Government Response to the Child Death Review Board 2020-21 Annual Report

Background

The Child Death Review Board (the Board) was established on 1 July 2020 under the *Family and Child Commission Act 2014* (Qld) (FCC Act), as a new independent model for reviewing the deaths of children connected to the child protection system.

Pursuant to section 29A of the FCC Act, the Board's purpose is to identify opportunities for continuous improvement in systems, legislation, and practices, as well as to identify preventative mechanisms to help children and prevent deaths that may be avoidable.

To achieve its purpose, the Board carries out systems reviews; analyses data; and applies research to identify patterns, trends and risk factors in relation to the child protection system following relevant child deaths. In addition, the Board makes recommendations about any legislative change and improvements to systems, policies and practices, which are annually reported on via an Annual Report submitted to the responsible Minister (the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence). The Annual Report is also a mechanism with which the Board carries out its function of monitoring and reporting on the implementation of its previous recommendations.

2020-21 Annual Report

The Board's Annual Report 2020-21 is the inaugural report and was provided to Government on 28 October 2021.

In this report, the Board reviewed 55 cases relating to the death of children and young people who were connected to the child protection system. In reviewing these deaths, the Board considered demographic information and categories of death in order to highlight several areas that require monitoring, including:

- overrepresentation of Aboriginal and Torres Strait Islander children in deaths
- changing circumstances in youth suicide – including females using more lethal means and younger children completing suicide
- multiple unexpected deaths in infancy (SUDI).

The Board has ultimately made **10 recommendations** (provided in the table below) in response to its findings across three focus areas:

1. engagement with targeted secondary services
2. accuracy and quality of child protection assessments
3. accessibility and availability of suicide prevention and postvention responses.

Government's response

The Queensland Government acknowledges the children and their families and other loved ones.

The Queensland Government commends the valuable work of the Board and its important role in keeping vulnerable children and young people in Queensland safe. The Queensland Government is also committed to improving systems, legislation, policies and practices, with the ultimate goal of preventing deaths that may be avoidable.

Government has now carefully considered the Board's first annual report and its recommendations, and is tabling this response alongside the Board's Report, within the tabling timeframes set out under the FCC Act. While not a statutory requirement to do so, for transparency and accountability, the Queensland Government considers it is important to publish a response to actions being taken to implement the Board's recommendations. A response to each of the Board's recommendations is provided in the table below.

Government's Response to the Child Death Review Board Annual Report 2020-21		
Recommendations	**Lead Agency**	**Response**
1. Engagement with targeted secondary services *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs strengthens its model of funded secondary services. This is to: **1.1** determine whether the model meets the needs of referred children and families by reviewing the: • efficacy of services in terms of improving outcomes for children and families and diverting them away from needing Child Safety intervention • equity of access for the families who are intended to benefit from these services. To do this, the perspectives of children, families and communities should be gathered and used to inform findings. For example, in implementing **recommendations 1 and 2** of the Queensland Audit Office's report, this can be done by speaking with communities and Aboriginal and Torres Strait Islander peoples to identify barriers and enablers to equitable access and active efforts (such as cultural safety and practical supports) to help families to participate. Findings from the agency's evaluations of these services and the Queensland Family and Child Commission's evaluations of the reform program could also inform this work. *The Board also recommends* the Department of Children, Youth Justice and Multicultural Affairs: **1.2** develops and implements best practice and culturally responsive strategies to improve outcomes for children and families	Department of Children, Youth Justice and Multicultural Affairs (DCYJMA)	**Recommendation 1.1 – Accepted** As the end of the 10-year Supporting Families, Changing Futures reform program approaches, DCYJMA will continue to look for opportunities to ensure that the model of funded secondary services is meeting the needs of children and families. Any review will be informed by service users including children, families and communities. Secondary services include services that provide local support for families. These services include: • Family and Child Connect, which can help families find the service they need; • Intensive Family Support services, which assist families to address multiple and/or complex needs and build their capacity to care for and protect their children; and • Aboriginal and Torres Strait Islander Family Wellbeing Services, which provide culturally responsive support for Aboriginal and Torres Strait Islander children and families. Any review of how these services operate will be informed by the experiences of children, families and communities who have been engaged with relevant services. Work already underway includes a move to a different way of measuring the success of Intensive Family Support. From 2022, these services will measure the extent to which families' needs are met, rather than just the number of families accessing the services. This approach will strengthen

1.3 supports and strengthens referral and reporting pathways for professional and mandatory notifiers by: • developing guidance for relevant agencies and services about responding to concerns for a child if a referred family is not successfully engaged by these services • requiring a referrer from a mandatory reporting agency to be advised by these services of case closure because of a family's non-engagement.		DCYJMA's ability to measure the impact of secondary services. Work to adopt a similar approach with Aboriginal and Torres Strait Islander Family Wellbeing Services is also underway. **Recommendation 1.2 – Accepted** Work to better meet the needs of Aboriginal and Torres Strait Islander children and families is guided by *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families* (*Our Way*) and its supporting action plans. A key activity under *Our Way* is to grow investment in Aboriginal and Torres Strait Islander services and the workforce in this sector to better reflect the proportion of Aboriginal and Torres Strait Islander peoples accessing these services and improve equity of access. *Our Way* is a partnership with Family Matters Queensland (Family Matters) and the Queensland Government, which sets out the plan to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children and families in the child protection system within a generation. Implementation of *Our Way* and its supporting actions plans is overseen by the Queensland First Children and Families Board (QFCFB). The partnership with Family Matters and the role of the QFCFB reflect the Queensland Government's commitment to the design and delivery of services for Aboriginal and Torres Strait Islander Queenslanders by Aboriginal and Torres Strait Islander peoples.

		Recommendation 1.3 – Accepted in principle DCYJMA will continue to identify opportunities to support and strengthen referral and reporting pathways for professional and mandatory notifiers as part of its current intake service delivery review. DCYJMA is currently reviewing how we respond to all information received by the department through a review of intake processes. This includes a focus on how we work with mandatory notifiers who raise concerns about children. This review is informing the development of a new technological solution, which will replace a number of existing information systems and transform the way DCYJMA works.
2. Reviewing child protection history at intake *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs improves its ability to undertake effective child protection history reviews at intake to support decisions about whether a child is suspected to be in need of protection. This must include strengthened intake processes to make sure staff are able to give proper consideration to: • complex or lengthy child protection histories (information about a family recorded on the data system) • indicators of cumulative harm (refer Recommendation 3), particularly when frequent child concern reports are recorded • patterns of parental behaviour (acts or omissions—refer Recommendations 3 and 4) • cultural factors. To support this, Child Safety's *Workload Management Manual* should include guidance on reasonable workloads for intake.	DCYJMA	**Accepted** DCYJMA is currently reviewing how we respond to information raising concerns about children, called an intake. The review of intake will identify operational improvements, including how decisions are made, the tools which support decision making and the availability of information about any other concerns that have been received by the department about a particular child or children. Different ways of reviewing historical information, or previous reports of harm, will be trialed in different locations across Queensland during 2022. DCYJMA is undertaking a review of all Child Safety Officer training and has delivered additional training to staff about assessing risk and identifying cumulative harm; that is, the impact of multiple episodes of abuse or neglect experienced by a child.

3. Identifying and assessing cumulative harm *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs develops additional guidance for assessing cumulative harm. This is intended to: • assist staff to decide whether a notification should be recorded on the basis of cumulative harm; • make sure screening and response priority decision-making tools adequately reference indicators of cumulative harm; and • be used in developing information technology platforms. This work should take into account the reviews by Child Safety and interstate jurisdictions on decision tools and cumulative harm. Any updates to decision tools must take into account intergenerational trauma for Aboriginal and Torres Strait Islander families as a result of past policies and the legacy of colonisation.	DCYJMA	**Accepted** Cumulative harm occurs where a child experiences multiple episodes of abuse or neglect. It is a pattern of circumstances or events, rather than one single harmful event. DCYJMA has delivered additional training to staff about assessing the risk and identifying cumulative harm. New approaches to reviewing multiple reports of concern and cumulative harm in the intake process will be trialed during 2022. A specific focus will be on the impacts for Aboriginal and Torres Strait Islander children during the trial period. This part of the trial will be led by a team of First Nations staff within DCYJMA.
4. Assessing a parent as able and willing *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs builds the capability of child safety officers on assessing whether a parent is 'able and willing', as it applies to making decisions about whether a parent can keep their child safe. This is to: • build understanding about cultural differences in parenting, family structures and child-rearing practices; • promote consistency in its application across decision points at intake, during investigation and assessment, and for interventions with parental agreement; • address how to identify and respond to patterns of concerning parental behaviour (acts or omissions— that is,	DCYJMA	**Accepted** The assessment of a parent as 'willing and able' is the primary assessment by child safety to determine the extent to which DCYJMA needs to intervene to protect a child. Child safety staff are provided with considerable guidance in the Child Safety Practice Manual about how to undertake this assessment. The Child Safety Practice Manual is reviewed in response to emerging practice trends and needs. Additional training is also provided to staff to assist them to respond to specific types of risk. For example, to support decision making about a parent's willingness and ability to

continuing to act in a way that harms a child, or not taking reasonable action to protect a child); • address ongoing practice issues with failing to apply perpetrator pattern-centred domestic and family violence practice51 (including by misidentifying victims of violence as failing to protect their child); • (separately to parents who actively avoid or disengage from services) strengthen assessments of, and responses to, parents who do not engage with services due to: – limited supply of, and timely access to, supports and services in regional and remote areas; – (for Aboriginal and/or Torres Strait Islander families) a lack of cultural safety within services or lack of active efforts taken by services to help families overcome barriers to their participation; and • recognise the importance of children's views about the safety of their home environment and their parents' willingness and ability to meet their needs. The findings of the Board and the Queensland Family and Child Commission's systemic review of intervention with parental agreements may be used to develop this training.		protect their child in the context of domestic and family violence, ongoing training is provided to child safety staff. This training focuses on the protective strengths of non-perpetrating parents while ensuring that violent parents are held accountable for their actions. The application of the Aboriginal and Torres Strait Islander Child Placement Principle assists child safety staff to consider cultural factors when determining whether a parent is 'willing and able'. This includes considering the parent and child's wider support network (connection), their place in community and how they are involved in decision making (participation), and how these can be leveraged to increase safety for children (prevention). Continued active efforts to better implement the Aboriginal and Torres Strait Islander Child Placement Principle are a major focus for DCYJMA in 2022. To encourage consistent practice across the state, DCYJMA has commenced a review of its Child Safety Officer training to ensure the program meets the needs of staff in delivering high quality service delivery responses to vulnerable children and their families.
5. Seeking advice from health professionals and recognising its importance *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs and Queensland Health address the ongoing barriers and enablers to seeking, weighting and engaging expert advice from health professionals (including Aboriginal and Torres Strait Islander community-controlled health services). This is to include:	DCYJMA and Queensland Health (QH)	**Accepted** DCYJMA is currently undertaking a review of Child Safety Officer training to ensure the program meets the needs of staff in delivering high quality service delivery responses to vulnerable children and their families. The department has recently internally reviewed the role of Child Safety Officer – Health Liaison. These positions work locally to create and maintain connections with local health

• mapping the structural and relational barriers and enablers. This will be informed by discussions with frontline workers and findings from the Board, Queensland Health and Child Safety internal agency review reports and other sources of external review; • developing actions to address the findings and act on opportunities to improve inter-agency coordination more broadly; and • increasing the capacity of the Child Safety Officer (Health Liaison) positions to: – facilitate access to expertise from health professionals about the health needs of children and the impact of parental mental illness on a child's safety; – work with Child Safety regional intake services to educate staff on health systems and to facilitate local relationships with hospital and health services and Aboriginal and Torres Strait Islander community-controlled health services; and – support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.		services. DCYJMA and QH will continue to work collaboratively to improve inter-agency coordination and responses to vulnerable children and their families through a specific project over the next 12 months. Initial planning has commenced within QH to scope the mapping exercise and to identify key stakeholders for consultation from across QH and within DCYJMA. An initial 12 months scoping exercise to map the current structural and relational barriers and enablers will be undertaken within existing resources. Any changes/outcomes to be commenced by the end of 2022, noting clinician engagement and changes processes are still liable to be impacted by the ongoing pandemic response.
6. Suicide prevention responses *The Board recommends*: the Queensland Mental Health Commission's Shifting minds Strategic Leadership Group (SLG), as the senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland, develops a targeted response to youth suicide. This group, with the support of the Queensland Suicide Prevention Network (once formed), should consider the findings of the research	Queensland Mental Health Commission (QMHC)	**Accepted** This recommendation aligns with the priority focus on child and youth mental health and wellbeing identified by the cross agency *Shifting minds* Strategic Leadership Group (SLG) and the Queensland Suicide Prevention Network currently under formation. As senior cross sectoral planning and oversight mechanisms, they each provide appropriate forums to support the development and oversight of an evidence based and integrated approach to youth suicide in Queensland.

commissioned by the Board into suicide prevention and effective child protection and mental health systems, specifically to: • establish a shared professional development program on the acute and long-term effects of adverse childhood experiences; • provide Queensland data that can be rapidly given to agencies; • map pathways to services to identify structural barriers to delivering an accessible, comprehensive and integrated continuum of care; • identify the need for new investment to expand services for infants and pre-school children with mental health presentations (and their carers); • promote service models designed by Aboriginal and Torres Strait Islander communities to effectively engage Aboriginal and Torres Strait Islander children and their families; • investigate multisystemic therapy (MST) for consumers who currently do not have their needs met by child and adolescent mental health services or Evolve Therapeutic services; and • undertake routine reviews of policies and procedures of agencies providing services to children to make sure they promote inter-sectoral collaboration and consistency in responses.		This includes the alignment with, and leveraging of relevant strategies and priorities across early years, education, child safety, youth justice, youth engagement, health, mental health, housing, and employment. A formal review of *Every life: Queensland Suicide Prevention Suicide Prevention Plan 2019-2029* will be undertaken in the first half of 2022 and inform the identification of *Every life* phase two priorities. The development of a targeted cross sectoral response to youth suicide will support the phased implementation of suicide prevention in Queensland.
7. Suicide prevention responses *The Board recommends:* the Department of Children, Youth Justice and Multicultural Affairs: **7.1** immediately examines why almost 60 per cent of young people under community supervision by Youth Justice considered	DCYJMA	**Accepted** An independent audit of all aspects of the approach to managing youth suicide risk has been conducted within the Youth Justice portfolio. The outcomes of the audit have been implemented or are being actively implemented.

eligible for a medium- to long-term suicide risk management plan have not had one developed. **7.2** reviews its suicide risk management policies and procedures to: • address barriers to developing and implementing medium- to long-term culturally responsive suicide risk management plans (examining the results from 7.1); • establish mechanisms similar to the Suicide Risk Assessment Team approach used in youth detention centres to assist Child Safety and Youth Justice community supervision staff to better identify and respond to suicide risk. This is intended to provide staff with expert, multidisciplinary support when responding to a young person at risk of suicide; and • ensure the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide, and that culturally responsive supports are provided to children who experience the suicide of a person known to them.		This includes procedural updates to strengthen suicide risk management which have been provided to all staff to address: • timeframes for risk management plan completion; • staff roles and responsibilities for completing medium to long term plans for young people in detention for whom a suicide risk is identified; • processes for review of established medium to long term plans when multiple suicide risk alerts occur in the same period of a detention; • consistency of practice in relation to assessment, response and recording of suicide risk and medium to long term risk management plans; and • identification of any history of suicide in a young person's peer, family or community group as an increased risk factor which recognises particular risks and emphasises provision of cultural supports for First Nations young people including through coordination with local health services. DCYJMA also has a strong focus on enhancing staff learning and development opportunities regarding suicide risk management including online and face-to-face training and forums.
8. Suicide prevention responses *The Board recommends:* the Queensland Mental Health Commission and the Queensland Family and Child Commission develop and deliver youth-friendly messages to raise awareness about mental health services for children and young people, and about their right and ability to consent to and access these.	QMHC and Queensland Family and Child Commission (QFCC)	**Accepted** QFCC will work with the QMHC to scope the work needed to ethically and meaningfully engage young people to participate in developing and delivering youth-friendly messages (to raise awareness about mental health services for children and young people, and their right and ability to consent and access

		these). The QFCC will use existing youth participation mechanisms to scope this work and inform the deliverables. Young people identify the importance of using appropriate and tailored communication channels and formats for effective engagement and reach. The co-design with young people is essential. Established and effective mechanisms exist for the engagement of children and young people in the design and delivery of strategies, such as the QFFC Youth Advisory Council and those through the Office of Youth. It is essential that any strategy to promote help seeking takes account of the availability of developmentally and culturally appropriate service responses commensurate to need. Current service demand pressures across public, private, and non-government mental health services are resulting in significant wait times for assessment and support. Increasing awareness and help seeking needs to be matched by provision of timely and appropriate service options.
9. Suicide postvention responses *The Board recommends:* the Department of Education undertakes an audit of a sample of schools to make sure: • suicide postvention plans are up to date and comply with departmental policy, part of which is having an Emergency Response Team that includes a representative from the local mental health service; • plans are tailored to meet the specific cultural needs of the individual school community; and • the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide and culturally responsive supports are provided to children who experience the suicide of a person known to them.	Department of Education (DoE)	**Accepted** DoE places the highest priority on supporting the mental health and wellbeing of all Queensland state school students and reducing suicide and its impact in school communities. DoE welcomes the recommendation to conduct an audit of suicide postvention plans in a sample of schools to ensure that Queensland state schools are taking an evidence-based, tailored approach to the management of and response to suicide risk and events. DoE anticipates the audit to be complete in August 2022. To conduct the audit, Regional Principal Advisors – Mental Health, located in each of DoE's seven regions, will each work with six schools in their region to review their suicide

		postvention plan. Plans (42 in total) will be reviewed against criteria that reflects the intent of Recommendation 9. A report outlining findings from the audit will be provided to the Chairperson of the Child Death Review Board. DoE has in place a range of strategies that contribute to a coordinated approach to reducing suicide and its impact in Queensland state schools. To assist all schools with secondary-aged students to have an up-to-date suicide postvention plan, schools can access support in the development and review of their plans from the Regional Principal Advisors – *Mental Health and Be You* (the National Education Initiative). Since 2016, DoE has also partnered with headspace to deliver *Suicide Prevention and Postvention Training* (STORM) to build the capability of all Guidance Officers working in secondary schools to identify and respond appropriately to student suicide risks and events in schools. As outlined in the Child Death Review Board Annual Report 2020-21, the QFCC alerts DoE when there is a suspected suicide of a child or young person in Queensland. This alert triggers an alert to the relevant regional office, provided the child or young person is a Queensland state school student. This process ensures that appropriate and timely support is provided to the school and young people who will be impacted by the suicide event. DoE will continue to strengthen its approach to suicide prevention and postvention in line with best practice through: • updating the Student Learning and Wellbeing Framework to incorporate learnings from the COVID-19 health pandemic and to reflect current research, DoE's

		mental health and wellbeing priorities, and ongoing feedback from stakeholders; and • updating the Supporting Students' Mental Health and Wellbeing procedure to highlight the importance of considering the context and unique needs of individual students when supporting their mental health and wellbeing and responding to suicide risk and events.
10. Suicide postvention responses *The Board recommends:* the Queensland Family and Child Commission extends its suicide notification process about children enrolled (or previously enrolled) in state schools to also include children enrolled in Catholic or independent schools. This will require consultation with, and the support of, the non-state schooling sector. For children not enrolled in either a state or non-state school, opportunities to notify the agency most closely linked with the family should also be explored as part of this work.	QFCC	**Accepted in principle** This recommendation is supported noting that implementation is reliant on the support of the non-state schooling school sector. QFCC will conduct consultation with the non-state schooling sector to extend its suicide notification process. QFCC will also explore opportunities to notify other agencies with close links to families not enrolled in state or non-state schools.