1. The Child Death Review Board (the Board) was established on 1 July 2020 under the *Family and Child Commission Act 2014* (Qld). The Board’s establishment followed the Queensland Government’s commitment to implementing a refined and independent model for reviewing the deaths of children connected to the child protection system in response to the Queensland Family and Child Commission’s (QFCC) recommendation in its 2017 report: *A systems review of individual agency findings following the death of a child*.
2. The Board’s purpose is to identify opportunities for continuous improvement in systems, legislation, and practices, as well as to identify preventative mechanisms to help children and prevent deaths that may be avoidable. To achieve this, the Board carries out systems reviews; analyses data; and identifies patterns, trends and risk factors relating to relevant child deaths.
3. The Child Death Review Board Annual Report 2020-21 is the Board’s inaugural report in which it examines the deaths of 55 children connected to the child protection system. The Board makes 10 recommendations in its report directed at relevant agencies to address systemic issues and to call for agencies to take specific actions regarding policies, procedures and practices.
4. The Queensland Government accepts or accepts in principle all of the Board’s 10 recommendations.
5. In addition, but separate to the work of the Board, the QFCC maintains a register of information relating to all child deaths in Queensland, not just those connected to the child protection system. The QFCC is also required to report annually on the results of analysing information included in the register, including reporting on trends and patterns over time, providing statistical data to inform research, policies, programs and public education campaigns to reduce deaths and to help keep children safe.
6. The QFCC’s Annual Report: deaths of children and young people, Queensland, 2021 provides important information and insights into trends and patterns relating to the deaths of children and young people in Queensland and is a valuable resource for informing child death prevention activities and measures.
7. Cabinet noted the Child Death Review Board Annual Report 2020-21 and the Queensland Family and Child Commission Annual Report 2020-21 and noted the Reports be tabled in the Legislative Assembly.
8. Cabinetapproved the Government Response to the Child Death Review Board Annual Report 2020-21 and noted the Government Response to be tabled in the Legislative Assembly.
9. *Attachments*
* [Child Death Review Board Annual Report 2020-21](Attachments/CDRBReport.PDF)
* [Government Response to the Child Death Review Board Annual Report 2020-21](Attachments/Response.PDF)
* [Queensland Family and Child Commission Annual Report: deaths of children and young people, Queensland, 2020-21](Attachments/QFCCReport.PDF)