RECOMMENDATIONS AND ACTIONS ARISING FROM DEPARTMENTAL CHILD DEATH CASE REVIEW REPORTS 2010-2011		
Case Number	Recommendation/s	Status
1	No recommendations	N/A
2	No recommendations	N/A
3	No recommendations	N/A
4	No recommendations	N/A
5	No recommendations	N/A
6	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
7	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
8	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
9	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on the learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
10	No recommendations	N/A
11	No recommendations	N/A
12	No recommendations	N/A
13	No recommendations	N/A
14	No recommendations	N/A

15	No recommendations	N/A
16	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. 2. The review report be referred to the Regional Director to undertake further discussions with the Regional Intake Team in relation to how the determination of Indigenous heritage is being approached.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was provided to the Regional Director for the purpose of undertaking further discussions with the Regional Intake Team in relation to how the determination of Indigenous heritage is being approached.
17	A de-identified copy of the report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
18	No recommendations	N/A
19	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
20	The review recommends that the review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
21	No recommendations	N/A
22	1. The review report to be provided to all Child Safety Services staff who participated in the review to allow critical discussion and reflection on learnings. 2. The issue of information sharing across agencies to locate mobile families by referred for discussion at the Child Safety Director's Network.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was provided to the Child Safety Director's Network for their review and discussion regarding information sharing across agencies to locate mobile families. The report was tabled at the Child Safety Director's Network on 7 December 2010

23	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. 2. The report be provided to the Assistant Director-General, Practice Improvement and Support, to develop and undertake specific training for staff within this Child Safety Service Centre on the use of Additional Notified Concerns, and to ensure staff within this Child Safety Service Centre are aware of current policy and procedures of the re-focused Suspected Child Abuse and Neglect (SCAN) model.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was sent to Assistant Director-General, Practice Improvement and Support, Regional Service Delivery Operations to develop and undertake specific training for staff within this Child Safety Service Centre on the use of Additional Notified Concerns and to ensure staff within this Child Safety Service Centre are aware of current policy and procedures of the re-focused Suspected Child Abuse and Neglect (SCAN) model.
24	No recommendations	N/A
25	No recommendations	N/A
26	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was sent to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.

27	1.The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.2.The Child Safety Service Centre Manager and Senior Practitioner engage staff in discussions regarding: the correct procedure for downgrading approved notifications, to revisit risk assessment, particularly as it relates to the vulnerability of new born children, the correct use of pre-notification checks and the importance of effective communication with key partners around decision making and outcomes to ensure they are kept abreast of any change to a notified departmental response to promote a coordinated approach to service delivery.3.A de-identified copy of the report be provided to the Child Safety Director, Queensland Health for that department information and possible learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the report was provided to the Manager and Senior Practitioner for the purpose of engaging staff in discussions regarding: the correct procedure for downgrading approved notifications, to revisit risk assessment, particularly as it relates to the vulnerability of new born children, the correct use of pre-notification checks and the importance of effective communication with key partners around decision making and outcomes to ensure they are kept abreast of any change to a notified departmental response to promote a coordinated approach to service delivery. The Manager and Team Leaders discussed the correct procedures regrading down grades and complete training with all intake and investigation staff. The Senior Practitioner, through her role, has commenced initial training of risk assessment regrading the vulnerability of new born children further training is being develop to implement across the service centre. As discussed in the report the Child Safety Officer who created the pre-notification form stated thatthis was not the correct form to use and further training was provided for staff. Further to this due tointake now occurring regionally staff have been training in intake procedures across the service centre. As discussed in the report the Child SafetyService Centre hase very open communication with key partners which has been further evaluated and has been subject to further reporting mechanisms being put in place. Further to this new strategies have been put in place due to the new regional intake process and Suspected Child Abuse and Neglect (SCAN) system. Recommendation 3. Completed. A de-identified copy of the report was provided to the Child Safety Director, Queensland Health.

28	1. The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes. 2. Managers of the two relevant Child Safety Service Centres remind all staff that the death of a child known to the department in the three years prior to their death irrespective of whether or not the child is subject to a current open case is to be notified as a critical incident.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development. Recommendation 2. Completed. The Managers of the two relevant Child Safety Service Centre were advised that all relevant staff in the service centres were to be reminded that the death of a child known to the department in the three years prior to their death, irrespective of whether or not the child is subject to a current open case, is to be notified as a critical incident. Advice to staff was confirmed.
29	The review report be provided to the Regional Director and Manager of the relevant CSSC to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.
30	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.
31	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and the Manager of the new Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.

32	1. The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for leaning and development purposes. 2. The review report also be provided to the Manager responsible for the relevant Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development. Recommendation 2. Completed. A de-identified copy of the review was provided to the Manager of the relevant Regional Intake Service for use as appropriate in learning and development.
33	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.2. A de-identified copy of the review report be provided to the Child Safety Directors Network for review and the consideration and discussion of issues raised in the report relating to implications for cross-agency work with high risk young people.3. A de-identified copy of the review report be provided to the Office of Youth for its review and consideration of issues raised in the context of the development of the Youth at Risk Intervention Framework.4. A de-identified copy of the review report be provided to the Child Safety Director, Department of Justice and Attorney-General for review and consideration of issues raised in relation to legal representation provided to the subject child and funded by Legal Aid Queensland. 5. An identified copy of the review report be provided to Child Safety Practice Improvement Unit for its review and consideration of potential practice improvement implications in relation to working with high risk young people and working collaboratively with government and community partners.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was provided to the Child Safety Director's Network for their for review, consideration and discussion of issues raised in the report relating to implications for cross-agency work with high risk young people. Recommendation 3. Completed. A de-identified copy of the review was sent to the Office for Youth for consideration. Recommendation 4. Completed. A de-identified copy of the review was sent to the Child Safety Director, Department of Justice and Attorney-General for consideration.Recommendation 5. Completed. An identified copy of the review was sent to the Child Safety Practice Improvement Unit for consideration.

	6. An identified copy of the review report be provided to Training and Specialist Support Branch for review, consideration of issues raised in the report and any implications for training of departmental staff working with high risk young people and working collaboratively with government and community partners. 7. Child Safety Practice Improvement Unit, in conjunction with Brisbane Region, monitor the effectiveness of the Youth at Risk Network developed by Child Safety Service Centre and Youth Justice Services 1 to identify potential learning for wider application. 8. Practice issues identified in the report relating to the use of SAAP youth shelters be brought to the attention of Placement Support Unit Directors by the Child Safety Practice Improvement Unit.	Recommendation 6. Completed. An identified copy of the review was sent to the Training and Specialist Support Branch for consideration. Recommendation 7. Completed. Report previously sent under Recommendation 5. Recommendation 8. Completed. Report previously sent under Recommendation 5.
34	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and the Manager of the new Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service for use as appropriate in learning and development.
35	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed - A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
36	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.

37	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.
38	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.
39	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.
40	A de-identified copy of the report be provided to all Involved for their learning, development and continuous improvement.	Recommendation 1. Completed - A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.

41	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.2. A de-identified copy of the report be provided to the Manager, Child Safety Practice Manual, Child Protection Development for review in relation to a potential lack of direction in the manual around the scope for inter-Child Safety Service Centre negotiation of temporary local casework tasks in special circumstances such as the long term hospitalisation of a child in care.3. A de-identified copy of the report be provided to Training and Specialist Support Branch for consideration of staff training needs in relation to:* Issues raised in the report concerning communication with the family of a subject child and the hospital where the subject child is under the guardianship of the Director-General and subject to end of life decision making, including additional communication requirements when a subject child is Indigenous. It is recommended this include consideration of the seniority and experience levels of Child Safety Service Centre staff communicating particularly sensitive end of life information, including responsibility for the subject child post death and funeral arrangements.* Issues raised in the report concerning how to best meet the unique needs of a subject child in care who is subject to an extended period of hospitalisation,and particularly those children who do not have a current placement, including consideration of local case work.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was provided to the Manager, Child Safety Practice Manual, Child Protection Development.Recommendation 3. Completed. A de-identified copy of the review was sent to Training and Specialist Support Branch.

	4. A de-identified copy of the report be provided to Regional Service Delivery Operations for consideration of any implications or opportunities arising for a specialist local case work service for children in care subject to medium or long term hospitalisation from the Queensland Government's new children's hospital, which is expected to be opened in South Brisbane in 2014. This hospital will bring the services of the Royal Children's Hospital and the Mater Children's Hospital together into a single new entity for the development of specialised paediatric services in Queensland and treat children up to the age of 16 years.5. A de-identified copy of the report be provided to the Child Safety Director, Queensland Health and the Director, Child Protection Unit, of the relevant hospital for reflection on learnings.	Recommendation 4. Completed. A de-identified copy of the review was sent to Director, Child Safety Practice Improvement Unit.Recommendation 5. Completed. A de-identified copy of the review was sent to the Child Safety Director, Queensland Health and the Director, Child Protection Unit of the relevant hospital.
	6. An identified copy of the review report be provided to the Child Safety Practice Improvement Unit for the purposes of: * raising issues associated with the placements for children with complex medical needs with Placement Support Unit Directors by Child Safety Practice Improvement. * consideration of potential practice improvement through the development of a protocol between the department, Queensland Health and the relevant hospital concerning standard procedures for children in care who are hospitalised.	Recommendation 6. Completed. An identified copy of the review was sent to the Director, Child Safety Practice Improvement Unit.

42	1. The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre and Regional Intake Service (RIS) to be used as appropriate for learning and development purposes. 2. The review report be provided to Training and Specialist Support Branch (Statewide Services) and Practice Development Unit (Regional Service Delivery Operations) to ensure the learning from this review is incorporated into relevant training around pre-notification checks.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service for use as appropriate in learning and development. Recommendation 2. Completed. A de-identified copy of the review was provided to Training and Specialist Support Branch (Statewide Services) and the Practice Development Unit (Regional Service Delivery Operations) to ensure the learning from this review is incorporated into relevant training around pre-notification checks.
43	The de-identified copy of the report be provided to all staff who participated in the review to enable reflection.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
44	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and the Manager of the new Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre and Regional Intake Service for use as appropriate in learning and development.
45	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. 2. A de-identified copy of the report be provided to the Child Safety Director Queensland Health for consideration.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the report was sent to Child Safety Director, Queensland Health.
46	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and the Manager of the relevant Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre and Regional Intake Service for use as appropriate in learning and development.

47	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and Manager of the Regional Intake Service to be used as appropriate for learning and developmental purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service for use as appropriate in learning and development.
48	1. The de-identified copy of the report be provided to all staff who participated in the review to enable reflection. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. It is recommended that the Manager of the Child Safety Service Centre leads the critical discussion and reflection process. 2. The Manager of the Child Safety Service Centre ensures, as a priority, a thorough understanding by staff of current procedures and roles within the Child Safety Service Centre for the management of new child protection concerns regarding families subject to Ongoing Intervention, with particular focus on unborn children.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. Critical discussion took place between the relevant staff which included the Senior Practitioner, Team Leaders and Co Co-Ordinator a number of times from August 2010 through to April 2011. Critical discussion with the office as a whole was not implemented due to shortages of staff and high turn over of staff and the varying degrees of experience and pressures including key staff within the leadership team on leave. However the Senior Practitioner led a process of review of the systems recommendations and identified the key issues and actions that were to occur within the Child Safety Service Centre. Further actions included: • Accessing and educating staff around the current policies in relation to unborn baby notifications - February 2011. • Tables outlining the process for unborn notifications were then created and disseminated to relevant staff at the time. • The Investigation and Assessment Team Leader then identified every unborn notification within the service centre - February 2011. •The unborn notifications were then allocated to an experienced Child Safety Officer who had been part of the discussions and learnings to complete. • This was supervised by a Team Leader who had been part of the above review process for quality assurance. • The service centre however ensured that any staff across the service centre who were part of any unborn notifications since February 2011 participated in practice panel discussion with the Senior Practitioner, Team leader and Court Co-Ordinator.

	3. The Regional Leadership Team and the Learning Operations Unit partner in conducting a detailed Training Needs Analysis (TNA) of Child Safety Service Centre1 which, as an outcome, should include as a minimum the following targeted areas of training:o Engaging with mothers and families prior to a child's birth, when childprotection concerns are known regarding unborn children.o Undertaking investigations and assessments, with particular regard to holistic assessment of a child's need for protection and the appropriate intervention to meet identified need.o Case planning, implementation and review of children identified as requiring ongoing intervention, with particular regard to; the management of risk when children assessed as in need of protection remain in the home, maximizing internal and external supports and partnerships in service delivery and collaborative and inclusive practice with families.The TNA should further be informed by this current review, previous departmental systems and practice reviews relevant to the Child Safety Service Centre, Child Death Case Review Committee reports associated with those departmental reviews and input by the region's leadership team and the manager and staff of the Child Safety Service Centre. The implementation of the training needs analysis outcomes should be recorded and closely supported by the regional leadership team, regional specialist support staff and central support and training staff.	Recommendation 3. Completed. • Linking has occurred between the Child Safety Service Centre and the regional based Principal Training and Specialist Support Officer • The Senior Practitioner has developed and implemented a casework training program that targeted existing Child Safety Officer's and has included a focus on case work, engaging with clients, conducting home visits etc.Following discussion with CLMU the following actions were undertaken:• A training audit of the key staff mentioned in the review to identify training areas relevant to this review• A discussion of the Practice Innovation Centre trial with the trial principal • A review of the training package developed by the Senior Practitioner and the Family Group MeetingConvener. Outcomes :1. A review of training records held by the Child Safety Service Centre indicates that staff mentioned in the report have attended the listed training. The above information indicates that staff have undertaken the relevant core training available for their roles. No core training needs indicatedAnother team is now developing practical solutions to address these issues. A unique configuration of seven selected Child Safety Service Centres called Practice Innovation Centres has been created to assist in the coordination of the project. With one PIC in each region, the project team can collect valuable data on the time it currently takes to perform various pieces of work. It provides a way to test new ways of doing the work that will still deliver high quality services to children and their families with less stress on the child safety officers involved. This initiative is providing the Child Safety Service Centre with a clear framework for progressing matters to court which was not evident in practice at the time of the review. No specific court training recommended.

		2. The following information regarding the PIC project outlines how involvement in this project is assisting the professional development of the Child Safety Service Centre staff, particularly the acting Court Coordinator. The project teams include business analysts and technical experts in court work from Statewide Services and the regions. The involvement of field staff in the project is seen as critical to its success. The teams are also provided with high level management and administrative support to ensure solutions that emerge from this work are well coordinated and easily integrated into the workplace. The first identified pressure point under investigation by the WAP teams targets the intensive work of seeking child protection orders. One team has already engaged in identifying the issues associated with this work and explored possible reasons for the pressure on staff. The project teams include business analysts and technical experts in court work from Statewide Services and the regions. The involvement of field staff in the project is seen as critical to its success. The teams are also provided with high level management and administrative support to ensure solutions that emerge from this work are well coordinated and easily integrated into the workplace.

		The first identified pressure point under investigation by the WAP teams targets the intensive work of seeking child protection orders. One team has already engaged in identifying the issues associated with this work and explored possible reasons for the pressure on staff. Another team is now developing practical solutions to address these issues A unique configuration of seven selected Child Safety Service Centres called Practice Innovation Centres (PICs) has been created to assist in the coordination of the project. With one PIC in each region, the project team can collect valuable data on the time it currently takes to perform various pieces of work. It provides a way to test new ways of doing the work that will still deliver high quality services to children and their families with less stress on the child safety officers involved. This initiative is providing Gladstone Child Safety Service Centre with a clear framework for progressing matters to court which was not evident in practice at the time of the review. No specific court training recommended.
49	1. The review report be provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service to be used as appropriate for learning and development.	Recommendation 1. Completed. The review report be provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service to be used as appropriate for learning and development.
50	1. The review report be provided to the Regional Directors and Managers of the relevant Child Safety Service Centre and Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. The review report be provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service to be used as appropriate for learning and development.
51	The review report be provided to the Regional Director, Manager of the relevant Child Safety Service Centre and the Manager of the relevant Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. The review report be provided to the Regional Director and Managers of the relevant Child Safety Service Centre and Regional Intake Service to be used as appropriate for learning and development.

52	1. The review report be provided to the Regional Director and manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.
53	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. 2. A de-identified copy of the report be provided to the following units for discussion and reflection on learnings: * Training and Specialist Support * Child Safety Practice Improvement * Legal Services Child Safety Services and Sport	Recommendation 1. Completed. The review report was provided to all staff who participated in the review to allow critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the report was provided to the following units for discussion and reflection on learnings: * Training and Specialist Support * Child Safety Practice Improvement * Legal Services Child Safety Services and Sport
54	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.
55	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.
56	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and relevant Child Safety Service Centre Manager for use as appropriate in learning and development.

57	1.The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes. 2.A de-identified copy of the report be provided to Child Safety Practice Improvement for discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development. Recommendation 2. Completed. A de-identified copy of the review was sent to the Child Safety Practice Improvement Unit for discussion and reflection on learnings.
58	1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings; and 2. The de-identified report be disseminated at the South East Senior Practitioner Forum for reflection and critical discussion.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings. Recommendation 2. Completed. A de-identified copy of the review was sent to the South East Senior Practitioner Forum for refection and critical discussion.
59	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.
60	The review report be provided to the Regional Director and Placement Service Unit Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Director of the Placement Support Unit for use as appropriate in learning and development.
61	The review report be provided to the Regional Director and Manager of the relevant Regional Intake Service to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Regional Intake Service for use as appropriate in learning and development.
62	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used for appropriate learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.

63	The review report be provided to the Regional Director and Manager of the relevant Child Safety Service Centre to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Child Safety Service Centre for use as appropriate in learning and development.
64	The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	Recommendation 1. Completed. A de-identified copy of the review was provided to all staff who participated in the review for their critical discussion and reflection on learnings.
65	The review report be provided to the Regional Director and Manager of Regional Intake Service1 to be used as appropriate for learning and development purposes.	Recommendation 1. Completed. A de-identified copy of the review was provided to the Regional Director and Manager of the relevant Regional Intake Service for use as appropriate in learning and development.
	Total departmental recommendations - 76	Total departmental recommendations completed - 76