 2016 Date report delivered to Director-General: 16 August 2016
Panel 24	Theme: Children under 1 External members: Ms Annette Sheffield (Chair) Professor Paul Colditz Dr Deborah Walsh Ms Raelene Ward Other government agency: Inspector George Marchesini Departmental officer: Ms Kathy Masters Meeting date: 29 July 2016 Date report delivered to Director-General: 30 August 2016
Panel 25	Theme: Diseases and disabilities External members: Ms Margaret Kruger (Chair) Associate Professor Rosa Alati Dr Anne Pattel-Gray Other government agency: Professor John Allan Departmental officer: Ms Kathy Masters Meeting date: 15 August 2016 Date report delivered to Director-General: 4th October 2016



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Panel 26	Theme: Adolescents External members: Professor Clare Tilbury (Chair) Mr Clinton Schultz Associate Professor James Scott Dr Nina Westera Other government agency: Ms Julie Kinross Departmental officer: Ms Bernadette Harvey Meeting date: 1 September 2016 Date report delivered to Director-General: 17 October 2016
Panel 27	Theme: Unthemed External members: Mr Clinton Schultz (Chair) Dr Kairi Kolves Ms Rebecca Sherman Ms Susan Teerds Other government agency: Detective Senior Sergeant Christopher Hansel Departmental officer: Professor Karen Nankervis Meeting date: 27 September 2016 Date report delivered to Director-General: 14 November 2016
Panel 28	Theme: Under 1 External members: Ms Annette Sheffield (Chair) Dr Anne Pattel-Gray Professor Paul Colditz Other government agency: Mr Graham Kraak Departmental officer: Ms Bernadette Harvey Meeting date: 1 November 2016 Date report delivered to Director-General: 20 December 2016



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Panel 29	Theme: Adolescents External members: Mr Bryan Cook (Chair) Professor Rosa Alati Ms Raelene Ward Other government agency: Ms Natalie Parker Departmental officer: Ms Barbara Shaw Meeting date: 13 September 2016 Date report delivered to Director-General: 21 October 2016
Panel 30	Theme: Accidental External members: Ms Laurel Downey (Chair) Associate Professor Kirsten Vallmuur Ms Raelene Ward Other government agency: Ms Jean Smith Departmental officer: Professor Karen Nankervis Meeting date: 22 November 2016 Date report delivered to Director-General: 31/01/2017
Panel 31	Theme: Unknown-Suspicious External members: Professor Clare Tilbury (Chair) Ms Raelene Ward Professor Paul Colditz Ms Betty Taylor Other government agency: Inspector George Marchesini Departmental officer: Ms Barbra Shaw Meeting date: 5th December 2016 Date report delivered to Director-General: 13 January 2017
Panel 32	Theme: Suicide External members: Mr Clinton Schultz (Chair) Dr Kairi Kolves Associate Professor Annabel Taylor Other government agency: Ms Natalie Parker Departmental officer: Professor Karen Nankervis Meeting date: 6th February 2017 Date report delivered to Director-General: 15 March 2017

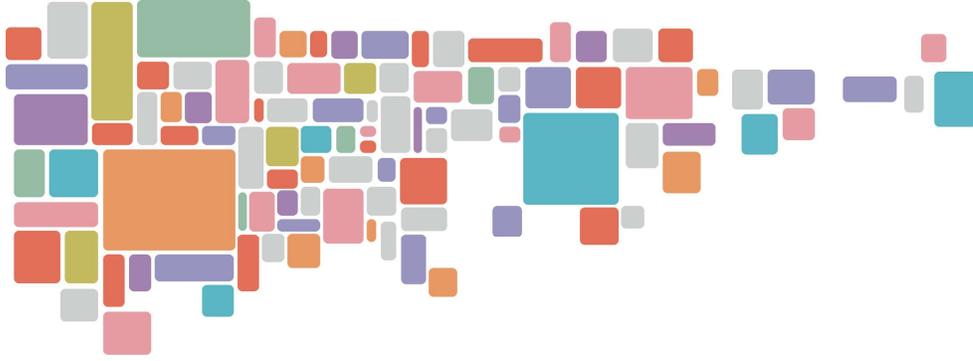


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Panel 33	Theme: Disease-Unknown External members: Ms Margaret Kruger (Chair) Ms Raelene Ward Associate Professor Mark Coulthard Dr Nicola Murdock (observer) Ms Shanna Quinn (observer) Other government agency: Ms Jean Smith Departmental officer: Professor Karen Nankervis Meeting date: 13th March 2017 Date report delivered to Director-General: 3 April 2017
Panel 34	Theme: Disease and Morbid conditions External members: Dr Nicola Murdock (Chair) Ms Annette Sheffield Ms Margaret Kruger Other government agency: Ms Natalie Parker Departmental officer: Ms Donna Lockyer (apologies) Meeting date: 14 May 2015 Date report delivered to Director-General: 31 May 2017
Panel 35	Theme: Under 2 External members: Ms Shanna Quinn (Chair) Professor Jeanine Young Associate Professor Kirsten Vallmuur Ms Raelene Ward Other government agency: Mr Graham Kraak Departmental officer: Ms Bernadette Harvey Meeting date: 27 April 2017 Date report delivered to Director-General: 13 June 2017
Panel 36	Theme: Disease and Morbid conditions External members: Dr Nicola Murdock (Chair) Ms Annette Sheffield Mr Clinton Schultz Other government agency: Ms Julie Kinross Departmental officer: Professor Karen Nankervis Meeting date: 22 May 2017 Date report delivered to Director-General: 28 June 2017



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Appendix B

External Members

Dr Nicola Murdock – Chair

Qualified as a doctor specialising in paediatrics and with experience in medical administration. Dr Murdock has worked in medicine since 1984 in both the United Kingdom and Australia, including work in regional Australia. She has worked for many years in developing and improving hospital systems and reports that her focus is on building partnerships and developing innovative solutions to healthcare problems, particularly in service redesign.

Ms Shanna Quinn – Deputy-Chair

With qualifications in law, social work and mediation, Ms Quinn has over 35 years' experience in the fields of child and family welfare, in the capacity of practitioner, investigator and advocate. Ms Quinn is a practicing Barrister and has 25 years of experience in the field of dispute resolution, both as a mediator and trainer and has mediation, negotiation and facilitation skills with individuals, groups and organisations. Ms Quinn has a well-developed appreciation of the significant impact culture, race, language and socio-economic context has on parenting, communication, behaviour, conflict resolution and values.

Professor Rosa Alati

Has a distinguished research background in life-course epidemiology of drug and alcohol use problems. She is Professor at the School of Public Health & Centre for Youth Substance Abuse 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 Alati identifies as from a culturally and linguistically diverse background.

Professor Paul Colditz

A practicing neonatologist with a Doctor of Philosophy in Medicine from the University of Oxford, UK. He is currently the Foundation Professor of Perinatal Medicine at the University of Queensland (UQ) and for the past 20 years has been Director of the Perinatal Research Centre, and more recently, Deputy Director (Clinical) of the UQ's Centre for Clinical Research. His research focuses on clinically important perinatal health problems and translation to clinical practice. It includes investigations relating to seizure identification and prevention, brain injury and neuroprotection, body composition and neural plasticity and pathways to improving neurodevelopmental outcomes. Professor Colditz is currently a board member of the Red Nose Board (both national and Queensland).



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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.

Associate Professor Mark Coulthard

A practising paediatrician and intensive care specialist based at Royal Children's Hospital, Brisbane. Associate Professor Coulthard is also the Head, Academic Discipline of Paediatrics and Child Health at the University of Queensland.

Professor Heather Douglas

Professor and researcher at the TC Beirne Law School, University of Queensland. She researches in the areas of criminal justice and domestic violence. She is particularly interested in the relationship between Indigenous people and the criminal law and the way the criminal law impacts on and constructs women. In 2014, she was awarded an Australian Research Council Future Fellowship to research the way in which women who have experienced domestic violence use the legal system to help them leave violence. She has also considered the criminal justice response to foetal alcohol spectrum disorders (FASD) and to the drug khat.

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 Kolves

A Principal Research Fellow and Lecturer at the Australian Institute for Suicide Research and Prevention (AISRAP) 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 60 peer reviewed papers, several chapters and reports on suicide research and prevention. Dr Kolves identifies as from a culturally and linguistically diverse background.

Ms Margaret 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.



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Ms Kathryn McMillan

Barrister practicing primarily in the areas of alternative dispute resolution, civil and human rights/discrimination, family law and child protection law as well as Coronial Inquests and work on behalf of the Australian Health Practitioner Regulation Agency and the medical and other statutory boards in the Queensland Civil and Administrative Tribunal.

Ms Gwenn Murray

A consultant criminologist in private practice for 12 years with specialist skills in child protection. Ms Murray is currently a part-time sessional member of the Queensland Civil and Administrative Tribunal (primarily hearing reviews of child protection decisions and blue card decisions) and the Mental Health Review Tribunal.

Dr Anne Pattel-Grey (identifies as Aboriginal)

An Indigenous Australian theologian and academic. Dr Pattel-Grey has been the Executive Secretary of the National Aboriginal and Torres Strait Islander Ecumenical Commission of the National Council of Churches in Australia, and a Research Fellow at the University of Sydney. She has represented Aboriginal Australia on various international bodies and organisations throughout the world. Her PhD and thesis was in relation to the influence the Catholic Church had over Aboriginal people.

Associate Professor James Scott

A consultant psychiatrist at Royal Brisbane and Women's Hospital Early Psychosis Service and Associate Professor at the University of Queensland. He completed his PhD in 2009, with a focus on psychosis and epidemiology. He also holds a certificate in the subspecialty of child and adolescent psychiatry. Associate Professor Scott has worked extensively in child and youth mental health in community and inpatient settings while continuing clinical and epidemiological research.

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.

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 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.

Ms Rebecca Shearman

Operations Manager of the Domestic Violence Action Centre. She is a trained social worker and has a degree in psychology. Ms Sherman is a member of the Domestic and Family Violence Death Review Panel and was a member of the department's Domestic and Family Violence Strategy Implementation Advisory Group from 2010-2012.



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Professor Clare Tilbury

Currently a Professor with the School of Human Services and Social Work at Griffith University and has 30 years' experience as a social work practitioner, researcher and educator. Professor Tilbury has worked in a range of positions with children and their families in both government and academic environments.

Associate Professor Annabel Taylor

Former Director of Te Awatea Violence Research Centre at the University of Canterbury, NZ and is currently the Director of the Queensland Domestic and Family Violence Research Centre, Central Queensland University. Prior to this, Associate 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

The Chief Executive Officer of Kidsafe Queensland. Ms Teerds is on the Child Restraint, Education and Safe Travel Committee, Queensland Council of Injury Prevention (QCIP), the QCIP Consumer Product Injury Research Advisory Group 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.

Mr Greg Upkett (identifies as Aboriginal)

Manager of the Indigenous Family and Child Support Service, which provides support and care to some of the most vulnerable members of the community by seeking suitable care arrangements for children and families who are in need. Mr Upkett has previously worked as a foster and kinship care support worker to provide appropriate placements for Aboriginal and Torres Strait Islander children under the care of Child Safety Services. He was also a Liaison Officer for Aboriginal and Torres Strait Islander Legal Service.

Associate Professor Kirsten Vallmuur

A Principal Research fellow with the Centre for Accident Research and Road Safety Queensland at Queensland University of Technology. Associate Professor Vallmuur was awarded her PhD in 2003 and has been focussed throughout her academic life on product safety, injury prevention, and wider accidental incidents, and has published a number of books and journal articles within this area.

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.



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Ms Raelene Ward (identifies as Aboriginal)

A registered nurse, holds a Masters in Health and is currently studying for her PhD. She 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 from a regional area.

Dr Nina Westera

A Research Fellow at Griffith Criminology Institute with a focus on investigations and policing. Dr Westera was conferred her PhD in 2012 and has a background in Psychology and criminal investigations.

Professor Jeanine Young

A Registered Nurse, Registered Midwife and qualified neonatal nurse. She completed her PhD in infant care practices and their relationship with risk factors for Sudden Infant Death Syndrome (SIDS). 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 chairs the Red Nose National Scientific Advisory Committee which works to ensure that safe sleeping public health recommendations are evidence-based.



Government members

Departmental members

The following positions within the Department of Communities, Child Safety and Disability Services were appointed to the pool of approved members:

- Centre Director, Centre of Excellence for Clinical Innovation and Behaviour Support
- Executive Director, Office for Women and Domestic Violence Reform
- Regional Director, Central Queensland Region
- Regional Director, South East Region

Government members

The following positions from other Queensland Government departments were appointed to the pool of approved members:

- Department of Justice and Attorney-General
 - Director, Strategic Policy and Child Safety Director
 - Executive Director, Youth Justice Services
- Queensland Health
 - Director, Strategic Policy Priority Areas
 - Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch
- Department of Education, Training and Employment
 - Executive Director, State Schools Operations
- Queensland Police Service
 - Operations Manager, Child Safety and Sexual Crime Group, State Crime Command
 - Detective Senior Sergeant, Child Safety and Sexual Crime Group, State Crime Command