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Inquiry into the relationship between DFSV victimisation and suicide

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Standing Committee on Social Policy and Legal Affairs

The Queensland Family and Child Commission

The Queensland Family and Child Commission (the Commission) welcomes the opportunity to provide a submission to the Inquiry into the relationship between domestic, family and sexual violence (DFS) victimisation and suicide.

The Commission is Queensland's statutory authority dedicated to promoting the safety, wellbeing and rights of children and young people. The Commission hosts the Queensland Child Death Review Board (the Board), which undertakes independent system reviews following the death of a child known to the child protection system in the 12 months before their death.

As part of Queensland's child death review process, government agencies that had contact with a child in the 12 months before the child's death undertake an internal agency review of their service delivery to the child and family. The Board Secretariat team review all internal agency reports relating to a case and assess the presence and degree of system issues for the Board's consideration.

The Commission also holds responsibility for maintaining and reporting on the Queensland Child Death Register, which records the deaths of all children and young people in Queensland under the age of 18 years. The Commission undertakes three core functions in relation to the Register:

- maintaining a comprehensive record of all child deaths notified by the Registrar of Births, Deaths and Marriages and reported to the Coroners Court of Queensland
- conducting research into the risk factors associated with these deaths
- preparing an Annual Report to inform prevention strategies and support public accountability.

Submission Overview

Suicide is the leading cause of death for children aged 10–17 years in Queensland.¹

The *Deaths of children and young people Queensland 2021–22* Annual Report, produced from the Child Death Register, identified suicide as the leading cause of death for 15–17-year-olds over the five-year period 2017–18 to 2021–22.²

Subsequent reporting periods indicate a continuation and broadening of this trend. In the years following that report, suicide has overtaken cancer and tumours as the leading cause of death in the 10–14-year-old age group. Across reporting periods from 2022–23³ to 2024–25, suicide has accounted for more deaths among children and young people aged 10–17 years than cancers and tumours or transport-related incidents.

In 2024–25, 24 child deaths were caused by suicide. Addressing youth suicide requires compassion, awareness, and a commitment to creating safe, supportive environments where every young person feels seen, heard, and valued. The sustained position of suicide as the leading cause of death in this age cohort represents a significant public health and child protection concern, indicating the need for coordinated, cross-sectoral prevention and early intervention responses.

Evidence shows a strong relationship between exposure to DFSV and higher risk of suicidal ideation, self-harm and suicide.⁴ Children exposed to DFSV often experience cumulative trauma, instability and fear. These harms are compounded by other Adverse Childhood Experiences (ACEs), including abuse, neglect, parental substance misuse and parental mental illness.⁵ Together, these intersecting adversities increase long-term suicide risk.

¹ Queensland Family and Child Commission. 2025 Annual Report: Deaths of children and young people Queensland 2024-25

² Queensland Family and Child Commission. 2025 Annual Report: Deaths of children and young people Queensland 2021-22

³ Queensland Family and Child Commission. 2025 Annual Report: Deaths of children and young people Queensland 2022-23

⁴ Child Death Review Board. 2021, *Preventing Suicide: Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*

⁵ Child Death Review Board. 2025, *Annual Report 2024-25*

Despite this evidence, policy and service responses often treat DFSV and suicide as separate issues. Systems across child protection, health, mental health, education, justice and community services remain fragmented. Children exposed to DFSV are not consistently recognised as victim-survivors in their own right, and opportunities for early identification and intervention are frequently missed.⁶

Addressing youth suicide in the context of DFSV requires a coordinated, trauma-informed, multi-agency approach. It should strengthen early identification of risk, improve data quality and linkage, enhance workforce capability, and respond to the cumulative harm experienced by children. We need to recognise children as victim-survivors in their own right and embed their voices in the design and delivery of DFSV and suicide prevention systems and services.

Term of Reference 1: The relationship between DFSV victimisation and suicide, including prevalence, patterns and at-risk groups

Relationship between DFSV and suicide

Exposure to DFSV is a well-established risk factor for poor mental health outcomes and suicidal behaviour. Children who experience or witness violence in the home are more likely to experience anxiety, depression, emotional dysregulation and trauma-related symptoms.

The Board has identified suicide risk concentrated among children experiencing cumulative adversity. The Board's analysis in *Preventing Youth Suicide* shows that youth suicide is rarely attributable to a single factor. It reflects multiple risks including trauma, abuse and neglect, family dysfunction, mental illness, substance use and social disadvantage. ACEs, including exposure to DFSV, are consistently present in the life histories of many children who die by suicide. This supports a trauma and harm framework, not only an individual mental health lens.⁷

Family environments marked by violence, instability and substance misuse create chronic stress and fear that undermine children's emotional safety and wellbeing. These environments frequently co-occur with other adversities such as housing instability, parental mental illness and criminal justice involvement. The Board emphasises that children exposed to DFSV should be recognised as victim-survivors in their own right, rather than invisible secondary witnesses to adult harm.⁸

The *Australian Child Maltreatment Study* (ACMS) is the first nationally representative population study in Australia to measure the prevalence and lifelong impacts of all five core forms of child maltreatment, including exposure to domestic and family violence, and their association with later health outcomes, including suicide attempts and self-harm. The ACMS found:

- Exposure to domestic and family violence is the most common form of child maltreatment, with 39.6 per cent of Australians aged 16 and over, reporting exposure during childhood, rising to 43.8 per cent among young people aged 16–24.
- Experiencing any form of maltreatment, including exposure to domestic violence, is associated with substantially higher rates of suicide attempts and self-harm in later life.
- Young people aged 16–24 with maltreatment histories show stronger associations with suicide attempts and health risk behaviours than older adults, highlighting the enduring mental health impact of childhood adversity.⁹

⁶ Child Death Review Board. 2024, *Annual Report 2023-24*

⁷ Child Death Review Board. 2021, *Preventing Suicide: Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*

⁸ *ibid*

⁹ Haslam D et al., 2023, *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology

Children in out-of-home care are more likely to have experienced multiple ACEs prior to entering the child protection system, including parental domestic violence, abuse and neglect.¹⁰ A study of adolescents involved with child protection services found that allegations of physical and sexual abuse were significant risk factors for suicide among adolescents aged 15–19 years.¹¹ The study also showed a clear link between how recently a young person had contact with child protection services and their suicide risk. Adolescents with more recent involvement were at higher risk of dying by suicide.

These findings show that child protection and family welfare services are critical points for identifying suicide risk early and acting quickly, especially when maltreatment is reported and children are already engaged with statutory or community services.¹²

Child sexual abuse

In November 2025, the Board delivered the *In Plain Sight* report¹³ – a systemic review into institutional and cross-system responses to child sexual abuse, commissioned by the Queensland Government. Using the offending of Ashley Paul Griffith as a case study, the review examined systemic responses over a 20-year period, spanning early childhood education and care, state and federal policing, and the Working with Children Check system.

In Plain Sight represents the most comprehensive examination of Australia’s safeguarding architecture since the Royal Commission into Institutional Responses to Child Sexual Abuse almost a decade ago. Its central finding is that those who harm children often operate openly within communities, visible to institutions and systems but not recognised or acted upon. The report identifies structural limitations across safeguarding, accountability and redress frameworks that impede effective protection and long-term healing for victim-survivors.

Child sexual abuse has complex and lasting impacts that vary according to the nature and duration of abuse, the victim-survivor’s circumstances and their relationship to the perpetrator. There is no single or predictable response to abuse. Research consistently shows increased risks of serious mental health problems, including PTSD, anxiety, depression, self-harm and suicidal behaviour. It also shows disrupted emotional development, physical health conditions, relationship difficulties, risky behaviours, substance misuse, and poorer educational and economic outcomes. These cumulative harms show that child sexual abuse is both an immediate child safety issue and a major contributor to long-term vulnerability and suicide risk. This requires early, trauma informed and sustained system responses.

The Board found that many victim-survivors face significant structural and procedural barriers in accessing specialist support services, especially where abuse has occurred outside institutional settings. *Operational Recommendation 12* specifically calls for improved access to trauma-informed specialist services and for reduced procedural burdens on victim-survivors navigating justice and redress systems. The Recommendation states:

The Queensland Government undertake a review of its current investment in sexual abuse counselling and support services, and establish a centrally coordinated, dedicated funding allocation specifically for responding to child sexual abuse. This funding should ensure:

- *Trauma counselling is available to children and parents at the point of disclosure and throughout court processes.*
- *Adolescent mental health support is accessible for children as they transition into adolescence.*
- *Adult survivors of child sexual abuse have access to ongoing therapy and support across their life-course in acknowledgement that the impacts of abuse may re-emerge at key life stages.*

¹⁰ Child Death Review Board. 2021, *Preventing Suicide: Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*

¹¹ Meyer, S et al., 2023, *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide – Current State of Knowledge Report*. Griffith University

¹² *ibid*

¹³ Child Death Review Board. 2025, *In Plain Sight – Review into System Responses to Child Sexual Abuse*

- Eligibility criteria and service coverage are equitable, removing postcode, age, or relational barriers that currently limit access.
- Investment is strategically coordinated across agencies to create a seamless, statewide network of trauma-informed services, replacing the current fragmented patchwork.

This approach will embed lifelong, consistent support for victim-survivors and their families, and strengthen Queensland’s overall child safeguarding framework.

The Queensland Government has committed to providing a response to the report in conjunction with the government’s response to the Child Safety Commission of Inquiry’s final report, due in May 2026.

Prevalence and patterns in Queensland

Suicide	<ul style="list-style-type: none"> • In 2024–25, 24 child deaths were attributed to suicide in Queensland (19 confirmed and 5 probable suicides), compared with 19 in the previous reporting period. Suicide remains the leading cause of death for young people aged 10–17 years.¹⁴ • Over the past two decades, the suicide rate has shown a gradual increase over time, rising by 1.2 per cent each year on average, despite overall child mortality rates decreasing by 2.2 per cent each year on average.¹⁵ • Over the last five years (2020–21 to 2024–25), the mortality rates for Aboriginal and Torres Strait Islander children were 2.5 times higher than the non-indigenous mortality rates for suicide.¹⁶
Domestic and Family Violence	<ul style="list-style-type: none"> • A recent national study of 5,021 young Australians revealed that one in two young people in Australia grow up with some form of DFV.¹⁷ • Charges for domestic and family violence related offences, or ‘flagged offences’, more than doubled in the last five years across the state. Over the past 10 years, statewide police service calls related to domestic and family violence have increased by 265 per cent.¹⁸ • The Queensland Police Service (QPS) attended more than 200,000 domestic and family violence-related incidents in 2024–25.¹⁹ • Between 2016 and 2022, 31.7 per cent of all domestic and family violence occurrences reported to QPS involved children. This is likely under-reported, as most children were not identified as witnesses or victims.²⁰ • As at 31 May 2025, there were 46,874 DVOs made in Queensland Courts in the 2024–25 period. Police lodged 83.6 per cent of applications. <ul style="list-style-type: none"> ○ In 82.8 per cent of DVOs the aggrieved was female, and in 82.1 per cent of DVOs the respondent was male. ○ In 72.1 per cent of applications, the nature of relationship was ‘intimate personal’ and in 27.5 per cent the relationship was ‘family’.²¹

¹⁴ Queensland Family and Child Commission. 2025 *Annual Report: Deaths of children and young people Queensland 2024-25*

¹⁵ *ibid*

¹⁶ *ibid*

¹⁷ Meyer, S et al., 2023, *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide – Current State of Knowledge Report*. Griffith University

¹⁸ Queensland Family and Child Commission. 2025, *Performance of the Queensland child protection system 2024-25 Annual Report*

¹⁹ Child Death Review Board. 2025, *Annual Report 2024-25*

²⁰ Queensland Family and Child Commission. 2025, *Performance of the Queensland child protection system 2024-25 Annual Report*

²¹ *ibid*

Child Sexual Abuse	<ul style="list-style-type: none"> • ACMS survey findings identified that children who experience sexual abuse in their childhood were 2.3 times more likely to report having attempted suicide in the past 12 months.²² • Between 2015–16 and 2024–25, 43,812 child sexual abuse offences were reported to or identified by Queensland Police Service. Of the offences that were reported to QPS, 80 per cent did not proceed to an arrest, notice to appear, summons, or other criminal justice outcome.²³ • The number of children who were the subject of a substantiated child safety investigation where sexual abuse was the most serious abuse type increased by 32.1 per cent over five years, from 368 children in June 2020 to 486 children in June 2024. As a proportion, substantiations of sexual abuse increased from 5.6 per cent to 6.8 per cent of all substantiations.²⁴
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Term of Reference 2: Opportunities for improved reporting and data collection

Current data systems do not consistently capture the relationship between DFSV exposure and suicide. DFSV is often under-reported or inconsistently recorded across suicide surveillance, coronial, health, justice and child protection datasets. This limits the ability to identify trends, understand cumulative harm and develop evidence-based prevention strategies.

The data gap in research

Studies report wide variation in prevalence estimates due to differences in definitions and data sources. Retrospective and self-report studies indicate that between 20 and 40 per cent of children have experienced domestic and family violence. Some parent and caregiver reports suggesting prevalence as high as 59 to 80 per cent. In contrast, studies relying on police, clinical and administrative data produce much lower estimates, ranging from nine to 24 per cent, reflecting substantial under-reporting and limitations in screening and detection processes. This discrepancy mirrors findings in the broader child maltreatment literature, where official datasets capture only a fraction of lived experience.²⁵

Although international research shows a strong association between childhood exposure to DFSV and adverse mental health outcomes, including suicidal behaviour, limited efforts have been made to systematically examine this relationship in the Australian context. Much of the available evidence derives from coronial inquests, child death registers and state-based inquiries rather than from linked national datasets. Among the few Australian studies conducted, one analysis of youth suicide deaths between 2006 and 2015 found that 7.4 per cent of cases had a documented history of abuse or neglect and 2.5 per cent had recorded exposure to domestic and family violence between adults in the home. However, because this study relied on police and coronial records, it captured only cases in which DFSV was identified during system contact. Where violence was present but not disclosed, detected or recorded, it was likely overlooked.²⁶

Data collection in Queensland

The Board's findings show both the presence of DFSV in suicide cases and the shortcomings of existing data systems. In 2024–25, the Board considered the deaths of 64 children, including five suicides among young people aged 15–17 years. Since its inception, the Board has reviewed 31 deaths of a child due to suicide, of whom 12 (38.7 per cent) were Aboriginal or Torres Strait Islander children. Case reviews indicate that domestic and family violence is frequently present in the lives of children who die by suicide, yet this exposure is not systematically or

²² Meyer, S et al., 2023, *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide – Current State of Knowledge Report*. Griffith University

²³ Child Death Review Board. 2025, *In Plain Sight – Review into System Responses to Child Sexual Abuse*

²⁴ *ibid*

²⁵ Meyer, S et al., 2023, *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide – Current State of Knowledge Report*. Griffith University

²⁶ *ibid*

consistently recorded across service systems. As a result, the contribution of violence to suicide risk remains poorly understood and cannot be reliably monitored over time.²⁷

Of the 70 child deaths reviewed by the Board in 2023–24, 56 per cent involved DFV in the child's life.²⁸ In seven cases examined in detail, all involved existing domestic violence orders, and most involved siblings living in the home alongside documented coercive control, physical violence, emotional abuse and sexual abuse. Despite this, children and young people continue to be largely overlooked as victim-survivors in DFSV data systems. Between 2016–2022, 31.7 per cent of all DFV occurrences reported to QPS involved children, yet most children were not formally identified as victims or witnesses.²⁹ Current police risk screening tools do not capture information about children's safety, fear or direct experiences of harm.

National data limitations compound this problem. The ACMS found that 43.8 per cent of young people aged 16–24 years had experienced exposure to domestic violence, yet more recent Queensland-specific prevalence data are unavailable due to reporting gaps. For example, Queensland Courts do not report the age of aggrieved parties in domestic violence order applications, preventing accurate identification of children and young people affected by DFSV. These gaps reflect a systemic failure to recognise children as direct victim-survivors of domestic and family violence and obscure the relationship between DFSV and suicide risk.³⁰

Overall, the evidence demonstrates that DFSV exposure is common among children and young people, strongly associated with adverse mental health outcomes, and frequently present in suicide cases — yet remains poorly captured in official data systems. This undermines efforts to understand pathways to suicide, evaluate prevention strategies and target early intervention to those most at risk.

There is a significant opportunity to strengthen national data capability by:

- improving data linkage between DFSV, child protection, health and suicide surveillance systems
- standardising the recording of DFSV exposure in coronial and health datasets
- improving consistency in child death review methodologies across jurisdictions.

Strengthening these systems would enable a more accurate understanding of the role of DFSV in youth suicide, support earlier identification of risk, and inform more effective prevention and intervention strategies.

Term of Reference 3: How systems recognise and respond to suicide in the context of DFSV

Many children who die by suicide had prior contact with government systems, creating opportunities for earlier identification of risk.

Consecutive Board reports highlight significant challenges in current system responses to suicide and the broader risks experienced by children and young people, particularly those exposed to cumulative adversity, including DFSV. The child death review process enables examination of children's life trajectories across multiple systems, identifying cumulative harm and missed intervention opportunities. The Board's examination of 70 child deaths connected to the child protection system revealed pervasive systemic shortcomings in how agencies identify, communicate, and intervene in suicide risk, especially when DFSV and co-occurring harms are present.³¹

In *Preventing Youth Suicide*, the Board found that many children who died by suicide had prior contact with multiple government systems, including child protection, health, education, and police. Despite this, risk was not always identified or responded to in a coordinated way. Fragmentation between systems limited information sharing and

²⁷ Child Death Review Board. 2025, *Annual Report 2024-25*

²⁸ Child Death Review Board. 2024, *Annual Report 2023-24*

²⁹ Queensland Family and Child Commission. 2025, *Performance of the Queensland child protection system 2024-25 Annual Report*

³⁰ Queensland Family and Child Commission. 2025, *Performance of the Queensland child protection system 2024-25 Annual Report*

³¹ Child Death Review Board. 2025, *Annual Report 2024-25*

reduced the ability to recognise cumulative harm. Early intervention opportunities were often missed because agencies focused on presenting issues in isolation rather than on the broader pattern of trauma and adversity in children's lives, including the impact of exposure to DFSV.³²

Multiple systems often fail to fill protective roles when family environments are unsafe, particularly where DFSV, substance misuse, and mental health needs intersect. Cross-agency coordination remains weak, with services responding to discrete presenting issues rather than the full pattern of risk factors contributing to suicide vulnerability. Children who die by suicide often have extensive contact with multiple service systems, yet their cumulative risk, including exposure to DFSV, neglect, and poly-victimisation, is not effectively recognised or addressed.

Educational disengagement is consistently identified as a significant marker of vulnerability among children who die by suicide. Many young people had histories of school disengagement, exclusion, or disrupted learning, often linked to family adversity, trauma, and instability. This pattern demonstrates that disengagement from education is not simply a behavioural issue but an indicator of deeper systemic and psychosocial harm, requiring coordinated responses across education, child protection, and health systems.³³

Mental health needs are a core theme in many child deaths, but accessibility and equity of mental health support for children – particularly those known to or involved with the child protection system – are limited. Children with complex trauma histories, including DFSV exposure, frequently experience barriers to sustained engagement with appropriate therapeutic services. These service limitations compound the risk of suicide and self-harm and highlight the need for systemic reform in mental health service delivery for vulnerable children.³⁴

DFSV, particularly coercive control, is a frequent and under-recognised risk factor. Coercive control involves repeated patterns of behaviour designed to dominate, frighten, isolate, and restrict the liberty of a victim and is almost always an underpinning dynamic in DFSV. The Board notes that coercive control can mask protective behaviours by victim-survivors, making it more difficult for practitioners to identify risk. Misidentification of victim-survivors, especially among First Nations women, can lead to inappropriate child protection responses, including unnecessary intervention or child removal.³⁵

Systemic gaps compound these risks. The Board has consistently found that intake and assessment processes, workforce capacity constraints, and limited interagency information-sharing impede timely identification of DFSV and suicide risk. In 50 cases reviewed for 2024–25, 58 per cent involved workload capacity issues, 50 per cent had information-sharing concerns, and 34 per cent exhibited both. Inadequate use of Child Concern Reports and failure to refer high-risk cases to SCAN teams or other coordinated multi-agency mechanisms were observed, resulting in missed opportunities for early intervention.³⁶

The Board emphasises that while reforms are underway—including enhanced intake and assessment frameworks, multi-agency coordination via SCAN teams, and QPS domestic violence reforms—the prevalence and complexity of DFSV, coercive control, and associated trauma demand sustained, prioritised system-wide action. Effective responses require strengthened training, improved screening and assessment tools, clear thresholds for action, and robust interagency collaboration to ensure that children exposed to DFSV and coercive control receive timely, coordinated, and child-centred protection.³⁷

³² Child Death Review Board. 2021, *Preventing Suicide: Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*

³³ Queensland Family and Child Commission. 2023, *Lessons from the life-story timelines of 30 Queensland children who have died: A small sample review of commonalities in child and family trajectories considered at the Child Death Review Board*

³⁴ Child Death Review Board. 2024, *Annual Report 2023-24*

³⁵ *ibid*

³⁶ Child Death Review Board. 2025, *Annual Report 2024-25*

³⁷ *ibid*

Term of Reference 5: Opportunities to enhance prevention and early intervention

Evidence from multiple reports by the Board highlight persistent gaps in the system's ability to respond to suicide risk for young people, particularly among children and young people exposed to DFSV, coercive control, and cumulative adversities. These reports emphasise that suicide risk often intersects with other indicators of vulnerability, including ACEs, neglect, educational disengagement, out-of-home care involvement, and mental health challenges.

Current system responses remain fragmented. Risk identification and intervention often occur in isolation across child protection, health, education, and justice sectors. The Board found that opportunities for early intervention were often missed because agencies did not share information effectively or adopt a holistic view of cumulative risk. This fragmentation underscores the need for integrated multi-agency strategies to address the complex interplay of risk factors contributing to youth suicide.

Several areas for policy and practice improvement are evident:

1. Enhanced Data Systems and Information Sharing

National and state-level data systems do not consistently capture the relationship between DFSV exposure and suicide, limiting the ability to detect trends, cumulative harm, and emerging risk factors. The Board recommends strengthening data linkage between child protection, health, education, justice, and suicide surveillance systems. Standardised recording of DFSV exposure, including coercive control, in coronial, clinical, and child protection datasets would improve risk identification, service evaluation, and policy planning.

2. Early Recognition and Intervention

Coercive control and other forms of DFSV are often under-recognised in risk assessments, particularly where victim-survivors display protective behaviours that may be misinterpreted as uncooperative. Enhanced practitioner training, updated screening tools, and clear guidance on identifying coercive control are essential to ensure early recognition of both risk and protective factors. Multi-agency mechanisms such as SCAN teams and High-Risk Teams should be consistently applied to coordinate early intervention, especially for children not yet known to statutory services.

3. Trauma-Informed and Holistic Responses

Evidence indicates that youth suicide frequently occurs within the context of poly-victimisation, including DFSV, neglect, physical or sexual abuse, and exposure to parental substance misuse or mental illness. Interventions must therefore be trauma-informed, recognising the cumulative impact of ACEs and supporting children's emotional, social, and educational needs alongside safety planning. Enhanced engagement with mental health services, culturally safe supports for First Nations children, and integrated education support are critical.

4. Targeted Support for Vulnerable Populations

Children in out-of-home care, youth justice supervision, or those disengaged from education are disproportionately represented among youth suicides. Coordinated interventions should prioritise these high-risk groups, with cross-sectoral approaches linking child protection, education, and health services to prevent gaps in monitoring, support, and follow-up.

5. Community and Family Engagement

DFSV and coercive control are often under-recognised in the broader community. Public awareness campaigns, support for victim-survivors, and engagement with families, particularly First Nations communities, are essential to improve early detection and reduce stigma. Policy and practice reforms must balance child protection imperatives with the need to avoid misidentifying victim-survivors as perpetrators.

6. System Capacity and Workforce Development

Workload constraints, inconsistent use of child concern reports, and limited information-sharing were identified in multiple case reviews as barriers to timely and effective intervention. Strengthening workforce capacity, providing ongoing specialist training, and supporting multi-agency collaboration are critical measures to ensure children at risk receive timely, effective, and coordinated protection.

Taken together, these findings suggest that preventing suicide in the context of DFV, particularly amongst young people, requires holistic, coordinated, and sustained action across policy, practice, and community systems. Effective prevention relies on early recognition of risk, improved data collection and information sharing, trauma-informed approaches, targeted support for high-risk children, and strengthened interagency collaboration. Without these reforms, the cumulative harms of DFV, coercive control, and other adverse childhood experiences will continue to undermine the safety and wellbeing of vulnerable children and young people.

Term of Reference 6: Other related matters

The Commission emphasises the importance of recognising children as victim-survivors in their own right and embedding children's voices in the design of DFSV and suicide prevention services.

Suicide prevention must be understood as a child safety and public health issue, not confined to a mental health response. Addressing cumulative harm, coercive control and family violence is central to reducing suicide risk among children and young people.

Conclusion

The evidence presented in this submission shows a clear and compelling relationship between DFSV victimisation and suicide among children and young people. The Board's findings consistently show that suicide rarely occurs in isolation, but rather within a landscape of cumulative harm that includes exposure to DFSV, coercive control, neglect, trauma, educational disengagement and unmet mental health needs. Despite repeated system contact, many children remain invisible as victim-survivors, and opportunities for early identification and coordinated intervention are frequently missed.

Preventing youth suicide in the context of DFSV requires a fundamental shift from fragmented, issue-specific responses to integrated, trauma-informed and child-centred systems of care. This includes strengthening data collection and linkage, improving recognition of coercive control and cumulative risk, enhancing workforce capability, and embedding robust multi-agency collaboration across child protection, health, education and justice sectors. Children exposed to DFSV must be recognised as victims in their own right, with their safety, voices and lived experience central to prevention and service design.

Without sustained system-wide reform, the cumulative impacts of DFSV and other adverse childhood experiences will continue to place vulnerable children and young people at unacceptable risk. A coordinated national approach that treats suicide prevention as both a child safety and public health priority is essential to breaking cycles of harm and ensuring that every child grows up safe, supported and protected from preventable loss of life.