December 2024

Monitoring of the implementation of recommendations made by the Queensland Family and Child Commission and the Child Death Review Board

Queensland Family & Child Commission

Queensland Government

The Queensland Family and Child Commission acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths, and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

About the Queensland Family and Child Commission (QFCC) and this report.

The QFCC is a statutory body of the Queensland Government. Its purpose is to influence change that improves the safety and wellbeing of Queensland children and their families. Under the *Family and Child Commission Act 2014*, the QFCC has been charged by government to review and improve the systems that protect and safeguard Queensland children.

Interpreter

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding this report, you can contact Translating and Interpreting Service National on 13 14 50 to arrange for an interpreter to effectively explain it to you. Local call charges apply if calling within Australia; higher rates apply from mobile phones and payphones.

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Executive summary

Recommendations as catalysts for systemic reform

Recommendations play a pivotal role in addressing complex challenges and driving systemic reform. They provide a clear, evidence-based roadmap for achieving desired outcomes, ensuring that issues are not only acknowledged but addressed with targeted, practical solutions. Recommendations from independent statutory bodies or commissions of inquiry hold particular weight, as they emerge from rigorous processes of evidence gathering, analysis, and consultation.

At the Queensland Family and Child Commission (QFCC), our recommendations are grounded in direct observation, quantitative data, case studies, stakeholder feedback, lived experiences, and extensive research. This approach ensures they are actionable and informed by real-world insights rather than remaining purely theoretical. However, it is crucial to acknowledge that recommendations are advisory in nature. The responsibility for adopting, adapting, or rejecting them ultimately rests with the regulated entity—typically the government of the day.

The role of evidence-based and contextualised recommendations

For regulators, the challenge lies in delivering recommendations that are both evidence-based and attuned to the operational realities of the regulated body. Effective recommendations must be persuasive, well-articulated, and sensitive to the systemic complexities, resource constraints, and competing priorities of those tasked with their implementation. By recognising these contextual factors, regulators can increase the likelihood of adoption and ensure recommendations resonate with the intended audience.

Equally, regulated entities have a responsibility to give thoughtful consideration to recommendations, evaluating them within their strategic, operational, and financial landscapes. Transparent communication about whether and how recommendations will be implemented is essential, as is the rationale for decisions to adapt, delay, or decline certain suggestions. This process fosters accountability, collaboration, and continuous improvement, transforming recommendations into opportunities for genuine growth rather than mere checklist items.

Tracking progress: monitoring and accountability

Over the last decade, the QFCC and the Child Death Review Board (the Board) have made 209 recommendations, of which this report outlines those completed and those that remain outstanding. Monitoring the implementation of recommendations is critical to ensuring systemic reforms achieve their intended outcomes. Without sustained monitoring, the momentum for meaningful change may stall, and opportunities for improvement risk being lost.

Effective monitoring strengthens accountability and transparency, providing mechanisms to track progress and measure the impact of reforms. It also supports continuous improvement by identifying barriers to implementation early and facilitating timely interventions. Furthermore, robust monitoring reinforces the commitment of all stakeholders to a shared reform agenda, fostering a culture of trust and mutual responsibility.

By maintaining a focus on recommendation monitoring, we create a dynamic feedback loop that tracks implementation, evaluates outcomes, and ensures reforms are both meaningful and effective. This adaptive approach enhances the system's capacity to evolve and achieve better outcomes for children, families, and communities across Queensland.

Background

The QFCC is a statutory body of the Queensland Government charged with responsibilities to review and improve the systems designed to protect and safeguard Queensland's children. The QFCC is governed by the *Family and Child Commission Act (2014)* which requires the Commission to:

1. promote the safety, wellbeing and best interest of children and young people;
2. promote and advocate for the responsibility of families and communities to protect and care for children and young people; and,
3. improve the child protection system.

The role of the QFCC in improving the child protection system is to influence systemic change by assessing the performance of the system and providing expert advice to government to improve policies, practices, and outcomes for children and families in Queensland. In some circumstances, this expert advice is provided in the form of recommendations to address specific needs in the systemic response. This may relate to limitations of governing legislation, internal policies for implementation of procedures, or practice improvements to promote better outcomes for individuals. Recommendations may take the form of discrete actions with a clear deliverable, or may call for improvements in training approaches, in resourcing structures, or in crafting operational guidelines. Ultimately, recommendations are made to government to address a systemic risk or challenge which has been identified through the review work of the QFCC, with an expectation that government will assess the recommendation and take reasonable measures to address the issue.

The QFCC also hosts the Board—an independent body which conducts systemic reviews following the death of a child connected to the child protection system within the last 12 months prior to their death, under Part 3A of the *Family and Child Commission Act 2014*. The reviews conducted by the Board identify opportunities to improve the child protection system and to prevent future deaths. The Board produces an annual report which reflects the key themes and issues identified in the cases reviewed and makes recommendations on systemic improvements which aim to address the risks identified as contributing to the death of a child known to child protection.

At the point at which recommendations are delivered, government has the opportunity to review the actions and accept, accept in-principle, or reject the recommendation. Where government accepts the recommendations made by the QFCC or the Board, responsibility for implementing the recommended actions sits with the identified government department or agency. The QFCC remains responsible for monitoring the progress of this implementation through regular updates from respective departments and remains responsible for endorsing and approving closure of a recommendation when the intended systemic improvement has been achieved to the extent required.

Monitoring of recommendations – purpose

The QFCC is responsible for monitoring the progress of implementation of recommendations made to government by both the QFCC and the Board.

Since 2015, the QFCC and the Board have delivered several system review reports on the child protection and youth justice systems, providing a total of 209 recommendations to government.

Monitoring and assessing the implementation of these recommendations is an important function of the QFCC as an oversight body as it provides for meaningful input from responsible agencies about the progress of systemic change. Monitoring the implementation of recommendations promotes accountability and continual improvement to the child protection and youth justice systems.

Understanding our impact

In 2021-22, the QFCC arranged for an independent assessment to determine if its reviews and recommendations were contributing to a system improvement, and consequently if the QFCC was influencing positive change. Specifically, the review considered:

1. if recommendations had improved child and family support systems;
2. the relevance of incomplete recommendations; and
3. how future recommendations could have a greater effect on system change.

The QFCC commissioned this review to be transparent about the strengths and gaps in its performance, and to inform how future reviews could be conducted. The 2022 report identified 'examples where QFCC reviews had led to positive system change' and that 'the QFCC has played an important role in leading reforms across the system that supports children, young people and families in Queensland'. The report also made findings on how the QFCC could be more effective regarding the 'the process of engagement with agencies and recommendation design'.

Of the stakeholders surveyed in 2022:

- 72 per cent believed that QFCC recommendations were designed to address the root cause and underlying issues identified in the system reviews and are aligned to a clear outcome;
- 45 per cent did not agree that QFCC recommendations were designed in a way that adapts to changes and allows for flexibility, for example, in response to changing risk and policy landscapes;
- 63 per cent did not agree that recommendations set by the QFCC are achievable, that is, their organisation had the time, funding and/or resources to implement the recommendation; and,
- 90 per cent believed their organisation proactively and effectively monitors progress of recommendation implementation.

The review made ten suggestions for improving the influence of QFCC, all of which have been accepted. These were:

1. To the extent possible under its functions, the QFCC should be cognisant of potential resourcing implications when making recommendations.
2. When deciding whether to accept recommendations, the Queensland Government should consider a range of factors including the resourcing for implementing recommendations.
3. The QFCC should consider options for:
    - improving the codesign of recommendations;
    - ensuring the socialisation of recommendations and a considered approach to reviewing recommendations with agency stakeholders; and,
    - building in flexibility to allow agencies to adapt recommendations over time as the policy landscape shifts.

4. The QFCC should provide ongoing support for agencies to encourage implementation, accompanied by regular monitoring.
5. The QFCC should consider exploring options for agencies that identify superseded recommendations and progress them for closure.
6. The QFCC should consider options for partnering with agencies earlier in the review and recommendation development processes. This would enhance understanding of system-wide and operational factors to support clearer linkages between recommendations and intended outcomes.
7. The QFCC should consider exploring methodologies that are used by other independent statutory agencies in Queensland and in other jurisdictions to determine if these could be used or adapted to support the QFCC's system oversight and monitoring functions.
8. The QFCC should consider the development of a standardised monitoring and evaluation approach to support effective evaluation of outcomes. This would also assist with determining whether investment from agencies and the QFCC is translating to improvements for children, young people, and their families.
9. The QFCC should consider ways for the review process to be simpler, more streamlined and transparent about the key enablers for implementing recommendations (for example, resources for implementation, resources for monitoring and reporting, policies and/or changes to governance).
10. The QFCC should explore options to introduce a structured approach to designing recommendations, which describes the threshold questions to be addressed before a new recommendation is made. These threshold questions may consider the extent to which issues are widespread; or time or circumstance specific; and the extent to which there is a clear evidence base for the recommendation. Providing transparency to agencies about this kind of framework would support greater buy-in and accountability about new recommendations.

Making good recommendations

Since 2022 the QFCC has proudly improved the way in which it creates and makes recommendations. The new process of developing recommendations under our Oversight Framework has allowed for the integration of evidence, expert opinion, and stakeholder input, ensuring that proposed actions are both feasible and effective. Well-crafted recommendations signal a commitment to accountability, demonstrating that problems have been thoroughly analysed and that specific, measurable steps are being proposed to resolve them.

We have deliberately focused recommendations on broader systemic issues rather than procedural non-compliance. This has been essential for creating a more resilient and effective child protection system. It has reduced the total number of recommendations, and strategically focussed on reform. When recommendations address large-scale, structural problems—such as gaps in interagency collaboration, inadequacies in legislative frameworks, or systemic capability shortages—they can lead to transformative changes that improve outcomes for all children in the system. Such recommendations aim to identify and address root causes, thereby preventing recurrence of the same issues across different cases. By contrast, recommendations focused on procedural non-compliance tend to offer limited, case-specific solutions that often do not translate into long-term, systemic improvements.

Focusing on the big picture allows the QFCC to influence meaningful reforms that strengthen the entire child protection framework, rather than placing a temporary fix on isolated incidents. Another reason for emphasising system-wide recommendations is that procedural recommendations can lead to overwhelming or overly prescriptive regulation, which may stifle flexibility and responsiveness among frontline workers and organisations. When compliance requirements multiply, organisations can become bogged down in a checklist mentality, meeting procedural requirements but losing sight of broader, child-centred goals. System-focused recommendations encourage innovation, adaptability, and holistic improvements, allowing organisations to address complex and evolving challenges in child protection. By limiting recommendations to large-scale issues,

the QFCC seeks to avoid this unintended consequence, empowering the government and departments to act with both accountability and agility.

Furthermore, limiting recommendations to big system issues ensures that the QFCC's influence remains credible and focused. The QFCC's voice is strongest when it speaks selectively on systemic issues, positioning it as an authoritative body capable of shaping policies that matter. This approach ultimately enhances the QFCC's reputation and its ability to drive impactful, long-term changes.

Understanding the shelf-life of recommendations in a dynamic policy landscape

Recommendations in child protection must be agile because the policy landscape is constantly evolving, influenced by changing societal values, new research findings, and shifts in political priorities. The dynamic nature of child protection means that what is relevant and effective today may become outdated tomorrow. Recommendations have a "shelf life" because they are developed in response to current conditions and assumptions, which can quickly change. For example, new insights from research on trauma-informed care, advances in digital safety, or shifts in social attitudes toward family preservation versus child removal may render previous recommendations insufficient or even counterproductive. Therefore, the QFCC has a responsibility to periodically revisit and reassess its recommendations to ensure they remain aligned with contemporary best practices and policy directions.

Moreover, evolving interagency relationships and government priorities also affect how recommendations can be implemented. A recommendation that was actionable under one administration or policy framework may become unfeasible or less relevant under another. Similarly, resource availability, funding allocations, and legal frameworks can shift, affecting the capacity of agencies to act on previously issued recommendations.

Revisiting recommendations ensures that they remain practical and relevant in the face of these changes. It also provides an opportunity to refine, consolidate, or retire recommendations that no longer serve their intended purpose, reducing unnecessary burdens on agencies and focusing efforts on what will truly make a difference in today's context.

Finally, acknowledging the shelf-life of recommendations underscores the importance of a cyclical, reflective approach to policy reform. In a field as complex and sensitive as child protection, static recommendations may lead to rigid practices that fail to address the evolving needs of children and families.

By building a feedback loop where recommendations are periodically reviewed, updated, or replaced, the QFCC can ensure its impact remains timely and relevant. This cyclical process also supports a culture of continuous improvement within child protection agencies, encouraging them to adapt policies and practices in response to emerging challenges and insights. Thus, understanding the shelf-life of recommendations not only improves policy effectiveness but also promotes a culture of responsiveness, learning, and resilience across the child protection system.

Monitoring of recommendations – 2024 review process

In 2024, the QFCC undertook a review of the internal process for recommendations monitoring. The findings identified several opportunities for improvement: the development of a comprehensive status classification schedule to categorise recommendation implementation status; the development of a register to capture closed and active recommendations and log their progress status.

Table One: Status classification schedule

Status	Description
Closed - completed	The recommendation has been implemented completely as detailed. For example, the intent of the recommendation has been achieved through implementation of actions described in the recommendation.
Closed – not completed	The recommendation has been accepted but is unable to be completed. For example, the recommendation was accepted in-principle but unable to be implemented due to budget/ scope/ time/ resource.
Closed – achieved through other means	The intent of the recommendation has been achieved through actions other than described in the recommendation. For example: • the intent of the recommendation has been achieved through existing strategy reform • the intent of the recommendation has been achieved through implementation of a different recommendation that actions were undertaken other than what was described in the recommendation, which achieved the same intended reform.
Closed – no longer relevant	The matter which the recommendation sought to address has changed; or the reform landscape has changed; or the recommendation as it is worded no longer achieves the intention.
Open – in progress	Actions have commenced in response to the recommendation.
Not started	Implementation has not commenced.

In September 2024, the QFCC Principal Commissioner wrote to the Directors-General and Commissioners of responsible agencies seeking an update on the implementation status of outstanding recommendations.

Details about the new classification schedule and guidelines to support agencies to align their responses with the updated status schedule were included. The responses were received and included qualitative summaries of actions undertaken to progress the intended actions of the recommendations, and any further or subsequent actions required to fully implement and satisfy the intent of the recommendation.

Key findings

The current review of recommendations is compiled from system reviews released by the QFCC and the Board, from 2016 to 2024, detailing a total of 209 recommendations across 17 reviews.

Outstanding recommendations and future monitoring

Of the total 209 recommendations assessed across the December 2021 review and the September 2024 review, 37 recommendations remain outstanding. These recommendations relate to eight separate system reviews dating from 2017 to 2024 and are directed to various agencies of the Queensland Government.

The majority of the outstanding recommendations derive from the *Keeping Queensland children more than safe: Review of the blue card system* (Blue Card Review), released by the QFCC in 2017. This review, released more than six years ago, accounts for 16 (43.2%) of all outstanding recommendations. In October 2024, the Crisafulli Government committed to reviewing all remaining recommendations from the 2017 Blue Card Review as a priority focus for the Department of Justice. The QFCC reasonably expects therefore that these remaining recommendations will be reviewed prior to the next reporting period, and likely progressed to closure.

In general, a large proportion of outstanding recommendations considered in this review relate to publications released prior to 2021, and therefore should be assessed for relevance in the present reform context.

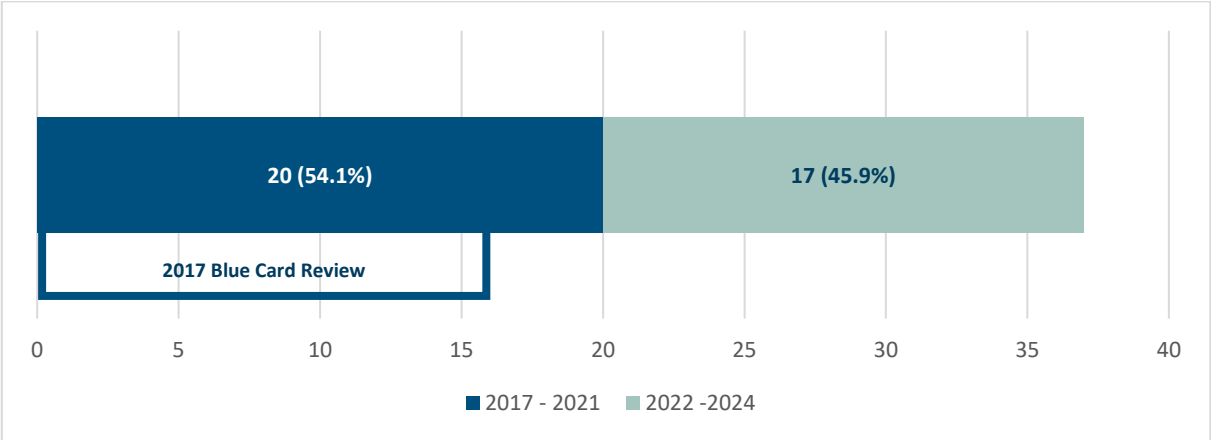

Figure Two: Proportionality of recommendations made by year range

Excluding the 2017 Blue Card Review, of the remaining 21 recommendations indicated as outstanding, four were delivered to government more than three years ago. Given the time elapsed since the direction of these recommendations and with an appreciation of the shifts in the policy and practice landscape in recent years, the QFCC will explore an appropriate mechanism for targeted review of recommendations released prior to 2021.

The QFCC will continue to actively monitor the 17 outstanding recommendations with government stakeholders. Active monitoring will provide opportunity for regular, timely updates from responsible agencies to better inform the QFCC and the Board of the progress, and in turn inform the QFCC and the Board when drafting new recommendations to avoid duplication and to build upon continuous reform and systemic improvements already underway.

Based on the information provided by responsible agencies, over 80 per cent of recommendations have been closed.

Table Two: Total number of recommendations and status update

Reported Status	Total (count)	Total (percentage)
Total closed	172	82.3%
Closed – complete	*160*	*76.6%*
Closed – not complete	*5*	*2.4%*
Closed – achieved through other means	*5*	*2.4%*
Closed – no longer relevant	*2*	*1.0%*
Open – in progress	31	14.8%
Not started	6	2.9%
Total recommendations	**209**	**100%**

Appreciating that the new classification schedule has been utilised only in the current review and status update, recommendations closed prior to the September 2024 review appear as *Closed – complete*.

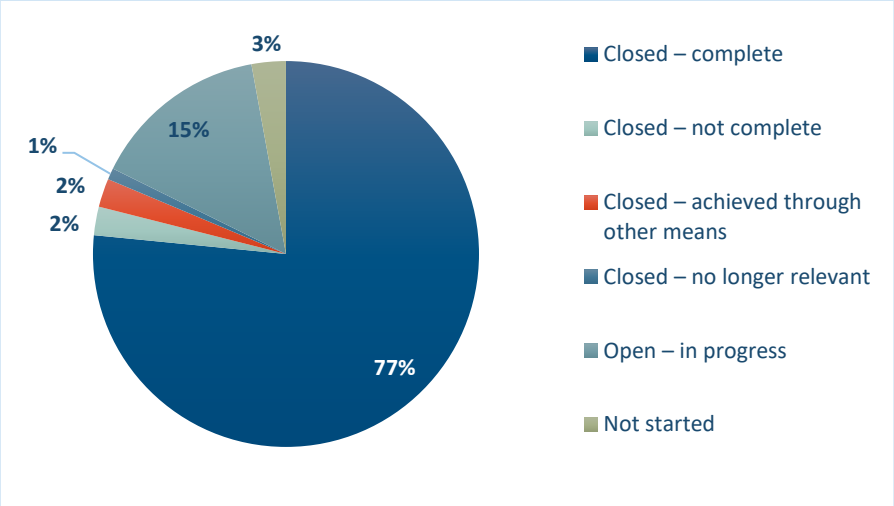

Figure One: Implementation status of recommendations per September 2024 update

Closed – not complete

Five recommendations have been recorded as *closed – not complete*.

Child Death Review Board Annual Report 2020–21	
10 **Queensland Family and Child Commission:** That the QFCC 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.	The recommendation as intended was not able to be completed without significant new resourcing allocated to independent schools to complete the actions, and therefore it was recommended to close noting consultation had been undertaken to better understand the notification processes between state, non-state, and independent schools.
Child Death Review Board Annual Report 2021–22	
6 **Queensland Government:** Engage with the Commonwealth Government to improve access for vulnerable children and families to the NDIS by: • demonstrating the cost benefit of establishing state-based positions across Queensland to help vulnerable children and parents with disability access the NDIS system and receive services – these positions need to be based in universal or secondary services with which children and parents engage • improving the mechanisms by which children and parents with complex needs can enter and access the NDIS – including consideration of an appropriate agreement that allows prescribed state professionals to refer children and parents to the NDIS on their behalf. • The CDRB expects the outcomes of the engagement to be reported back to it by August 2023.	The Queensland Government reported the commitment of funding towards disability supports and interaction with the National Disability Insurance Scheme (NDIS). The Queensland government confirmed its engagement with Commonwealth Government to improve the mechanisms by which children and parents with complex needs can enter and access the NDIS. This recommendation was closed as the intent of the recommendation had been largely realised through Independent Review of the NDIS, and through establishment of the Assessment and Referral Team.
Keeping Queensland's children more than safe: Review of the blue card system	
15 **Department of Justice and Attorney-General:** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the Working with Children (Risk Management and Screening) Act 2000 to: • have one consolidated list of regulated child-related services as recommended by the Royal Commission, which are: ○ Accommodation and residential services for children, including overnight excursions or stays ○ Activities or services provided by leaders, officers or personnel of religious organisations ○ Childcare or minding services ○ Child protection services	Child Safety advised further implementation of this recommendation was not considered necessary, as the construction of the relevant legislation provided separately for "regulated employment" and "regulated business" and enables different risk approaches to be applied under the Act.

○ Sports, clubs and associations and other community activities ○ Coaching or tuition services for children ○ Commercial photography, entertainment or party services, including gym or play facilities and talent or beauty competitions ○ Disability services ○ Education and care services (including early childhood education and schools) ○ Health services (including counselling) ○ Justice and detention services, including immigration detention facilities where children are regularly detained ○ Transport services for children, including school crossing services ○ Other services prescribed by regulation, where the service is targeted at children and requires contact with children • To provide that the following are not regulated services for the purposes of the Working with Children (Risk Management and Screening) Act 2000: ○ Services provided to the general public, including children ○ Friend or relative child minding arrangements ○ Workplaces employing children but not providing services to children. *NOTE: Workplaces will be regulated under the Child Employment Act 2006 and be required to meet child safe standards (see recommendation 14).*	
Keeping Queensland's children more than safe: Review of the foster care system	
5 **Office of the Public Guardian:** It is recommended that the Department of Communities, Child Safety and Disability Services (Child Safety) develops a 'community visitor' notifier category in its client management system to record any allegations of harm of children in care reported by the Office of the Public Guardian.	The recommendation had intended for the development of a 'community visitor' notifier category, and that the client management system for Child Safety had a notification type for 'Public Guardian', which is the agency responsible for the community visitor program.
11 **Child Safety:** It is recommended that Child Safety works with the Department of Justice and Attorney-General (DJAG) to become a party to the Intergovernmental Agreement Exchange of Criminal History Information for People Working with Children (ECHIPWC). Upon Child Safety meeting the participation requirements and becoming party to the Intergovernmental agreement for a national exchange of criminal history for people working with children, Blue Card Services (BCS) should immediately start sharing all criminal and disciplinary history information for carer applicants, along	Deemed to be unable to be completed pending Child Safety becoming a screening unit under the ECHIPWC. Further legislative reforms of the Working with Children (Risk Management and Screening) Act 2000 have since progressed to address the intent of this recommendation to improve intergovernmental information sharing for risk management purposes.

with the reasons for its decisions on working with children checks with Child Safety.	

Closed – no longer relevant

Two recommendations have been recorded as *Closed – no longer relevant.*

Keeping Queensland's children more than safe: Review of the foster care system	
1 **Child Safety:** It is recommended that the Minister for Child Safety proposes amendments to sections 245, 246A, and 246C of the Child Protection Act 1999, to include cases of substantiated physical and sexual abuse of children in care in its 'system of review' process, in cases where abuse is perpetrated by a carer or a member of the carer's household.	Child Safety considered recommendation one above to be no longer relevant as the intent of the recommendation was planned to be implemented in the next stage of reforms to the Child Protection Act 1999 through amendments to the compliance framework for the system of carer certification. Further analysis of the implementation impacts however, identified the need to further embed previous reforms, and that those transformative proposals related to reshaping the regulation of care be considered in a future stage of reforms. It was further advised by Child Safety that operational, non-legislative solutions would be explored to implement the intent of the recommendation without the need for legislative amendment.
12 **Child Safety:** It is recommended that the Attorney-General and Minister for Justice and Minister for Child Safety considers changes to the relevant legislation to allow Child Safety to nominate foster and kinship care services as alternative parties to verify the identification for blue card applications for all foster and kinship carer applicants (including adult household members).	Child Safety identified the recommendation was developed as an interim measure until an online application system for working with children checks was established, which has since been developed and implemented and therefore further implementation of this recommendation was not required.

Closed – achieved through other means

Five recommendations were recorded as *Closed – achieved through other means*. Four recommendations relate to the 2017 Blue Card Review:

Keeping Queensland's children more than safe: Review of the blue card system	
30 **Department of Justice and Attorney-General:** It is recommended that DJAG consults with the Australian Department of Immigration and Border Protection on opportunities for sharing information about international criminal histories.	The Department advised that, as part of ongoing interjurisdictional work, the Commonwealth has committed to explore opportunities for a direct criminal history exchange with New Zealand to support the rigorous checking of Working with Children Check applicants and holders and so met the intent of the recommendation through other actions

32 **Department of Justice and Attorney-General:** It is recommended that the Queensland Government reviews the criteria for giving investigative information to BCS to see whether they are sufficient to allow the Queensland Police Service (QPS) to share the information the BCS needs to assess risks of harm to children. **33** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the Working with Children (Risk Management and Screening) Act 2000 to: • allow the QPS to share information about a suspect with BCS to allow any risk to be managed while an investigation is finalised • develop criteria for giving information about suspects, including that the QPS has told a person that they are a suspect in a disqualifying offence • enable BCS to suspend a blue card to manage risks of harm to children while an investigation is finalised.	Consultation with the QPS and DJAG identified that there is no legislative amendment required to either the provision or the schedules of offences relating to harm to children and that existing risk management strategies can be employed by the QPS to limit risk to children during investigations.
57 **Department of Justice and Attorney-General:** It is recommended that, once the Royal Commission releases its final recommendations, the Queensland Government considers developing separate legislation to allow information sharing for the purpose of assessing and managing risks of harm to the safety, welfare or wellbeing of children.	Deemed to have been superseded by recommendations released in the Royal Commission into Institutional Responses to Child Sexual Abuse Final Report.
Keeping Queensland's children more than safe: Review of the foster care system	
30 **Child Safety**: It is recommended that Child Safety includes in the operational performance framework (being developed through the new quality improvement program) strategies to: • increase timeliness of and improve response to standard of care reviews and harm reports • monitor and report on responses to these reviews and investigations. Child Safety should continue working with entities in other jurisdictions and nationally to improve: • the quality and comparability of reporting of instances of and responses to harm to children in care • the public reporting of this.	It was reported by Child Safety that the intent of this recommendation was incorporated in other review processes and was included in the Child Safety Service Centre improvement plan.

Theming and grouping

The 2024 review of recommendations made by the QFCC and the Board aimed to not only understand the status of implementation, but also to achieve greater oversight of the types of recommendations made to government. Recommendations were grouped under six themes, based upon the wording of the recommendation and the intended systemic change the action aimed to effect:

- Legislative reform
- Policy and procedure
- Staff training
- Transparency/ monitoring and reporting
- Resourcing
- Program/ service design.

Almost half of the recommendations made by the QFCC and the Board relate to policy and procedural improvements (46.4%). This insight is to be expected, given the intent and scope of systemic review work conducted by the QFCC and the Board. The 2024 review indicated these recommendations have a reasonable closure rate, suggesting that government is responding to the policy advice from the QFCC and the Board.

Table Two: Distribution of recommendations by theme

	Closed			Outstanding			Total	
Theme	**No.**	**% of theme**	**% of total**	**No.**	**% of theme**	**% of total**	**No.**	**% of total**
Legislation reform	36	83.7%	17.2%	7	16.3%	3.3%	**43**	**20.6%**
Policy and procedure	84	86.6%	40.2%	13	13.4%	6.2%	**97**	**46.4%**
Program / service design	23	74.2%	11.0%	8	25.8%	3.8%	**31**	**14.8%**
Resourcing	6	85.7%	2.9%	1	14.3%	0.5%	**7**	**3.3%**
Training	5	83.3%	2.4%	1	16.7%	0.5%	**6**	**2.9%**
Transparency/ monitoring, and reporting	18	72.0%	8.6%	7	28.0%	3.3%	**25**	**12.0%**
Totals	**172**		**82.3%**	**37**		**17.7%**	**209**	**100.0%**

Recommendations grouped as ‘legislative reform’ account for 20.6 per cent of total recommendations. Many of these recommendations relate to older reviews; 16.3 per cent of these recommendations remain outstanding suggesting the logistical delays in progressing legislative reform is a barrier to complete such recommendations. There is opportunity for internal review of drafting processes to consider if the same systemic improvement could be achieved through policy or program/ service design, or whether the issue identified in the system response is as a result of limitations of the governing legislation. This insight is important for continual improvement in recommendations drafting by the QFCC and the Board, to ensure that recommendations made to government are achievable and will result in the intended outcome change for children, young people and families involved with the child protection and youth justice systems.

Conclusion

Comprehensive monitoring of the implementation of recommendations made to government is an important function in the oversight of the child protection and youth justice systems.

Timely and thorough review of the progress of recommendations is necessary for the QFCC to remain informed as to the systemic improvements recommended and acted upon in response to specific reviews, and to remain informed as to the areas of the system which require further attention.

The current status update reflects that many of the systemic improvements, recommended by the QFCC and the Board, have been addressed and implemented by government. The completion rate of recommendations highlights the limitations for government when systemic improvements require legislative reform, and the barriers which delay full implementation of such recommendations. These insights are important for the QFCC and the Board to consider when initiating approaches for developing recommendations for government and acknowledging the logistical delays which may impact an agency's ability to fulfil the intended actions.

The QFCC will focus on capacity building internally to better understand the interactions of recommendations made to government across the many review sources. This capacity building will also aim to improve understanding of the value of impactful recommendations in effecting the most meaningful reform and deliver systemic improvements for children, young people and families involved with the child protection and youth justice systems.

Appendix one

Register of outstanding recommendations

Queensland Government	Child Death Review Board Annual Report 2021 – 22
	1 Implement reform across the human services workforce to ensure it can meet the needs of children and families. This reform should: • examine and address the shortages in core skills areas that are projected to become more pronounced over the coming decade, particularly in regional and remote areas • recognise the overlap and competition that exists between departmental portfolios, and establish ways (such as exploring joint commissioning and pay parity) to help children, families and carers receive quality support, promote place-based approaches, particularly in the early intervention and secondary services areas, to address local workforce issues • include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers. **2 Implement reform across regional and remote communities of Queensland, particularly First Nations communities, to ensure there is a present human services workforce that can engage with the local community, particularly in culturally safe and engaging ways. This is to include:** • investigating how statutory roles can be redirected to local Community-Controlled Organisations to enable local employment and service delivery • empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community-Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces • investigating and repurposing unspent funding for long-term vacant positions to support place-based service design and delivery in regional and remote communities to address the departmental and portfolio silos that are impacting on the ability to delivery holistic family support and early intervention.

Queensland Government

Child Death Review Board Annual Report 2021 – 22 (cont'd)

3.1 Develop a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours that recognises that multiple government departments come into contact with these young people, and there is no single responsible owner for the assessment and response required to address the complex needs. The model should:

- be informed by a study of child death, serious injury or other relevant cases where the children were identified to have complex needs manifesting in high-risk behaviours to establish:
- commonalities with their trajectory into tertiary systems
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model.

3.2 Include an early intervention stream that provides a pathway for professionals working closely with children and families, such as schools, to trigger a case management response. The response should focus on:

- addressing the social, emotional, cultural and health and wellbeing needs of children and their families which contribute to their behaviours
- supporting the child's family and carers for the continuation of positive family functioning, behavioural guidance and treatment at home
- coordinating health-based assessments and treatments
- working with the child's school to ensure the child is engaged in education; and
- providing access to informal and formal respite for children and families.

3.2 Include a tertiary stream that provides a specialised accommodation service for children that meets the underlying causes of high-risk behaviours that are a danger to themselves or others that:

- is underpinned by a culturally appropriate case management response addressing the social, emotional, health and wellbeing issues of children and their families contributing to the behaviours
- is authorised by a clear and appropriate legal framework that clarifies if, when and how restrictive practices can be used, and how the system will be monitored with effective oversight to ensure decisions and actions are in the best interests of the young person; and
- integrates ongoing access for the child to family, culture and education.

Queensland Government	
	Child Death Review Board Annual Report 2022 – 23
	3.1 **Immediately fund and introduce improved reporting on youth detainees time out of cells (in alignment with the Report on Government Services reporting that already occurs for adults) and agree to champion this measure for inclusion in nationally consistent reporting with other jurisdictions.**
	3.2 **Commission the Board to utilise its review process to review a sample of cases of young people on the Serious Repeat Offender Index and advise Government on the common system issues and opportunities to prevent and reduce reoffending for young people in this cohort.**
	Exiting youth detention: Preventing crime by improving post-release support
	1 **That the Queensland Government fund and deliver a dedicated 12-month post-detention transition program that incorporates in-home family interventions and effective engagement education, training and employment.** Entry to this program should commence as part of case management of every young person as soon as they enter detention and should prioritise both their, and their family's direct participation. Program delivery must incorporate family and community participation that seeks to address criminogenic causes in the young person's life that commences prior to their release from custody.
	2 **That the post-detention transition program developed under Recommendation 1 should form part of a broader approach by the Queensland Government to target investment in a developmental approach to crime prevention.** Programs and services developed as part of such investment must address risk factors and promote protective factors associated with youth crime. At a minimum these should tackle the known factors associated with involvement in the youth justice system (family dysfunction, domestic and family violence, drug and alcohol use, education disengagement, mental health issues, housing instability and poverty), and should promote continuity of support and of relationships with key individuals whether the young person is in custody or in the community. This will require a coordinated and focused, whole-of-government approach that draws on, and integrates existing housing, employment, health, education, mental health, justice and federally commissioned programs.

Queensland Government

Looking beyond behaviours. Responding to the needs of vulnerable children with high-risk behaviours: A system review following the death of a child

1 We recommend that the QFCC leads the development of a system-wide solution to address the gaps in services and supports for children with high-risk behaviours. This solution will focus on:

- Intervening early when a child's high-risk behaviours first emerge, and sustaining intervention while they persist
- Promoting the safety of the child, and considering the causes and effects of the child's high-risk behaviours
- Deterring the child from crime by keeping them connected to school, culture, country and community
- Recognising and responding to the influence of the child's peer and family networks
- Self-determination of Aboriginal and Torres Strait Islander peoples in respect of the services and practices to assist families and communities to protect, care for, and educate their children.

The solution should include expanding:

- Health-based services and supports
- Pathways to respite to address a child's high-risk behaviours
- Disciplinary options in schools to educate a child on their behaviours and to connect them to positive influences
- Restorative justice processes to include the participation of the child's school to keep the child engaged in education (where appropriate)

To support the solution, QFCC will:

- Hold a multi-agency summit (Looking beyond behaviours) to determine a solution that keeps the needs of these children at the heart of system responses.
- Work with entities, particularly Aboriginal and Torres Strait Islander entities, to develop a coordinated plan to implement a culturally safe solution
- Provide the plan to Attorney-General and Minister for Justice within 12 months of this recommendation being accepted.

Queensland Government	
	Who's responsible? Understanding why young people are being held longer in Queensland watch houses
	1 That Youth Justice, the courts and the QPS collaborate to monitor the drivers identified in this report and reports back to the QFCC with a proposed action plan to reduce the length of time young people spend in watch houses.
	4 That the QPS and Department of Youth Justice improve the information they record about the circumstances of a young person's detainment, the full context behind bail and remand decisions, and the extent to which their needs and rights are being addressed while in custody.

Queensland Police Service	
	Who's responsible? Understanding why young people are being held longer in Queensland watch houses
	1 That the Queensland Government establishes a single point of accountability for producing regular (at least quarterly) public reports on the number and circumstances of young people held in watch houses (including age, Aboriginal and Torres Strait Islander status, location and time spent in watch houses).
	A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby
	4 We recommend the QPS revisits its responses to domestic and family violence perpetrators and victims, specifically: • Enquiring whether bail conditions create barriers for a parent in protecting the safety and welfare of their child • Promptly providing historical and current information to Child Safety about perpetrator patterns of behaviours and domestic and family violence to support assessments about a child's need for protection.

Department of Education	**Child Death Review Board Annual Report 2022 – 23**	
	1.1	**Initiate a regular process of data sharing with the Queensland Police Service and the Department of Child Safety, Seniors and Disability Services to identify home-schooling students who may benefit from in-school support services.**
	1.2	**Pursue legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.**

Queensland Health	**Queensland Paediatric Sepsis Mortality Study**	
	1	**Where sepsis (extreme immune response to infection) is known to have caused or contributed to death, this should be documented in the causes of death on the death certificate.**
	2	**Death certifiers should document the pathogen responsible for death on the medical cause of death certificate where known.** If a responsible pathogen cannot be identified via antemortem testing, the cause of death is arguably incompletely understood, and an autopsy should be recommended.
	3	**Media campaigns designed to increase caregiver and community awareness of sepsis and its symptoms should be developed, including culturally safe campaigns aimed at Aboriginal and Torres Strait Islander communities.**
	4	**Sepsis red flags should be embedded into the infection Health Pathways of all seven Primary Health Network regions in Queensland.**
	5	**Coronial investigations of unexpected infection-related child deaths should involve a paediatric healthcare professional, to gather and record a detailed clinical history, including underlying medical conditions, vaccination history, and touchpoints with health services in the lead up to death.** General practitioner and other health service records, including any laboratory test and culture results should be obtained and reviewed.

Department of Youth Justice	**Child Death Review Board Annual Report 2022 – 23**	
	2.1	**Take immediate action to articulate Queensland's Detention Operating Model, and Government commits to publishing this model.**
	2.2	**Produce a workforce strategy for Queensland youth detention centres for immediate effect, and for inclusion into the Detention Operating Model for Queensland's new detention centres.**
Department of Justice	**Who's responsible? Understanding why young people are being held longer in Queensland watch houses**	
	5	**That the Department of Justice and Attorney-General identifies strategies for courts to reduce the length of time young people are in unsentenced custody.**
	Keeping Queensland's Children More than Safe: Review of the Blue Card System	
	9	**It is recommended that the Department of Justice and Attorney-General:** • Develops an education and community awareness strategy for parents, carers and the community to: • Raise awareness about the role of the blue card system in keeping children safe • Help parents and carers choose child safe organisations for their children • Increase understanding about child safe standards and about the fact that the WWCC is only one component of a much broader strategy • Improves access to information about the blue card system that highlights the roles of parents, carers and the community in keeping children safe – including WWCC requirements.

Department of Justice

Keeping Queensland's Children More than Safe: Review of the Blue Card System (cont.)

13 **It is recommended that the Department of Justice and Attorney-General works with the Department of Transport and Main Roads to:**

- Define the types of child-related transport services that will be within scope of the system to ensure they are only those targeted at children
- Consider ways to reduce duplication of effort, processes and costs for those people affected

31 **It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to:**

- Require applicants to disclose if they have been convicted of a crime or any other offence, or charged with any offence in a country other than Australia
- Require applicants to disclose if they have lived or worked in New Zealand for six months or more
- Require BCS to obtain a New Zealand criminal history for applicants who disclose they have lived or worked in New Zealand for six months or more
- Enable BCS to require applicants to provide criminal history records from the relevant country and/or further information in relation to their criminal history
- Enable BCS to seek further information from applicants (including statutory declarations) where they have disclosed international criminal history or cannot provide information.

43 **It is recommended that the Department of Justice and Attorney-General:**

- Appoints a multi-disciplinary panel of advisors, including an Aboriginal person and a Torres Strait Islander person, with relevant expertise to advise on complex cases and more generally
- Establishes a complex case review committee to review proposed decisions and make recommendations. This should include appropriate representation to ensure the interests of Aboriginal and Torres Strait Islander peoples are heard and considered.

Department of Justice

Keeping Queensland's Children More than Safe: Review of the Blue Card System (cont.)

47 **It is recommended that the Department of Justice and Attorney-General implements an internal review process and generally requires applicants to use it before applying to the Queensland Civil and Administrative Tribunal. This process must be designed to:**

- Simplify the current appeal process
- Provide an opportunity to ensure that the best decision is made at the earlier available opportunity
- Promote early engagement by applicants before a formal appeal process
- Promote consistency of decision-making.

68 **It is recommended that the Department of Justice and Attorney-General reviews the risk assessment process to identify and implement ways to:**

- Automate the process for less complex risk assessments
- Manage all risk assessment files electronically.

77 **It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce a statutory review process. It should specify that:**

- The first review be completed within five years of commencement of the amendments arising from the recommendations in this report
- The review must consider the results of the evaluation in recommendation 81
- The report be released publicly.

In preparation for the statutory review, the Department of Justice and Attorney-General should consider appointing a panel of key external stakeholders to meet regularly and consider:

- How the blue card system is operating (based on analysis of available data, complaints, customer satisfaction measures and other information)
- What improvements are needed, including in relation to legislation, systems, policies and practices, on an ongoing basis.
- The panel should have appropriate representation on to ensure the interests of Aboriginal and Torres Strait Islander peoples are heard and considered.

81 **It is recommended that the Department of Justice and Attorney-General engages an independent entity to plan for and evaluate the success of these reforms of the blue card system.**

Department of Families, Seniors, Disability Services and Child Safety

Keeping Queensland's Children More than Safe: Review of the Blue Card System (cont.)

4 **It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to:**

- Remove reference to child and youth risk management strategies and instead introduce a requirement for organisations to meet child safe standards
- Remove the link between WWCC requirements and risk management strategy requirements so that child safe standards are the priority and the overarching mechanism for achieving safe service environments
- Reframe the current risk management strategy requirements to reflect the Royal Commission's 10 elements of child safe environments as simple standards
- Increase penalties for offences about child safe standards, to reflect each organisation's responsibility to keep children safe in service environments
- Require organisations to meet child safe standards before starting operation.

5 **It is recommended that the Queensland Government considers:**

- Whether there is merit in separating the administration of the functions related to child safe organisations and WWCCs
- The links between child safe standards and a reportable conduct scheme if the government introduces one in Queensland.

6 **It is recommended that the Queensland Government undertakes a review of the resourcing requirements necessary to support organisations in building capacity to be child safe.**

7 **It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to include a specific function - for the agency responsible for regulating child safe standards - to develop the capacity of people and organisations to create child safe environments.**

Department of Families, Seniors, Disability Services and Child Safety

Keeping Queensland's Children More than Safe: Review of the Blue Card System (cont.)

8 **It is recommended that the Department of Justice and Attorney-General develops:**

- An annual sector-wide education and training strategy to build the capacity of organisations to become child safe. In doing so, it should consider whether BCS should provide the training or if government will fund non-government organisations to provide it.
- An accreditation process for training providers, including a training program and resource materials, to ensure fee-for-service training organisations have knowledge and understanding of Queensland law and the requirements of child safe standards and WWCCs.
- A new suite of materials to support organisations in developing and implementing child safe standards. These should include sector-specific best practice guidelines on creating child safe standards – to build greater understanding in organisations and the broader community

10 **It is recommended that the Attorney-General and Minister for Training and Skills proposes amendments to the WWC Act to require organisations to publish or display information about how they are meeting their child safe standards obligations.**

11 **It is recommended that the Queensland Government considers further reforms to include any recommendations of the Royal Commission to strengthen child safe standards.**

14 **It is recommended that the Queensland Government reviews the Child Employment Act 2006 to ensure that organisations employing children are required to meet child safe standards.**

A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby

2.1 **The Department of the Premier and Cabinet designs and administers a scenario-based questionnaire for representative groups of frontline staff in the child and family support system to identify if assumptions and attitudes are having adverse effects on critical decisions for keeping children safe.** This questionnaire will focus on assumptions and attitudes towards domestic and family violence and family law court involvement. It will also seek information on how attitudes are influenced when the family is involved with more than one agency. The Queenslander's attitudes towards domestic and family violence survey may be used to support the questionnaire.

Department of Families, Seniors, Disability Services and Child Safety

A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby (cont.)

2.2 The Department of the Premier and Cabinet develops and implements an education tool to address the influence of assumptions and attitudes affecting decisions regarding a child's safety. It should include specific examples of commonly held assumptions that are not based on facts, and of occasions when assumptions have led to negative consequences for children.

2.3 The Department of the Premier and Cabinet evaluates, after 12 months of implementation of the training tool, whether the influence of assumptions and attitudes have been mitigated in decision making.

2.4 The Department of the Premier and Cabinet, once the evaluation is complete, uses the results to refine the education tool to support continuous improvement in decision making and to embed the tool within agencies.

5 We recommend the Department of Child Safety, Youth and Women develops and implements a standard of practice for staff that requires case escalation when multiple child concern reports are recorded for a family, including:

- Allocating the case to an experienced and skilled officer
- Allowing reasonable time to undertake a complete case review and assessment
- Establishing consultation points with senior officers and other professional
- Responding immediately to red flags for the child (Recommendation 1).

Appendix two

Register of all recommendations

Closed - complete		
Publication	**Status and recommendation**	**Reporting department**

Child Death Review Board Annual Report 2020 – 21	**Department of Child Safety, Seniors and Disability Services** 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. **1.2** Develop and implement best practice and culturally responsive strategies to improve outcomes for children and families. **1.3** Support and strengthen 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.

Child Death Review Board Annual Report 2020 – 21	**Department of Child Safety, Seniors and Disability Services** **2** 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.
Child Death Review Board Annual Report 2020 – 21	**Department of Child Safety, Seniors and Disability Services** **3.** The Department of Children, Youth Justice, and Multicultural Affairs develop 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 • 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. Department of Child Safety, Seniors and Disability Services

Child Death Review Board Annual Report 2020 – 21	**Department of Child Safety, Seniors and Disability Services** **4** The Department of Children, Youth Justice, and Multicultural Affairs build 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, 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 practice (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: o limited supply of, and timely access to, supports and services in regional and remote areas o (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 • 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 CDRB and the Queensland Family and Child Commission's systemic review of intervention with parental agreements may be used to develop this training.

Child Death Review Board Annual Report 2020 – 21	**Department of Child Safety, Seniors and Disability Services** **5** 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: • mapping the structural and relational barriers and enablers. This will be informed by discussions with frontline workers and findings from the CDRB, 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 • 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 services56 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 • support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.

Child Death Review Board Annual report 2020 – 21	**Queensland Health** **6** That the QMHC'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, develop 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 commissioned by the CDRB 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 • 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.

Child Death Review Board Annual report 2020 – 21	**Department of Youth Justice** **7.1** Immediately examine why almost 60 per cent of young people under community supervision by Youth Justice considered eligible for a medium-to long-term suicide risk management plan have not had a plan developed. **7.2** Review 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 • 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
Child Death Review Board Annual report 2020 – 21	**Queensland Health** **8** 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.
Child Death Review Board Annual report 2020 – 21	**Department of Education** **9** Undertake 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 • 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.

Child Death Review Board Annual Report 2021 – 22	**Queensland Government** **4** The CDRB recognises there is significant reform occurring in the area of domestic and family violence. The CDRB recommends that within this reform, the Queensland Government include a focus on: – children as specific victims of domestic and family violence in their own right – culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence – the role of fathers and fathering, as promising points for behaviour change intervention.
Child Death Review Board Annual Report 2021 – 22	**Queensland Government** **5.1** Extend health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to: – support and monitor the wellbeing and development of an infant within the family home; and – address families' health and psychosocial needs and wellbeing as they arise. **5.2** Implement or expand initiatives to crease safer sleep environments for all priority Queensland populations by: – supplementing home visiting with tiered support strategies using the family's existing resources – upscaling multimodal safe sleeping programs to provide an acceptable, feasible, safe, and culturally appropriate initiative for families – implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.
Child Death Review Board Annual report 2022 – 23	**Queensland Government** **4** That the Queensland Government strengthens its policies and commits to ensuring that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

Child Death Review Board Annual report 2022 – 23	**Queensland Government** **5** That the Queensland Government invests in a practice guide that will support frontline practitioners in their risk assessments of children whose parents' substance use is problematic. This practice guide should cover: 1. clear definitions of the thresholds for intervention types 2. a framework of identifiable markers of risks 3. the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety.
Child Death Review Board Annual report 2022 – 23	**Queensland Government** **6** That the Queensland Government Invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence (the frontline practitioners involved should include child protection, health services, education, law enforcement, courts staff and secondary services).
A thematic analysis of provisionally approved kinship carers who receive a subsequent Blue Card negative notice	**Queensland Government** **(1)** Remove the requirement for Aboriginal and Torres Strait Islander kinship carers, as defined in the Child Protection Act 1999, to hold a Blue Card if they are caring for children in their family.
A thematic analysis of provisionally approved kinship carers who receive a subsequent Blue	**Queensland Government** **(2)** Retain the existing Departmental assessment and approval process, in relation to Aboriginal and Torres Strait Islander kinship carers, removing the provisional status period in the absence of the blue card condition.

Card negative notice	
Who's responsible? Understanding why young people are being held longer in Queensland watch houses	**Queensland Government** **(2)** That Youth Justice immediately amend the reporting it provides to oversight bodies on the number of young people held in watch houses to also include the time they have spent in the watch house.
When a child is missing: Remembering Tiahleigh – A report into Queensland children missing from out-of-home care (2016) **(When a child is missing: Remembering Tiahleigh report)**	**Department of the Premier and Cabinet** The Director-General of the Department of Premier and Cabinet (DPC), in consultation with the Director-General of the Department of Communities, Child Safety and Disability Services (D-G, DCCSDS), leads a discussion through the Directors-General Leadership Board on agency cultural change needed to promote a while-of-government approach to vulnerable children living in out-of-home care. Discussion should occur within two months of publication of this report. Discussion will focus on the government services a child living in out-of-home care relies upon daily such as transport, housing and schools. Any actions from this discussion will be allocated to the Interdepartmental CEO Committee for Child Protection and Domestic and Family Violence reforms (IDCC).

When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** The Government establishes a Missing Children Pilot Governance Model - 'Our Child'. The proposed model will improve communication between agencies and develop specialist strategic operational responses to the management of occurrences for missing children in out-of-home care.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services develops an overarching media strategy.
When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** The QPS publishes a missing child media release (including an Amber Alert) immediately when required. • The QPS advises the D-G, DCCSDS (or delegate) of this decision at the earliest opportunity to allow Child Safety Services the opportunity to inform staff, carers and parents. • The QPS revise policies and procedures to remove any confusion with s189, Child Protection Act 1999.
When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** The QPS revises the interim protocol introduced following the death of Tiahleigh Palmer and incorporate into the QPS Operational Procedures Manual, /Chapter 12 - Missing Persons'.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** All agencies cease using the term 'abscond' as it relates to children missing from out-of-home care and adopt a single standard definition in all policies and procedures using the terms 'missing' and 'absent from placement'.

When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** The Government develops and implements a joint agency protocol for responding when a child is missing from out-of-home care
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services updates or creates relevant internal policies, procedures, guidelines and resources to align with the joint agency protocol and revised definitions of 'missing', 'vulnerable' and 'absent from placement'.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Officers develop a safety plan for children who are frequently absent from their placement.
When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** The QPS updates its Operational Procedures Manual, 'Chapter 12 - Missing Persons' to provide clearer guidance around processes involving children from out-of-home care and align with the joint agency protocol.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** The DET implements a state-wide, same day notification procedure in State, non-state and Independent schools (where feasible), advising parents/ carers when a child is absent from school.

When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** The QPS amend the School Based Policing Program, Memorandum of Understanding and staff induction booklet to clearly outline the role and responsibilities of School-based Police Officers during missing children investigations and supporting initiatives for children identified as a risk.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** The DET , Queensland Catholic Education Commission and Independent Schools Queensland review and achieve consistency for all policies and procedures for children living in out-of-home care, including processes for monitoring continuity of enrolment for children who move placements.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** The DET nominates a central after hours contact number the QPS can call to obtain necessary information about a missing child's school attendance record, their networks, or other relevant information to assist in the QPS investigation.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Justice and Attorney-General** The Office of the Public Guardian (OPG) makes certain children living in out-of-home care who have previously been reported as missing to the QPS or are frequently absent from their placement are visited by community visitors on a regular basis.

When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services amends the SCAN team system to reflect required responses to missing children from out-of-home care.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** Government agencies nominate a person to be contacted when local contacts are unavailable to expedite information and assist the QPS with its investigations when a child is reported missing. The nominated contact is required to have strategic oversight and decision making authority.
When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Health** Qhealth provides a greater focus on advocating for the sharing of information regarding children from out-of-home care, particularly those children who may present to a hospital during the time they are reported as missing or absent from their placement.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Education** Government establishes a process for collecting data on missing children from out-of-home care and reports information annually.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services regularly and proactively provides information to the QPS when a child is missing from out-of-home care as required by revised missing children's guidelines, forms and checklists

When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** The QPS updates the 'Form 1' to include whether a child in out-of-home care is reported missing.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services comply with the use of the Missing Persons Alert in the Integrated Client Management System (ICMS).
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Child Safety Services collects data via the System and Practice Reviews on any significant injuries or death of children during the period of time they are missing and reports information annually.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Justice and Attorney-General** QFCC updates the Child Death Register to enable recording of whether a child is reported as missing at the time of their death.
When a child is missing: Remembering Tiahleigh report (2016)	**Queensland Police Service** Training be provided immediately to key QPS staff on Amber Alerts and how these differ from the previous Child Abduction Alerts to ensure staff are aware of the criteria for issuing the alert. This training should be extended to other relevant agencies as required.

When a child is missing: Remembering Tiahleigh report (2016)	**Department of Child Safety, Seniors and Disability Services** Training is provided to all relevant Child Safety Services' staff, foster/ kinship carers, care service providers and relevant agencies to incorporate procedure and processes for responding to a child who is absent from placement or missing.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Justice and Attorney-General** The QFCC's action plan for the Strengthening the Sector Strategy includes appropriate training and guidance for residential care workers when children are absent from their placement or are reported as missing.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Justice and Attorney-General** (28) The QFCC to review legislation, policies and practices relating to information sharing between all parties, particularly the QPS, Child Safety Services and DET as responsible agencies for undertaking internal risk assessments and decision-making about the safety for all children in regulated service environments. The QFCC will provide advice to government on the supplementary review within three months of the publication of this report.
When a child is missing: Remembering Tiahleigh report (2016)	**Department of Justice and Attorney-General** The QFCC establishes a governance group to provide strategic oversight for monitoring the implementation of recommendations from the review.

Recommendation 28 Supplementary Review – A report on information sharing to enhance the safety of children in regulated home-based services (2016)	**Department of Justice and Attorney-General** **28.1.** Blue Card Services immediately begins work to establish a centralised system (i.e. a register) for recording and reporting on all child-related employment or businesses conducted from the home. This may be achieved through modifying existing blue card information systems. **28.3** The QPS and BCS work together to identify changes required to the Working with Children (Risk Management and Screening) Act 2000 to facilitate the proactive release of any information about international criminal history that comes to the attention of the QPS to BCS. All criminal history held by the QPS about a blue card holder or applicant should be provided to Blue Card Services as standard procedure to inform its assessment of the individual's ongoing eligibility. Work should begin immediately on changes to policies and procedures necessary to support this recommendation. The Blue Card and Foster Care Systems Review is considering any legislative change required to enable sourcing and use of international criminal history (beyond what may come to the attention of the QPS) for blue card screening as a matter of course. **28.4.** The DET and Child Safety Services work with Blue Card Services to develop a consistent definition of 'regular visitor' for regulated home-based services to be included within the Working with Children (Risk Management and Screening) Act 2000. This should consider legislative amendments to require that changes to the blue card status of 'regular visitors' should be disclosed to the 'notifiable person'. **28.5.** Blue Card Services and the DET amend the Working with Children (Risk Management and Screening) Act 2000 to require all adult household members of stand-alone care services to hold a blue card. **28.6.** The DET works with Blue Card Services and other relevant agencies to identify the most appropriate model to make sure family day car educators and standalone carers are subject to the same level of suitability screening as foster and kinship carers. This will include a review of child protection history, as well as traffic and domestic violence history where relevant. **28.7.** The DET and Child Safety Services mandate that 'regular visitors' to all regulated home-based services must hold a

current blue card.

28.8. Child Safety Services updates its policies and procedures to require the consideration of other regulated services provided from the home during the initial foster or kinship carer assessment, upon renewal of carer certificates, and at the point of time carer information is updated.
The DET updates its policies and procedures to require approved providers to consider other regulated services provided from the home when engaging family day care educators and at the point of time educator information is updated.

28.9. The OPG's Community Visitor Program considers whether other home-based services are being conducted from the residence during visits. The OPG should use this information in its assessment of whether the child's needs are being met and to inform the prioritisation of its visits. The OPG should also provide this information to Child Safety Services to support its ongoing assessment

28.11. Blue Card Services amends the Working with Children (Risk Management and Screening) Act 2000 to include the DET within the definition of 'notifiable person'. This will allow the DET to be notified of changes to the blue card status of individual family day care educators and adult household members.

28.12. The QPS updates its Operational Procedures Manual requiring officers to inquire about the following when investigating an offence where a child is the victim:
• Regulated employment undertaken by a blue card holder, and
• Any regulated services provided from a relevant residential address.

28.13. The QPS develops a decision-making framework to guide officers in sharing information to protect all children.

28.14. The DET and Child Safety Services update relevant policies and procedures outlining the range of risk management strategies to be followed, including increased monitoring:
• When information becomes known about the provision of more than one home-based service, and
• Upon receipt of information from Blue Card Services about a suspect in a disqualifying offence.
The DET should work with family day care regulators in other jurisdictions to establish and prescribe best practice for frequency of visits. This should be considered as part of its current work developing an improved risk-based framework for

	Queensland. **28.15.** BCS reviews the blue card application form, particularly for regulated home-based services, to include clear guidance for applicants to make sure they nominate the appropriate employer. **28.16.** The QFCC refers all additional findings from the review (section 5.1 of this report) to relevant agencies for further consideration of required systemic improvements. **28.17.** The governance group established under Recommendation 29 of When a child is missing: Remembering Tiahleigh – A report into Queensland's children missing from out-of-home care provides oversight of the implementation of the recommendations made in this report.
A Systems Review of Individual Agency Responses Following the Death of a Child (2017)	**Department of the Premier and Cabinet** **(1)** That the Queensland Government considers a revised external and independent model for reviewing the deaths of children "known to the child protection system" (s. 246A(1)(a-d) of the Child Protection Act 1999). This model will be designed by the Queensland Family and Child Commission and an expert advisory group in consultation with the directors-general from the 'nominated agencies' (s. 159K(a)(i-iv) of the Child Protection Act 1999) and other key stakeholders and be endorsed by the Interdepartmental Coordination Committee. A report will be provided to the Premier three months following the announcement with a framework for a contemporary child death review process for Queensland. 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. The review of the Child Protection Act 1999 will also provide an opportunity to reconsider the functions of the child death case review panel, including the determination of accountability, in consultation with the nominated agencies. As part of designing a contemporary model for child death case review, best practice benchmarks and experiences of other Australian jurisdictions, as identified by the Queensland Family and Child Commission, must be considered. This includes the following: • Extending the scope of powers and the authority of the child death case review panel in the new independent agency • Reconsidering legislative timeframes, including the receipt of information from other agencies • Reporting to government and public audiences on outcomes of child death reviews

	• Extending the scope to include other government and non-government organisations in the model • Extending the panels' power to make recommendations and require agencies to take action • Reconvening as necessary to consider new information, regarding the death of a child, to support systemic changes • Reconsidering selection, appointment of members, and period of membership, and ongoing support, guidance and strong governance to the panel member • Providing appropriate resourcing for secretariat, panel operation and agency reviews. Legislation will be required to compel nominated agencies who have provided service delivery to the child to undertake an internal review. Each nominated agency may be required to: • Establish an internal process for reviewing their involvement with children known to the child protection system who have died. These reviews should promote learning and analysis of internal decision making, consideration of systems issues, and collaboration with other agencies • Initiate this process whenever it has been determined that a child known to the child protection system and the agency dies • Provide the agency responsible for child death case review panels with the terms of reference for the internal reviews, and a copy of the internal review reports, including any findings and recommendations • Report regularly to the agency on progress in implementing any recommendations The revised model should also consider giving the child death case review panel members the additional capacity to undertake own-motion reviews (based on their own expertise and observations of what is needed). This would enable the panel to identify trends in all child deaths in Queensland and complete a review into service delivery to prevent future trends.
Keeping Queensland's Children More than Safe: Review of the Blue Card System (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government considers whether there are benefits from: • Consolidating screening functions across government where possible • Streamlining processes and implementing a revised funding structure to reduce invoicing across government departments.

(Blue card report (2017))	
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government undertakes an overarching review of the WWC Act to: • Implement the recommendations of this report • Simplify the laws and make it easier for stakeholders to understand their obligations.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government reviews the funding arrangements that support the blue card system (including funding for functions related to child safe standards and WWCCs).
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to expand the scope of the blue card system in line with the recommendation by the Royal Commission by: • Including additional categories of child-related work • Allowing regulation to prescribe other activities that involve providing services primarily to children and that require contact with children.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow its agency's chief executive to issue legally binding advice declaring whether a service is regulated (for example, through a statutory instrument).

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to require WWCCs for people who: • Operate a regulated service and make decisions that could impact on the implementation of child safe standards in the organisation • Provide regulated activities i.e.: o Engaged by a regulated service for an overnight camp where they will have contact with children, and/or o Engaged by a regulated service to work or volunteer for more than seven days in a calendar year and are: • In a position where they will have contact with children • In a specified child-related service while children are ordinarily present – this includes schools, boarding schools, long day care services or kindergarten services, residential facilities, child-related health services, child-related disability services and youth detention facilities • Are in a specified role – an adult member of a household where foster or kinship care, family day care or home stay is provided.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow its agency's chief executive to issue legally binding advice declaring whether a WWCC is required (for example, through a statutory instrument).

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to remove the requirement for a person to have an agreement to work with an organisation before applying for a WWCC. Consideration should be given to the following to make sure the system is sustainable and the focus remains on child-related activities: • Having an appropriate fee structure – with a new streamlined application process it may be possible to allow paid applications to be processed on a cost-recovery basis • Requiring volunteers to have an agreement with a regulated service in order to have an application processed free of charge • Allowing BCS to give a non-compliance notice to an organisation that does not provide regulated child-related services but is attempting to require employees or volunteers to obtain WWCCs rather than relying on alternative criminal history screening processes.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to: • Require organisations to make sure their employees and volunteers do not start regulated activities without a WWCC • Prevent people who are independent from an organisation and who need a WWCC from starting regulated activities without one.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that as part of the review of screening processes across government (recommendation 1), consideration is given as to whether removing the exemption for registered teachers is the most effective way to achieve a comparable level of screening. The following must be considered: • Whether the reforms recommended for implementation in the blue card system, in particular those about the range of information considered and the decision-making framework, can be adopted so that the teacher registration process remains comparable with the WWCC • Whether it is more cost-effective to maintain separate screening functions or consolidate them • Whether the issues with the operation of the current separate systems can be resolved, namely: o Barriers to information sharing o Differences in the information considered o Differences in decision-making processes and outcomes.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the exemption for police officers should remain in the WWC Act.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to: • Remove the exemption card process for police officers and registered teachers (if the exemption remains) and instead identify automated ways to link an exempted person with BCS when they are engaging in child-related work outside of their professional duties • Provide that a person should not be entitled to an exemption if there are conditions placed on their registration or employment that are relevant to a risk of harm to children.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that as part of the review of screening processes across government (recommendation 1), consideration is given as to whether removing the exemption for registered health practitioners and lawyers is the most effective way to achieve comparable screening for individuals providing child-related services.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to have a consistent exemption for volunteer parents when they are engaged in activities that are regulated. Volunteer parents who are in a position where they are responsible for the care of a child or children (for example, on an overnight camp) should not be exempt.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that paid employees under 18 years and students under 18 years on placement continue to need a WWCC for regulated services; and that children who are volunteering remain exempt.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills works with other states and territories to consider whether issues about mutual recognition of WWCCs can be resolved, namely: • The comparability of screening processes • The establishment of a centralised database • Barriers to information sharing about WWCC decisions. If these issues can be resolved, the Attorney-General and Minister for Justice and Minister for Training and Skills should propose amendments to the WWC Act to allow people screened in another Australian state or territory to be exempt from screening in Queensland. BCS will need to be able to do any additional checks necessary in Queensland, for example, disciplinary information.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to remove the ability for people to rely on an exemption if they: • Are subject to reporting obligations or a prohibition order under the Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004 • Have a suspended WWCC • Have a current negative notice.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce a new disqualification framework to: • Remove the current eligibly declaration process • Expand the range of offences that will result in the issue of an automatic negative notice as recommended by the Royal Commission, but consider excluding kidnapping offences that arise in the context of a family law dispute • Require the automatic issue of a negative notice to a person over the age of 18 who has been convicted of a disqualifying offence and sentenced to a period of imprisonment (including a suspended sentence) • Continue the agency's chief executive's discretion about all other applications involving a conviction for a disqualifying offence.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to: • Enable BCS to use information from a reportable conduct scheme, if introduced in Queensland, for WWCCs • In the absence of a reportable conduct scheme, enable BCS to consider disciplinary information under the Public Service Act 2008 and other regulatory frameworks as part of the risk assessment process, including for: Queensland Health employees, police officers, youth workers, child safety officers, Department of Education and Training employees, disability workers, health practitioners, corrective services officers.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to enable BCS to assess relevant child protection information as part of a WWCC. Relevant child protection information is: • Information about a substantiated allegation of harm • Information about unsubstantiated allegations of harm showing a pattern of concerning behaviour.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General develops relevant policies to make sure that BCS: • Checks for child protection information wherever there is information to suggest there may be a risk of harm to children • Has staff with expertise in assessing child protection history as part of a multi-disciplinary approach to risk assessments
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General and the Department of Communities, Child Safety and Disability Services identify the most efficient way to exchange child protection information so as not to adversely affect processing timeframes.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government considers the use of child protection information for WWCCs as part of the statutory review of the system recommended in this report (see recommendation 77). The review should determine if BCS should assess child protection information for all WWCC applications.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow BCS to obtain applications for domestic violence orders and all documents related to orders made where: • The applicant for a blue card is named as a respondent, and • The applicant has a charge or conviction related to a breach of a domestic violence order or another domestic violence offence as defined under the Criminal Code.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of justice and Attorney-General puts in place relevant policies to make sure that: • BCS has staff with sufficient expertise in assessing information about domestic violence as part of a multi-disciplinary approach to risk assessments • The most efficient way to exchange information about domestic violence applications and orders is identified so that it does not adversely affect processing timeframes.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce a new decision-making framework, to include: • A requirement to assess whether there is a risk of harm to the safety of children without the use of legislative tests that direct decision-making based on the type of information known about a person • A review of the list of serious offences (in order to focus on those offences that indicate a risk of harm to children) • The ability to conduct an assessment based on any information that is relevant to considering risk of harm to children • Specific criteria for assessing risks to children as outlined by the Royal Commission • An ability to suspend (rather than giving a negative notice) a blue card where there is a change in criminal history or other assessable information that suggests a risk of harm. (Consideration will need to be given to the feedback received from organisations about the difficulties associated with not being able to stand down an employee with a blue card is suspended).

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General implements a multi-disciplinary structure within the risk assessment unit in BCS so it includes people with expertise in, for example: administrative law, child protection, domestic and family violence, mental health, social work, drug and alcohol abuse, criminal law, youth justice. The structure should also include people with experience in working with culturally and linguistically diverse communities, and identified positions for Aboriginal and Torres Strait Islander risk assessment officers.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General: • Engages a consultant with relevant expertise to develop new risk assessment guidelines based on current research • Establishes a process for regular independent audits of risk assessment decisions and processes • Establishes a database to record decisions to support consistency and analysis of trends and statistical data.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to make the risk assessment guidelines a statutory instrument and subject to annual review.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General: • Engages a consultant with relevant expertise to review the suite of materials the BCS currently uses to communicate with applicants during the risk assessment process to make them easier to understand and less legalistic • Make sure all risk assessment staff are adequately trained in communicating with applicants • Establishes a new process for requesting submissions, including giving applicants: o Advice about the process before sending requests for submissions o Details of the types of information needed in submissions and referee reports o Details of the risk factors they need to address o Reasons for a proposed negative notice o Enough time to make submissions and gather related information o Ongoing support during the process, with the ability to make submissions orally
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General reviews the current QCAT process to identify opportunities to provide more support to applicants.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce an escalating compliance and enforcement model.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General develops, publishes and implements an annual compliance and enforcement strategy and evaluates the strategy each year.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government undertakes a review of the resourcing requirements necessary to support an enhanced compliance and enforcement function.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the following should be considered as part of the statutory review (see recommendation 77): • Introducing accreditation frameworks as potential ways to improve the levels of compliance across organisations • Introducing a public register of non-compliant organisations
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General explores options to implement an electronic case management system for compliance activities.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government considers whether authorised officers under compatible regulatory models could become authorised officers under the WWC Act for the exercise of all or some of the WWC Act enforcement powers.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that in developing the compliance strategy identified in recommendation 50, the Department of Justice and Attorney-General develops an annual compliance strategy for government regulatory bodies operating in child safe regulated environments. This should include processes for sharing information about compliance breaches and actions.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Queensland Government reviews offences and penalties in the WWC Act to: • Make sure offences for non-compliance with child safe standards requirements are kept and strengthened, including increased penalties, to emphasise the critical importance of creating and maintaining child safe environments • Consider whether the remaining offences relate to one of the categories of offences recommended by the Royal Commission and if they remain necessary under the new regime. Current safeguards in Queensland should not be reduced. • Create national consistency in relation to penalties where possible • Introduce new penalties to support the new compliance and enforcement model as required.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to introduce new information-sharing provisions to allow BCS and other relevant agencies to exchange information for the purposes of: • Completing a WWCC assessment or other screening process • Monitoring and enforcing compliance with child safe standards. Key features should include: • Allowing agencies to share information for specific purposes • Penalties for misuse of information or unauthorised disclosure • Protection from liability for individuals where information has been shared in good faith.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to require BCS to develop information-sharing guidelines.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General works with other relevant agencies to develop guidelines to provide: • Practical guidance about the new information-sharing provisions • A change management strategy to achieve the necessary cultural change.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General works with relevant agencies to develop an information and communication technology strategy to identify the technical solutions needed to automate information sharing. This is to maximise efficiencies and minimise the risk that agencies cannot share information quickly and easily.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow BCS to share risk assessment information with screening agencies in other states and territories and work with other state and territory screening agencies to identify ways to automate data matching and information exchange.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General urgently develops and implements: • An efficient online application process • A new manual application form to be used as an exception. In doing so, it should consult stakeholders to make sure the new forms are user-friendly.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General develops and implements an integrated online service for WWCC applicants, including, at a minimum, the ability to: • Submit a WWCC renewal • Update an applicant's or a card holder's details (for example, name and contact details) • Transfer from a volunteer blue card to a paid blue card • Replace or cancel a blue card • Pay card-related costs • Link or unlink an individual with different regulated organisations • View the progress of a pending application • Obtain reminders, notifications or communications from BCS (for example, upcoming card expiry dates) in many ways (including email or text message). • Provide customer experience feedback directly to BCS • View history of linked organisations, including the current and actively linked organisations.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General undertakes a full risk assessment against the Queensland Government Authentication Framework to determine the best way to check identities. This must strengthen the identity check process and, as far as possible, support a fully online application process. Department of Justice and Attorney-General

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General works with the QPS to: • Provide advice to the Queensland Government about the most efficient way to achieve electronic returns of police information that can be integrated into the BCS database. This should include advice about: o The service the Australian Criminal Investigation Commission (ACIC) currently provides o The timeframes for implementation o Any implications for the role of the QPS in providing criminal history screening services across government. • Establish the automated exchange of other police information, including QP9 Court briefs. Department of Justice and Attorney-General
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General works with all relevant agencies to automate and streamline information sharing to support WWCC process.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to: • Remove the positive notice letter as an outcome of a WWCC application • Include a photograph on the WWCC product. Any solutions developed should enable the: • Ability to issue a digital rather than a physical card at a point in the future • Use of biometric technology as it develops.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that, once daily national interstate monitoring of criminal history is operational, the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to extend the WWCC renewal process to five years. Consideration should be given to the appropriate fee structures to support a change in the renewal period and the protentional to offer applicants a choice in the renewal time period.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General develops an organisation portal with the following minimum functions: • Card holder management • Notification management • Compliance management, including allowing organisations to upload documents about their child safe standards on request
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General supports culturally and linguistically diverse communities by: • Promoting and advising applicants of the availability of interpreting services • Providing resources on the BCS website that are translated into multiple languages • Developing and undertaking targeted education about the blue card system in culturally and linguistically diverse communities.

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General develops and implements a specific strategy and action plan to provide more support for Aboriginal and Torres Strait Islander peoples and build cultural capability in the blue card system. Department of Justice and Attorney-General
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General: • Establishes a comprehensive reporting framework of key indicators and benchmarks • Commences regular public reporting on performance against the framework of indicators • Includes specific measures on participation by Aboriginal and Torres Strait Islander peoples, as well as by other culturally and linguistically diverse applicants and blue card holders Department of Justice and Attorney-General
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Attorney-General and Minister for Justice and Minister for Training and Skills proposes amendments to the WWC Act to allow genuine researchers to access data (with identifying details removed) about the blue card system. Department of Justice and Attorney-General
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General: • Promotes the benefits of analysing the data • Reports on research partnerships Department of Justice and Attorney-General

Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General establishes an implementation working group made up of government and non-government representatives to develop a detailed implementation plan and reporting framework. The working group should also oversee and report on progress over the implementation period. The panel should have appropriate representation to ensure the interest of Aboriginal and Torres Strait Islander peoples are heard and considered.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the implementation plan is regularly reviewed to consider any changes in the administrative arrangements for particular functions and to allocate responsibility for each recommendation to the agency with administrative responsibility for the relevant function.
Blue card report (2017)	**Department of Justice and Attorney-General** It is recommended that the Department of Justice and Attorney-General works with the Queensland Government Chief Information Officer to use agile and iterative project methodologies to build capability and functionality in the system over time.
Keeping Queensland's Children More than Safe: Review of the Foster Care System (2017) **(Foster care report (2017))**	It is recommended that the Department of Communities, Child Safety and Disability Services works with relevant agencies, and non-government organisations with knowledge of personal safety, to ensure that children in care have access to, and receive, age appropriate programs and resources to help keep them safe.

Foster care report (2017)	It is recommended that the Office of the Public Guardian reviews and updates practice guidelines based on contemporary evidence and provides regular training for community visitors about the critical functions of: • Building trusting relationships with children in care • Identifying and responding to abuse in care.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the Office of the Public Guardian reviews and updates practice guidelines based on contemporary evidence about the best way to match community visitors to children in care. The guidelines should: • Address the match of age, gender and culture that will best enable community visitors to build trusting relationships with children • Increase the likelihood that children will disclose abuse.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services works with external oversight (and other) agencies to develop an annual program of audit, review and compliance activities that focus on areas of highest risk for, and key service obligations to, children in care. The Department of Communities, Child Safety and Disability Services should seek further advice on the publication of this annual program on its website and in its annual report.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the QFCC works with the Department of Communities, Child Safety and Disability Services; the Office of the Public Guardian; and the child protection sector to provide a more outcomes-based account of the experiences and perspective of children and young people who rely on child protection services to stay safe and well. This should be reflected in the annual report produced by the QFCC	Department of Justice and Attorney-General

Foster care report (2017)	It is recommended that the department of communities, child safety and disability services makes the following (currently discretionary) suitability checks mandatory for each person who applies to be a carer: • Domestic violence • Traffic history • Referee checks (one referee to be selected by assessor) • Medical clearance from the applicant's general practitioner.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services reviews relevant policies and procedures to ensure clear guidance is provided about when further discretionary information should be gathered, and what this additional information may include, to inform the consideration of whether a person is suitable to hold a certificate of approval as a carer.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services provides the decision-makers for carer applications with full details of available personal history checks undertaken, including: • Information returned from personal history checks • Analysis of the information • A recommendation on suitability based on the personal history checks. The Department of Communities, Child Safety and Disability Services should provide information about all personal history checks to assessors before they start assessment interviews.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services reviews the adequacy of the legislative criteria for a person to be a suitable person to be a carer and amends policies and procedures accordingly.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services chooses and uses a standard carer assessment tool that: • Includes specific resources for assessing foster carers and kinship carers • Addresses cultural issues for Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services implements an accreditation requirement for all assessors as required by the selected standard assessment tool (see rec 15). If the chosen tool does not require accreditation of assessors, the Department of Communities, Child Safety and Disability Services should work with relevant stakeholders to develop and mandate appropriate minimum requirements for assessors (such as competency in the use of standard assessment tools, experience and legislative knowledge), training and ongoing professional development.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services recommences using its two-step carer assessment process once the Department of Justice and Attorney- General has streamlined the blue card system and reduced the processing timeframes for working with children checks.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services amends the Child Safety Practice Manual so that kinship carers do not undergo another full assessment process in situations where they have already been assessed for a previous placement within a two-year timeframe.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services: • Establishes, in each of its regions, a panel to review carer assessments and make recommendations about the approval of carer applicants • Develops criteria for defining when Child Safety Services must use a panel to support approval decisions. In additional to make a recommendation for approval, the panel may also consider: • The type of care for which approval is given • The numbers, ages and genders of children to be placed • Special conditions, including priority training • The level and type of support the carer will need. Each panel should include a range of professionals (representing various stakeholder groups) able to inform and confirm decisions and bring relevant cultural perspectives to the panel's deliberations. For example, representatives from the carer agency, DCYJMA representatives, Foster Care Queensland, Elder or Recognised Entity representative and the assessor.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services reviews relevant policies and procedures, in light of the recommended changes to carer assessment and approval processes, to confirm that the delegation level for approval of carers is appropriate.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services includes the following as part of the carer renewal process: • Interviews with children in placement • Discussions with child safety officers and the relevant community visitor/s Where relevant, the process should also include: • Interviewing children previously in the placement • Discussions with child safety officers of children previously placed with that carer • Discussions with any previous carer agency • Discussions with schools/ early childhood centres involved with children currently placed with the carer • An assessment of the carer's ability to meet and adhere to the standards of care.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services strengthens accountability for completing renewal assessments by: • Clarifying in legislation or policy the maximum time for completing renews once a carer has submitted a renewal application • Including a requirement in funding agreements for approved foster and kinship carer agencies to renew carers as required by legislation and policy • Monitoring the compliance of the agencies in undertaking carer renewals within timeframes • Including a performance audit about timeliness of renewals in the annual program of audit referred to in rec 6.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services: • Renews all carers with whom Child Safety Services has not placed children for more than 12 months and decides whether their carer certificates should be suspended or cancelled • Develops criteria for suspending and cancelling carer certificates (in the absence of a blue card cancellation or criminal charges) • Considers whether a panel should review cases for consistency.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services updates its policies and procedures to require the decision-makers, in situations where there is not a best match between a child and his or her carer/s, to document: • Any identified gaps between the child's needs and the carer's capacity • The additional support the carer will need to help meet the child's needs (and who will provide it and when) • The steps it will take to make sure the child's needs are being met.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services works with foster and kinship care services to: • Improve records management systems to better capture and use information gathered as part of the carer assessment process to inform placement-matching • Develop a standard profile document about foster and kinship carers and make this available to children and staff working with carers.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services puts in place checks and balances confirming Child Safety Services and foster and kinship care services are meeting their obligations to provide carers with information about children that will: • Help carers make an informed decision about accepting a placement • Help the carers meet the children's needs • Protect carers and members of their household from potential harm. Within two years of the date of this report, the Department of Communities, Child Safety and Disability Services should undertake a performance audit of this as part of the annual program of audit referred to in Rec 6.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services strengthens and clarifies definitions, documentation and communication regarding the roles, responsibilities and relationships of department staff and foster and kinship care services in the placement-matching process.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services develops a training program specifically for kinship carers: • Recognising the unique and varying nature, culture and challenges of kinship care • With flexible delivery modes (for example, online modules, attendance by video link, or one-on-one delivery methods) • Requiring all kinship carers to being the training within six months of their first placement.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services revises all aspects of carer training to make sure: • It is reflective of current research and evidence • It provides carers with the skills to manage complex behaviour and trauma, including modules on: o Understanding the impacts of trauma and providing trauma-responsive carer o Risk factors for child abuse in care o The principles of child safe organisations • Cultural competency (in all pre-service training) tailored to specific culture and language groups where possible.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services considers assessing the skills and experience of its trainers and also considers using alternative timing for training, improved training resources, and different modes of delivery of training.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services defines, documents and communicates the roles and responsibilities for providing support to carers, including the roles and responsibilities of: • Foster and kinship care services • Child safety officers • Child safety support officers	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services works with non-government partners to develop and implement measures to increase support and supervision for new carers during their first 12 months as carers. The measures must recognise the difference between the support needs of foster carers and kinship carers.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services updates policies and procedures and provides advice and training to all care team members about: • The roles, responsibilities and expectations of children's care teams • Whether a child's care team should, at given points, include additional members (for example, community visitors and teachers).	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services reviews current minimum contact requirements with children in care and establishes a coordinated approach with care team members. This should include: • Considering children's views on contact • Taking into account current research about approaches to the nature, type and frequency of contact across all child protection orders.	Department of Child Safety, Seniors and Disability Services

Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services develops a way to capture, monitor and report on child safety officers' compliance with its minimum contact requirements with children in care.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Department of Communities, Child Safety and Disability Services works with the CREATE Foundation, Foster Care Queensland, Office of the Public Guardian and other stakeholders to develop contemporary methods to improve engagement with children in care. The strategy should specifically assess and document the risks and benefits of using technology as a means of contact between children in care and child safety services officers and community visitors.	Department of Child Safety, Seniors and Disability Services
Foster care report (2017)	It is recommended that the Office of the Public Guardian, with oversight by the QFCC, reviews the current community visitor role and practice to: • Clarify the policy intent • Determine whether, post-Queensland Child Protection Commission of Inquiry, it is providing the intended safeguards for children in care. This review should inform the work undertaken by the QFCC to evaluate child protection reforms.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the Office of the Public Guardian works with the Department of Justice and Attorney-General and consults with stakeholders to identify and address any practical barriers to community visitors conducting unannounced visits with right of access without consent or warrant. The result of this consultation will determine whether legislative amendment is required.	Department of Justice and Attorney-General

Foster care report (2017)	It is recommended that the Office of the Public Guardian works with the Department of Justice and Attorney-General and consults with stakeholders to consider the practicality of conducting visits with children and young people away from their placement, in circumstances where visits are not otherwise able to be conducted in private. The result of this consultation will determine whether legislative amendment is required.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the Office of the Public Guardian works with stakeholders to develop a reporting framework with accompanying data to identify systemic issues such as: • Visit frequency – actual and planned • Number and rate of issues and complaints identified • Notifications to the Department of Communities, Child Safety and Disability Services.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the QFCC continues to use its existing governance group (which oversees the progress of the recommendations in the QFCC review reports, including this report), to monitor and report on whether the intent of each of the recommendations has been achieved.	Department of Justice and Attorney-General
Foster care report (2017)	It is recommended that the agencies responsible for implementing the recommendations in this report: • Develop a detailed implementation plan that provides advice on the planned staging and approach for implementing each recommendation • Provide the plans to the governance group referred to in rec 41 Agency implementation plans should be reviewed on release of the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse.	Department of Justice and Attorney-General

Strengthening Capacity Across Queensland's Child Protection System (2017) **(Strengthening Capacity Report (2017))**	**1.1.** Re-balance overall Child Safety resourcing in future budgets to focus on frontline staff by streamlining central office resources **1.2.** Streamline central governance resources into a dedicated change management team that focusses on monitoring performance and practice improvement. Undertake annual, formal gateway reviews of place-by-place outcomes to inform resource allocation decisions. **1.3.** Adopt a Regional Funding Allocation model to better link funding to demand. This should build on the Department's Needs and Services Assessment Tool. It should include population needs, other demographics such as Socio-Economic Indexes for Areas and analysis of data sets to predict which populations of children and families are at risk of entering the child protection system and may benefit from early intervention and support.	Department of Child Safety, Seniors and Disability Services
Strengthening Capacity Report (2017)	**2.1.** Allocate more frontline Child Safety positions at the local level. **2.2.** Employ more Child Safety Service Centre administrative support officers to allow Child Safety Officers and Child Safety Support Officers to focus on their statutory child protection responsibilities and not be diverted by non-core administrative duties **2.3.** Establish relief pools of mobile, qualified and trained Child Safety Officers, Child Safety Support Officers and Administrative Officers at the regional level, to backfill for staff on leave and to supplement overall staff numbers during peaks in activity **2.4.** Introduce mobile, specialist senior practice teams of child safety workers to target hot spots with backlogs, high caseloads, or emerging issues and to provide practice improvement advice.	Department of Child Safety, Seniors and Disability Services

Strengthening Capacity Report (2017)	**3.1.** Pool existing state wide child safety and family support program funds, apportion an allocation to the Regional Executive Directors and given them greater flexibility in commissioning quality local services to respond more quickly and effectively to changing local needs. There should be a particular focus on assisting Indigenous children and families to avoid involvement with the statutory system. **3.2.** Strengthen the existing non-government service system in future Budgets to fill identified gaps in child and family support. Specialist services should include community-based child and family contact centres. Specialist services should also include intensive family support such as coaching families in caring for children, behaviour management and relationship skills. Further, specialist services should be funded to connect children and families with specialised domestic violence and therapeutic services. There should be a particular focus on assisting Indigenous children and families to avoid involvement with the statutory system.	Department of Child Safety, Seniors and Disability Services
Strengthening Capacity Report (2017)	**4.1.** Undertake an independent business analysis of the work processes between Child Safety Service Centres, the Office of the Child and Family Official Solicitor, the Director of Child Protection Litigation, and the Courts with the aim of reducing double handling and improving the timeliness and quality of court material. **4.2.** Introduce targeted change management to progress the integration of the practices of the child protection and legal systems, which are now working more closely on court-related matters.	Department of Child Safety, Seniors and Disability Services
Strengthening Capacity Report (2017)	**5.1.** Pursue opportunities for greater collaboration between Child Safety and non-government organisations to improve the overall quality of services provided to children and their families, and increase their chances of moving out of the statutory system. **5.2** Support practice improvement across the child protection system by sharing learnings from Child Death Reviews.	Department of Child Safety, Seniors and Disability Services

Strengthening Capacity Report (2017)	Introduce a modern, integrated client management ICT system to replace the current outdated Integrated Client Management System in Child Safety.	Department of Child Safety, Seniors and Disability Services
A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby (2019)	**1.1** .The QFCC gathers and analyses information from agencies within the child and family support system about threats to murder a child, including the: • Number and frequency of threats • Nature of the threats • Action taken by agencies including when and with whom information was shared. **1.2.** The QFCC immediately begins work on defining evidence-based red flags for children. **1.3.** The QFCC develops a system-wide policy requiring all red flags to be treated as urgent and responded to immediately. **1.4.** The Department of Child Safety, Youth and Women establishes an information technology solution, in cooperation with agencies, to share information about red flags. Specifically, this solution will: • Identify shared clients with other agencies within the child and family support system for data matching • Use strategies such as predictive analysis to more easily determine patterns of behaviour for parents in the context of domestic and family violence • Trigger an information exchange response • Automate information sharing about red flags between agencies (using the results of Recommendations 1.1 and 1.2). **1.5.** The Department of Child Safety, Youth and Women and the Queensland Police Service – in consultation with the QFCC and the Crime and Corruption Commission Queensland – develops and implements a system-wide procedure and practice advice for agencies to use in	Department of Justice and Attorney-General

	responding to a threat to murder a child. This is to include: • A process for escalation to the highest-priority response • Clear guidelines on what and when information about a threat is to be shared with child protection services, the police or other authorities • A clear imperative for the QPS to launch a missing person investigation and broadcast an Amber Alert when required • Advice on risk factors for filicide. The threats to kill a child, parent or carer policy produced by the Victorian Department of Health and Human Services can be used as a model for this. **1.6**. The Department of Child Safety, Youth and Women and the Queensland Police Service coordinate the development of state-wide training on the red flag policy and the system-wide procedure and practice advice, to be delivered by agencies to their staff. Police officers should also receive refresher training on missing persons investigations involving children and Amber Alerts.	
A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby (2019)	We recommend Legal Aid Queensland improves responses to concerns for children by: • Establishing a child protection policy, including a clear requirement to quickly report information about red flags to authorities (for example, the QPS and Child Safety) • Implementing a monitoring system for complaints outside of office hours so matters are escalated and reviewed promptly • Training staff on the child protection policy. To implement this recommendation, LAQ will need to confront the cultural change required for an improved child-inclusive response. The QFCC will support LAQ in implementing this recommendation.	Department of Justice and Attorney-General

A spotlight on vulnerable infants. Improving responses to red flags. A system review following the death of a baby (2019)	We recommend the Attorney-General and Minister for Justice includes the findings of this report in a letter to the Attorney-General for Australia asking for them to be considered in the context of the federal response to the Australian Law Reform Commission, Family Law for the Future – An Inquiry into the Family Law System: Final Report, and emerging inquiries.	Department of Justice and Attorney-General
Hear me, see me. Keeping children at the centre of the child and family support system. A system review following the deaths of four young children (2020) (Hear me, see me	**1.1.** This review recommends the Department of Child Safety, Youth and Women establishes a new policy and procedure that put risk to a child as the central consideration when there are concerns about a reporter's motivations. This is to replace the existing procedures and guidance in the Child Safety Practice Manual and Practice Guide – Vexatious and malicious notifiers. **1.2.** The Department of Child Safety, Youth and Women develops an implementation plan for recommendation 1.1 that: i. Communications expectations to staff ii. Considers training needs iii. Includes case review processes and staff supervision to make sure the new practices work as intended.	Department of Child Safety, Seniors and Disability Services
Hear me, see me. Keeping children at the centre of the child and family support system. A system review following the deaths of four	**2.1.** The Department of Child Safety, Youth and Women and Queensland Health find ways to quickly and effectively identify the risks to children of parents with severe and persistent mental illness during Child Safety interventions. These responses must: i. Triage and assess parents as a top priority ii. Share information across agencies about a parent's mental illness, to help the parent's mental health iii. Use the Ryan's Rule process (or similar) as a model for an independent assessment (and, where appropriate, intervention) of a parent with severe and persistent mental illness where	Department of Child Safety, Seniors and Disability Services

young children (2020)	this may pose a significant risk to their child. **2.2.** The QFCC partners with Queensland Health to review the appropriateness and effectiveness of its practices, policies and guidelines to make sure they are keeping children of parents with mental illness safe. This is to: i. Identify one Hospital and Health Service in South-East Queensland and a second in another part of the state and review their practices in detail ii. Recommend improvements to address identified practice gaps and impediments iii. Pilot those improvements in at least one Hospital and Health Service iv. Evaluate the pilot and recommend on potential further implementation A copy of the evaluation report (and recommendations) is to be provided to the Interdepartmental Committee within 18 months of this recommendation being accepted.	
Hear me, see me. Keeping children at the centre of the child and family support system. A system review following the deaths of four young children (2020)	This review recommends the Chief executive Officer and Principal Commissioner of the QFCC writes to the Directors-General and Commissioner of the relevant agencies requesting action be taken in relation to the findings from this report. Specifically, that: i. The Department of Child Safety, Youth and Women identify and share information with relevant agencies about persistent help-seeking behaviour as part of its work to respond to red flags for children ii. The Department of Premier and Cabinet includes persistent help-seeking behaviour and mental illness as factors for its work to eliminate the influence of assumptions and attitudes on system responses. This work complements recommendations raised in the report, A spotlight on vulnerable infants: Improving responses to red flags. iii. The Queensland Police Service and Department of Child Safety, Youth and Women clarify processes for sharing criminal history information.	Department of Justice and Attorney-General

Seeking safety. Keeping children safe when they remain at home during Child Safety interventions. A system review following the death of two young children (2020)	We recommend the Department of Child Safety, Youth and Women takes immediate action to eliminate practice non-compliance within the Child Safety Service Centre that dealt with the Conley case to make sure all children on current IPAs are safe.	Department of Child Safety, Seniors and Disability Services
Seeking safety. Keeping children safe when they remain at home during Child Safety interventions. A system review following the death of two young children (2020)	We recommend the QFCC immediately commences a review into the safety of children during interventions with parental agreement (IPAs). At a minimum, this review must: i. Include a same of cases from each Child Safety region in the state in which a child had been assessed as in need of protection more than 30 days prior ii. Examine safety and case planning guidelines and practices, including changes needed to make sure children returned to their parents' care have a current case plan iii. Examine established practices for drug testing parents who use ice and engaging them in treatment and supports iv. Determine how to monitor whether or not a parent is maintaining engagement with secondary services v. Recommend improvements to strengthen assessment and reassessment of whether or not an IPA is/ remains appropriate A review report is to be published by the QFCC as soon as practicable.	Department of Justice and Attorney-General

Seeking safety. Keeping children safe when they remain at home during Child Safety interventions. A system review following the death of two young children (2020)	**3.1.** We recommend the Department of Child Safety, Youth and Women and Queensland Health commit to better assist professionals in making decision in the best interests of children under the Child Protection Act 1999 (QLD) by revising Queensland Health child protection policies and guidelines to require use of the Child Protection Guide when making decisions to refer families for support or report concerns to Child Safety. **3.2** We recommend the Department of Child Safety, Youth and Women and Queensland Health commit to better assisting professionals in making decisions in the best interests of children under the Child Protection Act 1999 (QLD0 by revising its Child Safety Officer – Health Liaison booklet to: i. Require the Child Safety Officer (Health Liaison) to refer professionals to existing referral and reporting processes (including the Child Protection Guide) ii. Require the CSO (HL) to provide relevant advice, within delegated authority, to help inform referral or reports, including information about a family's history of non-engagement with supports iii. Include information relevant to assessing or responding to the health needs of a child at risk of harm or in need of protection, resulting from circumstances such as parent's use of ice or other drugs	Queensland Health