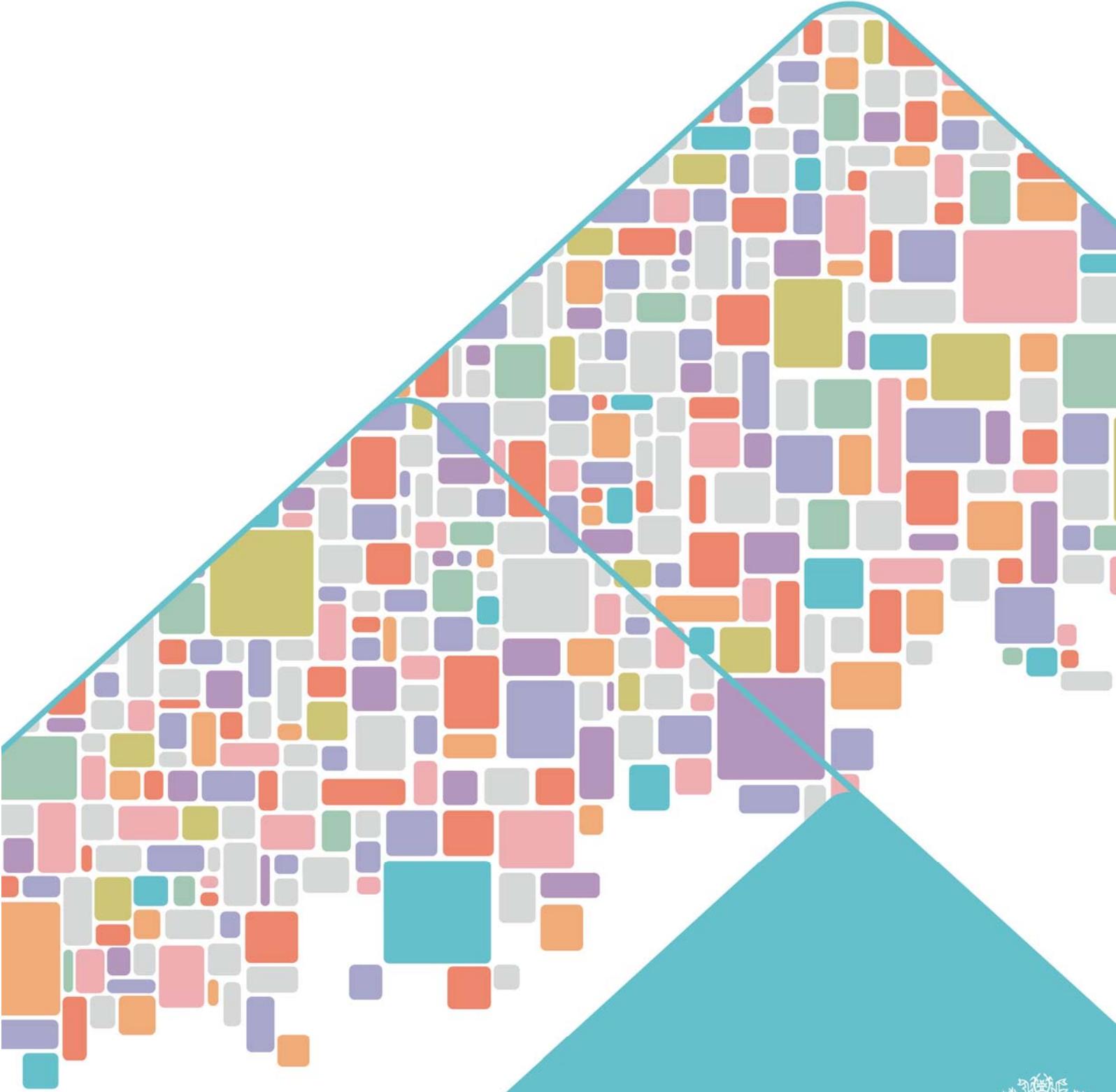


# Annual Report on the Queensland Child Death Case Review Panels 2017–18





Queensland Child Death Case Review Panels

**Annual Report 2017–18**

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 2017 to 30 June 2018.

Yours sincerely

Michael Hogan  
**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 2017–18.

When a child or young person dies or is seriously injured the impact is profound, not only upon the child's family members, carers and staff but also the broader community. When that child is known to the child protection system it is an important part of our accountability that there is a thorough review of the work with the child, young person, their family and carers. These reviews ensure that we identify what worked well and what are the areas of learning that need further attention.

Over 84,000 Queensland children and young people are currently 'known to child protection'. Just over 12,000 are subject to ongoing intervention and of these, about 9,600 children and young people are in care. When a child known to the child protection system dies or suffers serious injury in the previous twelve months, a two-tier review process is undertaken: first 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. This two-tiered approach ensures a robust and independent examination of our systems and practice. In addition the department is accountable through coronial processes, and where relevant misconduct investigations, and assists police in criminal investigations.

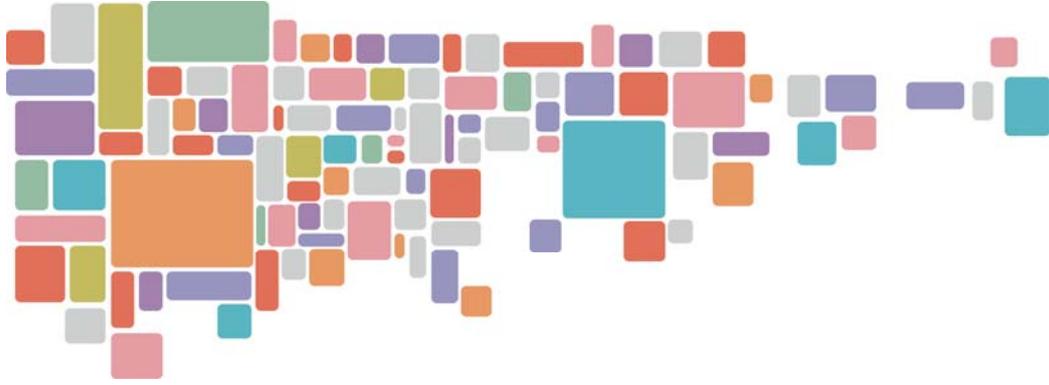
In 2017-18, the Child Death Case Review Panels considered 56 departmental Systems and Practice Review reports and two reports prepared by the Director of Child Protection Litigation. These dealt with 47 deaths and 9 serious injuries. Child Death Case Review Panels made a range of findings, conclusions and recommendations to the department as a result of their review and considerations. This report details key panel findings and insights that have arisen as a result of their review process.

I would like to thank the panel members for their significant investment of time and expertise in these cases and acknowledge the demanding and distressing nature of this role that they are undertaking. Members have expertise in the fields of paediatrics and child health, forensic pathology, mental health, investigations, child protection and child protection litigation. Members also include senior officers from the department other public service agencies, such as Health, Education and Police. This wide range of perspectives and expertise ensures that our child protection system will continue to strengthen.

I believe this annual report not only demonstrates the robustness of our review system but also details the significant advances being made in child protection systems and practice in Queensland.

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

Michael Hogan  
**Director-General**  
**Department of Child Safety, Youth and Women**



# Executive summary

## Background

Over 84,000 Queensland children and young people are currently ‘known to child protection’. Just over 12,000 are subject to ongoing intervention and of these, about 9,600 children and young people are in care.

When a child who is known to the Department Child Safety, Youth and Women (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 encourage 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 12 months preceding their death or serious 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 12 months 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 58 review reports, relating to 56 individual children/cases comprising 47 deaths and nine serious injuries. For two children, the panels considered the department’s Systems and Practice Review Report and the Director of Child Protection Litigation’s Review Report. Sixteen panels completed reviews during the reporting period.<sup>1</sup>

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 16 panels produced a report outlining broad conclusions and recommendations relating to the cases reviewed and detailed conclusions and recommendations for each individual case. Each panel made conclusions and recommendations aimed at systemic improvement based on the individual cases reviewed. The panels identified examples of high

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<sup>1</sup> 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 2017 and 30 June 2018.



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quality service delivery by departmental staff. The panels also identified key or recurring themes and a range of areas for improvement.

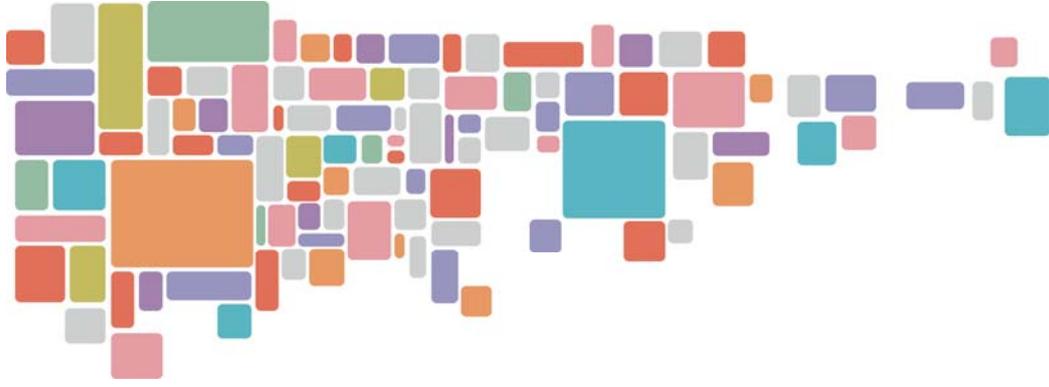
During the reporting period, the panels delivered 16 reports to the Director-General of the department, and three reports to the Director of Child Protection Litigation.

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. The Government is currently considering 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.

### **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 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 12 months preceding their death or serious 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.

### 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 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.



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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 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 injury<sup>2</sup>. 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 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 Child Safety, Youth and Women's 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 serious physical injury reviews, the Systems and Practice Review will also consider the injury event and analyse service delivery factors that may have helped to prevent the injury.

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 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 Panel Secretariat.

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

- Workforce Capability

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<sup>2</sup> Section 246AA *Child Protection Act 1999* (Qld)



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- Practice Advice and Support
- Review
- Operational Support
- Aboriginal and Torres Strait Islander Child Families
- Violence Prevention
- the Regional Director/s for each review being discussed.

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 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 reviews
- membership and panel formation
- the conduct of business by panels



## Queensland Child Death Case Review Panels Annual Report 2017–18

- Child Death Case Review Panel reports
- 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. 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.<sup>3</sup> A review panel may be allocated one or more reviews. The Child Death Case Review Panel 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.<sup>4</sup> 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

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<sup>3</sup> Section 246HF *Child Protection Act 1999*

<sup>4</sup> Section 246HG *Child Protection Act 1999*



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- 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 Panel 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.<sup>5</sup> 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.<sup>6</sup> *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.

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<sup>5</sup> Sections 246DB and 246DC *Child Protection Act 1999*

<sup>6</sup> Sections 246DB, 246DC and 246DD *Child Protection Act 1999*



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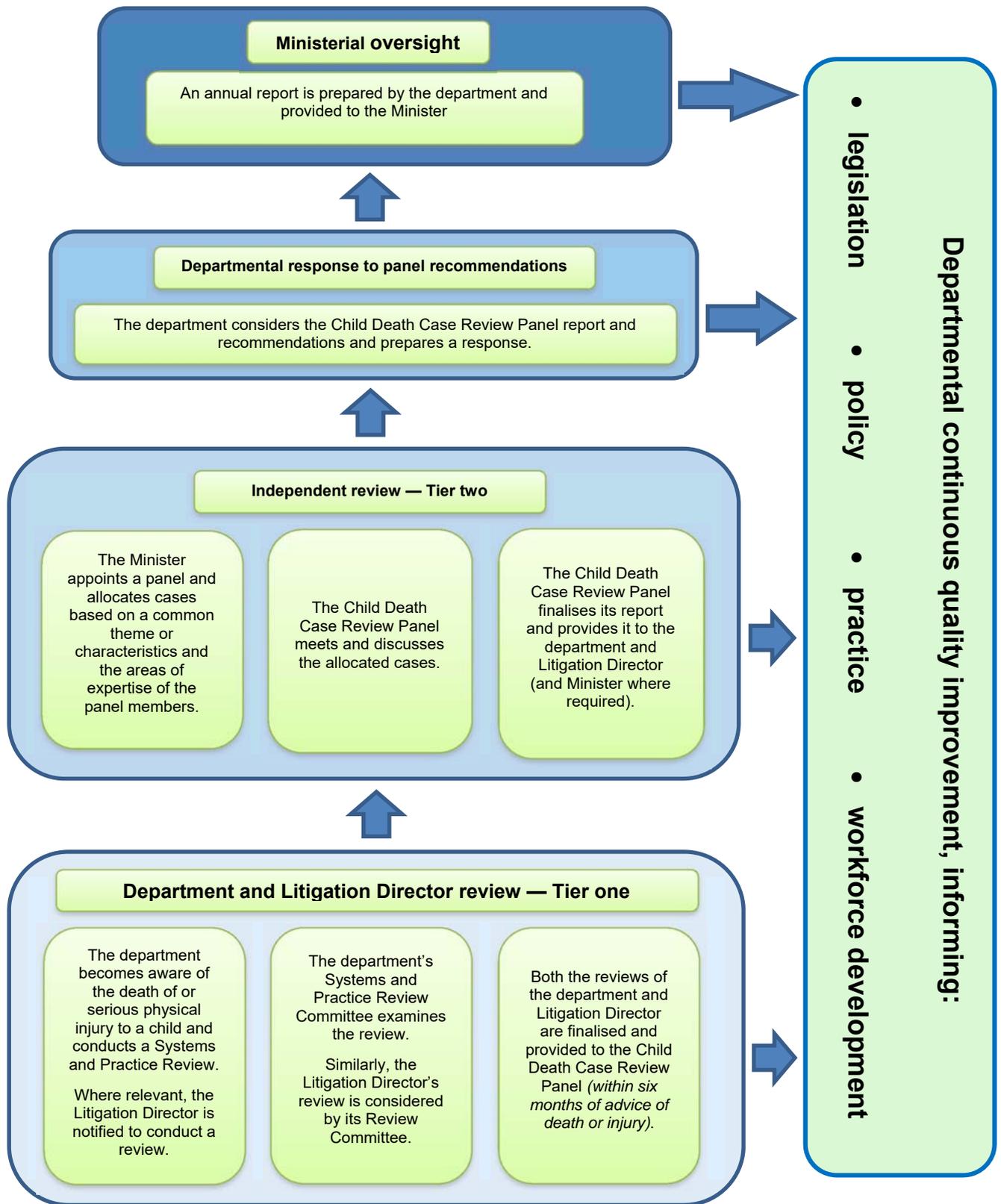
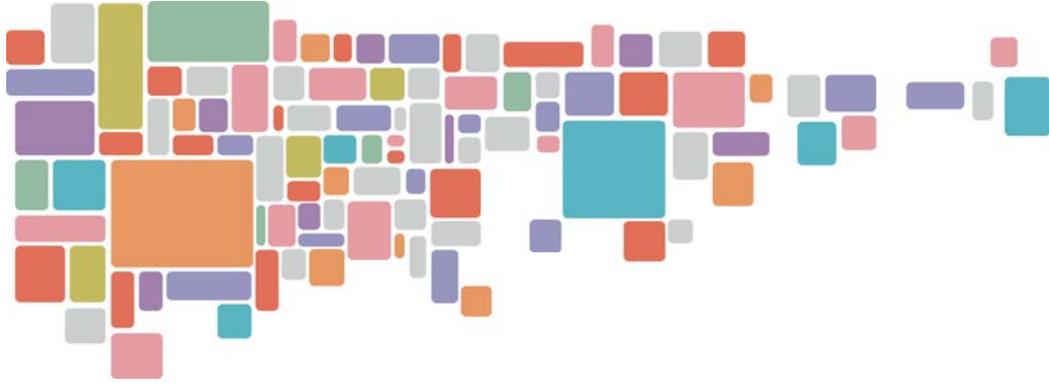


Figure 1. The Queensland case review system for children known to the child protection system



## Chapter 2

# Profile of children and young people subject to reviews

### Snapshot

In the 2017–18 reporting period, Child Death Case Review Panels completed reviews of cases involving 56 children and young people.<sup>7</sup> Forty-seven (47) cases involved children or young people who had died and nine (9) cases related to a child or young person who had sustained a serious physical injury.

Of the 56 children and young people reviewed, 29 were male and 27 were female. Thirteen of the children and young people identified as Aboriginal (23 per cent), one identified as Torres Strait Islander (two per cent) and one identified as both Aboriginal and Torres Strait Islander (two 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 12 months prior (previously the timeframe included children who were known to the department in the last *three* years) and introducing the requirement to also conduct a review for children who sustained a serious physical injury.

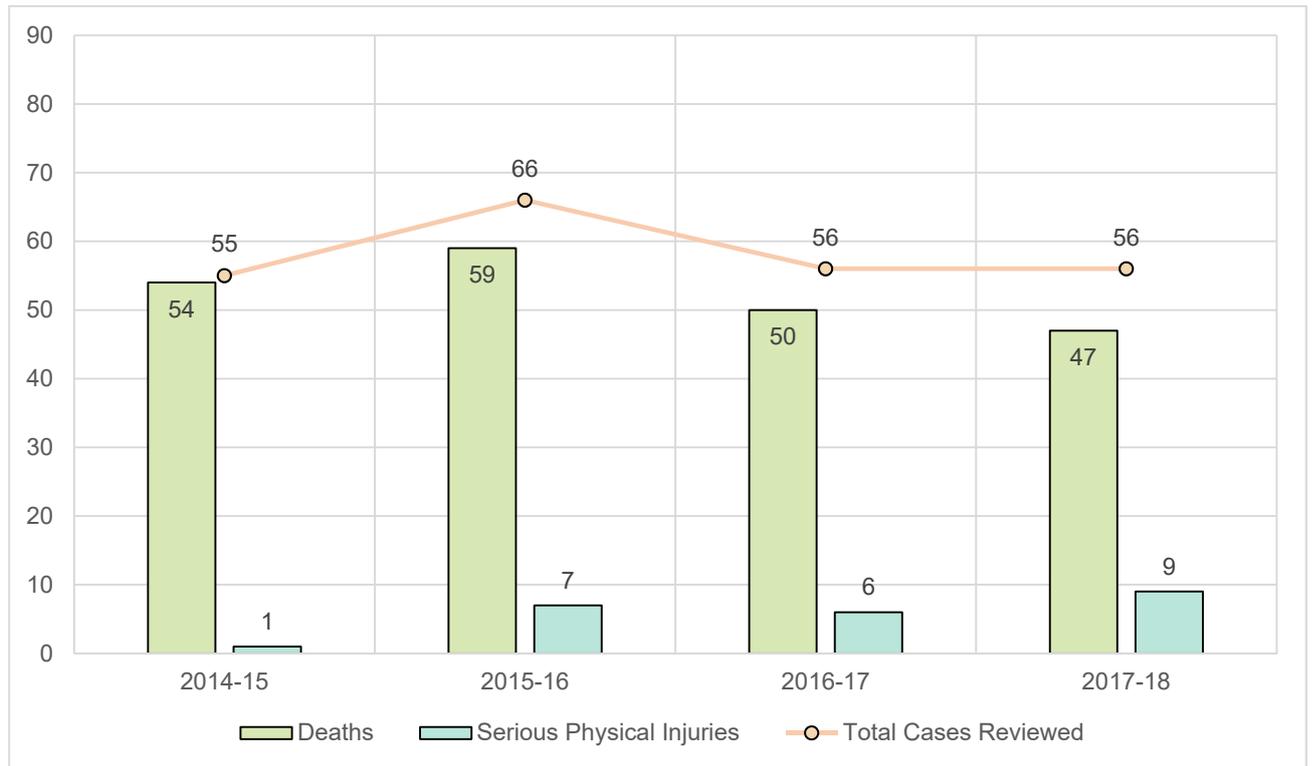
Information about all children whose deaths were registered in the 2017–18 year is found in the Queensland Family and Child Commission Annual Report, *Deaths of children and young people, Queensland, 2017–18*.

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<sup>7</sup> 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 2017 and 30 June 2018.



## Queensland Child Death Case Review Panels Annual Report 2017–18



**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 three of the nine cases (33 per cent). Two of these cases involved transport related injuries, while the third arose from misadventure. *Figure 3* shows the circumstances of serious physical injury in the cases reviewed in the 2017–18 reporting period.

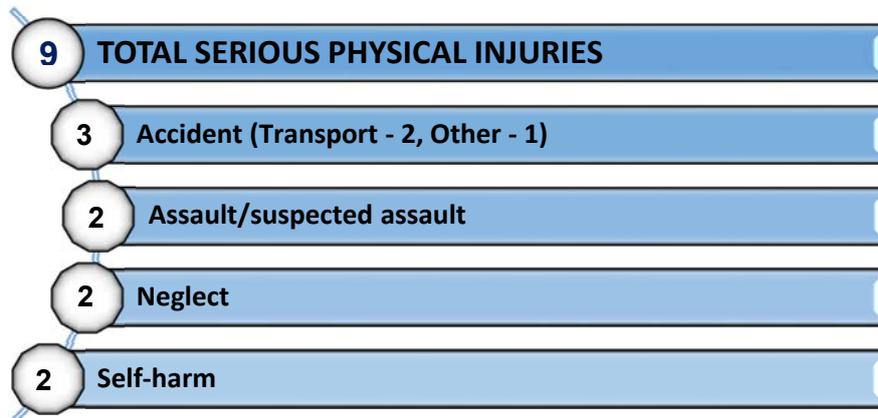
The remaining six serious physical injury cases consisted of equal circumstances of assault, neglect and self-harm (two cases each).

Four of the children/young people identified as Aboriginal.

The most common age category for cases reviewed were children aged 1-4 years or early adolescents aged 10-14 years, comprising of three each. The remaining age categories were equally represented by the cases (one each).



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**Figure 3. Circumstance of serious physical injury of children and young people in the 2017–18 reporting period**

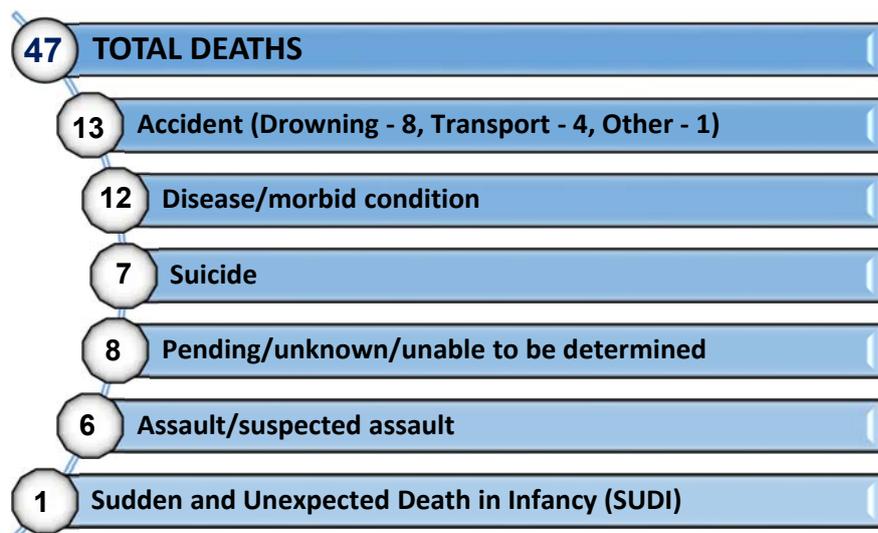
### Deaths

The most frequent circumstance of death was accident, accounting for 13 of the 47 cases (28 per cent). Eight of these cases involved drowning, while four related to transport and one was due to other circumstances. *Figure 4* shows the circumstances of death in the cases reviewed in the 2017–18 reporting period.

The second highest circumstance of death was disease/morbid conditions, accounting for 26 per cent of the cases. This category included children and young people who died due to disease or illness, disability or prematurity.

Suicide accounted for 15 per cent of the deaths (seven children), and all were adolescent aged. Two of the youths were in the 10-14 age category, while the remaining five were in the 15-17 age category.

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



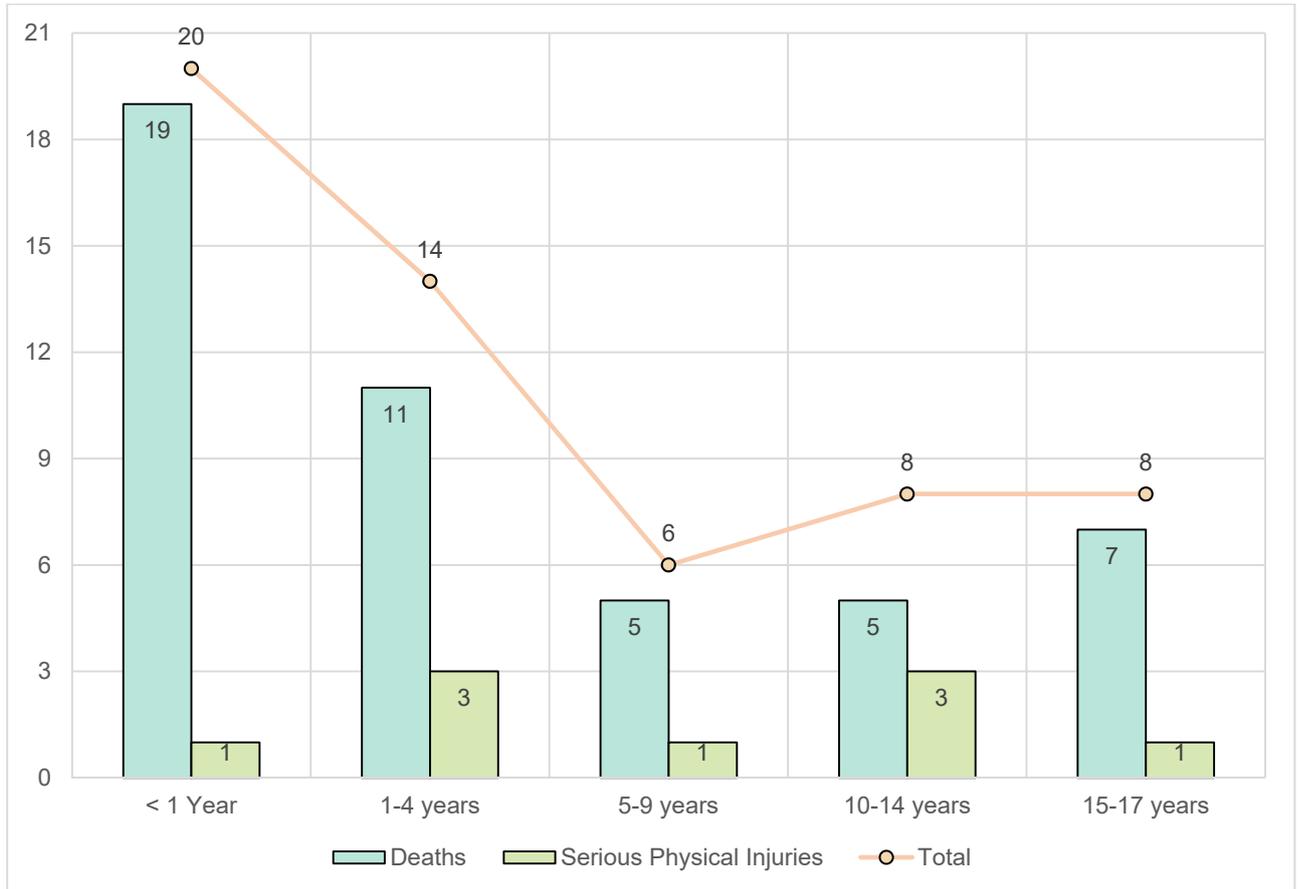
**Figure 4. Circumstance of death of children and young people in the 2017–18 reporting period**



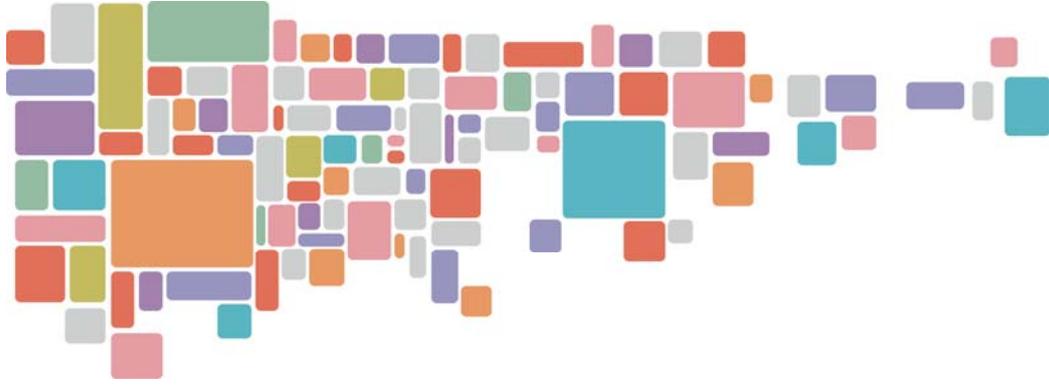
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Young children aged under one year were the highest represented, accounting for 19 of the cases (40 per cent). The second highest age category were young children aged 1-4 years, accounting for 11 cases (23 per cent).

Figure 5 shows the age categories of deaths and serious physical injuries in the cases reviewed in the 2017–18 reporting period.



**Figure 5. Age categories of deaths and serious physical injuries in the 2017–18 reporting period**



## Chapter 3

# Panel operations in 2017–18

### Panel composition

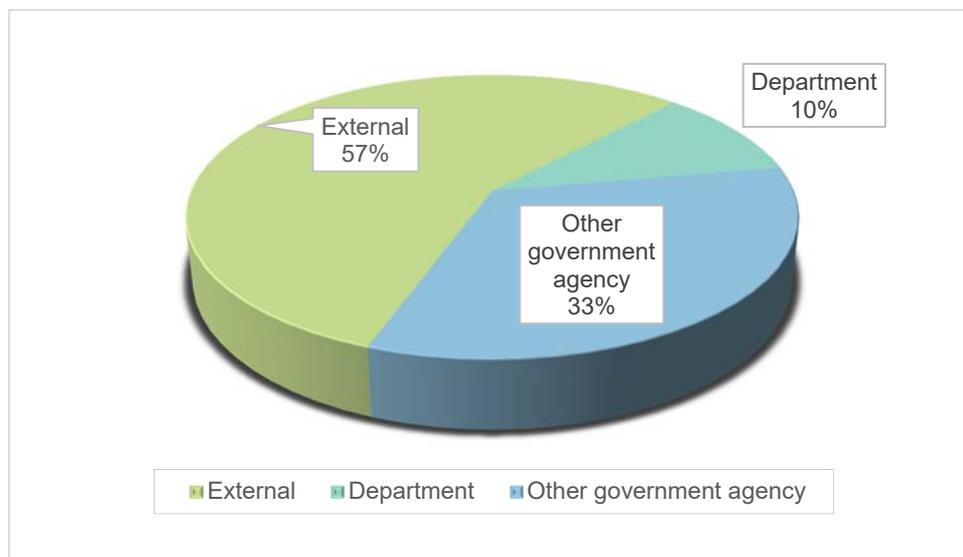
In July 2017, the department finalised a recruitment process that resulted in the appointment of four additional members to the Child Death Case Review Panels member pool by the Minister. In July 2017, 25 existing members of the pool were also extended for a further two years by the Minister.

In May 2018, the existing permanent Chair and Deputy Chair were retrospectively extended in these roles by the Minister for a further 12 months, until 31 January 2019. In May 2018, four existing external members of the pool were additionally appointed as Deputy Chairs by the Minister to increase the pool of available Chairs to facilitate panels.

In October 2017 and June 2018, two departmental representatives ceased employment with the department and consequently resigned their membership from the pool.

Machinery of Government changes during 2017-18, resulted in three departmental officers becoming representatives of other government agencies.

There are presently 39 members in the panel pool. Membership is comprised of 22 external members, four senior officers from the department, and 13 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.



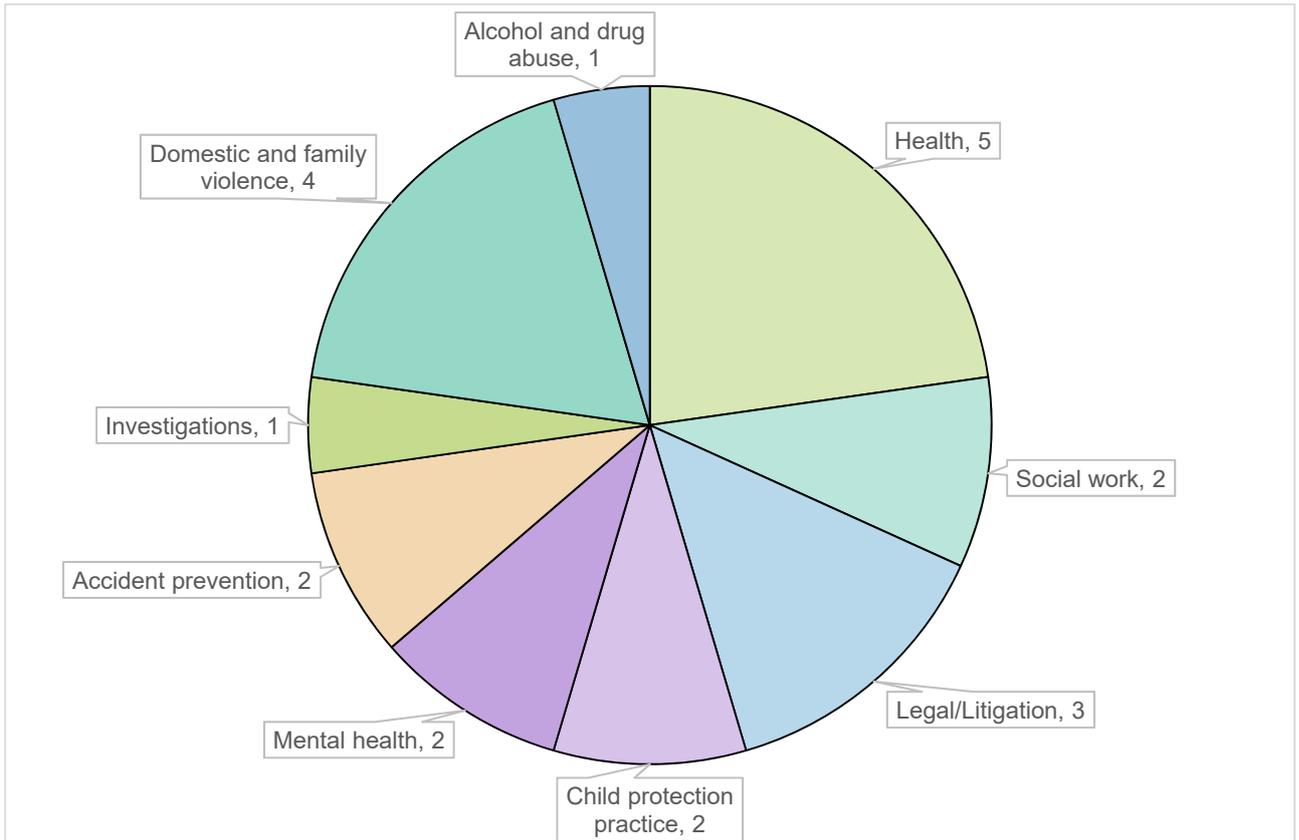
**Figure 6. Panel membership entity breakdown in 2017-18**



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Four members identify as Aboriginal, including one Deputy Chair. Currently, there are no Torres Strait Islander members. There are 30 female members in the pool and nine male members.

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 violence, legal and 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 2017-18**

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 Panel 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.



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## **Panel themes**

During 2017–18, 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
- who had suffered a serious physical injury
- whose cause of death was drowning
- whose death was caused by accidental incidents
- whose cause of death was non-accidental or unknown
- who were adolescents at the time of their death.

*Appendix A* provides more detailed information on membership of each panel convened in 2017-18.

## **Panel outcomes**

The 16 panels completed 56 reviews in the 2017–18 financial year. The panels considered cases involving 47 children and young people who died and nine 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 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 16 panels offered a number of findings, conclusions and recommendations to the department 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.



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## **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 nine key service delivery areas are highlighted:

### **Engagement with health providers**

The Panels identified opportunities for improvement in the department's engagement and information sharing with health providers involved with children and families, due to gaps in service delivery and miscommunication identified. The Panels encouraged the department to foster a culture where practitioners prioritise the development of wholesome and productive relationships with partner agencies involved with a family, with clear communication regarding expectations and the roles and responsibilities of each agency, to better inform ongoing service delivery, risk assessment and decision making.

### **Disability Services and the National Disability Insurance Scheme**

The Panels identified departmental staff struggled at times with service delivery to children and families with disabilities and experienced difficulty navigating the National Disability Insurance Scheme. The Panels encouraged the department to build staff capacity in understanding how different types of disability manifest and how the disability may impact a care provider's capacity to protect a child. The Panels promoted departmental staff utilising the expertise of Disability Services staff.

### **Accident and injury prevention**

The Panels encouraged the department to assess child safety holistically and develop an evidence based understanding of the links between neglect, sub-standard housing and inadequate supervision, and accidental death of or injury to children. The Panels identified that household safety needed to be addressed and identified the benefit of utilising injury prevention resources and services, such as those provided by Kidsafe Queensland and Queensland Fire and Rescue Service, during departmental engagement with parents and families.

### **Early childhood development**

The Panels encouraged the department to develop a better understanding of attachment theories for young children in early developmental stages, particularly when infants are removed from their biological parents at birth and placed with kinship carers or foster carers. The Panels noted that children form bonds and attachments with their primary care providers and extended family members and care must be taken to ensure that these bonds are retained during and following reunification.

### **High risk adolescents**

The Panels acknowledged that adolescent behaviours are becoming increasingly complex and departmental staff may not always be equipped to manage the complex areas of need of adolescents. The Panels encouraged a multi-agency response for these highly vulnerable clients, to ensure young people can access safe and supported accommodation, drug and alcohol rehabilitation, mental health care, safety and support networks, education and employment, particularly those adolescents transitioning from care.



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### **Palliative care and end-of-life decision making**

The Panel encouraged the department to build its capacity in relation to palliative care, end-of-life decision making and funeral arrangements for terminally ill children in the guardianship of the chief executive of the department, particularly for children who identify as Aboriginal and/or Torres Strait Islander where there are cultural protocols to be considered in these decisions. The Panel considered the department could benefit from resources and training offered by the Experience in the Palliative Approach program (PEPA).

#### **Case Study: Palliative care and end of life decision making**

Jessica\* died as an adolescent as a result of the life limiting condition she had suffered from as a child.

Jessica had multiple disabilities including cerebral palsy, spastic quadriplegia, vision and hearing impairments, scoliosis and epilepsy. Jessica had complex care needs and required a high level of care around the clock. She was wheelchair bound and non-verbal.

Jessica was subject to a child protection order granting long term guardianship to the chief executive at the time of her death. Jessica identified as Aboriginal.

Jessica was placed with a foster carer where she remained until her death in 2017, and had been considered palliative since 2012. An ongoing Acute Resuscitation Plan was put in place that supported breathing assistance but no invasive actions, including intubation.

In the last year of Jessica's life, departmental case work focused on her transition from care and planning was underway for Jessica to enter the National Disability Insurance Scheme.

During its review, the panel considered that from the outset of Jessica being identified as palliative the department needed to undertake end of life and funeral planning in collaboration with Jessica's extended family with consideration of their cultural and traditional practices relating to death, grief and loss. The panel considered Jessica's cultural connections, belonging to country and protocols around death needed to be front and centre in that planning.

The panel's recommendation was instrumental in the department's subsequent development of a palliative care training module discussed further in Chapter 4.

*\* name changed*

### **Growing cultural capability and improving Aboriginal and Torres Strait Islander service delivery**

The Panels encouraged the department to continue to develop staff understanding and awareness of the significance and importance of engaging with Aboriginal and Torres Strait Islander children and families in a culturally appropriate manner and to ensure that services are provided in a collaborative, meaningful and culturally appropriate manner.

### **Delays in commencement of Investigation and Assessments**

The Panels identified that delays in allocation and commencement of Investigation and Assessments within the assigned Response Priority Timeframe can impact service delivery to children and families, including information gathering, secondary support service referrals and



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minimisation of the original reported concerns and escalating risks. The Panels encouraged the department to continue improving the monitoring and triaging of unallocated Investigation and Assessments, and those not commenced within the allocated response priority timeframes, with a view to looking at escalation triggers, regional oversight and priority distribution of resources to manage workload backlogs.

### **Workload demands and staff fatigue**

The Panel identified a need for mobile units of experienced practitioners to be deployed to regions experiencing periods of unplanned staff absences, complex caseloads, workload management concerns, and other performance related issues. The Panel considered that such units could assist in the management of backlogs, provide backfill relief, and offer practice advice and casework support.

### **Future of Panels**

Under the Queensland Family and Child Commission 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 Queensland Family and Child Commission 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 Queensland Family and Child Commission 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.

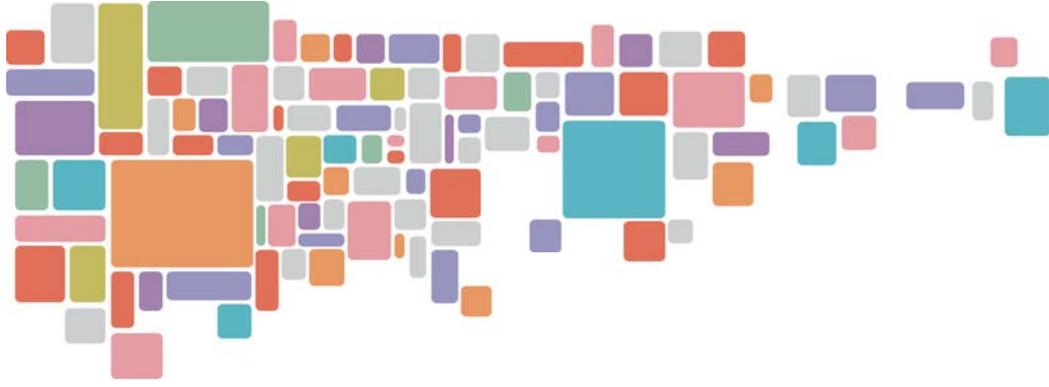
The review recommended in part:

*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.*

The Government is currently considering 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.



## Chapter 4

# Actions taken in 2017-18

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.

### Engagement with health providers

The department has placed 12 Child Safety Officers to work with and across Queensland hospitals and health services. Their function is to assist with issues of interagency communication and collaboration. The Child Safety Officers – Hospital Liaison play a key role in information sharing between the department and health providers. They are now successfully supporting staff and promoting the interface between Queensland Health and Child Safety with improved responses and service delivery to families.

In addition, increased staffing now improves the intersection of the health and the secondary family support system through the placement of Clinical Nurses in Family and Child Connect catchments to work with families involved in Intensive Family Support and Aboriginal and Torres Strait Islander Wellbeing Services.

There are a number of other initiatives occurring that will positively impact information sharing with health providers:

- My Health Records – In November 2018, the Federal Government's national My Health Records system will transition to an opt-out approach whereby General Practitioners, medical professionals and departmental staff will be able to access the health information of children on Child Protection Orders where the chief executive has custody and guardianship. This will provide online access to immunisation, prescription, hospital discharge and other medical event information for children and young people in, or transitioning from care, and their carers.
- The Health Assessment Model – a new Digitised Health Pathway has been developed to support health professionals to more effectively assess the physical and psychological health needs of children and young people in care. Implementation will be supported by seven communities of practice and a training program for General Practitioners to assist in improving their understanding of the particular health needs of children and young people with a care experience. The new model commenced implementation with the Labrador Child Safety Service Centre and is being progressively rolled out state-wide.



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The legislative amendments to the *Child Protection Act 1999* scheduled to commence in late 2018 require the Department of Child Safety, Youth and Women to develop, publish and embed an Information Sharing Guideline to provide guidance to government agencies and specialist services, on when information should be shared and on the secure use, storage, retention and disposal of information. The Information Sharing Guide will provide a consistent state-wide approach to appropriate information sharing practice for government agencies and non-government organisations.

The Queensland Family and Child Commission has reviewed how the Suspected Child Abuse and Neglect (SCAN) system should operate given the changes to the child protection system since its introduction in 1980. A key focus of the review was to consider whether the SCAN Team system remained a suitable model for multi-agency collaboration and response for Queensland in the contemporary child protection context.

The review commenced in 2017 with consultation with all key stakeholder agencies. Overall, the review found multi-agency collaboration and coordination remains an important and effective component of a system to address child protection, but that agencies must adapt to changes in how we share information and work together in response to government reforms and changes in policy and programs.

Consultation has begun internally with regions on key aspects of the proposed models. This will inform a revised SCAN model based on a multi-agency collaborative approach at a local level that is also focused on service delivery operations with children and families. Core member agencies will also be consulted on the principles and the proposed way forward for a revised SCAN Team model.

## National Disability Insurance Scheme

The department has led a range of National Disability Insurance Scheme (NDIS) readiness activities as the NDIS continues to roll out in each location across Queensland, these include:

- information sessions for child safety staff, families, carers, and providers
- support to Foster Care Queensland to support carers
- tools and resources for child safety staff
- information updates made available via <https://www.csyw.qld.gov.au/child-family/ndis-transition-implementation> and [www.qld.gov.au/disability](http://www.qld.gov.au/disability)
- SORTLI and kicbox apps for young people in care which provide information about accessing disability support and the NDIS
- communications materials and web content for carers and the wider sector.

Queensland's NDIS transition period has concluded in North Queensland, Darling Downs and West Moreton. NDIS transition is nearing completion in most of Central Queensland. For Child Safety districts of Far North Queensland, Brisbane, Logan/Beaudesert, Gold Coast/Bayside and the remainder of Central Queensland NDIS transition commenced on 1 July 2018.

As at 30 June 2018, 1,724 children and young people who were subject to ongoing child protection intervention had been referred to the NDIS, including 699 Aboriginal and Torres Strait Islander children and young people. Of these, 518 children and young people received approved NDIS plans, including 226 Aboriginal and Torres Strait Islander children and young people.

Like other mainstream service agencies, the department is working hard with the NDIA, and through the Queensland Government NDIS Transition Program Management Office within the



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Department of Communities, Disability Services and Seniors (DCDSS) to establish a smooth and well-functioning interface between the two agencies. Work in this area includes:

- development of information sharing processes
- emergency and crisis management processes
- Information and Communications Technology (ICT) solutions.

Child Safety is also working with the Department of Communities, Disability Services and Seniors on transition arrangements for children and young people currently living in voluntary out-of-home care due to their high and complex disability support needs. The government will continue to provide the accommodation support for these children following NDIS transition. The NDIS will be responsible for the disability supports for these children and young people following NDIS transition, through their NDIS plans.

In addition, a Specialist Services Team is being established in the department to provide integrated and coordinated services in collaboration with government and non-government partners. These specialist roles will address the complex and high risk behavioural, emotional, psychological, disability and mental health needs of children and young people at risk of entering or in the tertiary child protection and youth justice systems.

Priorities for the Specialist Service Team include:

- children and young people currently subject to Voluntary Out-of-Home Care (through Disability Services), or at risk of entering the tertiary child protection system due to their disability
- young people remanded in youth detention centres who may have an undiagnosed disability, or who require additional support due to their disability
- the most vulnerable children and young people in care with significant and complex needs, with a particular focus on Aboriginal and Torres Strait Islander children and young people.

The Specialist Services Team will also oversight the work of Transition and Post Care Support officers based in regions who will work directly with young people in care that are most at risk of homelessness as they transition to adulthood.

### **Palliative care and end-of-life decision making**

A new e-Learning course has been developed as a direct result of learnings from Child Death Case Review Panel deliberations and made available to provide child safety staff with a foundational understanding on the sensitive area of palliative care for children and young people. In this course staff explore the palliative care journey from defining what is palliative care and its impact on the individual child, young person, their families and carers, through to understanding practice implications and case management strategies. By the end of this course staff are able to:

- articulate a foundation understanding of palliative care for children
- recognise an Aboriginal and Torres Strait Islander perspective on palliative care for children with life-limiting conditions
- identify:
  - pain and symptom management
  - effective communication with children, their families and/or carers
  - how to manage end of life care and decision-making for children



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- strategies to acknowledge and address loss, grief and bereavement
- the potential legal and ethical issues associated with the end of life
- support strategies for children, their families, and carers through the palliative care journey and beyond.

The implementation of the Regional Aboriginal and Torres Strait Islander Practice Leaders and additional Cultural Practice Advisor roles in each region has encouraged stronger collaborative relationships with culturally-appropriate health services and assisted to build stronger communities. These roles have also had a significant impact on enhancing staff competency when engaging with Aboriginal and Torres Strait Islander families, and in providing support for making end-of-life decisions.

### **Accident and injury prevention**

The department has taken action to improve staff knowledge about child accidental death and child injury prevention in response to the recommendations and findings of the Panels.

#### **Risk Evaluation**

Significant research has identified certain features, or risk factors, that are found more often in families where harm has occurred than in the general population. These risk factors may indicate a heightened likelihood that a child may be harmed in the future, however, their presence needs to be considered against whether the factor can also be found in the general population and, if so, to what extent.

As predictors of harm, risk factors should be considered cautiously on their own. Critical analysis of all information gathered needs to occur, to determine each factor's significance for the ongoing safety of the child. While acknowledging it is not possible to predict future behaviour of a person with any certainty, risk factors can be viewed as markers which require further consideration and analysis, using professional knowledge and judgement. It is the interaction between factors that may combine to increase the probability of harm occurring.

The mandatory Family Risk Evaluation (FRE) tool outlines 13 risk indicators for neglect, and 12 risk indicators for abuse, and the Family Risk Re Evaluation tool outlines specifically 10 risk indicators to consider when reviewing a case.

In terms of clear visual depictions, these are provided to staff in the document: Risk factors relating to harm; the child; the parent; the family context; and the environment. As all types of harm have a detrimental effect on the child, these risk factors are generic, however may carry different weight within an assessment due to the interplay between factors – for example, being a young parent is not a risk factor in itself, but combined with substance misuse and housing instability, the risk of harm to the child increases.

#### **Training**

Child Safety Training material includes a number of modules which assist staff to consider aspects of child injury prevention. Learnings and feedback from panel reports are directly utilised in the development of and updating of training and practice resources and material.

Child Safety staff have access to a six-hour workshop on Cumulative Harm, a five module eLearning series on Domestic and Family Violence, an eLearning module on Crystal Methamphetamine, two eLearning modules on the topics of Parental Mental Health and Alcohol and Other Drug Use and Structured Decision Making training. Mandatory Child Safety face-to-face training includes a one and a half-day workshop on Risk Assessment and Decision Making. This training, along with other ongoing practice development resources,



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support staff in the use of their professional judgement and in determining the possible risk associated with supervisory neglect, for example, accidental injury.

There is now a staff training module on water safety (compulsory for Child Safety Officers, Child Safety Support Officers, Senior Team Leaders and all Placement Support Unit staff). The water safety training is an ongoing practice development course which is part of GRO<sup>8</sup> (the Department of Child Safety, Youth and Women's learning and development program, for child safety officers).

In 2017-18 Child Safety Training partnered with Kidsafe, who also consulted with Royal Life Saving Australia in the development of the water safety training. The learning objectives are for staff to be able to:

- explain the basics of water safety and why it is important
- identify different types of water injury
- identify risk factors for water injury for different age brackets
- identify the factors that influence the occurrence of water related injury
- identify water hazards
- locate different resources available to increase your personal understanding of water safety awareness.

The Queensland Family and Child Commission video and information from the *Seconds Count* campaign has been distributed to all staff for their ongoing awareness about the importance of spreading the water safety message.

In 2018 the department participated as a member of the Ministerial Water Safety Roundtable hosted by Minister Grace Grace, Minister for Education and Minister for Industrial Relations. Other key stakeholders included Surf Lifesaving Queensland, Royal Lifesaving, AUSTSWIM, Queensland Council of Parents and Citizens' Association and government representatives. Key outcomes of the Roundtable will include:

- improving the funding available for state schools
- release of the Queensland water safety action statement
- publishing a water safety and swimming education program for Prep to Year 10
- releasing a statement of expectations
- a pledge of commitment to water safety (to be signed by all key stakeholders)

## Early childhood development

The quality of the attachment relationship between the child and their caregiver is central to decision-making across the child protection continuum, from intake to assessment of safety and risk, through permanency planning, including reunification and long-term alternative care options. Transition planning incorporates consideration of relationships established in alternative care environments.

During intervention with parental agreement work and post reunification, the department aims to educate parents on the importance of attachment relationships for children. In addition to

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<sup>8</sup> G – Getting started in child protection practice, R – Readiness for child protection practice, O – ongoing practice development



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the development of the child's internal working model, those close to the child may be able to provide support to the parents through their informal safety and support network.

The department provides specific practice guidance in the 'child protection intervention with high-risk infants' practice resource regarding the life-long importance of the early-establishment of a healthy attachment with a consistent caregiver. Child Safety Officer training materials also include the Practice Guide on Assessing Harm and Risk of Harm; and the Child Development Trauma guide – 0 to 18 years.

The Safety Assessment and Immediate Safety Planning course materials, and the ongoing workshop GRO-O Working with High Risk Infants and Unborn Children, have been reviewed to contemporise content relating to trauma and attachment, with an intersectional perspective.

Additionally, as part of Child Safety Training's ongoing review of content, the existing suite of learning assets now contains a multitude of contemporary resources in which the complexities of attachment and development are considered. The relevant modules include:

- *GRO-O: Maintaining family connection through family contact incorporates content in relation to:*
  - defining family connection and its purpose in a child protection context through the lens of culture and trauma
  - basing meaningful family contact on legislation, strengths based practice and the principles of attachment and belonging
  - planning, supporting, reviewing and recording family connection in the context of reunification and out of home care
  - respectfully engaging with parents, children, foster and kinship carers and network members in facilitating family connection for children
  - describing the risk factors which lead to the development of postnatal depression.
- *GRO-O: Family Reunification includes information and learning opportunities relating to:*
  - strengthening the use of the Structured Decision Making® (SDM) reunification assessment
  - increasing collaborative family decision-making following on from collaborative family decision-making reforms
  - increasing awareness of the impact of trauma on reunification work
  - increasing understanding of the capacity to change, the importance of motivation and the change process.
- *GRO-O: Parenting and Attachment in Child Protection is a course is divided into four e-learning modules with an accompanying workbook in which staff apply their learnings to a case study. The core content of this course includes:*
  - parenting styles and behaviours
  - impact of culture on parenting behaviours
  - children's responses to parenting
  - rigorous and balanced assessments and parenting interventions.
- The learning program on Working With Young People (high risk adolescents), contains a foundational module *GRO-O: Working with Adolescents – development, attachment and trauma* which focuses on:



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- basics of adolescent development and attachment
- trauma and its impact on adolescent development and attachment
- agencies and other resources that offer further information on these themes.
- *GRO-O: Child Development in Child Protection is a suite of modules exploring:*
  - identifying the major theorists in child development
  - articulating the theoretical contributions
  - understanding of the developmental stages of childhood.

## High Risk Adolescents

Responding effectively to high risk adolescents is a complex issue faced by the Queensland community generally and is an area of focus for number of government departments. There are many initiatives occurring in partnership with the sector that seek to strengthen system responses to these young people.

### Practice leaders

As part of the 2017-18 Budget, funding was received for the recruitment of a Practice Leader (Mental Health) to strengthen departmental skills, resources and knowledge in the assessment and ongoing work with children and families with mental health issues. The Practice Leader (Mental Health) is based within Practice Connect and provides leadership and expertise with regard to mental health issues to strengthen practice and improved outcomes for children, young people, their families and communities impacted by mental illness.

The Practice Leader (Mental Health) provides state-wide consultation, mentoring, expert advice and training/education services about the impacts and interface of mental illness and complex child protection matters, to departmental staff and key partners working with children and families. The role operates as part of a state-wide network of practice leaders.

### Trials

In the Moreton Region the department is establishing an accommodation and recovery-oriented support service for children and young people, who are experiencing complex mental health issues often accompanied by substance misuse. This is occurring in collaboration with specialist mental health services provided by Queensland Health.

Children and young people referred to this service will present with a range of severe and complex mental health difficulties and will require specialised and skilled service responses. Many young people will also present with peer, family and social functioning problems and behaviours which can exacerbate mental health problems and disorders and contribute to substance misuse.

### Our Child

An investment of \$7.2 million has committed to upgrading Information Technology systems to allow for faster information sharing between Queensland Police Service, Department of Education and Child Safety for responding to children and young people in care who are missing. Our Child is a data system that was launched on 29 March 2018 and allows Police to access the department's Integrated Client Management System (ICMS) and One School information when a child is reported missing. This is the first time that police have direct access themselves to key information. The learnings from *Our Child* will inform opportunities to broaden the direct information sharing platform.



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#### Youth Justice

Following machinery-of-government changes the department has combined with youth justice and has moved to a structure that will enable service delivery with greater holistic and integrated approaches to the complex and interrelated needs of shared clients and communities. The structure will enable 'like' functions to be operate together to strengthen capacity and flexibility; and continue to give effect to broader departmental statutory and systems responsibilities.

Currently, approximately 83% of young offenders are known to Child Safety, and 15% of young people in youth detention are also on child protection orders.

In February 2018, the department established the Senior Child Safety Officer positions for the Cleveland and Brisbane Youth Detention Centres. These positions are responsible for ensuring the safety, belonging and wellbeing of all children and young people subject to Child Safety and Youth Justice Intervention, through the coordination of statutory child protection services, in conjunction with the Child Safety Service Centre that has case management responsibility, to young people entering, within and/or exiting the youth detention centres.

Priority focus of these positions includes:

- developing strategies for early engagement with young people in detention centres to identify multi-agency and culturally appropriate responses and supports required to access and utilise bail support services and other accommodation support options to reduce the time spent in custody.
- leading the coordination of access to relevant assessment of needs to inform the most appropriate interventions to keep children out of custody and transition to the community as quickly as possible.
- strengthening case management processes to develop more integrated and consolidated case plans with shared goals to support young people and their families to address identified child protection and offending concerns.
- facilitating service provision for young people in detention centres across the full range of required services and programs from whole of government and NGO providers ensuring access to services and supports in the context of Child Safety and Youth Justice frameworks.
- developing working relationships with partners from Government agencies such as Queensland Health and Department of Education, to ensure ongoing collaboration in addressing the needs of young people in detention centres and to plan for their transition back into the community.
- working alongside Child Safety Officers, Youth Justice Officers and detention centre staff and their management to gain understanding, knowledge and skills regarding the Youth Justice Service system and management of detention centres to be able to assist and provide the highest possible services to children and young people at their most vulnerable time in detention centres and to facilitate their transition and re-engagement with their community and families.

Additionally, a Youth Justice/Child Protection action plan has been developed. This outlines the actions and strategies being implemented by different areas within the department to improve outcomes for young people in detention centres and to strengthen service responses to young people in contact with both systems.

The Action Plan identifies collaborative responses to the needs of young people requiring dual interventions through a review of policy, programs, systems and processes currently existing



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within the two areas. The Action plan is monitored regularly and helps department officers in problem solving and addressing operational challenges to service delivery to enable positive transition of young people requiring dual intervention to access the support to transition from the detention centres into the community.

With the creation of the Department of Child Safety, Youth and Women the investment and commissioning for all of the department has been streamlined with opportunities for the alignment between the commissioning of services for young people. Current work includes review of individualised placement and support, and improving referral pathways for at risk young people between the child safety, youth (including youth justice) and violence prevention service systems.

#### **Safety and Support Networks**

The department has introduced Safety and Support Networks to support collaborative responses to high risk and complex children, young people and families. A core component of a strengths-based, safety-oriented practice approach is the development and strengthening of a child, young person or family's Safety and Support Network. A Safety and Support Network is made up of a range of people, and could include family members, professionals, carers, and community members. These network members will support parents, children and young people to develop and maintain safety through case and safety planning. At time of crisis or high complexity, children, young people and their families may require a more intensive response to ensure their safety.

High Intensity Response by the Safety and Support Network is a particular way of coordinating, planning and working with the purpose of providing a very intensive, seamless, wraparound safety and support plan to identified children, young people or families for a time-limited period. This includes the mapping of relevant information about a child or young person and ways to reduce risk.

#### **Training**

Child Safety Capability Development are developing an ongoing series of training in partnership with an external agency *Encompass family & community*, consultants in child protection and child and family welfare, in relation to Working with Adolescents. Currently, staff have access to these resources within this learning pathway: *Working with Adolescents – development, attachment and trauma*, *Working with Young People in Statutory Child Protection*, and *Understanding Suicide*. Following on from these modules, there has been further advanced training on working within a multi-agency and high intensity response context called "Managing the Challenges". This will link to specific content on working with high risk adolescents in Family Based Placement, Residential Placements and Family Relationships respectively, which will be piloted throughout late 2018, with a final version launched in early 2019.

#### **Growing cultural capability and improving Aboriginal and Torres Strait Islander services**

In 2017–18, the department has undertaken a range of actions to address the critical issue of over-representation of Aboriginal and Torres Strait Islander children in the child protection system with focus on responding differently and closing the gaps in life outcomes.

Key actions have focused on growing the cultural capability of staff and improving access to appropriate services.



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#### Our Way

The *Our Way – A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* (the strategy) is the Queensland Government's strategy to contribute to closing the gap in life outcomes for Aboriginal and Torres Strait Islander children and families, and eliminating the over-representation of Aboriginal and Torres Strait Islander children in the child protection system.

The strategy is a long-term generational commitment by the Queensland Government, Family Matters and Aboriginal and Torres Strait Islander organisations and communities to work together to ensure Aboriginal and Torres Strait Islander children and young people in Queensland grow up safe and cared for in family, community and culture.

The strategy commits to transformational change to be delivered over the next 20 years, recognising that meaningful and sustained change will take a generation to be realised. It will be delivered through a series of action plans aimed to empower families and communities to care safely for their children, solve problems and achieve their aspirations.

Over time, through successive action plans, the foundations will be built, changes implemented and actions consolidated to achieve positive outcomes for Aboriginal and Torres Strait Islander children and families. Each action plan will continue to build the evidence base to inform future directions.

As part of the strategy, the department has shifted and balanced investment to focus on prevention and early intervention services, recognising that the community-led and Aboriginal and Torres Strait Islander community controlled sector is best placed to design and deliver services for Aboriginal and Torres Strait Islander children, families and communities.

Through the strategy and action plan, the department is working closely with key agencies to ensure:

- all families enjoy access to the quality, culturally safe, universal and targeted services necessary for Aboriginal and Torres Strait Islander children to thrive
- Aboriginal and Torres Strait Islander peoples and organisations participate in and have control over decisions that affect their children
- law, policy and practice in child and family welfare are culturally safe and responsive
- government and community services are accountable to Aboriginal and Torres Strait Islander peoples.

#### Changing Tracks

*Changing Tracks* – the first three year action plan – contains 35 actions with 15 government and non-government partners. *Changing Tracks* five priority areas include:

- better meet 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
- increase access to and involvement in early years, health and disability programs for Aboriginal and Torres Strait Islander children aged two to five years
- provide Aboriginal and Torres Strait Islander families who have complex needs and children at risk with the right services
- enable 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



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- enable Aboriginal and Torres Strait Islander children and young people aged 15 to 21 years leaving care to learn and earn.

Ten actions within the *Changing Tracks* action plan have already been completed.

For Aboriginal and Torres Strait Islander children and young people, the proportion placed with kin, other Aboriginal and Torres Strait Islander carers or Aboriginal and Torres Strait Islander residential care services (proxy for the Indigenous Child Placement Principle) has increased from 54.4 per cent (as at 31 March 2015) to 56.3 per cent (as at 31 March 2018).

The department has established the foundation for much of this work and commenced significant investments in the secondary service system aimed at reducing the over-representation of Aboriginal and Torres Strait Islander children in the child protection system:

- \$34.34 million per annum has been allocated to community-controlled organisations to deliver 33 Family Wellbeing Services (FWS) across the state.
- FWS supports Aboriginal and Torres Strait Islander families to establish safe and nurturing environments for their children, including families who have come into contact with the child protection system. Since October 2017, FWS received referrals from 4,597 families, including 1,115 who referred themselves for assistance.
- 23 per cent of referrals to mainstream Intensive Family Support Services are for Aboriginal and Torres Strait Islander families.
- Changes to the *Child Protection Act 1999* are resulting in repurposing of investment in Recognised Entities, with a focus on supporting families so they can participate in child protection decisions that affect their children.
- The department has delivered the Pepi-Pod safe sleeping program, making available 600 Pepi-Pods across Queensland so Aboriginal and Torres Strait Islander women can improve safe sleeping practices.
- Funds of \$1.5 million are invested over three years for the First 1000 Days Australia collective impact initiative in Moreton Bay and Townsville. The First 1000 Days Australia initiative focuses on best start to life by improving the health and wellbeing of parents and children from the time a child is conceived to their second birthday.

### **Aboriginal and Torres Strait Islander Family Wellbeing Services**

The Family Wellbeing Services program provides access to quality universal and targeted services necessary for Aboriginal and Torres Strait Islander children and families to thrive and to ensure that Aboriginal and Torres Strait Islander peoples and organisations participate in, and have control over, decisions that affect their children.

The design occurred through a partnership with key stakeholders to capture voices of community, including:

- Queensland Aboriginal and Torres Strait Islander Child Protection Peak
- Indigenous service providers
- children and families.

The program makes it easier for Aboriginal and Torres Strait Islander families to access culturally responsive support to improve social, emotional, physical and spiritual wellbeing, and build capacity to safely care for and protect their children. The services are spread across 20 child and family catchments, with the relative funding levels determined based on demographic indicators about Aboriginal and Torres Strait Islander families, including:



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- levels of involvement with Child Safety
- domestic and family violence
- substance use
- Australian Early Development Census.

FWSs are located in Cherbourg, Caboolture, Mackay, Toowoomba, Roma, Ipswich, Lockyer Valley, Beaudesert, Gold Coast, Logan, Beenleigh, Browns Plains, Sunshine Coast, Townsville, Palm Island, Rockhampton, Bundaberg, Gladstone, Mount Isa/Gulf (including Doomadgee and Mornington Island), Cairns, Mareeba, Gympie, Brisbane (four services), Cooktown and surrounding communities, Kowanyama, Pormpuraaw, Lockhart River, the North West Cape, the Northern Peninsula Area and Torres Strait.

They provide easy access to help when it's needed, allowing the services to change their level of support as needs change. An evaluation framework will be developed to understand the impact FWSs are having on families. An independent evaluation will be conducted, commencing 2019/20 to assess whether the program is having the intended impacts on outcomes for Indigenous children.

#### **Case Study: Family Wellbeing Service**

Child Safety had contact with a family where both parents were using Ice and perpetrating domestic and family violence against each other, resulting in safety concerns for their two boys. The mother was sentenced to jail over a domestic violence incident involving a weapon. At the time she was pregnant and gave birth while in jail.

The two boys were placed with their paternal grandmother and their father continued contact with them while the mother was in jail. The Family Wellbeing Service supported the mother while she was in jail by providing emotional support and encouraged her to get clean of drugs, look after her new baby and plan for her return home.

The Family Wellbeing Service continued in-home support when the mother was released from jail and she was linked to a local parenting program. The Family Wellbeing Service supported the mother towards reunification with her two boys and attended all meetings the mother had with Child Safety and supported her through supervised visits and sleepovers.

After six months the boys returned home to live with their mother and the new baby. The Family Wellbeing Service continues to be involved, along with foster and kinship care staff.

Partnering with the Aboriginal and Torres Strait Islander community-controlled sector enabled community-led and culturally appropriate services, designed and delivered by Aboriginal and Torres Strait Islander services and peoples that will better respond to the needs of Aboriginal and Torres Strait Islander children and families.

#### **Legislative amendments**

Changes to the *Child Protection Act 1999* later in 2018 will introduce 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 embedding of the Aboriginal and Torres Strait Islander Child Placement Principle in the administration of the Act will place a stronger focus on ensuring anyone who



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undertakes a function under the Act does so in alignment with the five elements of the child placement principle — prevention, partnership, placement, participation and connection.

This broadens responsibility for supporting the self-determination of Aboriginal and Torres Strait Islander peoples beyond frontline Child Safety staff to all those who work within the department and the child protection sector. Embedding all five elements of the child placement principle will see a significant shift in how the department works with, partners with, supports and empowers Aboriginal and Torres Strait Islander children and families in Queensland.

#### **The safe care and connection of Aboriginal and Torres Strait Islander children with family, community and culture**

The amendments represent a significant shift in how the department supports the connection of Aboriginal and Torres Strait Islander children and young people with their family, community and culture, acknowledging that stronger connections result in better outcomes for Aboriginal and Torres Strait Islander children and young people. The changes also recognise the significant and long-term effect of decisions on a child or young person, their family and community; and acknowledges the role of family and community as the primary source of cultural knowledge.

Ensuring the safe care and connection of Aboriginal and Torres Strait Islander children and young people is also vital to achieving the intent of the Supporting Families Changing Futures Reforms, the Our Way Strategy and the Changing Tracks Action Plan.

Implementing the changes effectively requires active efforts from all levels of government, funded services and community to ensure collective application of the values of family and community connection, cultural integrity, strengths and solutions that support self-determination for Aboriginal and Torres Strait Islander families.

#### **Self-determination**

The amendments insert a new principle into the Act to recognise the right of Aboriginal and Torres Strait Islander people to self-determination. One way the amendments support the principle of self-determination will be through the introduction of a new power for the chief executive of the department to delegate some, or all, of their functions and powers in relation to an Aboriginal or Torres Strait Islander child or young person to an appropriate Aboriginal or Torres Strait Islander entity. This change contributes to the implementation of Action 4.2 of the Changing Tracks Action Plan. The department is working work with government and non-government partners to support implementation of this change.

#### **Child Placement Principle**

The changes embed all five elements of the Aboriginal and Torres Strait Islander Child Placement Principle – prevention, partnership, placement, participation and connection – as a set of principles for working with Aboriginal and Torres Strait Islander children and families.

Anyone who undertakes functions under the Act, whether that is the department, funded services, or the court system, will be required to apply the five elements of the Child Placement Principle.

#### **Cultural advice about Aboriginal and Torres Strait Islander children**

The amendments introduce the new concept of an independent Aboriginal or Torres Strait Islander entity, effectively replacing and broadening the existing role of ‘recognised entities’ under the Act. This will enable the family to choose the person or organisation best placed to facilitate their meaningful participation in decision-making. The introduction of the independent entity helps to respect and protect the rights of families to take an active part in



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decision-making. This change recognises that Aboriginal and Torres Strait Islander children, young people and families have the best knowledge of the strengths and needs that exist in their own families and communities, and are the primary source from which cultural advice should be sought to inform decisions that affect them.

#### **Cultural support planning**

The changes require a case plan for an Aboriginal or Torres Strait Islander child or young person to include details about how the child or young person will be supported to develop and maintain connections with their family, community and culture.

#### **Internal staff capacity**

In late 2017, Indigenous Child Safety Support Officers had their position name and description changed to strengthen their role in working with Aboriginal and Torres Strait Islander families. Now known as Cultural Practice Advisors, these staff, along with regional Aboriginal and Torres Strait Islander Practice Leaders are playing a more significant role in providing cultural practice advice, engaging with the community, and in cultural support planning.

### **Delays in commencement of Investigation and Assessments**

Over recent years the department has prioritised improving the commencement of investigation and assessment of Notifications. A range of strategies are being progressed to address this, which has seen significant improvement in response times.

As at March 2018 92.9 per cent of investigations that needed to be started within 24 hours were commenced in that timeframe, up 2.7 per cent compared to the same period for the year prior and the best result since reporting on this measure commenced in September 2009. This represented the seventh consecutive quarter of improvement in this measure. Response rates for five and 10 day Notifications have also improved. This work will continue.

In June 2017, the government announced an additional \$200 million would be invested over four years to improve child protection service delivery. This funding provided an extra 236 new child safety staff for the 2017-2018 financial year, increasing to 292 staff in 2018-19. In 2018-19 there are a further 56 FTE new regionally based frontline and frontline support positions to be filled. This is in addition to 127 new child safety staff who commenced in 2016-17. In total, there will be an increase of 458 new child safety staff over three years.

The allocation of these positions has increased the number of Child Safety Officers undertaking Investigation and Assessment (IA) work across all regions. The department is actively tracking the impact of this resource on the timeframes for allocation, commencement and completion of IAs.

The Assessment and Service Connect (ASC) initiative has been implemented across the state. ASC is an approach to undertaking the assessment of whether a child or young person is in need of protection, in partnership with ASC 'co-responder' non-government services.

The purpose of ASC is to ensure children, young people and families are provided with the right service at the right time, in the right place to meet the safety needs of children and young people.

It is envisaged that the implementation of the ASC across the State will assist in the commencement and response to five and 10 day child protection notifications.



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## Workload demands and staff fatigue

In addition to the information detailed above, the following has also occurred in response to issues identified regarding workload demand and staff fatigue.

### Staffing strategies

The department is developing and implementing additional strategies to address challenges in the recruitment and retention of Child Safety staff. These include:

- rebranding the public face of Child Safety roles
- improving applicant interface, candidate care and streamlining of the recruitment processes
- building closer relationships with feeder universities through career discussions and field placement programs
- promoting and supporting the implementation of flexible working arrangements
- proactively seeking feedback from former child safety staff to understand why they leave and help inform further retention strategies.

### Practice Response team

A Practice Response team has been established to provide an onsite service to service centres and regional units experiencing urgent and emergent issues in practice, systems, staff development and service delivery. This includes six experienced staff. The Practice Response team has a focus on working with regions to achieve sustainable change. The feedback from regions has been very positive.

The response themes have primarily been focused on developing new staff through coaching and modelling best practice with families, children and young people and facilitating reflective practice processes to promote learning for staff. Other themes include increasing leadership capability and supervision practices and strengthening business processes, including the implementation of predictive planning in a number of service centres.

This approach has been well received, with feedback indicating that staff feel energised by the investment of time and resources to walk alongside them in their work with families, as well as supporting them to develop strategies that they can sustain post the team's involvement.

#### Case Study: Practice Response team

The team provided an on-site response to a Child Safety Service Centre to assist staff to strengthen the interface between the court process and child protection practice. The team partnered with the Office of the Child and Family Official Solicitor to provide training for staff on court processes, facilitated learning circles to critically reflect on working with families according to the principles of the *Child Protection Act 1999* and assessment of families in the reunification phase of intervention, and coached staff to improve the timeliness of court work and the quality of evidence. The team also supported the CSSC to implement predictive planning across the workgroup.



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#### Quality Improvement Program

The Quality Improvement Program (QIP) has been established in 2017-18 to strengthen and enhance the department's capacity to provide quality child protection services for children and families. The QIP processes will focus on quality practice, effective business systems and processes, data quality and leadership development.

A Continuous Quality Improvement (CQI) process is a collaborative process with a Child Safety Service Centre to assess service delivery against standards and quality indicators. The process aims to identify strengths, areas of effective practice and opportunities for improvement. The CQI process is part of QIP.

The CQI process involves gathering and analysing information and data; obtaining feedback from departmental staff and stakeholders (including parents, young people, foster and kinships carers and agencies, other government and non-government partner agencies) on work processes, practices and outcomes ; and making suggestions for improvements that will result in better outcomes for children, young people, parents and families.

In 2017-18, CQI processes were undertaken with nine Child Safety Service Centres with a further 13 CQI processes planned to occur by the end of 2018.

As part of the establishment of the QIP team further analysis will be undertaken in conjunction with regions to identify and monitor current work loads of Service Centres. This will include reporting mechanisms that alert Regional Directors and Regional Executive Directors that individual workloads need to be monitored and supports implemented where necessary.

#### **Case Study: Quality Improvement Program**

A full Continuous Quality Improvement process in a Child Safety Service Centre identified inconsistent engagement with the Cultural Practice Advisor and some relationship breakdown with the Recognised Entity as barriers to departmental staff engaging effectively with Aboriginal and Torres Strait Islander children, young people and families.

Following feedback from this process, the Child Safety Service Centre Manager worked closely with the Cultural Practice Advisor, the Recognised Entity and Child Safety staff to clarify roles and responsibilities, remove any systems barriers and put in place processes to support greater collaboration and engagement with children, young people and families.

As a result, all engagement with Aboriginal and Torres Strait Islander children, young people and families for this Child Safety Service Centre now involves either the Cultural Practice Advisor and/or the Recognised Entity, whichever is appropriate, and staff are building their cultural capability.



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# Appendix A: Panel compositions

<b>Panel 37</b>	Theme: Adolescents External members: Dr Nicola Murdock (Chair) Ms Shanna Quinn Ms Raelene Ward Dr Deborah Walsh Other government agency: Professor Stephen Stathis Departmental officer: Ms Barbara Shaw Meeting date: 3 July 2017 Date reports delivered to Director-General and Director of Child Protection Litigation: 19 October 2017
<b>Panel 38</b>	Theme: Accidental (Drowning) External members: Dr Nicola Murdock (Chair) Ms Susan Teerds Associate Professor Kirsten Vallmuur Ms Raelene Ward Other government agency: Detective Senior Sergeant Christopher Hansel Departmental officer: Ms Megan Giles Meeting date: 1 August 2017 Date report delivered to Director-General: 13 October 2017
<b>Panel 39</b>	Theme: Suicide External members: Ms Shanna Quinn (Chair) Mr Clinton Schultz Dr Kairi Kolves Other government agency: Professor Stephen Stathis Departmental officer: Ms Bernadette Harvey Meeting date: 24 August 2017 Date report delivered to Director-General: 3 October 2017



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<b>Panel 40</b>	Theme: Accidental External members: Dr Nicola Murdock (Chair) Ms Shanna Quinn Ms Susan Teerds Associate Professor Kirsten Vallmuur Other government agency: Ms Julie Kinross Departmental officer: Mr Phillip Brooks Meeting date: 1 September 2017 Date report delivered to Director-General: 13 November 2017
<b>Panel 41</b>	Theme: Under 2 External members: Ms Raelene Ward (Chair) Professor Rosa Alati Ms Rebecca Shearman Professor Paul Colditz Other government agency: Ms Hayley Stevenson Departmental officers: Ms Tammy Myles Ms Susanne Le Boutillier Meeting date: 18 September 2017 Date report delivered to Director-General: 27 November 2017
<b>Panel 42</b>	Theme: Disease and morbid conditions External members: Mr Clinton Schultz (Meeting Chair) Dr Nicola Murdock (Report Chair) Dr Deborah Walsh Other government agency: Professor Stephen Stathis Departmental officer: Ms Donna Lockyer Meeting date: 29 September 2017 Date report delivered to Director-General: 8 December 2017



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<b>Panel 43</b>	Theme: Disease and morbid conditions External members: Ms Gwenn Murray (Chair) Ms Raelene Ward Professor Clare Tilbury Other government agency: Ms Hayley Stevenson Departmental officer: Professor Karen Nankervis Meeting date: 16 October 2017 Date report delivered to Director-General: 4 December 2017
<b>Panel 44</b>	Theme: Accidental External members: Dr Nicola Murdock (Chair) Ms Susan Teerds Mr Clinton Schultz Other government agency: Ms Julie Kinross Departmental officer: Ms Susanne Le Boutillier Meeting date: 27 October 2017 Date report delivered to Director-General: 21 December 2017
<b>Panel 45</b>	Theme: Under 2 External members: Ms Shanna Quinn (Chair) Professor Paul Colditz Ms Raelene Ward Other government agency: Detective Senior Sergeant Christopher Hansel Departmental officer: Ms Barbara Shaw Meeting date: 6 November 2017 Date report delivered to Director-General: 18 January 2018
<b>Panel 46</b>	Theme: Un-themed External members: Dr Nicola Murdock (Chair) Ms Annette Sheffield Ms Raelene Ward Other government agency: Detective Senior Sergeant Glenn Horan Departmental officer: Ms Bernadette Harvey Meeting date: 17 November 2017 Date report delivered to Director-General: 19 February 2018



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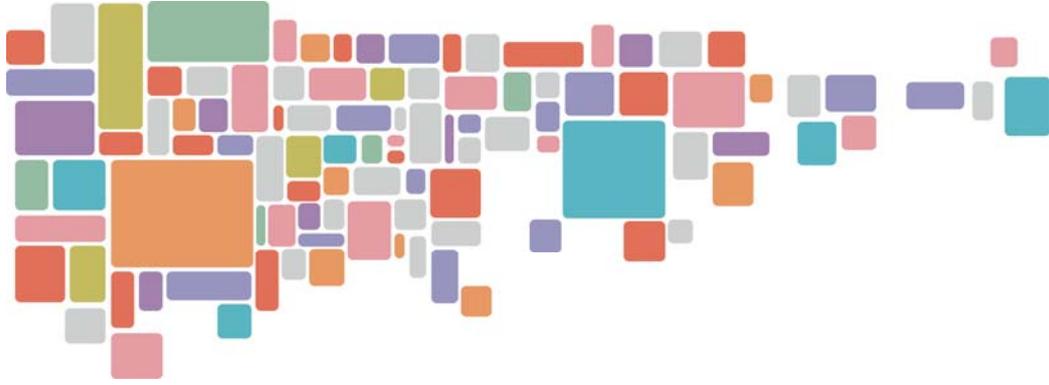
<b>Panel 47</b>	Theme: Un-themed External members: Ms Shanna Quinn (Chair) Professor Cindy Shannon Ms Annette Sheffield Other government agency: Ms Anne Edwards Departmental officer: Donna Lockyer (apologies) Meeting dates: 11 December 2017 and 3 January 2018 Date report delivered to Director-General: 27 February 2018
<b>Panel 48</b>	Theme: Disease and morbid condition External members: Ms Shanna Quinn (Chair) Dr Nicola Murdock Professor Rosa Alati Dr Deborah Walsh Ms Raelene Ward Other government agency: Ms Julie Kinross Departmental officer: Ms Megan Giles Meeting date: 28 November 2017 Date reports delivered to Director-General and Director of Child Protection Litigation: 27 February 2018
<b>Panel 54</b>	Theme: Serious injury External members: Dr Nicola Murdock (Chair) Ms Raelene Ward Dr Kairi Kolves Other government agency: Ms Hayley Stevenson Departmental officer: Ms Tammy Myles Meeting date: 30 January 2018 Date report delivered to Director-General: 27 February 2018



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<b>Panel 50</b>	Theme: 0-4 years External members: Ms Annette Sheffield (Chair) Ms Susan Teerds Professor Cindy Shannon Other government agency: Mr Graham Kraak Departmental officer: Ms Bernadette Harvey Meeting date: 18 January 2018 Date report delivered to Director-General: 29 March 2018
<b>Panel 52</b>	Theme: Under 1 External members: Dr Nicola Murdock (Chair) Mr Clinton Schultz Professor Paul Colditz Ms Laurel Downey Other government agency: Ms Anne Edwards Departmental officer: Ms Donna Lockyer Meeting date: 13 February 2018 Date report delivered to Director-General: 3 May 2018
<b>Panel 49</b>	Theme: Serious Injuries External members: Dr Nicola Murdock (Chair) Professor Rosa Alati Ms Raelene Ward Other government agency: Mr Peter Henderson Professor Stephen Stathis Departmental officer: Ms Susanne Le Boutillier Meeting date: 8 March 2018 Date report delivered to Director-General: 8 June 2018



## 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 Clare Tilbury – Deputy Chair**

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.

### **Ms Annette Sheffield – Deputy Chair**

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.

### **Ms Gwenn Murray – Deputy Chair**

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.



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#### **Mr Clinton Schultz (identifies as Aboriginal) – Deputy Chair**

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 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).

#### **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.



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#### **Dr Kairi Kõlves**

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 Kõlves identifies as from a culturally and linguistically diverse background.

#### **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**

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.

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

Professor Shannon is 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 Rebecca Shearman**

Is the Team Leader of the Brisbane Domestic Violence Service, and prior to that was the Operations Manager of the Domestic Violence Action Centre for over 10 years. She is a trained social worker and has a degree in psychology. Ms Shearman was a member of the department's Domestic and Family Violence Strategy Implementation Advisory Group from 2010-2012. Ms Shearman has been the Co-convenor of the state-wide Domestic Violence Court Assistance Network for the past 5 years, and currently sits on the Women's Legal Service Management Committee.

#### **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.



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#### **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.

#### **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.

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

Raelene has completed her PhD into 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 from a regional area.

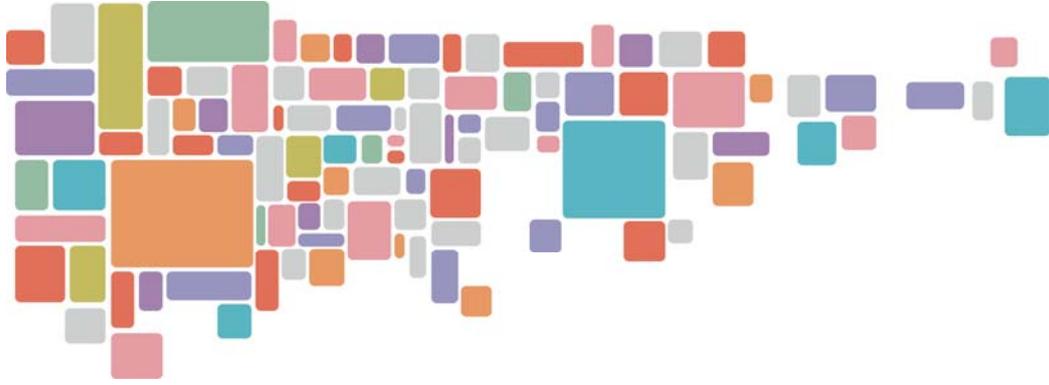


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#### **Professor Jeanine Young**

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.



# Appendix C: Public Service members

## Departmental members

The following public service officers within the Department of Child Safety, Youth and Women are appointed to the pool of approved members:

- Ms Barbara Shaw, Executive Director, Office for Women and Violence Prevention
- Ms Megan Giles, Executive Director, Policy and Legislation
- Ms Susanne Le Boutillier, Executive Director, Child, Family and Community Services Commissioning
- Ms Bernadette Harvey, Regional Executive Director, 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
  - Ms Tammy Myles, Executive Director, Community Recovery
- 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
  - Mr Peter Henderson, General Manager, Borallon Training and Correctional Centre.
- 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