

Chapter 1

Child death reviews in Queensland

The response when a child dies in Queensland

When a child dies in Queensland, a number of public sector agencies respond in various ways. The obligations that drive this response are described in the *Commission for Children and Young People and Child Guardian Act 2000*, the *Child Protection Act 1999* and the *Coroners Act 2003*. The essential elements of these legislative processes and the child death review jurisdiction have remained intact since they commenced in 2004 and still closely reflect the recommendations of the Ombudsman's 'Baby Kate' investigation and the Crime and Misconduct Commission's inquiry into abuse in foster care. The Queensland system is in its fourth year of operation and is now adding significant public value to the essential review process through system level reporting about trends and patterns in the deaths of children known to the child protection system.

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Appendix 4 contains further detail about the specific roles of each Queensland agency and a comparison with processes in other jurisdictions. This comparison highlights the depth of the Queensland model, which (based on feedback from other jurisdictions) is gaining recognition as the national benchmark for the review of deaths known to the child protection system.

Figure 1.1 Public sector agencies interactions supporting a child death review process in Queensland

