Child Death
Review Board
Queensland **Family & Child** Commission

Annual Report 2023–24

A report on the operations and systemic findings of the Queensland Child Death Review Board

Queensland
Government

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Acknowledgements

The Queensland Child Death Review Board (the Board) 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.

The Board acknowledges the difficult and important work of the government agencies that are required to review the services they provided to these children. We are all committed to working together to learn from these reviews and to make the changes needed to promote the safety and wellbeing of children and help prevent future deaths.

The Board relies on the collective knowledge and contributions of government agencies and non-government organisations to inform its systemic reviews. It thanks these agencies and organisations and acknowledges their efforts in protecting Queensland children and assisting their families to care for them.

The Board also acknowledges the work of its Secretariat in analysing child death reports, gathering research, collating data, preparing reports, and coordinating meetings.

Warning

This report may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline: Phone: 13 11 14

Beyond Blue: Phone: 1300 22 4636

Kids Helpline (for 5–25-year-olds): Phone: 1800 55 1800

13YARN [Thirteen YARN] for Aboriginal and Torres Strait Islander people: Phone: 13 92 76

Aboriginal and Torres Strait Islander peoples should be aware that this report contains data about deceased children and information about systemic issues facing Aboriginal and Torres Strait Islander peoples.

Media requests

Further details about the children mentioned in this report will not be released.

Child Death
Review Board
Queensland **Family & Child** Commission

Reference: TF24/438 – DOC24/1177

Attorney-General
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29J of the *Family and Child Commission Act 2014*, I am pleased to provide for presentation to the Parliament the 2023–24 Annual Report of the Queensland Child Death Review Board.

In 2023–24, the Child Death Review Board reviewed the deaths of 70 children. This Annual Report details the key system issues identified in those child death reviews and offers the Child Death Review Board's insights and recommendations to improve the system in the areas of:

- The system as a parent (Chapter 2)
- Addressing the mental health needs of children (Chapter 3)
- The needs of children living with disability and chronic conditions (Chapter 4)
- Responding to families experiencing domestic violence (Chapter 5)
- Recognising and responding to disclosures of harm (Chapter 6)
- Assessing the impact of parental substance use on the child (Chapter 7)

We also include our monitoring of the 12 recommendations made in the prior three years that were open at the commencement of the reporting period (1 July 2023).

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

31 October 2024

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Message from the Chair

I am pleased to present the 2023–24 Child Death Review Board Annual Report, which highlights the ongoing challenge of addressing systemic issues across our social support structures.

The Queensland Child Death Review Board (the Board) is a significant feature of Queensland's child protection system. Through its independent reviews it provides an opportunity for cross-government analysis of the lives of families and children that needed our support.

The Board grounds its business in acknowledgement of the critical role government systems play in keeping families safe. We know that thousands of frontline workers in child safety, health, education, policing, and justice are driven to make a positive difference to the children and families they work with. The Board is always conscious that in hindsight, system failures often become starkly visible, allowing for reflection and learning. Our role is to provide forward-looking advice aimed at improving the future, rather than judging actions in the past. We are proud of the positive impact the Board's recent contributions have made to the safety and wellbeing of children, young people and families in Queensland.

Now in its fourth year of operation the Board has been pleased to see clear and tangible impact from its work.

- Our 2023 analysis of the life trajectories report called for greater access to early education, behaviour specialists in schools, and greater effort for school reengagement. This year government provided funding for 85 behaviour specialists in 299 primary schools, increased access to free kindy, particularly for families with vulnerabilities, and invested in school reengagement, staff and new models of learning.
- Our 2022–23 Annual Report and research on Sudden Unexpected Death in Infancy (SUDI) called for improved health home visiting and access to safer sleep options. Through this year's *Putting Queensland's Kids First* strategy the government has provided $65 million dedicated to providing more sustained health home visiting and antenatal support and $11.09 million for essentials, including access to the culturally responsive and evidence-based Pepi-Pod® Program.
- In our 2022–23 Annual Report we highlighted issues with the regulation of home education and in 2024 the government announced and commenced a review of the home education accreditation scheme.
- Last year we raised concerns about the limited empowerment of First Nations-led research in the child safety sector. This year government established a $15 million dedicated partnership fund for non-government organisations and Aboriginal and Torres Strait Islander community-controlled organisations.

Seeing pragmatic and tangible actions taken to improve the system gives us hope and motivation to continue our work.

Reading about child death cases is an emotionally difficult and deeply challenging experience. The details of each death, especially when they involve preventable circumstances, evoke feelings of sorrow, frustration, and helplessness. It is not only the loss of young lives that is hard to process, but also the complex layers of systemic inadequacies, missed opportunities, and uncoordinated responses that often contribute to these tragedies. Engaging with this material requires confronting the emotional toll it takes while maintaining a commitment to understanding and improving the systems responsible for safeguarding children's wellbeing. Knowing that our reports have an impact gives us reassurance that our efforts are not futile.

The 2023–24 reporting year marked significant progress for the Board, with the addition of five new board members and the introduction of a refined process to focus more intently on systemic and thematic issues. This new approach, combined with the Board's dedicated efforts, has resulted in the Board reviewing the lives of 70 Queensland children known to the child protection system, resulting in recommendations covering six clear and important social issues.

In response to the insights gained in 2023–24 and learnings from past years, the work of the Board this year focuses on:

- the system as a parent (Chapter 2)
- addressing the mental health needs of children (Chapter 3)
- the needs of children living with disability and chronic conditions (Chapter 4)
- responding to families experiencing domestic violence (Chapter 5)
- recognising and responding to disclosures of harm (Chapter 6), and
- assessing the impact of parental substance use on the child (Chapter 7).

In presenting this fourth Annual Report, the Board offers a set of nine recommendations for the Queensland Government to consider—some of which echo earlier recommendations that remain unaddressed.

It is clear that to prevent future child deaths we must foster a collective sense of responsibility for the health, wellbeing and safety of children and their families.

I commend the outstanding work of the Board and its secretariat staff, dedicated Queenslanders who are deeply committed to making a meaningful impact.

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

31 October 2024

Introduction

This report has been prepared under section 29J of the *Family and Child Commission Act 2014*. It describes the work of the Board in 2023–24 in carrying out its reviews and other functions under Part 3A of the *Family and Child Commission Act 2014* and the Board's *Procedural Guidelines*.

Chapter 1 provides an overview of key characteristics of the 70 children and young people reviewed in the reporting period. It looks at the causes of death of the children, basic demographics and cultural status.

Chapters 2 to 7 discuss the key themes and service system issues identified by the Board in 2023–24. The chapters also share relevant case studies of children's lived experiences. Each of these chapters introduces recommendations for system improvements made by the Board during the reporting period.

The key themes and service system issues explored in this report are:

- Chapter 2—The system as a parent
- Chapter 3—Addressing the mental health needs of children
- Chapter 4—The needs of children living with disability and chronic conditions
- Chapter 5—Responding to families experiencing domestic violence
- Chapter 6—Recognising and responding to disclosures of harm, and
- Chapter 7—Assessing the impact of parental substance use on the child.

Chapter 8 Revisits the recommendations that were made in the previous three annual reports and provides an update on the implementation of these recommendations. The chapter presents a summary of key actions, practice reform and changes that the responsible agencies have reported for the years 2020–21, 2021–22, and 2022–23.

Chapter 9 outlines the governance of the Board.

Recommendations made in this report

Recommendation 1: Improved cross-government commitment to all children in care

The Board recommends that the Department of the Premier and Cabinet (DPC) facilitate the publication of commitments from each portfolio Minister or Director-General regarding their commitment to children in state care. This public commitment to children in care should include commitments regarding the core business of the portfolio, as well as broader employment and training, economic and work placement opportunities.

Recommendation 2: Supporting conversations with young people about healthy relationships and sexual and reproductive education

The Board recommends that the Department of Child Safety, Seniors and Disability Services (Child Safety) and Queensland Health collaborate to revise and/or develop new practice guidance for child protection practitioners, foster carers and residential care providers on providing regular, effective, sensitive and contextual guidance to children in care to support and promote their sexual health and wellbeing. This must include topics of sexual and reproductive education, contraception, healthy relationships and consent.

Recommendation 3: Continuity of care for children with complex needs (Revisiting Recommendation 3 from the Board's 2021–22 report)

The Board recommends that government prioritise its response to the *Child Death Review Board 2021–22 Annual Report Recommendation 3: Continuity of care for children with complex needs*, noting that cases reviewed by the Board in 2023–24 reinforced the need for flexible, specialised care models, particularly those who display violent and dysregulated behaviours or who are experiencing significant substance use or mental health concerns. Given the ongoing seriousness of this issue, government's response to this recommendation should include nomination of a lead role who will produce quarterly public reporting on the status of this work.

Recommendation 4: Guaranteed access to mental health supports for children in care

The Board recommends that Queensland Health:

1. take action to ensure that where a child in state care does not engage with a public mental health service, their referral is not closed until:
   - the child's case is discussed at a Suspected Child Abuse and Neglect (SCAN) meeting (or other equivalent multi-agency coordination mechanism); and,
   - a multi-agency strategy to support engagement has been developed and enacted.
2. take action to ensure that where there is non-engagement of a young person in state care with a mental health service including Child and Youth Mental Health Services (CYMHS) or Evolve Therapeutic Services (ETS), this does not result in the closure of the referral and Queensland Health maintains responsibility and takes alternative action to respond to the mental health needs of the child.
3. improve access to mental health supports for children and young people by:
   - improving staff awareness of Gillick competency and the ability for Gillick competent children and young people to access mental health services without parental consent; and,
   - allowing young people who are Gillick competent to nominate any appropriate adult as their support person.

Recommendation 5: Improving risk assessments of children with disability and chronic medical conditions

The Board recommends that Queensland Health take action to provide clear guidance that will support Child Safety to better assess the safety of children living with disabilities and/or chronic medical conditions with a specific focus on distinguishing between intentional parental neglect or maltreatment compared to deficits in the health literacy or competency of the parent that should be addressed through health and/or disability support services.

Recommendation 6: Coordinated health service delivery for sibling groups

The Board recommends that Queensland Health develop guidelines for clinicians to promote a family-centred approach to the provision of health services to children and young people, such that clinicians consider the wellbeing of siblings and can directly refer siblings into the health service, or to the clinician, if risks or health concerns are identified.

Recommendation 7: Maintaining action on reducing family and domestic violence

The Board recommends that Queensland Government continue to prioritise its response to the impact of family and domestic violence on Queensland children, and continue to implement the past recommendations of the Board and the following reviews:

- *Not Now, Not Ever report, the Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland*
- *Hear Her Voice – Report Two – Women and girls' experiences across the criminal justice system*
- *Independent Commission of Inquiry into Queensland Police Service A Call for Change.*

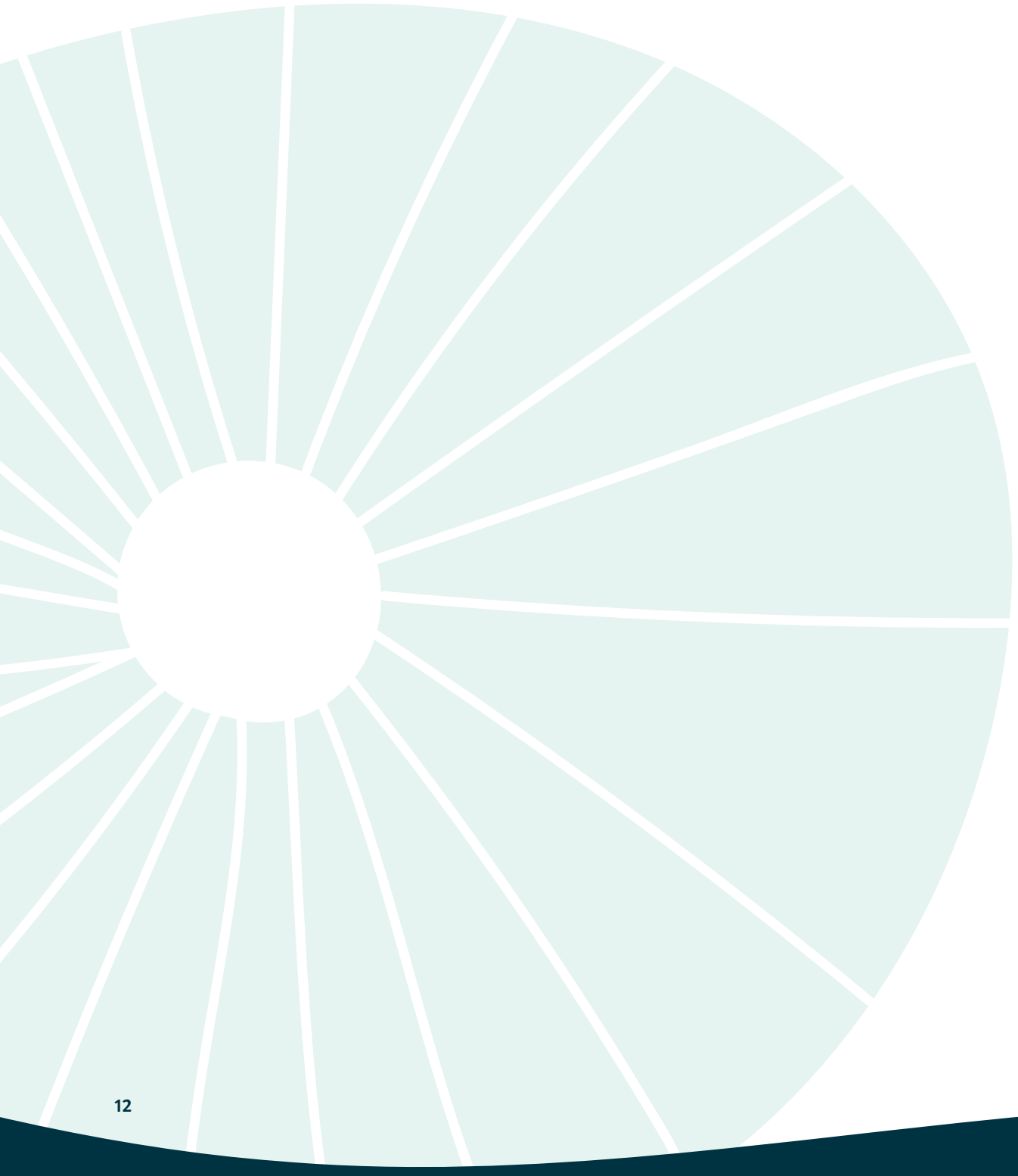
Recommendation 8: Enhanced awareness of, and improved response to, the additional vulnerabilities of young and non-verbal children

The Board recommends that:

1) the Queensland Government invest in a public campaign to assist parents to understand childhood behavior development, positive parenting techniques and the consequences of corporal punishment; and,
2) all child protection entities (Child Safety, Queensland Health, Education, QPS and Youth Justice) enhance staff awareness of the additional vulnerabilities of young (under five years) and/or non-verbal children. This may include how to interpret and seek corroborating evidence in response to verbal and non-verbal disclosures. It is recommended that this includes:
    - consideration of implementing a bruising clinical decision rule, such as the Ten-4-Faces-P material, to ensure that it is captured in their current guidance on indicators of physical abuse to increase their capacity to identify non-accidental injuries;
    - consideration of the need to seek information from a broader range of sources who know the child than might otherwise be required for verbal children. This would include early childcare workers, support workers, neighbours and extended family; and,
    - improving how agencies facilitate and receive medical assessments of children including how they provide relevant context as to why the review has been requested, contact the medical practitioner prior to the review, and nominate an independent medical professional.

Recommendation 9: Revisiting 2022–23 Recommendation 5: Strengthening child safety practice in response to parental substance and methamphetamine use

The Board recommends that the Queensland Government outline the work it is doing to further embed the practice guidance it created in response to the *Child Death Review Board 2022–23 Annual Report Recommendation 5: Strengthening child safety practice in response to parental substance and methamphetamine use*, noting cases reviewed by the Board in 2023–24 confirmed the ongoing need to support frontline practitioners in their risk assessments of children whose parents' substance use is problematic.



CHAPTER 1

Cases reviewed by the Board in 2023–24

The Board is responsible for conducting system reviews following the death of a child known to the child protection system in the 12 months prior to their death.

The Board's reviews are not intended to investigate the cause of death and instead are intended to identify system improvements that can increase children's safety and prevent future child deaths.[1] It is important to note that not all children reviewed by the Board are in the child protection system at the time of their death. In 2023–24 13 per cent of reviewed cases related to children in care. It should also be noted that the cause of death for 41 per cent of these children was natural causes.

Queensland's child death review process is two-tiered. Government agencies that had contact with a child in the 12 months prior to their death undertake an internal agency review of their service delivery to the child. The agencies required to undertake reviews are:

- the Department of Education (Education)
- the Department of Child Safety, Seniors and Disability Services (Child Safety)
- the Department of Youth Justice, Employment, Small Business and Training (Youth Justice)
- Queensland Health (includes Hospital and Health Services)
- the Queensland Police Service (QPS)
- the Director of Child Protection Litigation (DCPL).[2,3]

Agency reviews are provided to the Board's staff who then analyse the gaps and correlations between each agency's knowledge and actions regarding the child and their family. The Board uses these agency reviews to consider the collective Queensland Government service delivery to the child. After the Board receives all agency review reports and supporting information for a child death case, a three-tier categorisation framework is utilised to determine the terms of reference and depth of analysis required for each review.[4] The categorisation framework is based on the extent to which systemic learnings and opportunities can be identified from a case, with those categorised to a Level 3 presenting the most significant opportunities for improvements and requiring in-depth review by the Board. Level 2 reviews are primarily focused on practice improvements, where agencies might have correctly identified areas of improvement in their own reviews. Level 1 cases contain minimal opportunities for learning or child death prevention mechanisms. Cases across all three levels of reviews are monitored to identify recurring issues and trends.

In 2023–24 the Board received 240 agency review reports and completed reviews of 70 cases.

To improve its efficiency and impact, in 2023–24 the Board adopted a themed collective review process. This meant that individual child death matters were grouped into similar themes and considered together to highlight opportunities for system improvement and child death prevention. This process enabled board members to analyse the common practices, policies and services across multiple child death cases, and to discuss the systemic and thematic issues that arose.

This year was the first time in three years that the Board has reviewed more cases than it received, meaning it is reducing the backlog of cases that it reported on in its 2022–23 Annual Report. As at year end there are 65 cases awaiting review by the Board.

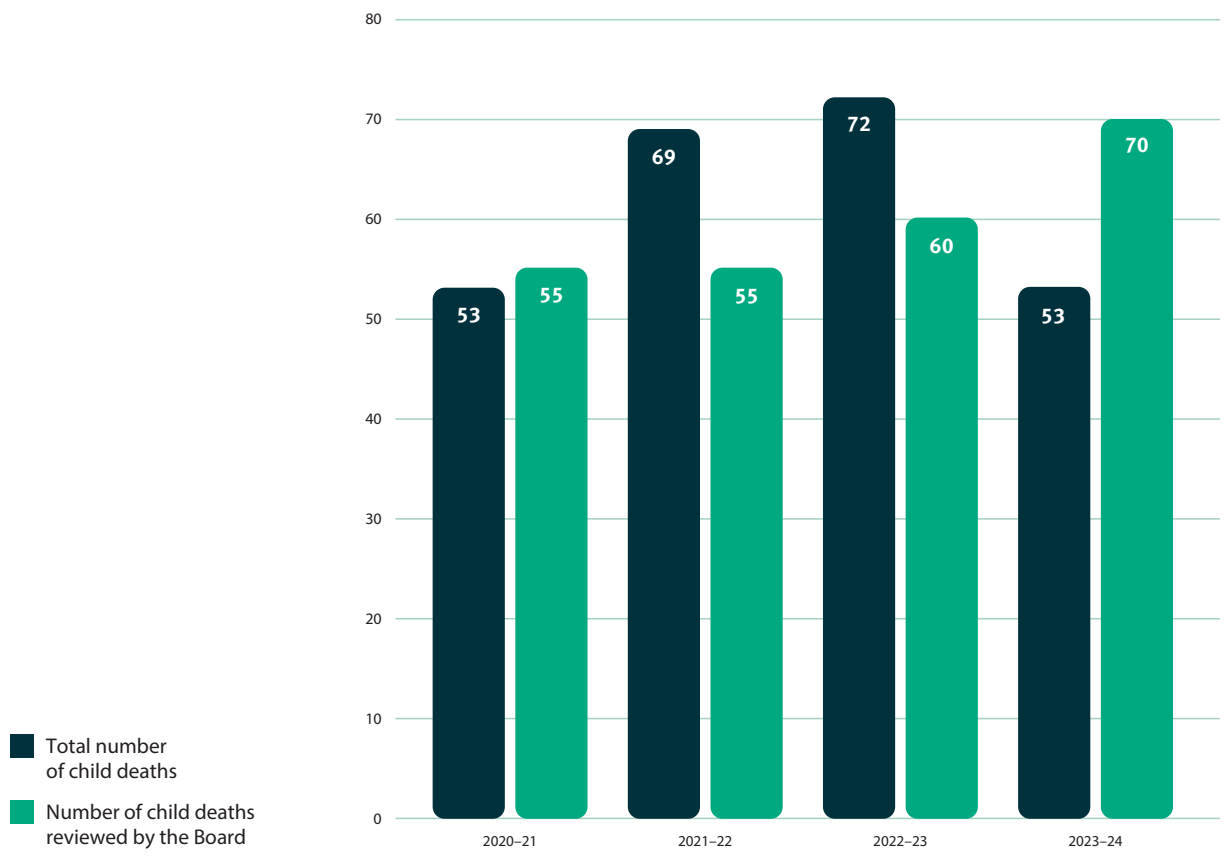
1 Family and Child Commission Act 2014, s. 29A.

2 See Child Protection Act 1999, s. 245H and 245I for details of requirements for reviews, and s. 245K for further details on the scope of a relevant agency review.

3 See Child Protection Act 1999, s. 245J for details of requirements for the Director of Child Protection Litigation reviews and s. 245L for further details on the scope of those reviews.

4 For further information, see the Child Death Review Board Procedural Guidelines, Procedural-Guidelines-version-1.4-August-2023.pdf (qfcc.qld.gov.au/board).

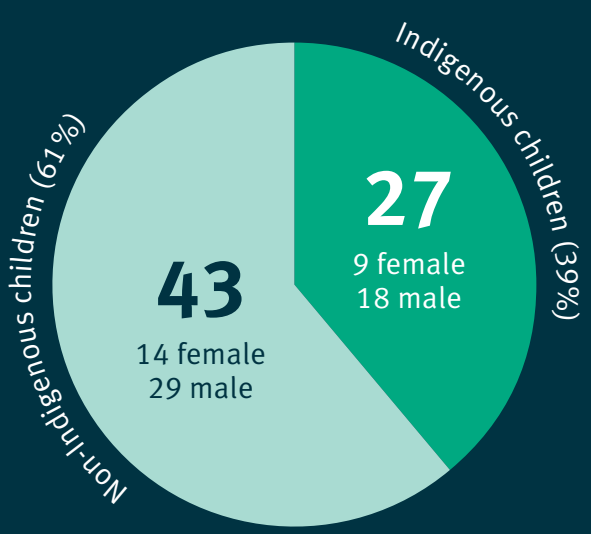
Figure 1: Number of child deaths known to the Queensland child protection system and reviewed by the Board by year, 2020–21 to 2023–24[5]

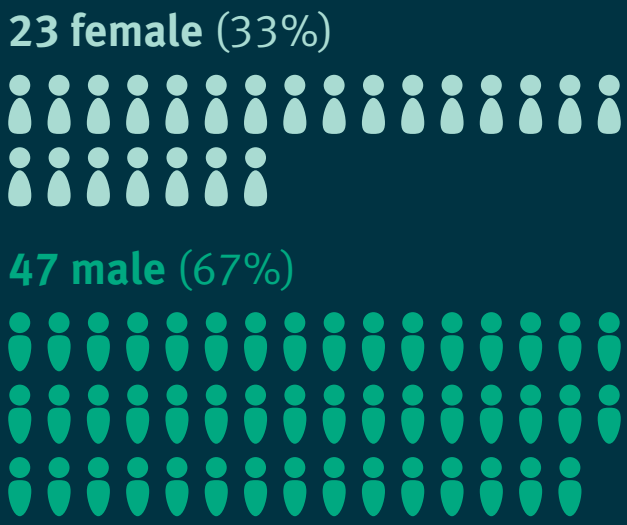


5 In its first year of operation, the Board reviewed two additional cases that had previously been reviewed by the former Child Death Review Panel, due to new information becoming known.

In 2023–24, the Board considered the deaths of **70 children**

Demographics





The number of deaths reviewed in each age group

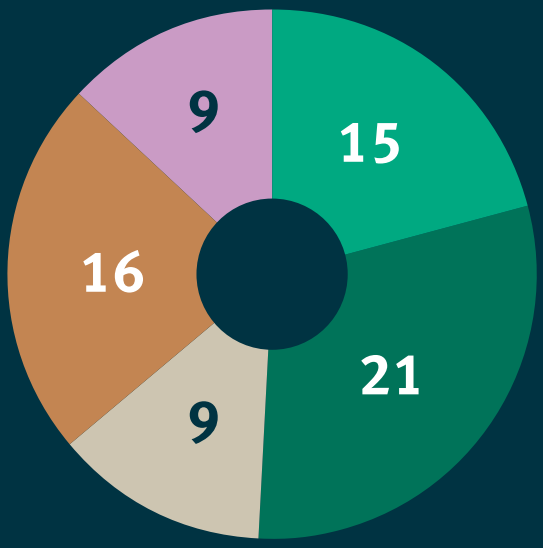
15 **Under 1 year** (21%)
(7 Aboriginal or Torres Strait Islander / 8 Non-Indigenous)
(4 female / 11 male)

21 **1-4 years** (30%)
(11 Aboriginal or Torres Strait Islander / 10 Non-Indigenous)
(8 female / 13 male)

9 **5-9 years** (13%)
(3 Aboriginal or Torres Strait Islander / 6 Non-Indigenous)
(3 female / 6 male)

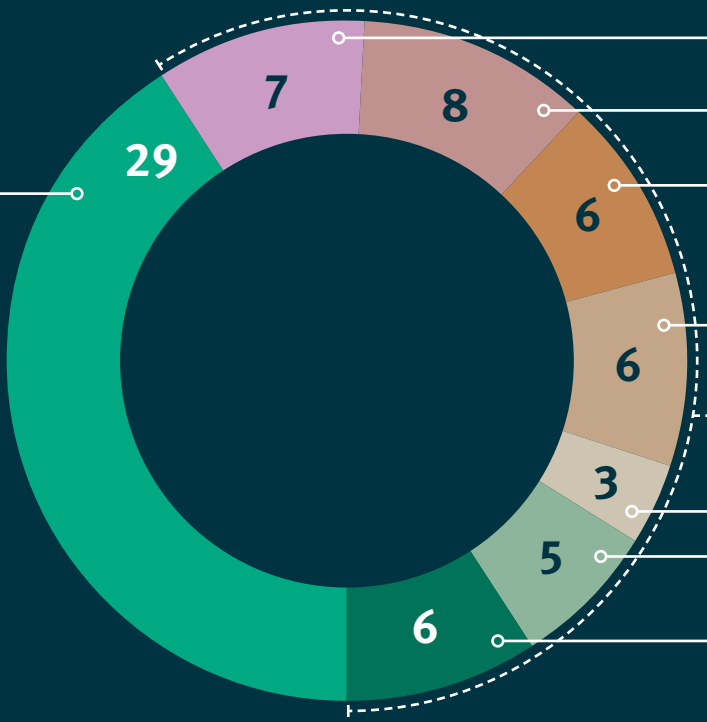
16 **10-14 years** (23%)
(4 Aboriginal or Torres Strait Islander / 12 Non-Indigenous)
(6 female / 10 male)

9 **15-17 years** (13%)
(2 Aboriginal or Torres Strait Islander / 7 Non-Indigenous)
(2 female / 7 male)



Category of deaths reviewed by the Board

29
41% were from natural causes



10% **Other non-intentional injury**

11% **Transport related**

9% **Suicide**
(**3** male (50%) / **3** female (50%)
(**4** 10-14 years (67%) / **2** 15-17 years (33%)
(**2** Indigenous (33%) / **4** Non-Indigenous (67%)

9% **Unexplained (SIDS and Undetermined)**

41 59% were from external causes

4% **Drowning**

7% **Fatal assault and neglect**

9% **Cause of death pending**

SUDI[6]

7 (10%) deaths fell within the SUDI research classification (**4** Aboriginal or Torres Strait Islander / **3** Non-Indigenous)

Care circumstances

61	(87%) were living with family or friends or independently at the time of their death[7]
7	(10%) were in foster or kinship care or on a permanent guardianship order
2	(3%) were in residential care[8]

Agency reviews considered by the Board (240)

70	Child Safety
112	Queensland Health[9]
26	Education
25	QPS
4	Youth Justice
3	DCPL

Case Review Classification

Level 1	**35**	50%
Level 2	**25**	36%
Level 3	**10**	14%

6 This is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause.

7 One child was under Child Protection Orders granting custody to the Chief Executive but was homeless/sleeping rough at the time of death.

8 One child was in residential care with parental consent.

9 The higher number of review reports from Queensland Health (compared to the number of child deaths) is reflective of multiple Hospital and Health Services undertaking reviews for some children.

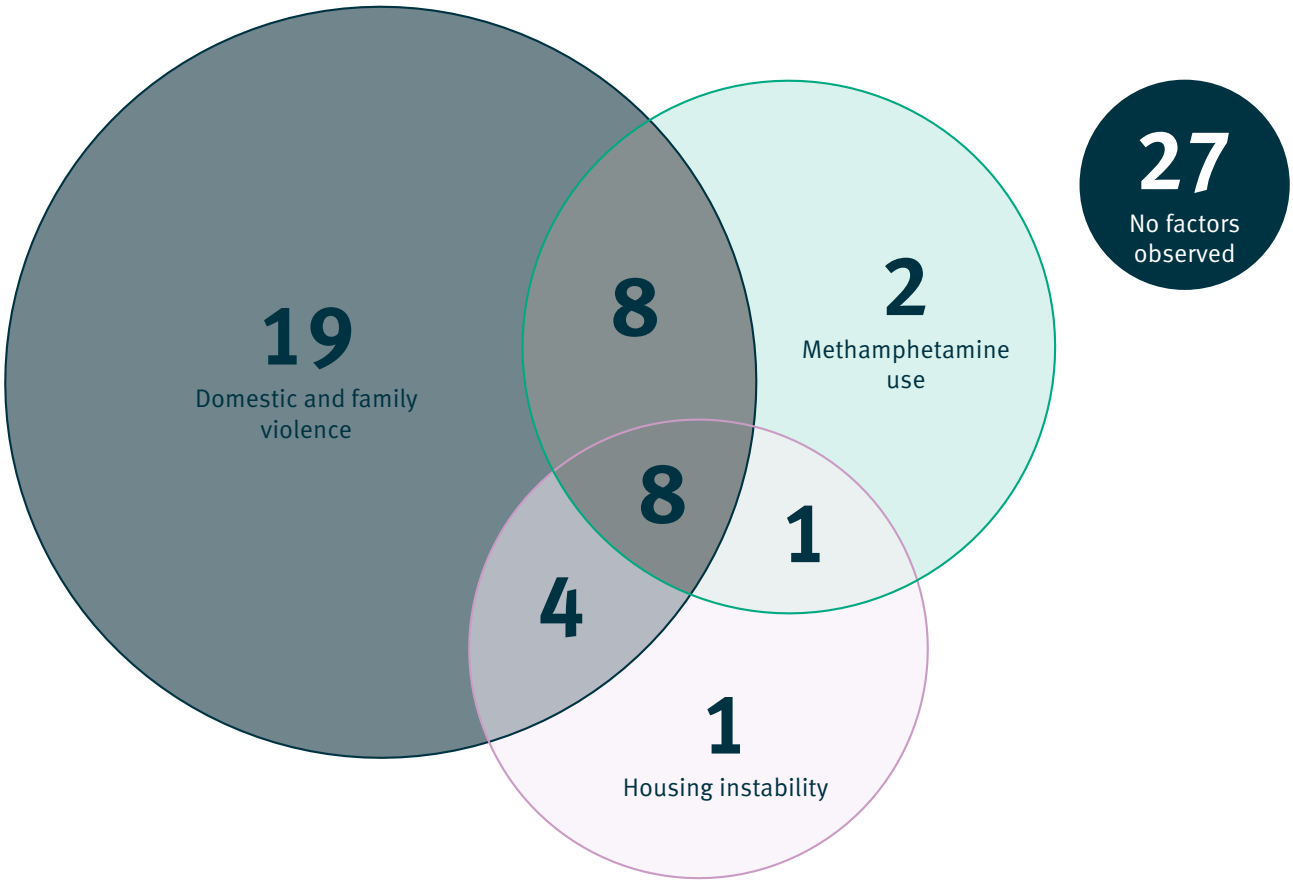
Case Characteristics 2023–24

In the financial year 2023–24, the Board received a number of cases where three select characteristics were noted. These were: presence of domestic and family violence, methamphetamine use and housing instability.[10]

Characteristics	Cases	Per cent
Domestic and family violence presence	39	56%
Methamphetamine use	19	27%
Housing instability	14	20%

This reporting shows the high prevalence of domestic and family violence across cases, and the co-occurrence of multiple safety risks in the families within the Board's remit.

Figure 2: Characteristics from the Board case reviews for the period 1 July 2023 to 30 June 2024.



10 For the purposes of this report, housing instability includes homelessness (sleeping rough and couch surfing), multiple families sharing a single dwelling for non-cultural reasons, financial insecurity regarding housing costs, and incidents where women were left without stable accommodation in the context of domestic and family violence.

CHAPTER 2

The system as a parent

"To thrive, children and young people need to be valued, loved and safe, they need their basic material needs met, they need to be healthy, learning, participating in family, community and decision making, and have a positive sense of their identity and culture."[11]

The child protection system is responsible for ensuring children in care are safe, well looked after, and have their rights upheld.[12] This includes but is not limited to providing:

- a safe and stable place to live
- access to dental, medical and therapeutic services
- the ability to play and take part in activities they enjoy
- cultural connections
- appropriate education opportunities.

Child Safety must take reasonable steps to ensure a child is cared for in a way that meets the Statement of Standards as outlined in section 122 of the *Child Protection Act 1999* (the Act).

The Act lists the Charter of Rights of all children in care – including those in residential care. It is a profound list of obligations that the state holds towards all children in its custody or guardianship. The rights are presented here as a reminder that delivering quality of life to children in care is not only a moral imperative but a legally enforceable requirement placed on the state of Queensland through its own legislation.

In 2022 the *Child Protection Reform and Other Legislation Amendment Bill 2021* further strengthened the rights of children in the child protection system to participate in plans and decisions about their lives. This law requires the participation of children in matters that affect them and requires the views of children in care to be sought. The government advised that the legislative amendments present a platform to enhance the voices of children and young people in decision making, their care arrangements and the care system.

11 ARACY and UNICEF Australia, The Wellbeing of Australia's Children: A story about data, a story about change, Revised and updated March 2023, https://www.aracy.org.au/wp-content/uploads/2024/09/Australian-Childrens-Wellbeing-Index-Report_2023.pdf

12 https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010#sec.74

Charter of Rights for Children in Care – *Child Protection Act 1999*

"The Parliament recognises the State has responsibilities for a child in need of protection who is in the custody or under the guardianship of the chief executive under this Act, this Act establishes the following rights for the child:—

(a) to be provided with a safe and stable living environment;

(b) to be treated fairly and with respect;

(c) to be placed in care that best meets the child's needs and is most culturally appropriate;

(d) to maintain relationships with the child's family and community;

(e) to develop, maintain and enjoy a connection to the child's culture of origin;

(f) for an Aboriginal child—to develop, maintain and enjoy a connection to Aboriginal tradition;

(g) for a Torres Strait Islander child—to develop, maintain and enjoy a connection to Island custom;

(h) to develop, maintain and enjoy the child's identity, including, for example, the child's sexual orientation or gender identity;

(i) to choose and practise 1 or more languages;

(j) to choose and practise 1 or more religions;

(k) to be consulted about, and to take part in making, decisions affecting the child's life (having regard to the child's age or ability to understand), particularly decisions about where the child is living, contact with the child's family and the child's health and schooling;

(l) to be given information about decisions and plans concerning the child's future and personal history, having regard to the child's age or ability to understand;

(m) to keep, and have a safe space to store, personal belongings;

(n) to engage in play, and other recreational activities, appropriate for the child;

(o) to privacy, including, for example, in relation to the child's personal information;

(p) if the child is under the long-term guardianship of the chief executive, to regular review of the child's care arrangements;

(q) to make a complaint to the chief executive if the child considers that the charter of rights is not being complied with in relation to the child;

(r) to have access to dental, medical and therapeutic services, necessary to meet the child's needs;

(s) to have access to education appropriate to the child's age and development;

(t) to have access to job training opportunities and help in finding appropriate employment;

(u) to receive appropriate help with the transition from being a child in care to independence, including, for example, help about housing, access to income support and training and education."

Child deaths and residential care experience

In 2023–24, the Board considered the circumstances of two young people who were living in residential care at the time of their deaths. One young person died due to natural causes and the other died in a transport incident. A third young person, whose circumstances were considered by the Board, was in the care of Child Safety and had spent time living in residential care. This young person died by suicide.

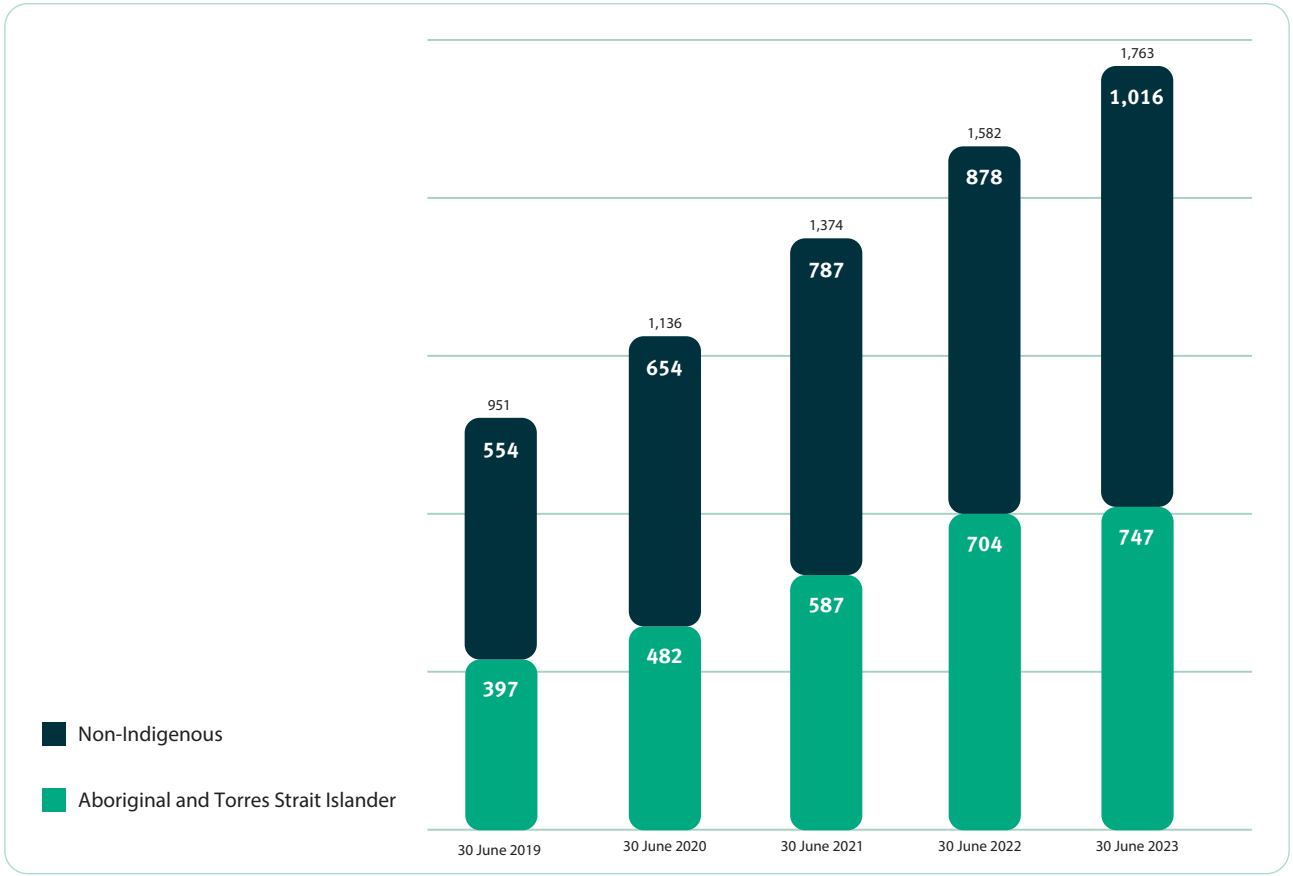
A fourth young person was living in a residential care when she gave birth to a baby who died of natural causes soon after its birth. While the baby's mother was not the focus of the Board's review (rather, her baby was), her experience in residential care shared similar themes to the other young people considered by the Board.

The priority when a child enters care is finding them a safe and stable place to live. The most common care arrangement is family-based care, where a child lives with an approved kinship carer or foster carer. Child Safety recognises that family-based care leads to better outcomes for children and is the preferred placement option.[13]

In cases where children and young people have more complex needs, or where family-based care has been unsuccessful or unavailable, they are placed in residential care where they live with other young people supported by youth workers who work on a rostered shift.

The number of children and young people placed in residential care in Queensland is increasing. As of 30 June 2023, 1,763 children in Queensland were living in residential care, with 312 aged 0-9 years.[14] This was an increase from 951 in residential care as of 30 June 2019 (see Figure 3).

Figure 3: Number of children and young people in residential care in Queensland[15]



13 Department of Child Safety, Seniors and Disability Services (DCSSDS), Key messages, Child Safety Practice Manual, Queensland Government website, 29 November 2021, accessed 8 July 2024.

14 DCSSDS, Our performance: Children requiring care and ongoing support, DCSSDS website, 2024, accessed 8 July 2024.

15 DCSSDS, Our performance: Children requiring care and ongoing support

Case example: How does a system build connection, show love and address trauma

The Board reviewed the case of a boy who entered residential care in early adolescence after the death of his only parent. He had experienced significant adversity and trauma across his lifetime including exposure to domestic and family violence, parental substance misuse, parental mental health issues, homelessness, alleged neglect, physical and emotional abuse. He had a mild intellectual disability, language disorders and complex behavioural, developmental and mental health needs.

There were early indicators that the residential model of care was not meeting his need for connection, love, support, consistency and care. His behaviours escalated and he was threatening, violent and intimidating towards other young people and care staff. It was believed a lot of his behaviours were aimed at scaring, intimidating or impressing others. Records state: *"Care workers…described him as angry but relate this anger directly with his grief and believe if he is supported to work through his grief and loss he will present in a very different way."*

The boy was moved to a short-term placement that was a shelter model for young people with independent living skills, which required out-of-placement between 9am and 4pm daily. The boy did not have an opportunity to engage with staff during these times and there was no plan in place for him. He was not attending school and youth worker support was limited to 15 hours per week. This meant he spent hours of the day unsupervised, unsupported and without planned activities. He often returned to the placement in the early hours of the morning affected by substances. During this period his offending behaviours increased and he had his first overnight stay in a watchhouse and appearance in court.

Despite Child Safety identifying the boy's need for a stable home and to be supported with managing his grief and loss, evidence shows these needs remained unmet. In the year prior to his death, he experienced four different primary placements, spent 12 nights in a watchhouse, nine nights in youth detention and had two long-term episodes of self-placing, four contingency placements and one temporary unit placement (see Figure 5). The boy would stay with adult acquaintances; many of whom were not safe or stable and had their own complex issues including drug use, mental health issues, suicidal ideation, and domestic and family violence in their households. Adults would at times exploit the boy, providing him with drugs in exchange for undertaking criminal acts. In an email to Child Safety, a health worker trying to engage with the boy said: *"I would like to reiterate the importance of a safe and secure placement. If he is experiencing verbal and physical abuse at his "safe place", there is no hope of him engaging with other services."*

In the year of his death the boy's placement was closed after he was away from his placement for three weeks. In the following three months, he had no placement. He continued to be allocated a youth worker for 15 hours a week, however, was unsupported for the remainder of the week. The youth worker reported concerns for the boy's safety and wellbeing: **He was homeless, had no safe place to sleep, was living out of a cardboard box, had no place to shower, no clean clothes and no food to eat.**

Figure 4: Placement history

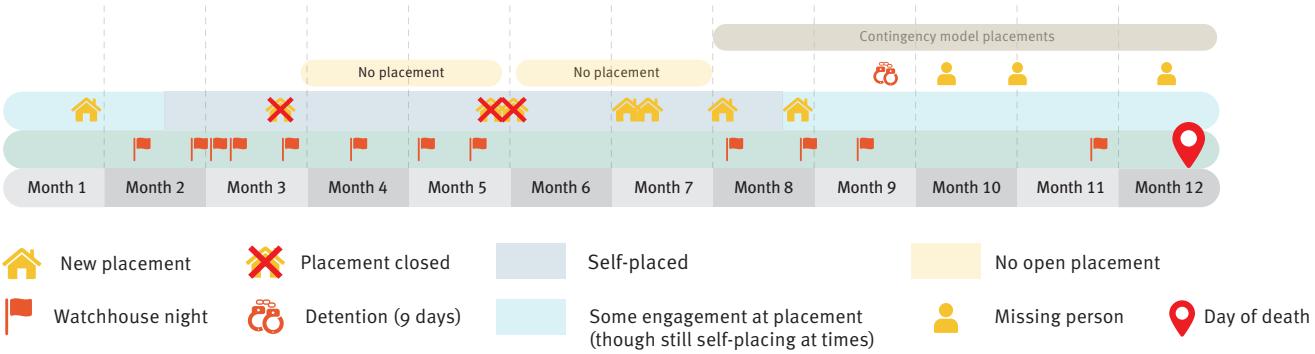
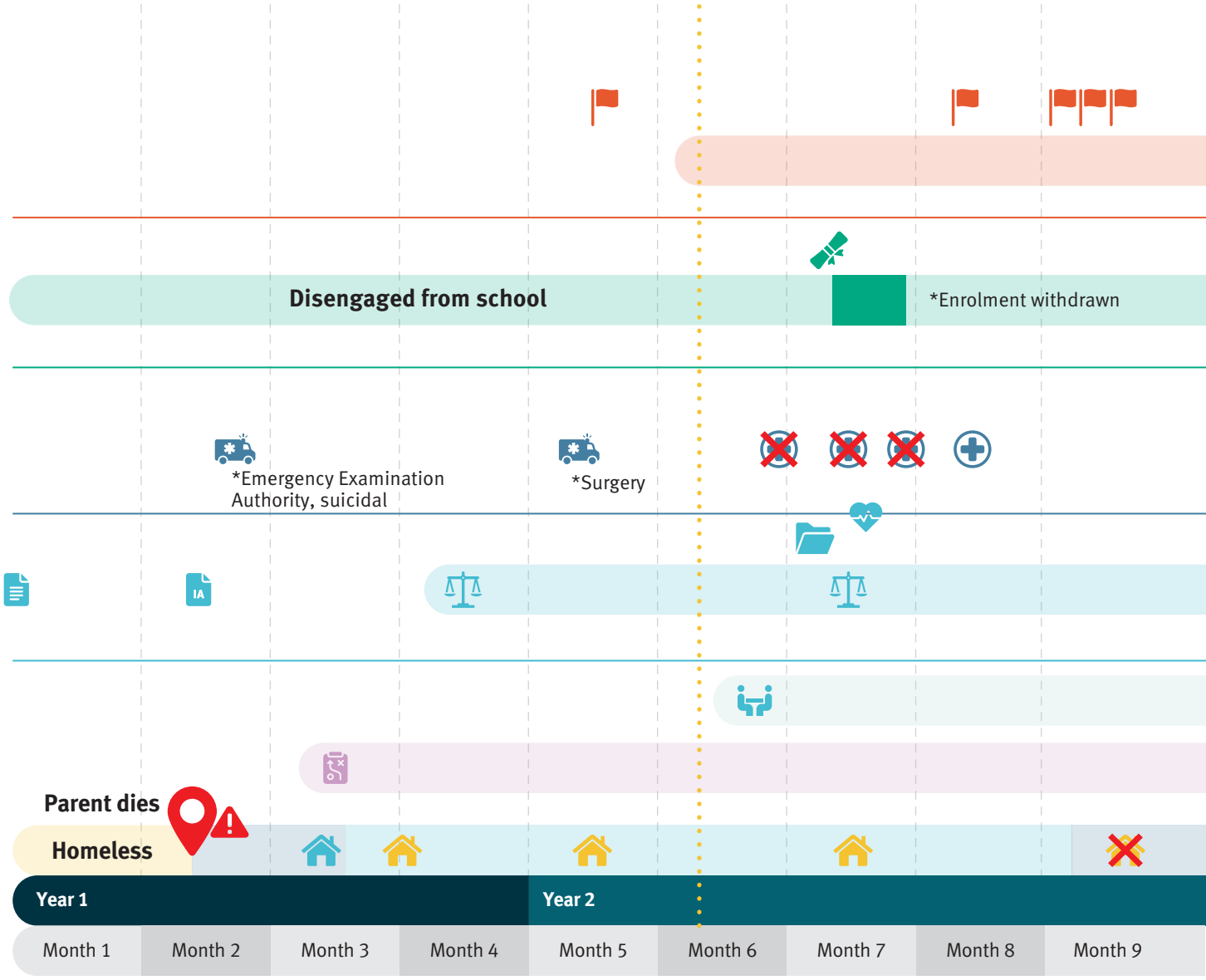
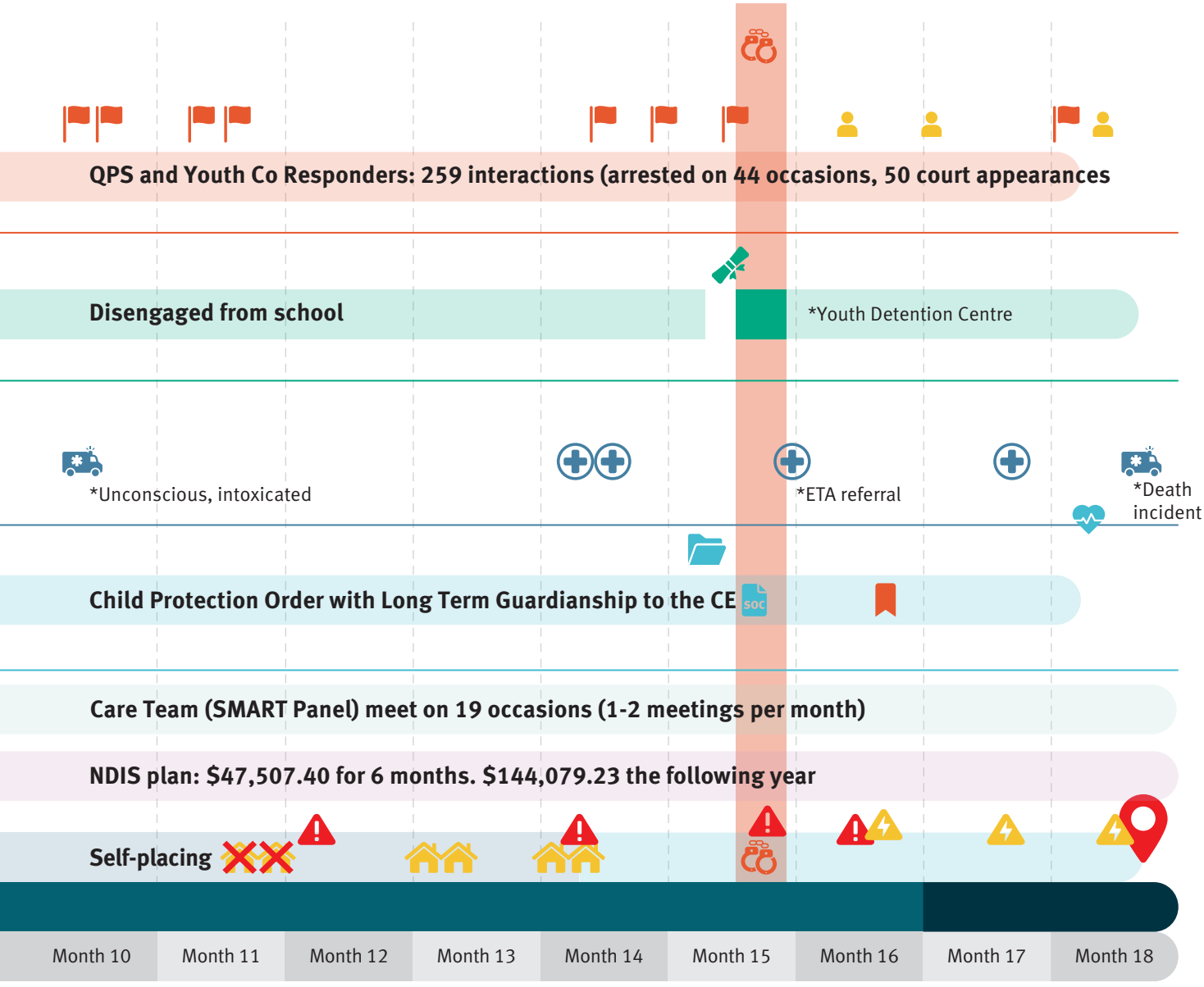


Figure 5: Timeline of system touchpoints



Legend

- Notification
- Investigation and Assessment (I&A)
- Child Protection Order granted
- Case plan
- Residential placement
- Standard of care review
- Standards of care outcome (Standards not met)
- Suicidal ideation
- Navigate Your Health Management plan
- Queensland Health services accessed/referred
- Fail to attend outpatient appointments (fracture)
- QAS response



Care Team meeting (SMART Panel)
School enrolment
Missing person report
Detention (9 days)
Stolen vehicle crash
NDIS Plan
Watchhouse night
Placement change
Placement closed
Day of death

Case example: Understanding the survival behaviours of children who experienced abuse

The Board reviewed the case of a young person who was placed in residential care as a teenager. The young person had experienced sexual abuse as a child and had complex mental health and behavioural needs.

The young person did not want to be in the residential care placement and often left and stayed overnight at unknown places with unknown people. Case workers considered their behaviours were *"a result of frustration at the restrictions on (their) independence and circumstances, i.e. not being afforded the same level of independence as a (young person their) age, such as (having) a key to (their) own home or being able to stay at home alone."* The young person was not happy living in the residential placement and had voiced to their Child Safety Officer (CSO) their feelings:

"I sit in my room everyday and want to kill myself."

"I sit in my room and smoke weed all day – I'm so depressed."

"I just want to do something with myself and be happy but no one can help me succeed."

"I want to get out of this house and no one wants to help me.. you are all useless."

"You all only do visits to tick boxes and you don't really care..."

The young person was physically and verbally abusive towards staff and their behaviour frightened co-tenants, causing concerns for their safety. The young person's residential placement ceased six and a half months prior to their death due to them assaulting a youth worker. Following the closure of the residential placement, the young person lived with a friend's family. This was not an authorised placement. They lived with the family for four months and their CSO made multiple unsuccessful attempts to visit the home. The young person left the home and then relied on two emergency accommodation services organised by Child Safety.

At times, the young person was banned from one or both emergency accommodation services due to drug use and aggressive and unsafe behaviour. With no formal placement or emergency accommodation available to them, they were homeless. They moved between staying with family members, friends and adult acquaintances. These adult acquaintances were understood to be adult men who sexually exploited young people in exchange for drugs, money and a place to stay. At other times, the young person slept under a bridge or near a Child Safety Service Centre. Child Safety provided them with a tent when no other placement option could be identified.

Child Safety records show staff recognised the dire situation the young person was in and the system's lack of capacity to meet their needs:

"There are no community agencies that will accept [them] now or at 18 when [they] are engaging in the behaviours that (they are) currently displaying..

Transition planning cannot be completed...as this young person is not in a space to do this, without (their) primary need for safe accommodation being met, no one is able to address higher level needs or thought processes. The young person is preoccupied with the thought of where (they) will sleep that night, how to obtain drugs, managing (their) own thoughts in (their) head and if (they) will need to sell (their) body to be sexually abuse(d) in order for (their) needs to be met."

Figure 6: Placement history, increasing hospital presentations and high-risk behaviours

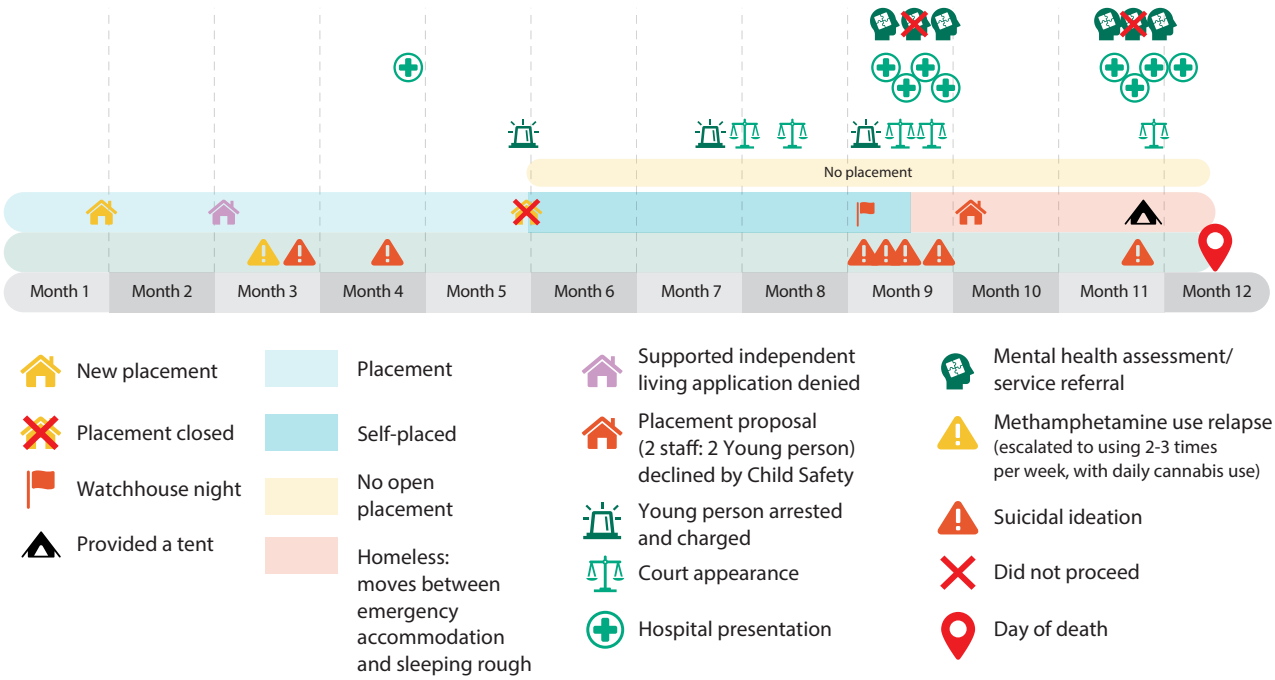
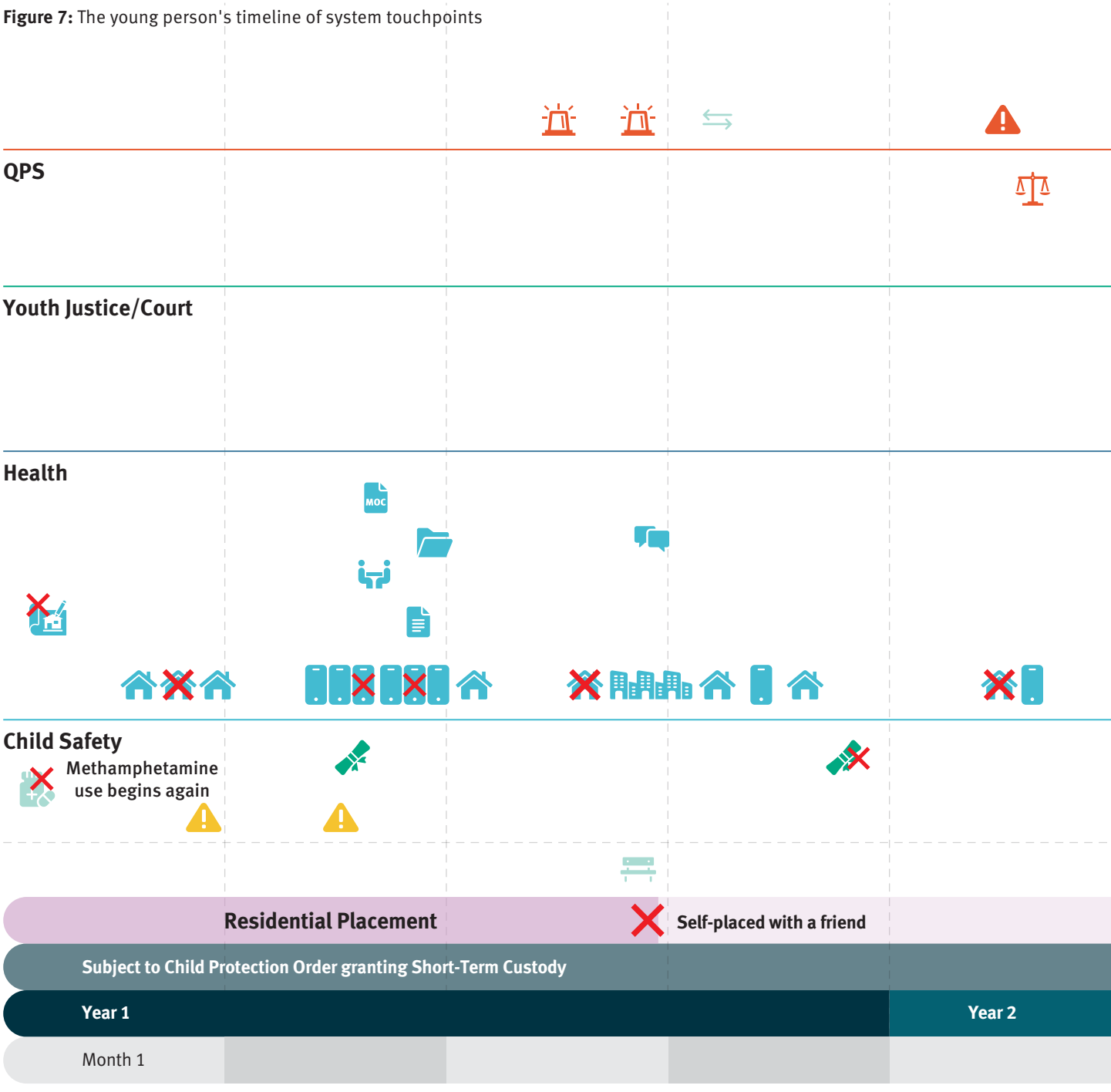
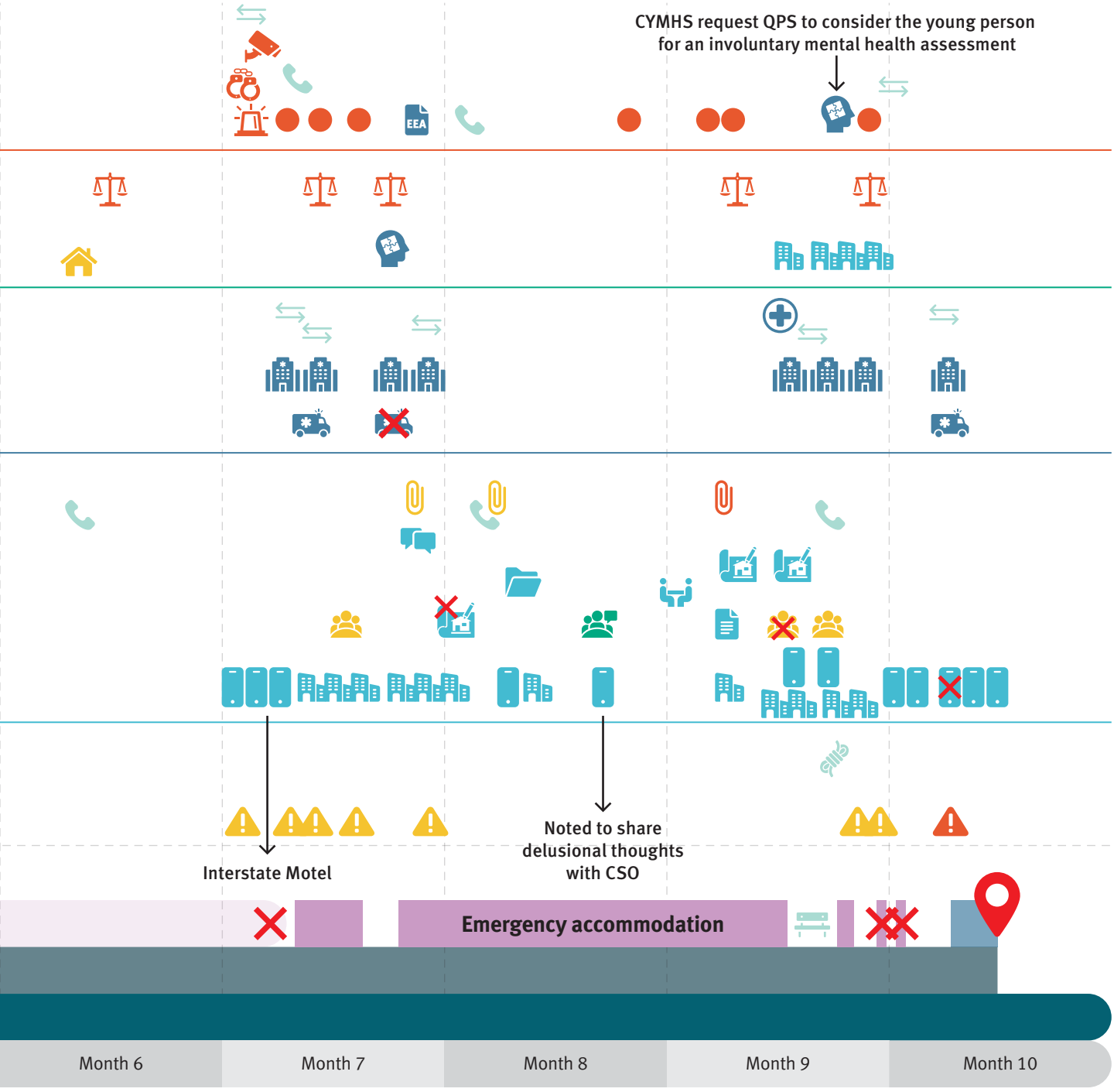


Figure 7: The young person's timeline of system touchpoints



Legend

- Substance use
- Young person sleeping rough
- Phone call
- Did not proceed, occur or was ended
- Enrolment
- Young person attends Child Safety or Youth Justice office
- CS, secondary service provider and young person meetings/discussions
- Rope/noose belonging to young person
- Housing/accommodation support referral
- Notified concerns
- Child strengths and needs assessment
- Information shared or requested (under Child Protection Advocacy (CPA))
- Text and calls between YP/or YP's family with Child Safety staff / CSOs
- Home, residential or other location visits
- Residential placement
- Child Safety and service provider communication
- Family Group Meeting
- Model of care review
- Case plan
- Parental strengths and needs assessment



- Emergency Examination Authority
- Queensland Health services accessed/referred
- Queensland Ambulance Service (QAS) response
- Mental health assessment/ services referral
- Hospital admission
- Prescribed medication
- Risk factors reported to agency (i.e., suicide completed/ideation/ attempt, mental illness, domestic and family violence)
- Youth Justice Co-responder visit
- Secondary service referral
- Conditional release/ Bail order
- Watch House
- Charged / arrested
- Police attendance
- Court appearance
- Victim of Crime
- Day of death

The suitability of residential care for traumatised young people

Residential care services in Queensland are provided by non-government organisations, funded by Child Safety, and licensed under the Act. Services should be delivered in line with the Hope and Healing Framework for Residential Care. The framework recognises that all children and young people in residential care have experienced trauma, and their care should be therapeutic and needs informed. Experiences of trauma may include abuse or neglect, disrupted attachments, complicated grief and loss, or other adverse childhood experiences impacting on a child's development.

Children and young people impacted by trauma may display trauma-based behaviours. They may struggle to regulate their emotions and they can become aggressive, violent or antisocial.[16] They may be hesitant to trust or resistant to caring gestures and may use behaviour to reinforce a view of themselves as unlovable.[17] Within this complicated and complex mix of trauma and behaviour, it is the responsibility of the child protection system to ensure every child in care has a home where they feel safe, loved and cared for; to have their needs met and the opportunity for healing from the trauma they have experienced.

"All children and young people living in residential care have been impacted by trauma, disrupted attachment and/or loss. For Aboriginal and Torres Strait Islander children and young people, inter-generational trauma and loss compounds this. All require support to recognise and make sense of their feelings, talk about them, and learn to manage them in positive ways. Healing is not a smooth process. It is multi-faceted, built on the foundation of restorative relationships and gaining hope for the future. It includes consistently responding to even very challenging behaviour in ways which provide safety and limits at the same time as compassion and acceptance, understanding behaviour as seeking attachment. For young people with significant trauma-related needs, integrating specialist therapeutic intervention with everyday care leads to 'hope and healing'."[18]

Hope and Healing Framework

16 Department of Child Safety, Youth and Women (DCSYW); PeakCare Queensland Inc; Encompass Family and Community Pty Ltd; and Paul Testro Consulting, The Hope and Healing Framework [PDF 426KB], 1 May 2019, accessed 8 July 2024.

17 DCSYW, et. al. The Hope and Healing Framework

18 DCSYW, et. al. The Hope and Healing Framework

Lack of suitable placements leading to homelessness

Both of the case studies highlight the lives of young people that experienced homelessness while subject to a Child Protection Order and under the guardianship or custody of the chief executive.

One boy left his allocated housing because he felt unsafe and had been threatened by an older co-tenant. As a result, his placement was closed, and it was a further three months before he was offered another placement (excluding offers of emergency overnight accommodation which he declined due to safety concerns).

The other young person's placement was closed after they assaulted a youth worker. Their behaviour had become more violent and threatening towards staff and co-tenants, and it was noted the young person was using methamphetamines again. The young person was without a placement for the next six months and remained homeless at the time of their death.

Their experiences show that the system continues to lack the capability and capacity to provide safe and stable homes for some vulnerable children and young people in care, particularly those with more complex needs, including displaying violent and dysregulated behaviours or significant substance use or mental health concerns.

The experiences of both young people are not unique. Staff from Brisbane Emergency Response Outreach Service (BEROS) reported to the ABC in March 2023 on their experiences of supporting children and young people who were sleeping rough. Some were as young as 11. BEROS staff noted they see more children from residential care than foster or kinship care.[19] Two young people shared their experiences of homelessness and advised that some children had their placements closed by Child Safety, or they left their allocated placement due to feeling unsafe. BEROS staff noted they saw more children from residential care than foster or kinship care.[20] Another young person shared his experiences of living under a bridge, with occasionally children as young as 13 years-of-age staying there.

The Queensland Family and Child Commission (QFCC) recently released an Insights Paper: Absent from Care, that examined how the Queensland Government meets the safety, care and protection needs of children in out-of-home care, monitors placement safety and respond when a child leaves their approved care placement. Key points in the report include the following:[21]

- As at 31 December 2022, there were an estimated 833 Queensland children in care staying at a place that was not their approved placement. The majority were aged over 14 years and had left a residential care placement, and more than half (55 per cent) were Aboriginal and Torres Strait Islander children. This represents 7.6 per cent of all children involved with Child Safety.
- If they seek to return to an approved placement, a young person's experience will often depend on the individual CSO or carer and their relationship and connection.
- There is only one specific service that explicitly provides outreach and support to children who self-place – BEROS – and it only services the greater Brisbane area and the Sunshine Coast. Other services, such as youth homelessness services, have contract provisions that prevent them from supporting young people in care.

The report also noted there was, at that time, no funding for government-run youth homelessness services for young people under the age of 16 years who were absent from care.[22]

19 https://www.abc.net.au/news/2023-03-25/queensland-homeless-child-safety-department-street-kids/102105936

20 https://www.abc.net.au/news/2023-03-25/queensland-homeless-child-safety-department-street-kids/102105936

21 Insights paper – Absence from care.pdf (qfcc.qld.gov.au)

22 Insights paper – Absence from care.pdf (qfcc.qld.gov.au)

Connection and attachment

Research shows that children who end up doing well, even those facing significant adversities, have at least one stable and committed relationship with a supportive parent, caregiver, or other adult. [23] Children who enter care may lack positive and consistent attachments with supportive adults to help guide them through childhood and adolescence.

The consistency and stability of caregiver/s typically offered by home-based placements is not a given for young people in residential care. Residential care models typically result in young people navigating changes in staffing from shift to shift, turnover of staff due to industry retention and recruitment issues, staff with different levels of skills, training and motivations, and changes in co-tenants. These factors mean it can be more difficult for young people in residential care to build and maintain trusting relationships with key adult caregivers.

There is a need for care models to provide opportunities for children to form connections with carers, co-tenants, professionals and independent advocates. Residential care needs to be enjoyable to encourage engagement, create opportunities to develop secure attachments and provide an alternative to the chaos of high-risk behaviours, such as substance use, self-harm and offending.

> Children in care do not want services. They want relationships, connection, consistency, trust, respect, and love. Imagine if our child protection system was designed for and held accountable to meet these basic human needs. We can and must change the system to put relationship back in the centre where it belongs.[24]

> Engagement by youth workers can make or break the experience in residential care. The young people shared that the overwhelming difference between a good and bad residential care experience was the staff. We heard the importance of a worker showing that they genuinely care about the kids in the house, taking the time to listen to the young person, and working with the young person to understand their experiences, their needs, and their behaviours before making decisions about their care.[25]

23 National Scientific Council on the Developing Child, Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13 [PDF 559KB], 2015, accessed 8 July 2024.

24 Queensland Family and Child Commission (QFCC) (2023). "I was raised by a checklist", QFCC Oversight of Child Safety's Queensland Roadmap: A contemporary care system for Queensland – Review of Residential Care, words of Tom Allsop, Chief Executive Officer, PeakCare Queensland, p 9 https://www.qfcc.qld.gov.au/sites/default/files/2023-10/I%20was%20raised%20by%20a%20checklist%20-%20QFCC%20Review%20of%20Residential%20Care.pdf

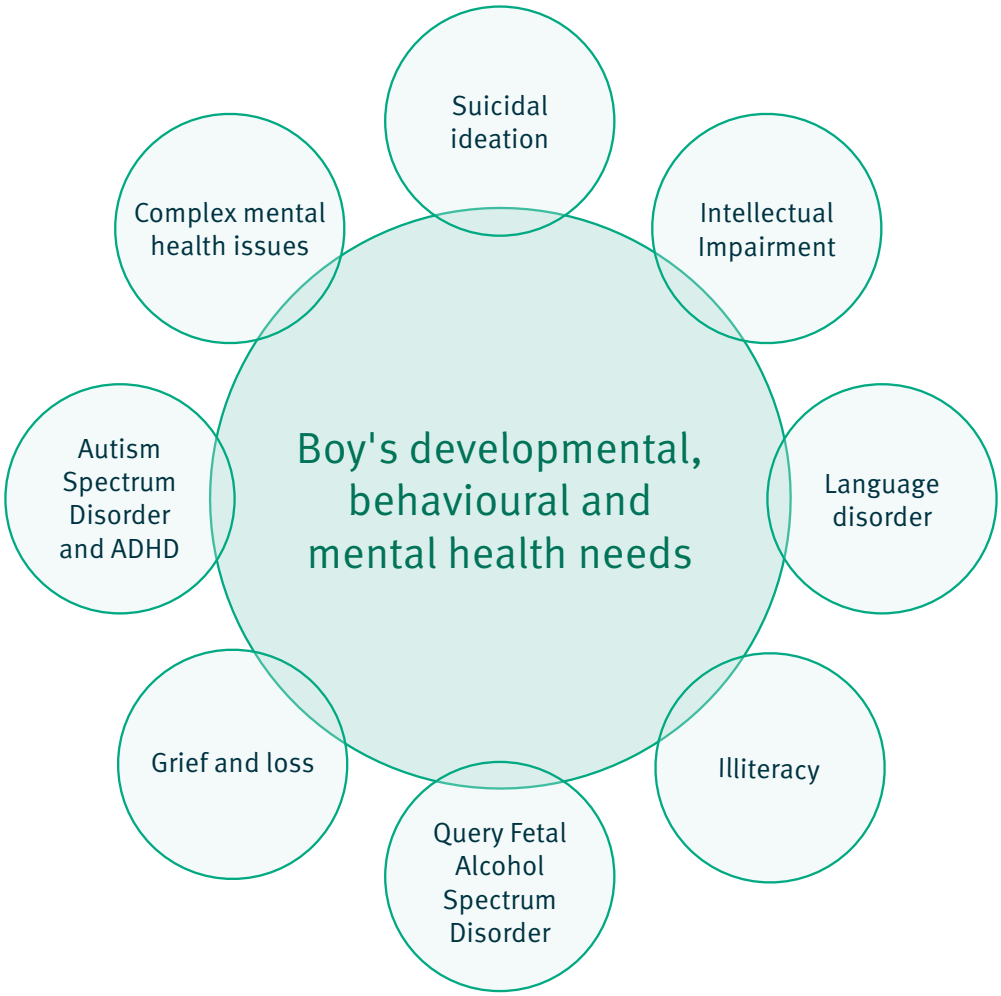
25 QFCC, QFCC Oversight of Child Safety's Queensland Roadmap: A contemporary care system for Queensland – Review of Residential Care, QFCC website, 2023, accessed 8 July 2024.

Developmental, behavioural and mental health needs

The boy had multiple developmental, behavioural and mental health issues linked to a lifetime of adverse experiences, loss and trauma. Many of his needs went unmet, or were met inconsistently, both before and after he entered care.

Like the cases of other high-risk young people recently considered by the Board, there was a lack of clarity around the young person's diagnoses. By the time he entered care, it was identified that updated assessments needed to be completed to give a contemporary understanding of his diagnoses and needs, however, his level of transience and resistance to engaging in assessments, appointments or programs made it difficult for services to engage with him. In the weeks prior to the boy's death, ETS had identified a working diagnosis of Fetal Alcohol Spectrum Disorder (FASD). ETS had not been able to engage with him personally but had collected information from all the agencies involved about his history and previous diagnoses. At the time the child died, ETS was still trying to facilitate a face-to-face session.

Figure 8: The boy's developmental, behavioural and mental health needs



The importance of diagnosis and applying a disability lens

The Board identified the importance of seeking an official medical diagnosis of a child's disability or impairment to ensure appropriate functional supports (such as speech and occupational therapy) can be provided to children with complex needs. Official diagnoses better enable the child protection system to have an acute understanding of what is required to effectively engage with a child in care, particularly in terms of service provision and identifying appropriate housing and support options. The Board considered there was a clear need to prioritise complex needs assessments for children entering care.

In the review of the boy, the Board considered a disability assessment should have been applied, because every aspect of his functioning and communication ability affected his engagement with Child Safety and support services. Despite concerns about his intellectual impairment, illiteracy, lack of understanding around time, and inability to understand the conditions imposed by the courts, it appears at no stage was his fitness to stand trial assessed.

In 2022–23 and 2023–24, the Board conducted in-depth analyses of the deaths of three adolescent males who were known to the child protection and youth justice systems, and who had a history of early behavioural issues, developmental concerns and poor school engagement. All three were suspected of having FASD, though never formally diagnosed. Appropriate screening and diagnosis of FASD in the early years provides the opportunity for multi-disciplinary support and early interventions for children and their families. This is particularly important given children and young people with FASD are over-represented in youth justice settings and are at increased risk of mental health issues including suicidality.[26]

The prevalence of FASD and suspected FASD in the child protection cohort, and the frequency with which the Board observes a lack of targeted intervention for their complex needs, suggests more is required to help support these vulnerable children and young people achieve their potential, and avoid further harm.

> A young person who does not receive appropriate interventions in childhood is likely to enter the care system as an angry, confused young adult who has had negative experiences at school, at home and among peers. Secondary disabilities emerge around this time and young people with FASD frequently experience mental health problems, addictions, or display behaviour which puts the safety of themselves and others at risk, including inappropriate sexual behaviours or involvement in criminal activities.[27]

26 S McLean. Fetal Alcohol Spectrum Disorder (FASD): An update on policy and practice in Australia. Canberra: Australian Institute of Family Studies, 2022, accessed 8 July 2024.

27 P Walker. Fetal Alcohol Spectrum Disorder in the Child Arotection System: Opportunities for Prevention and Intervention [PDF: 125KB], Submission to the Inquiry into Foetal Alcohol Spectrum Disorder, House Standing Committee on Social Policy and Legal Affairs Submission No. 29, 2011, accessed 8 July 2024.

Early intervention to promote school engagement and literacy

Our vision is for a world class education system that encourages and supports every student to be the very best they can be, no matter where they live or what kind of learning challenges they may face.[28] – Australian Government Education Declaration, December 2019

The Board observed transience in care and living arrangements correlated with significant transience in schooling for all young people it reviewed. Before entering care, one boy had 15 separate enrolments at 14 state schools and an enrolment at a private school. His behavioural incidents at school, his suspensions in early school years and his reduced attendance at a young age, together with child protection concerns, were red flags that he and his family required extra support. The specifics of any learning and/or education support put in place for this boy and his family throughout his schooling are unknown, however, records show that by the time he entered out-of-home care in early adolescence, he remained illiterate and was not engaged in education.

The boy's illiteracy significantly impacted his ability to engage in the world around him. He could not read text messages so relied on phone communication, he was unable to administer his own medication because he could not read the measurements, he needed help from staff to type song names and download music, and he did not understand time. He frequently identified that he wanted support to learn to read and write. He was significantly disadvantaged by his inability to read and write. While he was diagnosed with a mild intellectual impairment, a communication disorder and vision issues, every child deserves the opportunity to achieve their literacy and learning potential, to progress, and not to be left behind.

Sexual education and contraception for children in care

Support for a child to understand their body, sex, sexuality, and healthy and unhealthy sexual behaviour and relationships is a human right and helps children make safe choices.[29]

28 Australian Government, Department of Education (DoE), signed by The Hon Grace Grace MP, Alice Springs (Mpartntwe) Education Declaration, Australian Government DoE website, December 2019, accessed 8 July 2024.

29 DCSSDS, Child Safety Practice Manual: Practice Kits; Child sexual abuse; Adequate sex education, DCSSDS website, 13 September 2022, accessed 8 July 2024.

Case example: When young people in care become parents themselves

The Board reviewed the case of a girl who was subject to a Child Protection Order granting Long Term Guardianship to the Chief Executive when she had a trauma history including exploitation, neglect, and abandonment.

The service system identified the girl was at high-risk of pregnancy as there was a significant number of risk factors present. Her mental health, substance use, intellectual impairment, and history of sexual abuse left her particularly vulnerable.

As a child in care of Child Safety, the system which existed to protect and care for her appeared ineffective at being able to address or stop this further trauma.

While records suggest sexual education and contraception had been discussed and attempts had been made to link her with a General Practitioner (GP) for her medical needs, further specifics about the provision of sexual education and contraception advice are unknown. This includes the timeframe and the circumstances of the discussions.

As Child Safety acknowledges, opportunities to provide appropriate sex education, including discussion of consent, healthy relationships, sexual health, and contraceptives for young people can be limited. It requires a concerted effort and commitment from service providers across the system to be proactive, creative, and opportunistic in meeting the sexual health needs of young people in care.

There is a reliance on contraception being the realm of a young person's GP, however, often young people known to the child protection system may not proactively engage with GP services, and it is incumbent on child protection workers to fulfill the role of parents in educating and safeguarding children in care. It was evident that the baby's mother would attend hospital emergency departments in times of accident, acute illness, or mental health crisis. The Board questioned whether, with appropriate coordination, these presentations could have been used as opportunistic mechanisms to promote pregnancy prevention, safe sex education, including education about consent, and holistic health and wellbeing.

Sex education is not a "once only" conversation. Children and young people require ongoing conversations throughout the developmental stages of their lives. For children in care, particularly children with unstable care arrangements, opportunities for appropriate sex education are limited. Ensure consideration is given to addressing a child or young person's sex education when reviewing the child's case plan or placement agreement.[30]

The system has a responsibility to ensure that young people in its care are safe and protected from further harm. This includes ensuring that young people are supported and counselled about safe sex, consent, and encouraged to proactively consider their contraception options. Child Safety staff and sector workers must be responsible for the level of awareness children in care have regarding sex, consent and protection.

30 DCSSDS, Child Safety Practice Manual: Practice Kits; Child sexual abuse; Adequate sex education.

Responding to high-risk behaviours and safety concerns

Children and young people in care may exhibit a range of behaviours considered to be challenging or high-risk. Some behaviours may be regarded as developmentally or age appropriate, while others may be linked to trauma, mental health, disability, drug and alcohol use or the environment young people are in. Child Safety recognises challenging or high-risk behaviour as:

> "Behaviour(s) of such intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities."[31]

Practice guidelines remind staff that often high-risk behaviours are a way for the child or young person to communicate an unmet need.[32]

The impacts of substance use

Many of the young people being considered by the Board were living in residential care and known to use alcohol, illicit and volatile substances during their time in care. This included intravenous use of methamphetamines and cannabis use. One young person was allegedly injecting other co-tenants.

The drug and alcohol use by these young people contributed to behaviours that were violent, erratic and a danger to themselves and others.

The Board observed the service system was challenged by how to respond to the impacts and escalating risks of drug use by at least three young people, particularly when they chose not to engage with the drug and alcohol support offered. Residential care services expressed they did not have the capacity or expertise to respond to the level of drug use and addiction of the young people while simultaneously trying to ensure the safety and wellbeing of the young person, co-tenants and their staff.

The Board reflected on the need for specialised care and accommodation services for young people providing on-site drug and alcohol rehabilitation services.

31 DCSSDS, Child Safety Practice Manual: Positive behaviour support and managing high risk behaviour [PDF: 821KB], DCSSDS website, n.d., accessed 8 July 2024.

32 DCSSDS, Child Safety Practice Manual: Positive behaviour support and managing high-risk behaviour.

Case example: The impact of substance use

During the final year of this young person's life, their methamphetamine use increased alongside their existing cannabis use. This increased use coincided with setbacks they faced including a Supported Independent Living Service (SILS) placement not progressing due to Child Safety and the SILS provider not reaching an agreement on the funding level and terms of the placement.

The young person experienced increased episodes of drug-induced psychosis and suicide ideation resulting in increased presentations at hospital emergency departments. They were identified by Child Safety staff and their family to be experiencing delusions and paranoia. While in hospital, attending clinicians completed mental health assessments to determine if their symptoms were due to acute intoxication or emerging psychotic illness. The hospital admissions were often brief with the young person requesting to be discharged, advising they only needed a place to stay. On occasion they would leave against medical advice.

Transient psychosis, or brief psychotic disorder, can result from heavy methamphetamine use with common clinical characteristics including persecutory delusions, auditory and visual hallucinations, hostility, anxiety, depression, cognitive disorganisation, and hyperactivity.[33] Combined cannabis and methamphetamine use in adolescence is found to be associated with significantly more neurocognitive impairment than methamphetamine use alone, and the impacts of combined use may also be enduring.[34]

The young person's mental and behavioural decline occurred in the context of living between two emergency accommodation placements, homelessness, and the further breakdown of their relationship with their family. A hospital social worker identified that the young person's mental and physical health would deteriorate due to an absence of shelter to stay safe and store belongings and medication.

One week after their last hospital admission the young person attempted suicide and later died in hospital.

Case example: Trauma, hope for the future and substance use

In the months prior to his death, a boy's substance use escalated. He used marijuana, volatile substances and methamphetamines intravenously two to four times per week. Residential staff reported he was waking up feeling the need to use drugs. He had also allegedly injected other young people from his placement.

The boy's substance use was linked to him displaying increasingly erratic, heightened and, at times, violent and threatening behaviours. The boy's care team expressed their significant concerns about his substance use and their ability to keep him, co-tenants and staff safe. Records report co-tenants feeling terrorised and youth workers left traumatised by his behaviours.

His care workers identified: "(His) trauma is deep and would benefit from a drug treatment facility where he is safe to deal with his grief and has space and time to change his behaviour while detoxing."

In the days prior to the boy's death his care team was noted to be exploring options for drug rehabilitation. There was an increasing sense of desperation and worry from the team as they recognised the extreme risks of his drug use, self-destructive behaviours, and his risk of suicide. At the time of his death, he had dangerous levels of methamphetamines in his blood.

33 D Beckmann, KL Lowman, J Nargiso, J McKowen, L Watt, AM Yule. Substance-induced Psychosis in Youth. Child Adolesc Psychiatr Clin N Am. 29 January 2020, doi: 10.1016/j.chc.2019.08.006.

34 NL Cuzen, SM Koopowitz, HL Ferrett, DJ Stein, D Yurgelun-Todd D. Methamphetamine and cannabis abuse in adolescence: a quasi-experimental study on specific and long-term neurocognitive effects | BMJ Open

Planned system improvement: Queensland Health - Cairns youth residential rehabilitation and treatment service

The Queensland Government is planning to deliver a new youth alcohol and other drugs treatment service to better meet the needs of young people and their families in North Queensland, with a service based in Cairns.

The new service is voluntary and will include a purpose-built 10-bed residential rehabilitation centre as well as a suite of non-residential treatment to support young people experiencing problematic substance use. It will include services tailored to meet the needs of Aboriginal and Torres Strait Islander young people, their families and community. The provisional age range for the residential service is 13 to 18 years with the primary target group expected to be 16 and 17 years. The Ministerial Infrastructure Designation was completed in October 2023. Construction is due to commence in mid-2024.[35]

System response to exploitation of vulnerable young people

One of the boys in the cases reviewed by the Board was believed to be exploited by older adult men who were influencing young people to commit property offences and supplying the young people with illicit drugs. These young people were all transient and vulnerable youths. In another case the young person in care was a victim of sexual exploitation while homeless and seeking shelter, food or drugs.

Project Paradigm, with the support of PeakCare and the QFCC, has released a best practice guide for workers when children and young people in out-of-home care go missing - Safe & Sound in Queensland: Enhancing safety for young people who go missing from care (the practice guide). The practice guide is a practical toolkit intended to provide effective, professional support for children who go missing from their home or place of care. It suggests strategies and practical steps that workers may take to:

- engage and communicate effectively with children to prevent missing episodes
- better understand the push and pull factors associated with missing episodes
- assess contributing risk factors and be able to respond appropriately if a child leaves their home or place of care
- support conversations with a child, following an episode of missing
- consider appropriate responses to various factors within the home or place of care to help reduce risk
- consider effective approaches for reporting concerns to statutory agencies, such as QPS and Child Safety services.

The practice guide notes that missing episodes (where the child's location is unknown) and homelessness are both issues for children living in out-of-home care who experience sexual and criminal exploitation and provides a guide on the warning signs/indicators and behaviours to be aware of. Several of the warning signs and behaviours were noted in the young people's cases reviewed by the Board, including but not limited to sexually transmitted infections, using public transport to visit locations beyond their usual radius travel, and saving money for no apparent reason.

35 Queensland Health (QH), Cairns | Queensland Health, QH website, 14 March 2024, accessed 8 July 2024.

The review of Queensland's residential care system

In July 2023, the Queensland Government announced a review of Queensland's residential care system. Child Safety led the review and QFCC Principal Commissioner and Board Chair, Luke Twyford, provided independent oversight of the review and independent advice on the review's outcomes.

More than 800 stakeholders were consulted through 41 engagement activities, including 15 regional forums, and a Ministerial Roundtable which sought input from child safety experts, frontline workers, advocates, Aboriginal and Torres Strait Islander community-controlled organisations, and young people with lived experience.

The review informed the development of a Roadmap for contemporary residential care in Queensland (the Roadmap) which was delivered for the Minister's consideration in December 2023 and published in February 2024. The Roadmap includes a number of actions to address the systemic issues identified by the review and to strengthen the delivery of residential care services for Queensland children and young people. The systemic issues identified in the residential care review and the Roadmap are consistent with the issues identified by the Board in 2023–24. For example, the Roadmap notes the following areas for system improvement, which correlate strongly with the experiences of the young people considered by the Board.

- We need to focus on the voices of children and young people.
- We can better share children and young people's stories and identities.
- We must recognise attachment and relationships as fundamental needs.
- We need to adopt a flexible approach to residential care.
- Each young person needs a trusted adult who is available to them.
- We can improve service quality standards.

Notably, there are several actions in the Roadmap that aim to identify and trial alternative care models to better meet the needs of Queensland children and young people. For example:

- Trial new models of residential care and build an evidence base of what works to meet the needs of Queensland children and their families (e.g. sibling house, respite care, short-stay assessment centre, house parent, transition to independent living).
- Pilot new and innovative models of foster and kinship care (e.g. recruitment services, respite care, shared care, specialist family-based care, professional care).

In April 2024, the QFCC published its response to the Roadmap, providing further actions required for successful implementation – A System that Cares: Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'. The QFCC will continue to provide an ongoing oversight role in the implementation of the Roadmap over the next three years.

Concluding comments

For too many of the young people considered by the Board in 2023–24, residential care was unable to meet their fundamental needs for connection, love, safety and stability. The placement models funded by Child Safety did not adequately recognise or respond to the complex and unique needs of the young people, resulting in a path of placement instability, transience, self-placing, increasingly high-risk, and ultimately self-destructive, behaviours.

System issues including a lack of therapeutic care placements, poor placement matching, and a lack of system flexibility and capacity contributed to a path where these young people experienced further harm and trauma through their experiences of placement instability, homelessness, sexual and criminal exploitation, and unmet basic needs.

In its 2021–22 Annual Report, the Board made a recommendation in relation to developing a continuum of care for children with complex needs, including 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.

2021–22 Annual Report
Recommendation 3

"The Board recommends: that the Queensland Government develops 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:

1. Be informed by a study of child death, serious injury or 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. (Recommendation 3.1)
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. (Recommendation 3.2)
3. 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 issue of the children and families contributing to the behaviours
    - 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. (Recommendation 3.3)

The government's response to Recommendation 3 was received in August 2023, during the early stages of the residential care review. It stated:

For further consideration: The Queensland Government recognises that children with high-risk behaviours require specialised support, together with the importance of early interventions to support the social, emotional, health and wellbeing needs of children, young people and their families before their behaviours escalate or reach a crisis point.

The Queensland Government provides a range of supports for children with complex needs who are engaging in high-risk behaviours through the health, education, child protection, and youth justice systems. A number of initiatives are currently underway to improve the responses to children and young people with complex needs, including from a continuum of care perspective, but we recognise that more can be done.

The Queensland Government has a strong interest in working with the Queensland Family and Child Commission and Child Death Review Board to further explore this recommendation over the next 12 months, with a particular focus on:

- better understanding the trajectories of children and young people;
- providing for more coordinated and integrated responses; and
- considering which targeted early interventions could best support children, young people and their families.

In this context, and given the expansive scope of this recommendation, it has been designated as 'for further consideration.'

The learnings from the cases considered by the Board in the 2023–24 reporting period reinforce the Board's original reason for making Recommendation 3 and confirm the need for the government to enact the outstanding recommendation.

This report provides further evidence of the poor life trajectories that arise in residential care. Specifically this year the Board has drawn the following conclusions from the child death cases it has reviewed:

- Children and young people impacted by trauma are likely to be hesitant to trust and resistant to caring gestures and may use behaviour to reinforce a view of themselves as unlovable. They are more likely to struggle to regulate their emotions and they can become aggressive, violent and antisocial as a direct consequence of their mistreatment as a child. Within this complicated and complex mix of trauma and behaviour, it is the responsibility of the child protection system to ensure every child in care has a home where they feel safe, loved and cared for; to have their needs met and the opportunity to heal from the trauma they have experienced.
- There is a need for care models to provide opportunities for children to form connections with carers, co-tenants, professionals and independent advocates. Residential care needs to be enjoyable to encourage engagement, create opportunities to develop secure attachments and provide an alternative to the chaos of high-risk behaviours, such as substance use, self-harm and offending.
- The systemic issues identified by the Roadmap remain relevant and are consistent with the experiences of the young people considered by the Board. That means:
  - We need to focus on the voices of children and young people.
  - We can better share children and young people's stories and identities.
  - We must recognise attachment and relationships as fundamental needs.
  - We need to adopt a flexible approach to residential care.
  - Each young person needs a trusted adult who is available to them.
  - We can improve service quality standards.
- Decision makers need to be vigilant in making assessments of the physical and mental state of a young person in cases where there is a transience or resistance to engagement with support programs and services. The prevalence of FASD and suspected FASD in the child protection cohort, and the frequency with which the Board observes a lack of targeted intervention for their complex needs, suggests more is required to help support these vulnerable children and young people achieve their potential, and avoid further harm.
- Young people are experiencing further significant harm – including sexual exploitation while in care. This compounds each child's existing complex trauma background. In some cases, the system which existed to protect and care for a child was ineffective at preventing further abuse and trauma.
- The system continues to lack the capability and capacity to provide safe and stable homes for vulnerable children and young people in its care, particularly those with more complex needs, including displaying violent and dysregulated behaviours or significant substance use or mental health concerns. The Board observed the service system was challenged by how to respond to the impacts and escalating risks of drug use. Residential care services expressed they did not have the capacity or expertise to respond to the level of drug use and addiction of the young people while simultaneously trying to ensure the safety and wellbeing of the young person, co-tenants and their staff. Turning away addicted young people from a safe home and service because of drug use, ultimately resulted in further individual and community harm.

Ultimately the children and young people reviewed by the Board did not have their basic and fundamental needs met. Systems such as health, education and housing were less involved in these young people's lives than police and justice. Workers with care and connection to the young people struggled to implement solutions, while adults in the community exploited the young people for their own gratification.

While the Board is committed to working with the Queensland Government to deliver Recommendation 3: 2021–22, it will require the commitment and effort of multiple government portfolios, and a clear, responsible owner within government.

The Board has considered this situation and is recommending a fundamental prioritisation of the needs of children in state care across all government portfolios. It is only through this whole-of-system, social recalibration that we will meet the needs of children with adverse life experiences.

The Board would like a future where all government workers – bus drivers, schoolteachers, housing officers, librarians – see children in state care as partly their responsibility to parent, wherein their service access is not unfair, or unequal, but is certainly special.

Recommendations

Recommendation 1

Improved and specialised placement options for children in care

The Board recommends that the DPC facilitate the publication of commitments from each portfolio Minister or Director-General regarding their commitment to children in state care. This public commitment to children in care should include commitments regarding the core business of the portfolio, as well as broader employment and training, economic and work placement opportunities.

Note: The above commitments to system improvements should be developed and implemented in alignment with the findings of Child Safety's 2023 review of the residential care model, A Roadmap for contemporary residential care in Queensland and the identified solutions from the A System that Cares: Queensland Family and Child Commission's response to the Roadmap. For First Nations children in care the commitments must be developed with reference to the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP).

Recommendation 2

Supporting conversations with young people about healthy relationships and sexual and reproductive education

The Board recommends that Child Safety and Queensland Health collaborate to revise and/or develop new practice guidance for child protection practitioners, foster carers and residential care providers on providing regular, effective, sensitive and contextual guidance to children in care to support and promote their sexual health and wellbeing. This must include topics of sexual and reproductive education, contraception, healthy relationships and consent.

Recommendation 3

Continuity of care for children with complex needs (Revisiting Recommendation 3 from the Board's 2021–22 report)

The Board recommends that Government prioritise its response to the *Child Death Review Board 2021–22 Annual Report* Recommendation 3: Continuity of care for children with complex needs, noting that cases reviewed by the Board in 2023–24 reinforced the need for flexible, specialised care models, particularly those who display violent and dysregulated behaviours or who are experiencing significant substance use or mental health concerns. Given the ongoing seriousness of this issue, Government's response to this recommendation should include nomination of a lead role who will produce quarterly public reporting on the status of this work.

CHAPTER 3

Addressing the mental health needs of children

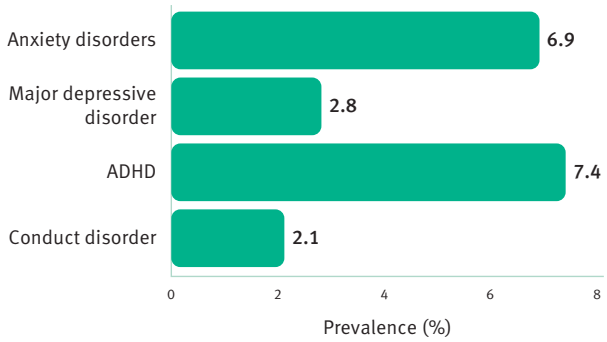
Mental health disorders impacting young Queenslanders

Mental health is a significant, ongoing concern for young Queenslanders. Mental health disorders impact one in seven (13.9 per cent) of children aged between four and 17 years, according to the most recent (2013) national count.[36] With the significant societal, economic and technological shifts in the last decade, this number likely underestimates the number of children experiencing mental ill health. The Board continues to observe that many of the children and young people it reviews experience mental health concerns, significant emotional dysregulation, non-suicidal self-injury (self-harm) and suicidal ideation.

Suicide is the leading cause of death for Queensland children aged 10 to 17 years.[37] Aboriginal and Torres Strait Islander children, and children known to the child protection system, remain over-represented in deaths attributed to suicide or suspected suicide.[38] Of the 70 cases the Board reviewed in 2023–24, six children died by suicide. A further 17 child deaths by suicide were reviewed by the Board in its first three years of operation (2020–21 to 2022–23). The Board remains concerned that the system is failing to adequately address the mental health needs of children in care, especially when the evidence suggests these conditions are common and largely predictable.

Mental health disorders are common among Australian children and young people. The last comprehensive study of the mental health and wellbeing of Australian children and adolescents, the Young Minds Matter study, was undertaken in 2013–14. Attention Deficit Hyperactivity Disorder (ADHD) was the most common in children and adolescents (7.4 per cent), followed by anxiety disorders (6.9 per cent), major depressive disorder (2.8 per cent) and conduct disorder (2.1 per cent).

Figure 9: Prevalence of mental disorders in 4 to 17-year-olds – source Young Minds Matter[39]



Since the Young Minds Matter study a decade ago, there have been significant shifts in the societal, economic and technological context in which children and adolescents are growing up. It has been a decade in which children and their families have felt pressures from increasing costs of living, housing affordability and availability issues, the impact of natural disasters, uncertainty over climate change and future environmental security, and the COVID-19 pandemic and lockdowns. Society is increasingly connected via smartphone and social media use, but young people are reporting greater feelings of isolation and loneliness.[40] Public discourse suggests worsening mental health for children and young people, with increasing rates of psychological distress, growing complexity, and a "genuine mental health crisis in children and young people in Australia and in other developed countries".[41,42]

36 D Lawrence, S Johnson, J Hafekost, K de Haan, M Sawyer, J Ainley and S Zubrick, *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,* Department of Health, Australian Government, 2015, p iii, doi:10.1177/1077559523122633.

37 Queensland Family and Child Commission (QFCC), *Deaths of children and young people Queensland 2022–23* , p 12. https://www.qfcc.qld.gov.au/sites/default/files/2024-03/QFCC_Report_Child_Deaths_2022–23_Chapter_1.pdf. [Confirm with CDP if still leading cause of death in 2023–24.

38 QFCC, *Deaths of children and young people Queensland 2022–23,* p 14.

39 https://www.health.gov.au/sites/default/files/documents/2020/11/the-mental-health-of-children-and-adolescents_0.pdf

40 https://www.theguardian.com/australia-news/2024/feb/12/number-of-young-australians-in-psychological-distress-continues-sharp-rise

41 https://www.abc.net.au/news/2024-05-05/mental-health-crisis-teenagers-generation-overwhelmed/103611004

42 https://www.abc.net.au/news/2023-10-05/abs-data-shows-mental-health-anxiety-depression-rising/102928618

Case example: The crossover between mental health, neurodivergence, behavioural concerns and parenting

The Board reviewed the system response to a girl who was diagnosed with ADHD and autism spectrum disorder. Child Safety was involved with the girl and her family in the year prior to her death due to concerns about her mother and stepfather's ability to manage her behaviours. When the girl became heightened, she would put herself and others at risk due to aggressive and unpredictable behaviours. Her family reported they were unable to keep the child safe at these times and on multiple occasions, this resulted in the need for emergency services including police and paramedics, to calm the child or respond to her suicidal ideation.

The girl was repeatedly assessed as not meeting the criteria for CYMHS involvement. CYMHS attempted to refer her mother to support to assist the family to access National Disability Insurance Scheme (NDIS) funding and behavioural supports, however, the family chose not to accept referrals. While the Specialist Services Clinician from Child Safety worked with the mother to submit Access Request Forms for the girl and her two siblings, it does not appear that this correlated with any progress towards obtaining a NDIS plan at the time of the child's passing.

The girl had two presentations to hospital due to escalating behaviours of self-harm, suicidal ideation, violence and aggression, running away from home and threatening to harm others. It was noted she had recently been taken off her medication and she acknowledged to paramedics this left her feeling "overwhelmed and agitated".[43] The child was again referred to CYMHS, which completed a home visit. CYMHS identified no acute risks and assessed the girl's recent suicidal statements as "behavioural-based seeking a response from family".[44] The girl's case was closed by CYMHS with a referral made to the public paediatric service and a support letter arranged for the child's NDIS application. The paediatric referral was accepted, with the team noting: "The support that can be provided through a general paediatric clinic is likely to be insufficient to meet the needs you have described…We will see [her] in our clinic, but please also refer [her] for appropriate supports to meet her current needs".[45] It does not appear that the child protection and health systems were effective at linking the girl and her family with the supports that she needed to have her mental health and behavioural needs met.

The *National Children's Mental Health and Wellbeing Strategy*, released in 2021, recognised the need for contemporary data in relation to the mental health and wellbeing of children and young people in Australia. To address the data gap, the National Child and Adolescent Mental Health and Wellbeing study is scheduled to commence in 2024. The study will provide updated prevalence rates of mental health disorders for Australian children and young people.

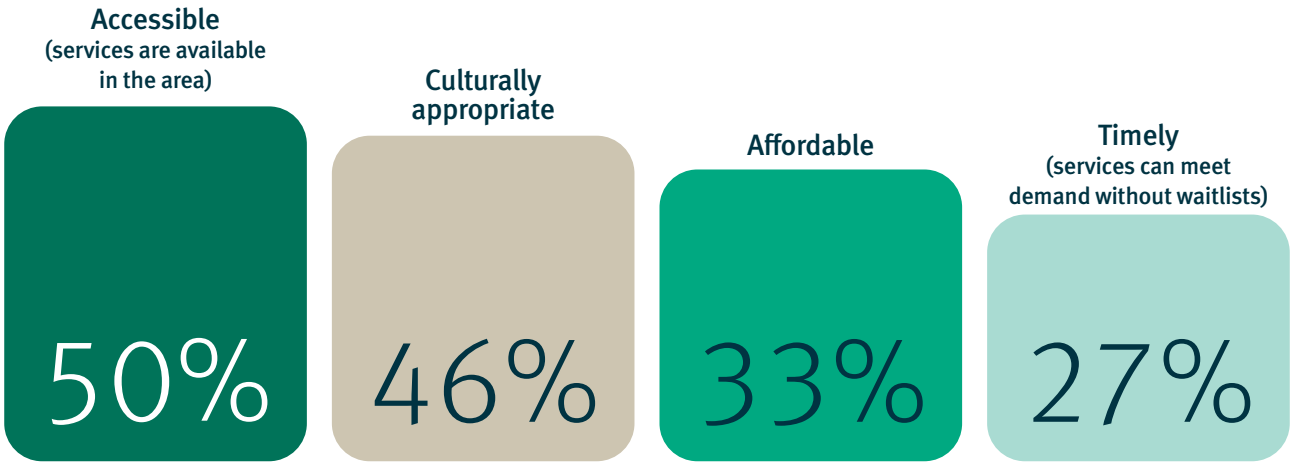
In Australia, half of adult mental health disorders emerge before the age of 14 years, however, more than 50 per cent of children experiencing mental health challenges are not receiving professional help.[46] Seeking help for mental health requires children and their parents to navigate a complex system of public and private services.

43 Form 20A, Coronial findings, Girl C, p 6
44 Form 20A, Coronial findings, Girl C, p 6
45 Form 20A – Coroner's findings, Girl C, 04/04/2024, p 6
46 https://www.mentalhealthcommission.gov.au/projects/childrens-strategy

The earlier we intervene in life, in distress and in the onset of illness, the chances for better recovery are much, much greater. If we give children the best start, they will grow into happier, healthier adults.[47] - Professor Helen Milroy, Child and Adolescent Psychiatry, Perth Children's Hospital

Figure 10: Results of Community Perceptions Survey 2023, QFCC[48]

Youth mental health services in my area are:



Source: QFCC Community Perceptions Survey, 2023

Rates of suicide among young people

In 2022, 77 deaths by suicide occurred among children and adolescents (aged 17 years and below) in Australia.[49] Deaths by suicide represented 30.9 per cent of all deaths of young people aged 15 to 17 years, up from 16.5 per cent in this age group in 2001. In Queensland, 20 children and young people died by suicide in 2022–23, with a total of 128 young people dying by suicide in Queensland over the last five years. Suicide was the leading overall cause of death for young people aged 10 to 14 years and 15 to 17 years over the five-year period. There has been a slowly increasing trend in youth suicide rates over time (**see Figure 11**). In 2018–23, the rate of suicide was 4.8 per 100,000 young people aged 10 to 17 years. For children known to Child Safety, this rate was 17.5 per 100,000 young people aged 10 to 17 years.[50] Of the cases reviewed by the Board to date, three young people who died by suicide were subject to a Child Protection Order.

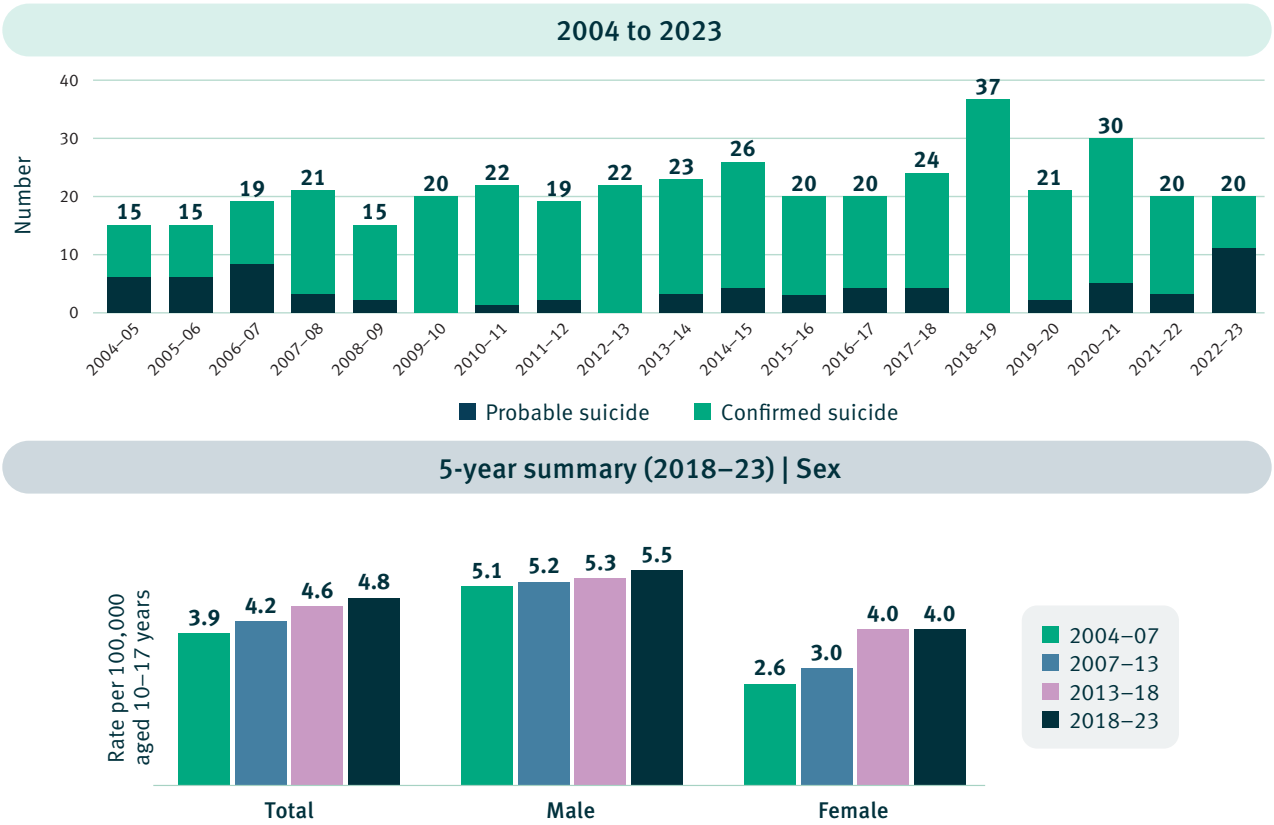
47 National Children's Mental Health and Wellbeing Strategy | National Mental Health Commission

48 https://www.qfcc.qld.gov.au/sites/default/files/2024-02/9022_QFCC_Growing%20Up%20in%20Queensland.WCAG%20reading%20order_01%20COMPRESSED.pdf

49 https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-among-young-people

50 Queensland Family and Child Commission: Annual Report: Deaths of children and young people Queensland 2022–23 (qfcc.qld.gov.au), p 41

Figure 11: Number and rate of youth suicides in Queensland[51]



The QFCC Community Perceptions Survey 2023 asked respondents to provide feedback on their experience of mental health services. The results identified significant concerns in relation to the timeliness, affordability, accessibility and culturally appropriateness of services.

51 https://www.qfcc.qld.gov.au/sites/default/files/2024-03/QFCC_Report_Child_Deaths_2022–23_Accessible2.pdf

Cohorts at greatest risk of mental ill-health

Certain cohorts of children are known to be at increased risk of experiencing mental ill health. These include:

- **Children and young people who have experienced child maltreatment:** Adverse Childhood Experiences (ACEs) are measurable adverse situations from early in an individual's life. There is some variation in what is measured to determine an ACEs score. Professor Brett McDermott, in the QFCC's commissioned research into preventing youth suicide, found there was a significantly higher risk of suicide for children with ACEs.[52] This finding is supported by the Australian Child Maltreatment Study (ACMS), which showed that people who have experienced child maltreatment are 4.6 times more likely to have attempted suicide in the past 12 months.[53] In addition to a direct correlation between abuse and suicidal thinking, Professor McDermott identified indirect effect from abuse with disengagement with school, lower educational and employment outcomes, self-medication with drugs and alcohol, and cumulative stresses that lead to suicidal thinking.[54] The Board continues to see a high prevalence of ACEs in the early lives of the children it reviews, including cases where suicide ideation was present. The cases outlined below of two girls show evidence of significant adversity at a young age, including multi-type maltreatment, parental substance use, parental mental ill health and parental incarceration.
- **Children experiencing sexual abuse:** Sexual abuse is one of the three abuse-type ACEs, with a known direct correlation to suicidal thinking.[55] 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 prior twelve months. The cases of the two girls outlined below both include disclosures of sexual abuse as young children by family members. Their abuse is alleged to have continued over an extended period of time.
- **Aboriginal and Torres Strait Islander young people:** Aboriginal and Torres Strait Islander young people (15 to 24 years old) are more likely to report high or very high psychological distress than their non-Indigenous peers.[56] Since the Board's inception in July 2020, it has reviewed 23 cases of children who died by suicide. Of these 23 cases, 10 (43.5 per cent) were Aboriginal and/or Torres Strait Islander children, indicating disproportionate challenges faced by these children. For example, Girl A expressed that she felt disconnected from Country, that any mention of her community made her feel sad, and that she wished for cultural healing. These expressed emotions indicated that there was a high need to assist her to safely reconnect with her culture and Country. Cultural support cannot be separated from a young person's mental health support.
- **Gender diverse young people:** The ACMS examined the associations of diverse gender and sexuality identities, and child maltreatment. It found that the prevalence of physical abuse, sexual abuse, emotional abuse, neglect and exposure to domestic violence was very high for those with diverse sexuality and/or gender identities.[57] A 2019 La Trobe University national survey of LGBTQIA+ young people aged 14 to 21 found more than a quarter of participants had attempted suicide at some point in their lifetime. [58] In 2023–24, the Board reviewed the cases of two young people who identified as gender diverse. Both young people died by suicide. One of the young people previously presented to hospital with suicidal ideation in the context of increasing home stressors around gender identity.

52 B McDermott, *Highly vulnerable infants, children and young people: A Joint protection mental health response to prevent suicide*, James Cook University, Cairns, 2021, p 14. www.qfcc.qld.gov.au/sites/default/files/2024-10/CDRB%20Preventing%20Youth%20Suicide.pdf

53 D Haslam, B Mathews, R Pacella, J G Scott, D Finkelhor, D J Higgins, F Meinck, H E Erskine, H J Thomes, D Lawrence, E Malacova, *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, Brisbane, 2023, p 28. https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/

54 B McDermott, *Highly vulnerable infants, children and young people*, p 14.

55 B McDermott, *Highly vulnerable infants, children and young people*, p 14.

56 Australian Institute of Health and Welfare (AIHW), *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, AIHW, Australian Government, 2018, p 96, doi: 10.25816/5ebcc63bfa7e8.

57 D J Higgins, D Lawrence, D Haslam, B Mathews, E Malacova, H E Erskine, D Finkelhor, R Pacella, F Meinck, H J Thomes, J G Scott, 'Prevalence of Diverse Genders and Sexualities in Australia and Associations With Five Forms of Child Maltreatment and Multi-type Maltreatment', *Child Maltreatment*, 2024, doi:10.1177/10775595231226331.

58 A O Hill, A Lyons, J Jones, I McGowan, M Carman, M Parsons, J Power, A Bourne, 'The health and wellbeing of LGBTQA+ young people in Australia', *Writing Themselves In 4*, monograph series number 124, Australian Research Centre in Sex, Health and Society, La Trobe University, 2021, p 16, doi:10.26181/6010fad9b244b.

Case example: The correlation between mental health and the care experience for children

The Board reviewed the case of a girl that entered out-of-home care at a young age and had experienced seventeen placements across multiple geographic regions over 13 years. Her family had a history of trauma, parental criminal offending and substance misuse. As illustrated in **Figure 12**, the girl was subjected to multiple traumatic incidents that impacted her and continued to cause pain and distress throughout her life. At the time of her death, she was in foster care.

The girl had a well-documented history of mental health concerns. On multiple occasions over a three-year period, she was taken to hospital with concerns around self-harm and suicidal ideation. Stressors included her conflicting feelings of returning to her home community, disconnection from Country, identity struggles, family members not attending contact visits and the ongoing court matter in relation to the sexual abuse she had suffered.

Child Safety and Queensland Health practitioners were aware of the above matters however the review team noted that "the limited contact Child Safety staff had with [the girl] during the review period would have impacted on their knowledge of her emotional wellbeing".[59]

In the year prior to her death, the girl ran away from school and was located a few days later when it was discovered she had not eaten, had written a suicide note and had self-harmed. When found, she disclosed a history of sexual abuse. The girl was referred to ETS following the incident and had two therapy sessions in the following six months.

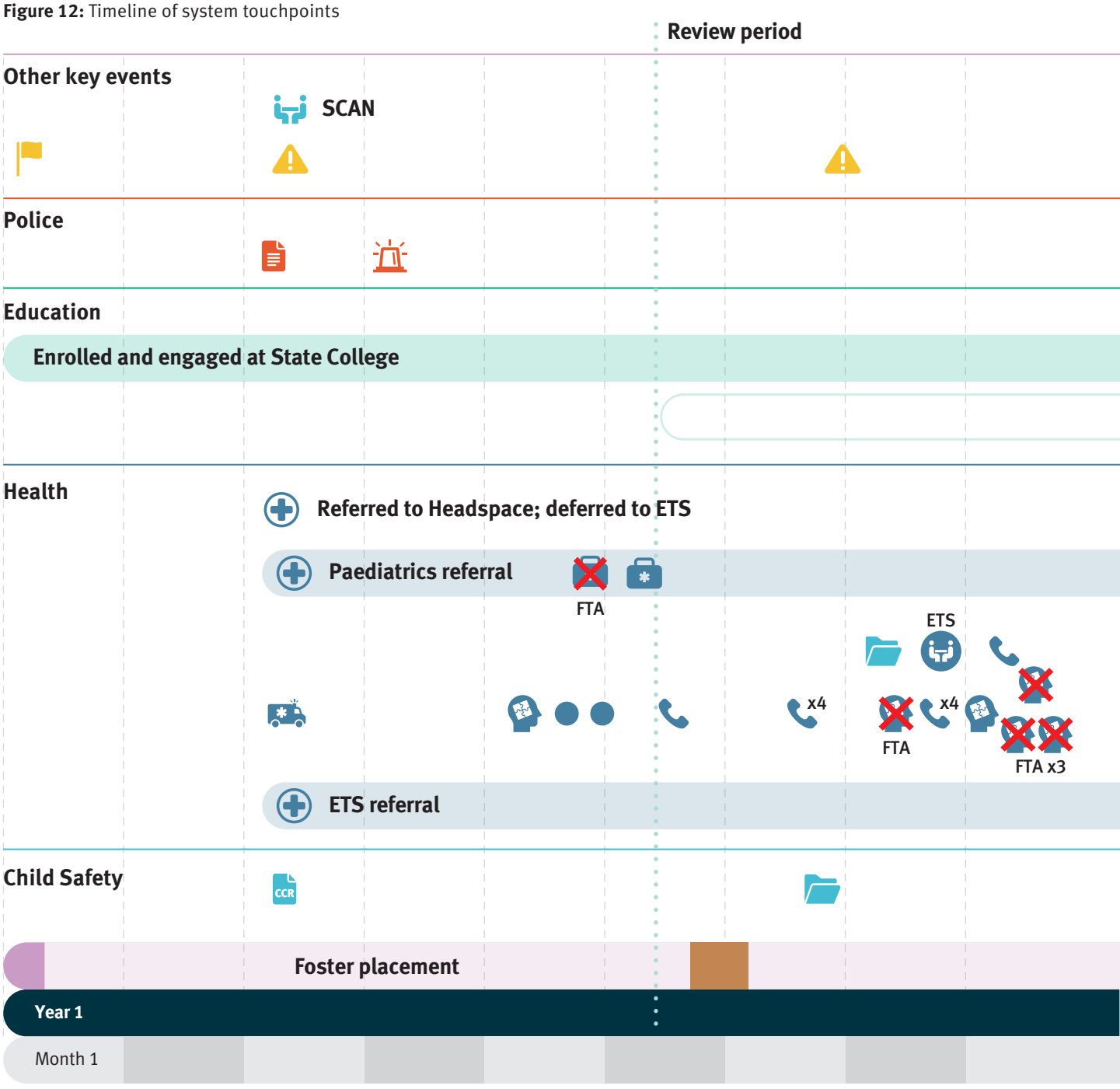
The girl was reported to be "motivated and willing to engage" with ETS in the six months following her referral. At this time, the girl was recorded as indicating that she "would like to engage with (an) ETS Clinician on a regular basis" and she also voiced her wish for cultural healing. ETS was unable to engage the girls carer to attend appointments and support her further treatment. ETS made multiple attempts to contact the carer, and then asked Child Safety to transport the girl to appointments. Child Safety was unable, citing lack of capacity. Without the assistance of a safe adult to accompany the girl to appointments and monitor her mental wellbeing between sessions, ETS decided that there was a risk that treatment might harm rather than help her "if there isn't any follow up with a safety plan after each session".

The referral was subsequently closed.

Some months after her referral closed, the girls willingness to engage with therapy appeared to have waned. During a home visit three months later, her Child Safety officer recorded: "(She) mentioned that she does not attend ETS therapy anymore. (She) said that she did not engage with ETS and doesn't want to go back. (She) said that she just didn't want to go, and she didn't want to engage with any counselling services." The reason that she changed her mind about attending therapy is not recorded as being explored further and she did not receive any further individual psychiatric treatment prior to her death by suicide.

59 Child Safety, *System and Practice Review for Girl A*, 16

Figure 12: Timeline of system touchpoints

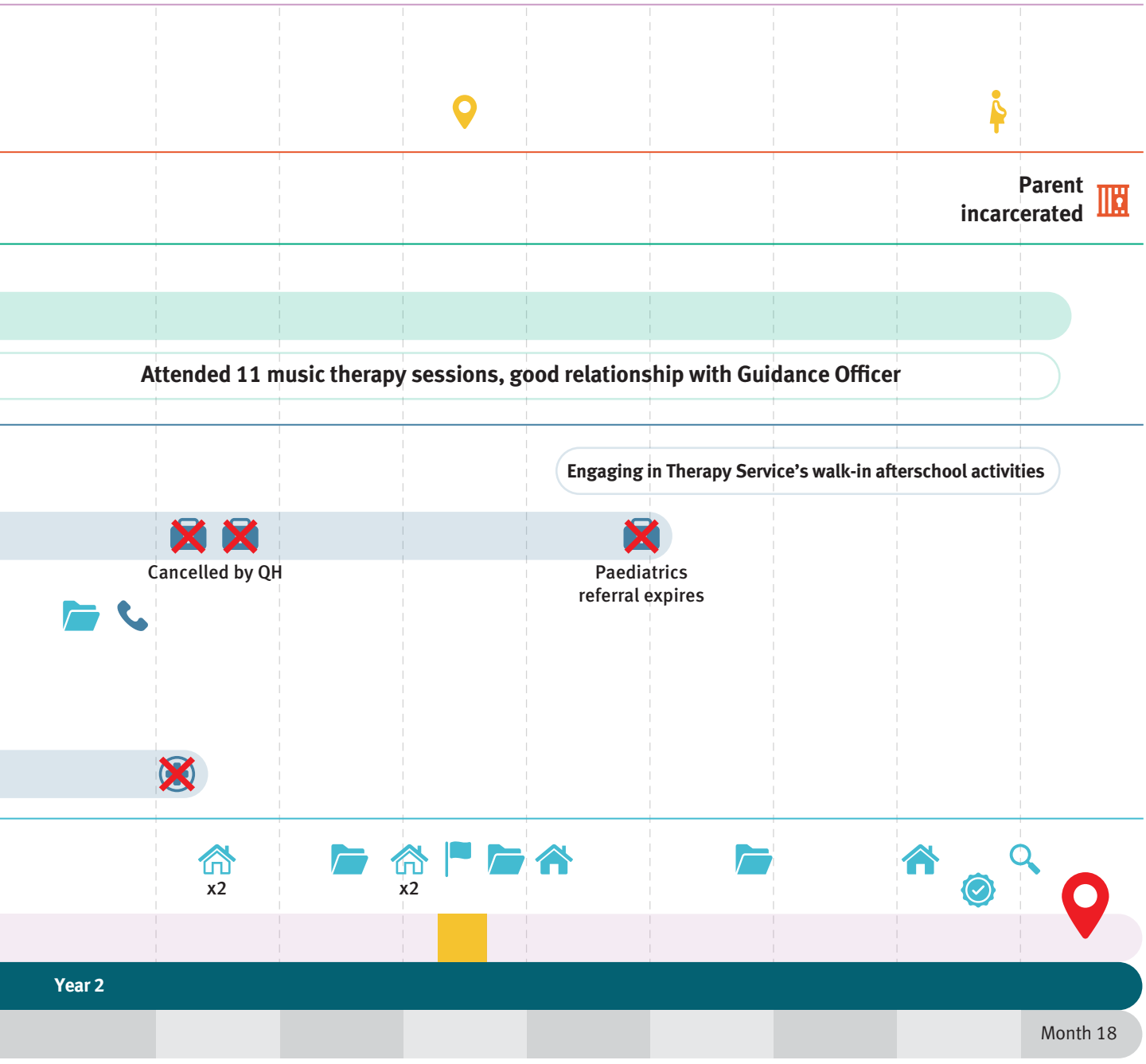


Child Safety

- Child Concern Report (CCR)
- Case plan review
- Home visit
- Attempt to arrange home visit
- Case note regarding behavioural incident
- Foster Care's approval renewed
- Sighted by Child Safety staff at activity stall
- SCAN meeting

Health

- Emergency Examination Authority
- Health referral
- Referral closure/expiry
- ETS appointment
- Missed ETS appointment
- ETS rapport session
- Paediatric appointment
- Missed Paediatric appointment
- ETS stakeholder meeting (Foster Care declined to attend)
- Attempts by ETS to contact Foster Carer/ Child Safety



Police

- Missing persons report
- Perpetrator arrested
- Parent incarcerated

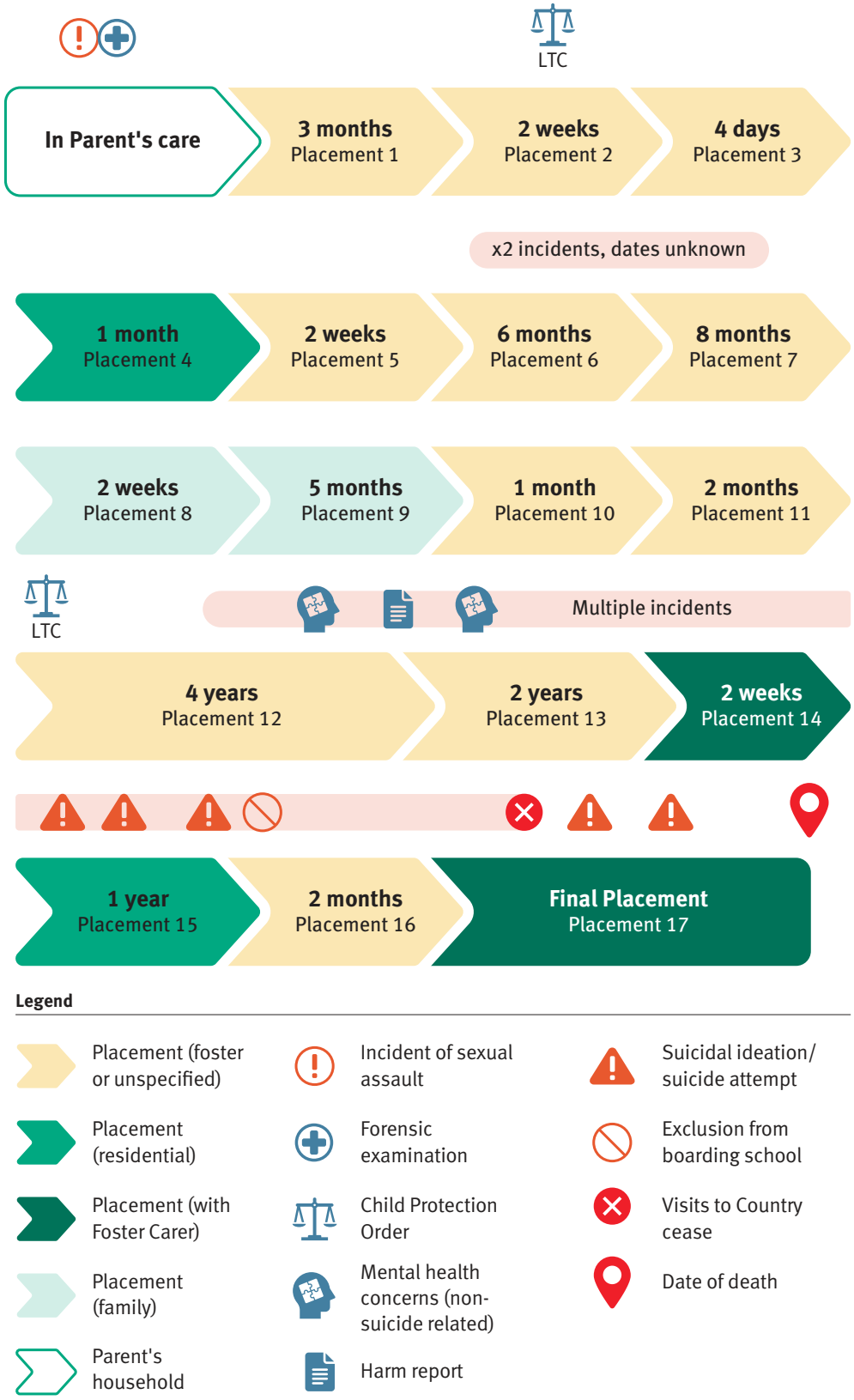
Placements

- Respite 1
- Primary placement
- Respite 2
- Respite 3

Other key events

- Suicidal ideation
- Last known incident of sexual assault
- Sibling born
- Sibling ages out of care
- Date of death

Figure 13: Factors in life and households, as captured in agency review reports and supporting documents



Responding to the sexual abuse and suicide risk

Child Safety's internal review of the case highlighted the intersection between sexual abuse and suicide risk was identified as an area of practice that required development. In response, the Office of the Chief Practitioner committed to leading capacity building around suicide risk factors for vulnerable young people and the interface between sexual abuse and suicide risk. On 22 March 2024, Child Safety wrote to the Board confirming that:

- "Practice leaders from the Office of the Chief Practitioner had implemented a joint case consultation with frontline child safety practitioners where there were known concerns regarding sexual abuse and suicide risk.
- A review of both the child sexual abuse practice kit and the practice guidance regarding support for suicidal young people is underway.
- Targeted capacity building to strengthen responses to the co-occurrence of sexual abuse and suicide risk and to enhance case consultations and provision of professional development for frontline practitioners was underway.
- Targeted professional development opportunities for child safety practitioners inclusive of occurrence of sexual abuse and suicide risk is being explored and consultation was underway with a view to pilot this approach in 2024".[60]

Case example: Consent for mental health support for children not in care

The Board reviewed the case of a girl who, at age 14, called an ambulance for herself following a suicide attempt. This was alleged to have occurred following a verbal altercation with her parent. At the hospital, the girl was supported by a grandparent. She was referred to CYMHS. Following this event, the girl's parent requested an alert be placed on her medical records advising them not to contact or share information with the grandparent. CYMHS subsequently closed the first referral due to lack of engagement by her parent.

Later that month, the girl's school submitted a Student Protection Report alerting Child Safety to her recent hospitalisation. During the subsequent investigation, Child Safety interviewed the girl's parent who stated they were not against the girl receiving support for her mental health. Child Safety subsequently contacted CYMHS seeking to re-refer the girl for psychological support. Child Safety advised CYMHS that the girl was living with her grandparent under an informal care arrangement. CYMHS requested Child Safety provide a Confirmation of Care Arrangement letter to allow her grandparent to consent to the girl's mental health treatment. Child Safety was delayed in providing this letter due to confusion about where the girl was residing.

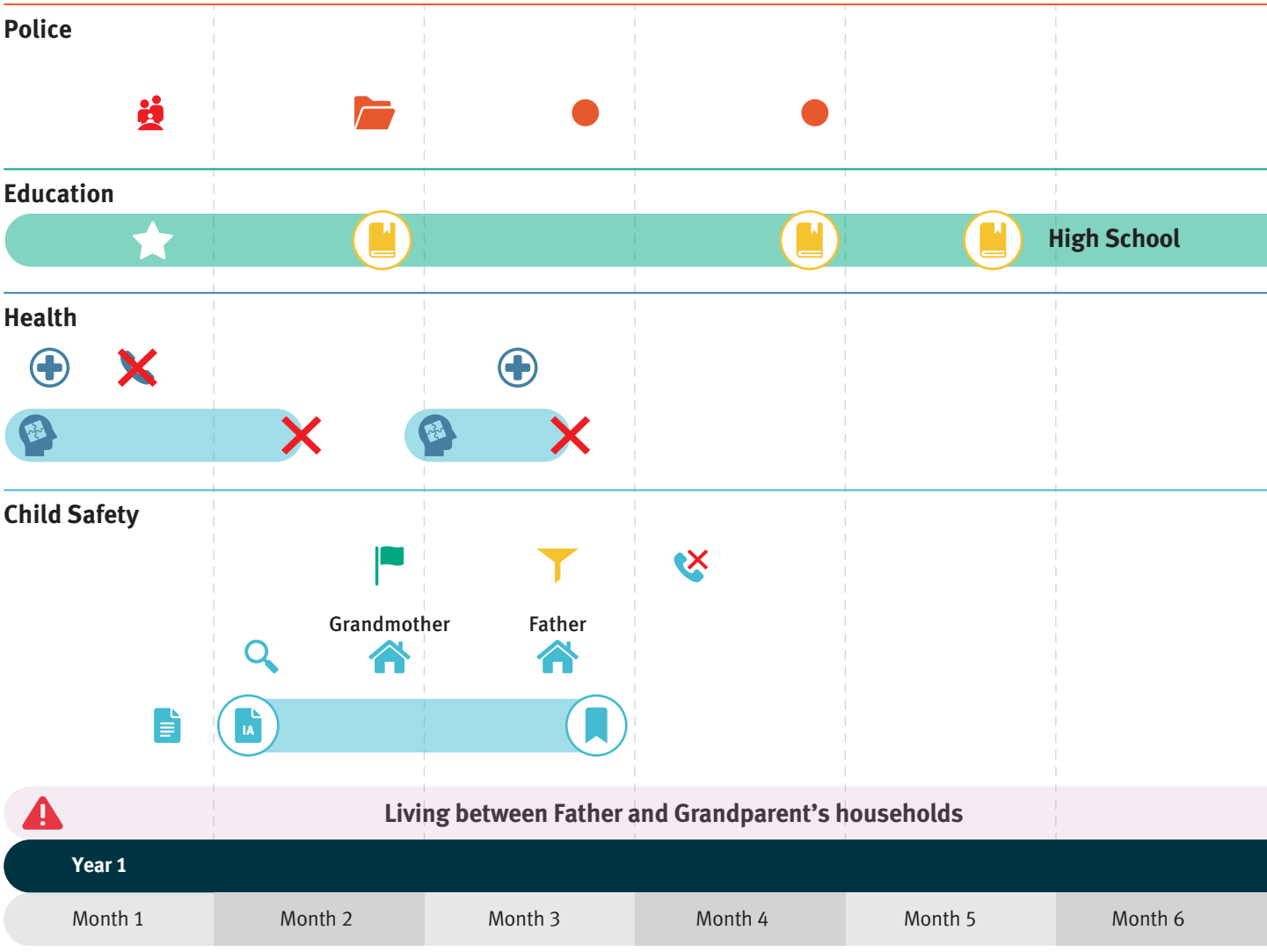
After interviewing her parent, Child Safety Officers determined that the girl would continue living with her parent (at least partially). CYMHS was advised of this, and informed Child Safety that her parent would have to contact CYMHS to reopen her second referral. Child Safety recorded the investigation outcome as "unsubstantiated" with the rationale that the parents and grandparents were willing and able to meet the girls care and protection needs.

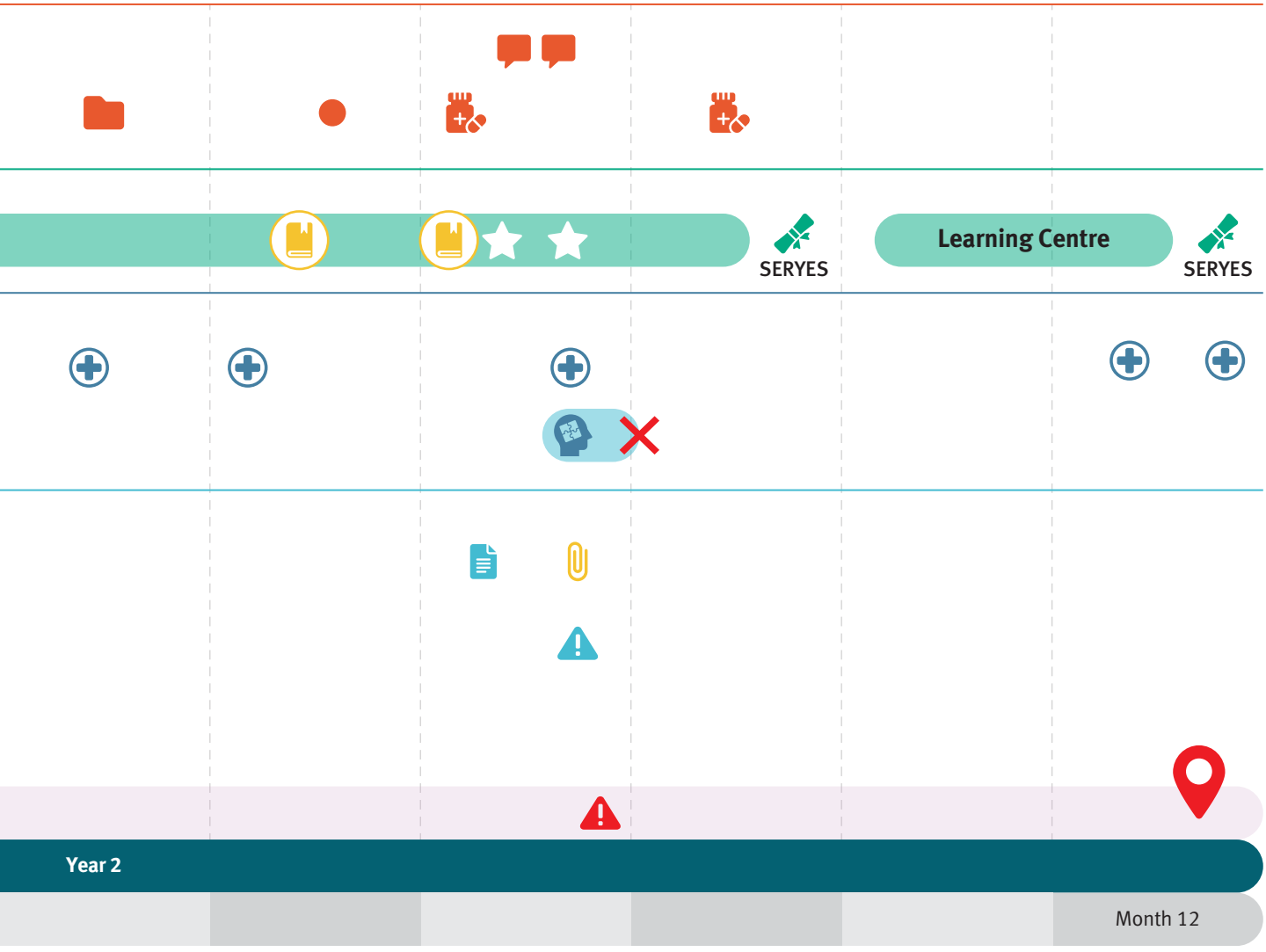
Records provided to the Board contained multiple instances where the girl expressed that she wanted to engage with CYMHS, however her requests for mental health support were denied. Twice CYMHS closed referrals because her parent did not provide consent for her to obtain mental health treatment.

Nine months later, the girl's school submitted a further Student Protection Report to Child Safety that contained concerns for the girl's mental health. Child Safety recorded the concerns as a Notification. The corresponding investigation was not commenced prior to the girl's death three months later.

60 D Mulkerin and Department of Child Safety, Seniors and Disability Services (DCSSDS), *Letter to the Chair, Child Death Review Board*, 22 March 2024.

Figure 14: Timeline of system touchpoints





Education

- School suspension
- Referral to Youth Engagement Services
- Professional report to Child Safety

Police

- Street check
- Domestic Violence Order (DVO) application lodged – agg. grandmother, resp father.
- DVO granted
- Drug diversion
- Family and Child Connect (FaCC) referral – no engagement
- Police advise Child Safety their investigation yet to commence
- Suicidal ideation
- Day of death

Evolve Therapeutic Services

ETS is a partnership between Child Safety and Queensland Health to provide planned and coordinated therapeutic intervention to children in care. The ETS program was established to deliver a tertiary level mental health intervention service to address the mental health therapeutic needs of children and young people in the statutory child protection system identified with severe and/or complex needs. ETS aims to improve emotional wellbeing, support the development of skills and enhance participation in education and the community.

ETS teams are situated within CYMHS and are managed within Hospital and Health Services across Queensland, as part of the continuum of service delivery by state public mental health services.

Currently children between five and 17 years may be eligible for referral to ETS if they:

- require assistance in relation to severe and complex psychological and/or behavioural problems
- are subject to an interim or finalised Child Protection Order granting custody or guardianship to the chief executive or a child protection care agreement during an Intervention with parental agreement (IPA).[61]

Memorandum of Understandings and Local Service Agreements have led to expanded eligibility criteria—for example, IPA and Support Service Cases.

Once a young person is accepted to the ETS program, the team's direct intervention occurs over three levels - individual (young person), dyadic (young person and their primary carer), and systemic—for example, carers and stakeholders—with varying degrees of intensity, depending on the identified needs of the young person. If individual intervention with the young person is assessed as potentially being counterproductive at this time and/or the young person does not wish to engage, considered support is provided by ETS to their carer provider and stakeholders to reduce identified risk/harm. It is acknowledged that stakeholder collaboration can be challenging due to the complexity and vulnerability of young people referred to ETS.

The key focus of the ETS program is to provide planned and coordinated therapeutic and behaviour supports to vulnerable children and young people, the majority of whom have histories of disrupted attachment relationships and significant experiences of abuse and neglect, with an aim to improve their emotional wellbeing and the development of skills to enhance participation in school and in the community. The ETS program places specific emphasis on specialist trauma and attachment informed models of care. Service provision commences from point of acceptance and is achieved through a flexible use of appropriate evidence-based and informed individual, dyadic, and systemic therapeutic interventions and a coordinated and sustainable partnership with key government and non-government and private sector agencies. It is grounded in well-established theoretical perspectives (child development, systemic theory, trauma, attachment, psychodynamic theory, grief and loss, and culture) that provides a collaborative wrap-around model of service. ETS interventions are tightly coordinated with the work of the other departments/services through the multi-agency collaborative framework. Clinicians have lower clinical caseloads to allow for the intensity of the mental health therapeutic work and liaison with the multiple stakeholders involved.

ETS delivers capacity building in the broader child protection sector through the provision of trauma and attachment informed psychoeducation, training, and consultancy. During 2023 there were 726 training events held with a total of 19,466 training attendees, an increase of over 5,000 attendees compared to 2022 (14,210). Total hours of professional development provided to achieve inter-sectorial capacity building was 2,056. Topics of most interest focused on trauma-informed care/practice, the needs of children and young people with a care experience, harmful sexual behaviours, Aboriginal and Torres Strait Islander mental health, and mental health treatment and intervention.

61 *DCSSDS, Child Safety Practice Manual: Meet a child's health and wellbeing needs, DCSSDS*, Queensland Government, n.d., accessed 8 July 2024. Available from https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/meet-a-child-s-health-and-wellbeing-needs#Work_with_Evolve_to_support_a_child

Barriers to accessing mental health support

If a young person does not have their basic care needs of safety, stability and security met they will be unable to address any of their other needs.[62]

Both girls in the case studies above expressed their wish to receive mental health treatment. Both recognised their need for mental health support following suicide attempts, obtained referrals to ETS and CYMHS respectively, and showed interest in engaging with therapy. Their insight and help-seeking behaviour was clear, however, both girls' referrals were closed by the service providers prior to treatment. It is evident that one girl did not face a lack of service availability, rather that there was a lack of responsibility between the service provider (Queensland Health) and her legal guardian (Child Safety) as to who would organise transport for the girls' attendance at appointments and provide her with mental and emotional support.

Many of the young people considered by the Board experienced barriers to accessing mental health and paediatric services due to systemic issues. This included a lack of availability, lengthy waitlists, fragmented services, and tensions between access or eligibility mechanisms via the public and private systems. The significant out-of-pocket costs and logistical factors, particularly for rural and remote young people, of accessing mental-health support are also recognised as key barriers.[63]

Issues relating to resourcing and workforce inadequacies in the mental health system are not unique to Queensland. The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) recent Federal Pre-Budget Submission 2024–25 acknowledged a chronic and severe workforce shortage, the growing community need for mental health care services and a system that cannot keep pace with this need.[64] RANZCP highlighted that three in four children with severe mental health disorders are not able to see a psychologist.[65]

The *National Children's Mental Health and Wellbeing Strategy (2021)* highlighted that seven out of 10 presentations to paediatricians were mental health related.[66] Experts argue *"paediatricians are carrying a big part of the burden but they're not trained in mental health, particularly, so we definitely need Child Psychiatrists working alongside paediatricians much more strongly"*.[67]

Barriers to accessing mental health services are not always systemic, with the QFCC highlighting that mental-health related stigma and lack of knowledge about mental health services are two commonly identified barriers to professional help-seeking.[68]

62 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
63 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
64 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
65 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
66 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
67 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf
68 QFCC Mental Health Advocacy Paper Non-Systemic barriers to young people's use of mental health services.pdf

Case Example: The interplay or private and public mental health services

The Board reviewed the case of a girl and her family that experienced barriers in accessing psychiatry services when it was recommended by the public mental health system. Queensland Children's Hospital Acute Response Team first recommended the girl be reviewed by a psychiatrist in the context of low mood.[69] The girl's parents put her name down on multiple private psychiatrist's wait lists in a large geographical area, however, initially the earliest available appointment they were able to find was seven months later. Accordingly, the family GP referred the girl to CYMHS requesting a psychiatrist review. CYMHS declined the referral on the basis that a standalone psychiatrist service is not provided by CYMHS and the girl was already engaged with a private psychologist.

After another emergency presentation with increasing episodes of low mood, self-harm and the girl reporting she was hearing voices, her parents asked again for a referral to CYMHS for support. CYMHS accepted a referral and her care was transitioned from her private psychologist to CYMHS. The girl continued to be an active client of CYMHS at the time of her death.

Children's Health Queensland's review of the case found that **"There does not appear to be a guideline or procedure directing a review by a psychiatrist in the event of frequent and repeat emergency presentations for new onset mental health concerns"**.

A combination of systemic and non-systemic factors leads to almost half of children and young people with a mental illness not receiving the help they need for their mental health. In a 2018 study, parents reported that 51.1 per cent of 4 to 17-year-olds with mental disorders had attended a health professional during the previous 12 months (see **Figure 15**), however, 13.6 per cent of these children had attended on only a single occasion, most commonly with a GP.[70]

Figure 15: Percentage of children with mental illness who have seen a health professional in the past 12 months

^ Sawyer, M.G, Reece, C. E, A. C, Johnson, S. E, Hiscock, H., Lawrence, D. (2018). Access to health professionals by children and adolensents with mental discorders; Are we meeting their needs?. Australian & New Zealand Journal of Psychiatry, 52(10), 972,982

69 QH – 3, Girl D, p 1

70 https://journals.sagepub.com/doi/10.1177/0004867418760713

Access to the Community Visitor Program

Some of the young people in the case studies above were eligible to receive visits from a Community Visitor as part of the Office of the Public Guardian (OPG)'s child community visiting program. In one girl's case this service was limited due to the region where she lived and challenges in recruiting locally based Community Visitors. Community Visitors attempted to visit the girl at her care location on three occasions, however all attempted visits were unsuccessful. OPG's records also reflect consistent unsuccessful attempts by both Community Visitors and the Regional Visiting Manager to contact the girl's carer. OPG records indicate that the telephone contact details provided were routinely either disconnected or calls went unanswered and unreturned. It is vital that vulnerable children and young people in out-of-home care have access to an independent and safe person that they can share their experiences with, and who can identify and escalate issues on their behalf if needed. OPG Community Visitors are an independent advocate for their rights, interests and wellbeing, but delivery of these services relies on all agencies working together to ensure community visiting services can be received by the children and young people who need them. The case study of this girl highlighted the difficulties experienced by child protection agencies in maintaining visibility of children in care, and these issues were also experienced by the OPG.

In May 2022, the OPG implemented the *Setting Visiting Priorities and Frequencies Practice Direction* to align OPG's legislative mandate with the operational delivery of its community visiting services. The OPG advised the Board that "the frequency of discretionary visits to children and young people in visitable homes has been varied, standardised and streamlined based on a refined set of risk factors. When determining visit frequency to visitable locations, OPG considers these risks factors, as well as placement safety and stability, disability and high-risk behaviours". The Board received advice that the management of visit frequency is overseen centrally in OPG and is reviewed each month to ensure resources are being appropriately directed.

The Board is concerned that vulnerable children and young people in remote communities, particularly First Nations children and young people, remain at significant risk of experiencing suboptimal protection, including through their lack of access to the Community Visitor Scheme.

Assessing whether a child has a parent able and willing to protect

As the cases outlined above demonstrate, the child protection system is sometimes required to step in when a parent is not acting in their child's best interests by not meeting their needs for mental health, disability, behavioural or developmental supports. Given that young people are not always able to legally give informed consent for their own mental health treatment, the child's parents or guardian are the guardian for this service. This gives rise to Child Safety consideration as to whether parents are acting in the best interests of the child and in doing so the determine if further supports are needed or if the young person is in need of protection.

Section 10 of the *Child Protection Act 1999* *(Qld)*, deems a young person in need of protection as a child who:

(a) has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; and

(b) does not have a parent able and willing to protect the child from the harm.

Procedures: Investigate and Assess: Assess the information and decide the outcome

When determining parental ability and willingness to protect a child from harm, consider:

- the parents' capacity (not just intention) to act protectively
- the parents' demonstrated ability and motivation to protect the child
- if the child lives across more than one household, the ability and willingness of the parents across each household to protect the child.

The Board reviewed cases where parents were reluctant or resistant to authorise their child's participation in counselling and mental health interventions. This posed issues for Child Safety investigations, some of which were closed as "not in need of protection" on the basis that the parents had made statements suggesting they would support the child to engage with mental health services – however the Board can see that this did not happen prior to the child's death. In one case, four days after the investigation was finalised, Child Safety was advised by CYMHS that the child's referral had been closed. This shows that quite promptly after the closure of the investigation, and despite the parent's verbal assurance that they would support their child to engaging with CYMHS, this was not the case. In another case, despite a mother having a long history over many years of not engaging with in-home support, disability, mental health and paediatric services, the investigation was closed based on the mother's verbal consent to engage with support services.

In one case the Board found significant issues in the family dynamics, particularly with multiple people in parent roles taking oppositional approaches to consenting to the child receiving support – ultimately resulted in a lack of service to the child prior to their death. In particular a grandparent was left unable to act protectively towards the child, because her lack of legal guardianship meant that the parent was able to assert their authority to not consent to mental health treatment. Child Safety's own review of the case acknowledged that more proactive steps should have been taken, such as coordinating with mental health services and the girl's school, and keeping the investigation open until appropriate mental health support was in place.

Gillick competence and support persons for young people to access mental health treatment

Given the problematic impact of parental withholding consent for young people that are seeking mental health support, the Board investigated how the system can better empower young people who have sufficient autonomy and decision-making capacity to access their own support.

In the case of one girl, prior to closing their investigation, Child Safety contacted CYMHS to request a referral without parental consent. CYMHS discussed the case at an Intake Review meeting, resulting in a recommendation to "review legality of care given that [her parent] did not consent to referral. CYMHS agreed to undertake an assessment of Gillick Competence if the CSO can provide a Confirmation of Care Arrangement letter to their service". It appears CYMHS did not receive the requested letter from Child Safety and did not undertake an assessment of the girl's Gillick competence. This girl's second referral was closed, "due to not knowing the situation for the family or supports required. (The girl's parent) will have to contact CYMHS to reopen the referral".

Gillick competence

A minor is presumed not to have capacity to give their own consent, unless there is sufficient evidence (e.g. an assessment of capacity by a clinician) they have such capacity to consent. This is referred to as 'Gillick competence'.

Part 3 of the *Queensland Health Guide to Informed Decision-making in Healthcare* provides information about decision-making and consent for minors:

"The following considerations are relevant for determining whether a minor has capacity to consent to treatment for a mental illness:

- The age, attitude and maturity of the child or young person, including their physical and emotional development
- The child or young person's level of intelligence and education
- The child or young person's social circumstances and social history
- The nature of the child or young person's condition
- The complexity of the proposed health care, including the need for follow-up or supervision after the healthcare
- The seriousness of the risks associated with the healthcare, and
- The consequences if the child or young person does not have the health care".[71]

If the girls subject to review by the Board in the above case studies had been assessed as Gillick competent they may have been able to commence treatment and identify a safe adult of their choosing to provide them with support while receiving treatment and provided CYMHS practitioners with an understanding of their family situation and the supports they required.

The cases in the earlier chapter of this annual report highlight the impact of a child or young person not having a stable, safe and supportive adult in their lives. The girls that are the major case studies in this chapter were denied treatment due to the non-engagement of others.

For the young person in chapter 2 it was noted that "he also doesn't experience positive attachments and being surrounded and supported by people he feels love and care about him."[72] In lieu of a home, he would often visit a local child safety service centre, and at times a youth justice service centre, to use bathroom and washing facilities. On many occasions, he called a child safety after hours service centre seeking help with emergency accommodation and transport. He called on these government agencies like a teenager calling their parent or a trusted person to help them.

In relation to the other boy, the Board discussed that complex cases required safety plans of significant scale. "There is a need for an acute residential care option for high-risk children, including involuntary or diversionary options."[73] This boy's story is another child death case that highlights the lack of acute residential care options for children and for young people who are experiencing significant challenges.

The Roadmap noted the need for 'parenting approaches', instead of institutionally designed 'bed nights', that incorporate the child/young person being able to meet workers before moving into a placement, having support to access earning/learning opportunities, organised holidays, activities, sleepover and pets, and graduated independence.[74] The QFCC's response to the Roadmap noted that frontline workers, executives and managers should see children in state care as "their own children" as this would go a long way in changing the life outcomes for children in care.[75]

The Board acknowledges that children and young people need to be adequately supported while receiving mental health treatment. Treatments such as talk therapy and medication can initially make a patient feel increasingly vulnerable or heighten their emotions before the benefits become apparent. Access to a safe support person is essential during this time. Where no suitable support person is identified, this must be recognised as a risk to the child.

71 Queensland Health, *Chief Psychiatrist Policy – Treatment and care of minors*, Queensland Health, Queensland Government, 2020, p 4, accessed 8 July 2024. https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf

72 The Healing Foundation, *Community Healing*, The Healing Foundation, Canberra, accessed 8 July 2024. https://healingfoundation.org.au/community-healing

73 The Healing Foundation, *Community Healing*, The Healing Foundation, Canberra, accessed 8 July 2024. https://healingfoundation.org.au/community-healing

74 The Healing Foundation, *Community Healing*, The Healing Foundation, Canberra, accessed 8 July 2024. https://healingfoundation.org.au/community-healing

75 The Healing Foundation, *Community Healing*, The Healing Foundation, Canberra, accessed 8 July 2024. https://healingfoundation.org.au/community-healing

Culturally safe, flexible healing supports

"For Aboriginal and Torres Strait Islander people, healing is a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people."[76]

Across Queensland, over 43 per cent of children and young people that engaged with ETS identified as being Aboriginal and/or Torres Strait Islander. In 2022, an ETS study published in *Australian Social Work*, reported that improvement in overall well-being for those accessing ETS was consistent between Aboriginal and/or Torres Strait Islander children and young people and non-Aboriginal and/or Torres Strait Islander children and young people. To support and enhance the ETS program's capacity to ensure culturally appropriate, and culturally safe service delivery, six ETS teams are funded to employ an Indigenous Program Coordinator (IPC). The IPC supports mental health clinicians through the provision of cultural consultancy, training, peer supervision and the development of therapeutically orientated resources. In addition, the role contributes to assessment, case planning, management and review processes.

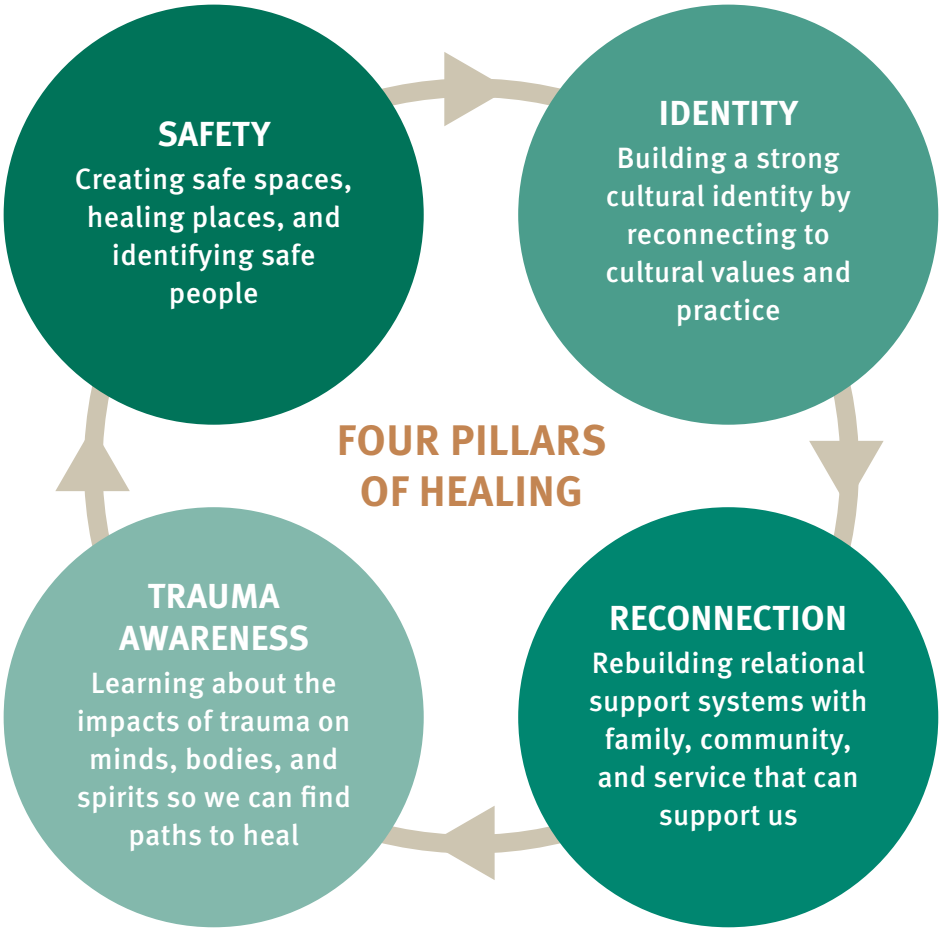
One girl featured in this chapter was an Aboriginal girl who required a trauma-informed and healing approach specific to her cultural and mental health needs. Records show that she spoke of her disconnection from Country and desire to visit her Aboriginal community for a "cultural healing from the land and the ancestors". She described enjoying fishing and being in nature because they reminded her of Country. ETS recognised that her mental health treatment would benefit from a visit to Country. ETS wrote to Child Safety with the suggestion and recommendation how to best manage her safety while she was there.

Child Safety acknowledged the impact family disconnection had on the girl. Child Safety's records noted that safe family contact and visits to her home community needed to be explored in accordance with her wishes, however, this was aspirational and repeatedly recorded as something to be done "in the future".

The Board's review of this case highlighted the need to connect Indigenous children with their culture, family, and community as core tenet of their mental health. If children cannot safely visit Country, alternatives should be considered, such as connecting them with people from their cultural or language group in their local area or supporting them to spend time in similar natural environments. Mental health services should look to incorporate cultural healing into their treatment of Aboriginal and Torres Strait Islander children. The Healing Foundation suggests four pillars as the basis for effective, culturally safe trauma recovery: safety, identity, reconnection and trauma awareness (see Figure 16).

76 The Healing Foundation, *Community Healing*, The Healing Foundation, Canberra, accessed 8 July 2024. https://healingfoundation.org.au/community-healing

Figure 16: Four Pillars of Healing (source: The Healing Foundation)[77]



Accessing NDIS supports for children with mental health and disability challenges

For some of the children reviewed by the Board the child protection system repeatedly identified that they would benefit from access to supports via the NDIS. For instance, in one case, after responding to the child's behavioural escalations and emergency department attendances following reports of suicidal ideation, CYMHS advised a child's mother to explore access to the NDIS and offered to link her with the Acute Response Team (ART) or Parent to Parent service, though the mother declined any referrals. The Board identified that the family had support needs that remained unmet by the system and this re-raises the issue of how the child safety system supports parents to access the disability system, including where the line of reasonable effort sits.

77 The Healing Foundation 2020, *QLD Government becomes first state or territory to implement Healing Strategy*. Accessed 30 October 2023. https://healingfoundation.org.au/2023/08/24/qld-government-becomes-first-state-or-territory-to-implement-healing-strategy/

Review of Queensland's residential care system

Child Safety's Roadmap and information about the associated oversight role and reporting undertaken by the QFCC was presented to the Board at meeting 20 on 29 February 2024. In April 2024, the QFCC published its response to the Roadmap, providing further actions required for successful implementation – A System that Cares: Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'. The QFCC referred to a recommendation made by the Board in its 2021–22 annual report - Recommendation 3: "the Queensland Government develop a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours", in its advice to government to consider the continuum of mental health support in the redesign of residential care models. The QFCC acknowledged the Board's recommendation aligns in principle with the following action of the Roadmap:

"Design a specialist services project to support a trial of intensive therapeutic care and support for young people with disability, mental health and behavioural support needs (Commence Year 4)."

The QFCC reported its expectation that this action will be completed by 2025, and health, disability and mental health sectors must remain involved, be accountable and funded in the action's implementation. The Roadmap also outlined the following action:

"Develop and pilot a community-based mental health response including supports and treatment for young people at risk of entering or who have recently entered care (Commence Year 4)."

The QFCC noted that a model of adolescent mental health accommodation is a clear need in Queensland and Child Safety should not be seen as the best owners and operators of this type of service. It articulated the following expectations in relation to this action:

- the quality and extent of mental health support to young people in residential care must improve, and the Department of Health must lead and contribute to the prioritisation of this action item.
- in defining the models and service expectations, the Department must be clearer about when each residential care model:
  - » must include 'in-house' mental health support;
  - » does not require 'in-house' mental health support and will instead use 'in community' support; and
  - » must have a primary and specialist focus on mental health support.

Better Care Together

The Queensland Government's *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*, is a five-year plan developed in response to the Mental Health Select Committee's Inquiry into the opportunities to improve mental health outcomes for Queensland. The Queensland Government allocated $1.645 billion over five years in the 2022–23 State Budget for improving mental health, alcohol and other drug services as well as initiatives to support suicide prevention as well as an additional $119.8 million committed in its first year.

This plan acknowledges that a large proportion of recommendations made by the Inquiry focused on the state-funded Mental Health Alcohol and Other Drugs service system. This includes the need to expand services for young people. Priority 1 key actions in the plan include (but are not limited to):

- establishing new and enhancing existing specialist alcohol and other drug treatment options for young people
- expanding harm reduction responses for young people at risk of alcohol and other drug-related harms, including supporting coordinated responses at a statewide and regional level
- exploring models of service to better respond to children, adolescents and young people with mental health needs and other complexities, including challenging behaviours and/or intellectual or developmental disability.

Concluding comments

In its inaugural Annual Report, the Board made five recommendations to improve the availability and accessibility of suicide prevention and postvention supports for vulnerable Queenslanders. The Board also commissioned the research report, *Highly vulnerable infants, children and young people*, to inform its recommendations. Three years on, there has been some improvement towards a coordinated system response to youth suicide. However, cases reviewed in 2023–24 continue to highlight opportunities to improve system responses to children and young people experiencing mental health issues, including suicidal ideation and self-harming behaviours.

Many of the young people considered by the Board this year experienced barriers to accessing mental health and paediatric services due to systemic issues. This included a lack of availability, lengthy waitlists, fragmented services, and tensions between access or eligibility mechanisms via the public and private systems. The significant out-of-pocket costs and logistical factors, particularly for rural and remote young people, of accessing mental-health support are also recognised as key barriers.

The Board observed children and young people are faced with an increasingly in-demand mental health system that lacks the capacity to provide timely and tailored, culturally safe mental health supports. In other cases, services had capacity, but children were denied treatment due to an inability to consent to their own treatment or because they did not have a safe person to support them. Across these cases the Board identified the need for:

- improved mechanisms for meeting a child's basic care needs is essential to mental health and wellbeing
- providing clinical care and mental health support to young people who exhibit high-risk behaviours
- system supports for gender diverse children and young people
- issues of consent of a minor to mental health services
- availability of and access to specialist mental health and paediatric services.
- Assessing whether a child has a parent able and willing to protect them and their mental health. Specifically:
  - A child with additional needs due to mental health, disability, developmental or behavioural disorders has every right to have those needs met by their parents and service system. It is essential that the system understands the child's needs and ensures assessments are framed in terms of how those needs are being met and what is in the child's best interests.
  - A parent's verbal commitment to engage with a service should not be considered as equating to an additional level of safety or protection for a child. While verbal commitments may indicate a parent's motivation, they might also be empty promises made with the intent of appeasing the system. The system should seek evidence of actions to inform an assessment of true ability and willingness (e.g. direct feedback from service providers about attendance at appointments and the level of engagement).
  - Where there is doubt about a parent's ability and willingness to protect and an absence of evidence to support this, a parent's history of action or inaction (e.g. declining support services, refusing to engage with service providers, or failing to provider parental consent) should be given significant weight and careful consideration.

The health and child protection systems must jointly champion the rights and autonomy of young people to access mental health treatment when they seek it. Cases outlined in this report highlight important learnings for the system in enabling young Queenslanders to access mental health support.

The Board holds specific concerned that the system is failing to adequately address the mental health needs of children in care, even when the evidence suggests these conditions are common and largely predictable. The state government is responsible for the shelter, safety, education, behaviour and wellbeing of children in care, and it is not acceptable to withhold one of these responsibilities because the others don't exist.

Recommendations

Recommendation 4

Guaranteed access to mental health supports for children in care

The Board recommends that Queensland Health:

1) take action to ensure that where a child in state care does not engage with a public mental health service, their referral is not closed until:
   - the child's case is discussed at a SCAN meeting (or other equivalent multi-agency coordination mechanism); and
   - a multi-agency strategy to support engagement has been developed and enacted.
2) take action to ensure that where there is non-engagement of a young person in state care with a mental health service including CYMHS or ETS, this does not result in the closure of the referral and the Health Department maintains responsibility and takes alternative action to respond to the mental health needs of the child.
3) improve access to mental health supports for child and young people by:
   - improving staff awareness of Gillick competency and the ability for Gillick competent children and young people to access mental health services without parental consent
   - allowing young people who are Gillick competent to nominate any appropriate adult as their support person.

CHAPTER 4

The needs of children living with disability and chronic medical conditions

In 2023–24, the Board reviewed the cases of 29 children and young people who died of natural causes. A large proportion of these children had chronic medical conditions or disabilities that impacted on their day-to-day lives.[78] The Board specifically reviewed the service response to nine children and young people who lived with disability and/or chronic medical conditions, and had recorded child safety concerns in the year prior to their deaths. The children ranged in age from one year and eight months to 17 years and five months at the time of their deaths. Two children identified as Aboriginal.

Seven children were neither Aboriginal nor Torres Strait Islander, with three of these children from Culturally and Linguistically Diverse (CALD) backgrounds. The Board examined issues in relation to these cases, including the role and capacity of the child protection system to identify and meet a child's disability and medical support needs when a child is subject to intervention, and the capacity of the health systems to support parental health literacy. The experiences of CALD families were of particular focus due to the additional challenges they experience in navigating the health and child protection systems.

Figure 17: Prevalence of disability in Australian children

Prevalence of disability by age[79]	0 to 14 years	15 to 24 years
Any disability	7.6%	9.3%
Severe disability	4.5%	3.4%

In Australia, 7.6 per cent of children aged 0 to 14 years have some level of disability and 9.3 per cent of young people aged 15 to 24 years identify as having a disability.[80] Around 210,000 (4.5 per cent) of children aged 0 to 14 years have a severe or profound disability, meaning they always or sometimes need assistance or supervision with self-care, mobility and/or communication (see Figure 17).

In 2024 in Queensland more than one quarter of children and young people subject to ongoing child protection intervention had a disability.[81]

Chronic medical conditions, also known as long-term conditions or non-communicable diseases, are defined as a wide range of conditions, illnesses and diseases that tend to be long lasting with persistent impacts. For example, common chronic medical conditions in children include asthma, hay fever and allergic rhinitis, anxiety disorders, food allergies, diabetes, and epilepsy. In 2017–18, approximately 43 per cent of Australian children aged 0 to 14 years had at least one chronic medical condition, while 20 per cent had two or more.[82]

78 It is not possible to provide a definitive number of cases pertaining to children who had chronic conditions and/or disability due to the children (and their families) having differing levels of engagement with agencies and/or a lack of information available to the Board. In other cases, the information available is anecdotal and potentially inaccurate.

79 ABS, 2019, Microdata: Disability, Ageing and Carers, Australia, 2018. AIHW analysis of TableBuilder data, accessed September 2021.

80 The Australian Bureau of Statistics' Survey of Disability, Ageing and Carers (SDAC) defines a person having a disability if they report having a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities. A person with a very high level of disability will sometimes or always need help with self-care, mobility or communication. The SDAC defines this level of disability as 'severe or profound core activity limitation'. Australian Institute of Health and Welfare (AIHW), Australia's children: Children with disability, AIHW Website, 2022, accessed 21 August 2023.

81 Letter to the Chair, CDRB from Deidre Mulkerin, Director-General, Department of Child Safety, Seniors and Disability Services dated 12 February 2024.

82 AIHW, Australian's Children, Chronic conditions and burden of disease, AIHW Website, 25 February 2022, accessed 21 August 2023.

Abuse and neglect of children with disability

Children with disability are recognised as a population at increased risk of maltreatment. In 2011, the World Health Organisation commissioned a systemic review and meta-analysis on violence against children with disability. The review found children with disability, as a group, had nearly a four times higher risk of violence than their non-disabled peers. In terms of specific violence, children with disability were:

- at more than three times higher risk of physical violence
- at nearly three times higher risk of sexual violence, and
- over four times higher risk for emotional abuse and neglect.[83]

The risk for an individual child with disability is dependent on a range of factors including the impact of their disability on their functioning, the presence of family/parental risk factors and the presence of protective factors. Child Safety encourages practitioners to consider the following risk and vulnerability factors when conducting risk assessments in relation to children with disability (see Figure 18).[84]

Figure 18: Risk and vulnerability factors for children with disability

Child with disability risk factors	Parental/family risk factors
Communication barriers – a child may have speech or communication needs that make disclosing abuse more difficult. **Disempowerment** – a child may feel voiceless or have had their views disregarded previously preventing them from disclosing abuse. **Dependency on others** – a child may lack independence, may rely on others for their daily support and intimate care, or may be unable to physically defend themselves. **Mistaking abuse or neglect for a child's disability** – a child with disability with bruising may not cause the same level of concern as it would if similar bruising was seen on a non-disabled child due to the assumption that mobility issues, equipment or a child's own challenging behaviours may have caused the injuries. **Lack of education** – a child with disability may be less likely to receive meaningful education on personal boundaries and safety, which may impact their ability to understand or recognise abusive behaviour. **Increased isolation and lack of support** – some children with disability may have fewer people in their safety and support network be less visible in the community.	**Disrupted attachments** – the bond between a parent and their child who is born or acquires a disability may be impacted by negative reactions to the child's disability, unrealistic expectations for the child's development or abilities, post-natal depression, or the child exhibiting behaviours associated with their disability that are mistakenly perceived by the parent to be the child's disinterest in them. **Stress** – a parent may experience higher stress levels due to financial costs, concerns for their child's wellbeing and future, actual or perceived stigma, difficulty managing behaviour and the requirement for them to provide increased levels of support and supervision to their child on an ongoing basis. **Isolated and limited support** – a parent may experience higher stress levels due to financial costs, concerns for their child's wellbeing and future, actual or perceived stigma, difficulty managing behaviour and the requirement for them to provide increased levels of support and supervision to their child on an ongoing basis.

83 Australian Institute of Family Studies (AIFS), Understanding safeguard practices for children with disability when engaging with organisations, AIFS Website, 2017, accessed 22 August 2023.

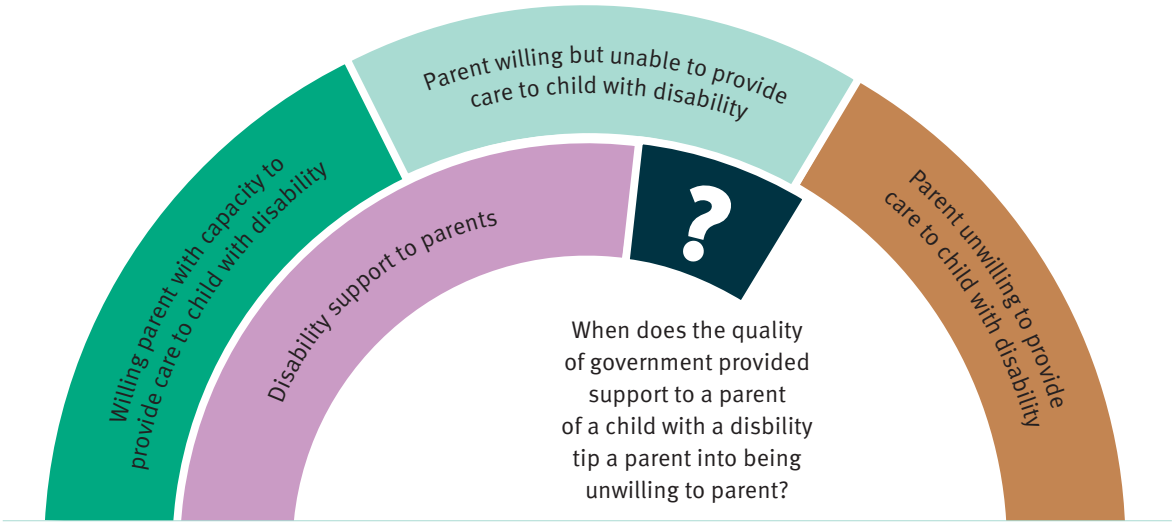
84 Department of Child Safety, Seniors and Disability Services (DCSSDS), Child Safety Practice Manual, A child's disability: Risk and vulnerability factors, DCSSDS Website, 16 September 2022, accessed 22 August 2023.

Recognising child protection risks for children with disability

"It is easy to become distracted by the disability and accept, excuse and have empathy for the parental behaviour because of the child's disability, instead of recognising the child protection concerns."[85]

The Board brought a specific focus to the cases it reviewed to distinguish the separation between parents who need more assistance to meet the disability needs of their child, and parents who posed a risk to the safety and wellbeing of their child. In reviewing child safety practice, the Board identified that bias, conscious or unconscious, often influenced how practitioners responded to reports of harm to children with disability. Equally the lack of disability support that met the needs of the family too often resulted in blame on the parent, rather than blame on the disability service sector.

Figure 19: Understanding the overlap or gap between a parent's ability and willingness to support their child and the system's ability and willingness to support the parent.



85 DCSSDS, Child Safety Systems and Practice Review Report (not publicly available).

Case example: Child safety, disability support and a parent's choice to relinquish care

The Board reviewed the case of a 16-year-old who was primarily cared for by one parent. The young person was diagnosed with low-functioning autism spectrum disorder, intellectual disability, and epilepsy and was non-verbal. His parents had separated, and his non-custodian parent had no contact with him. His parents were of a CALD background and English was not their first language.

The boy had been enrolled in special school but had not attended during the year prior to his death. His parent removed him from school due to his significant aggression and violent behaviour and he was supported by the school to participate in its home learning program.

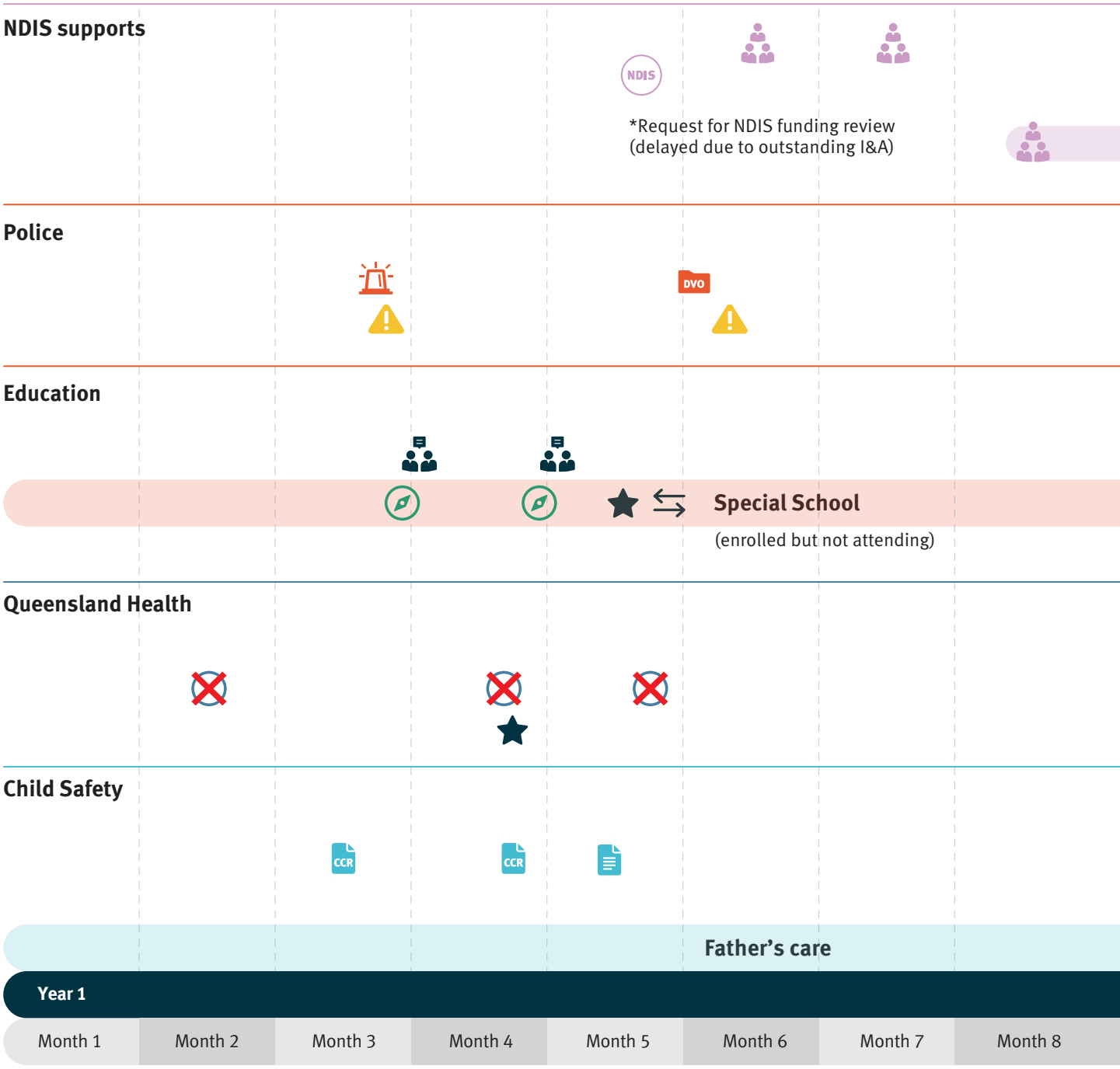
Thirteen child protection reports were made to Child Safety in relation to the young person in the year prior to his death. Medical professionals, disability support workers, school staff and community notifiers in contact with the young person expressed concerns about neglect, emotional and physical abuse in his parent's care. The concerns included that his parent was struggling to care for his needs and was:

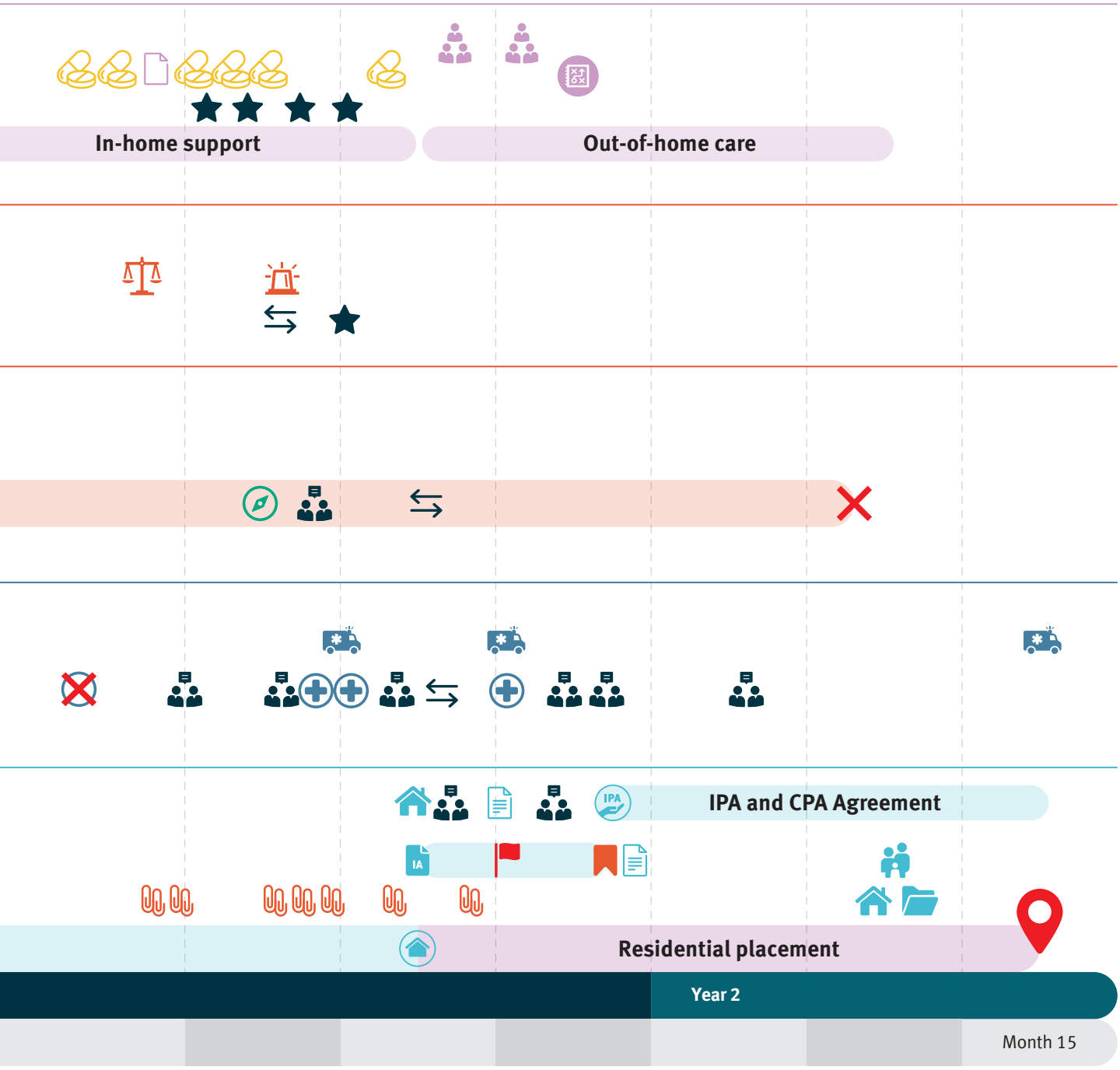
- mismanaging his medication (overdosing, underdosing and adding additional medications)
- restricting his access to and intake of food
- using excessive physical discipline
- not providing medical intervention when he experienced seizures
- not calling an ambulance
- failing to attend scheduled medical appointments.

Despite the repeated concerns, it took six months before Child Safety commenced an investigation. The commencement of the investigation was triggered by the young person's parent taking steps to relinquish care. Following this, a NDIS care provider took on his full-time care in an unlicensed care arrangement.

During the child protection investigation, a focus on young person's disability and chronic medical conditions appeared to overshadow consideration of the child protection concerns. Child Safety contemplated the possibility that the young person could be safe in his parent's care with additional disability-funded support to help him care for his son. NDIS service providers expressed concern that he was unsafe in his parent's care, and other government agencies warned of the possibility that mismanagement of his medications could lead to serious complications or death. Ultimately, Child Safety determined that he was at risk of future physical and emotional harm because of neglect, and he was without a parent both able and willing to protect him and he was placed in residential care.

Figure 20: Timeline of system touchpoints





Police/Justice

- DVO — DVO
- Arrested / charged
- Domestic and family violence breaches finalised
- Domestic and family violence incidents

Education

- Guidance officer involvement
- Unenrolled

NDIS supports

- NDIS Plan – updated
- Services provided
- Functional Capacity Assessment
- Medication misuse by father observed

Cross agency/systems

- SCAN Meeting
- Professional report to Child Safety
- Stakeholder discussions
- Information shared (under CPA)
- Day of death

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

In April 2019, the Australian Government established the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission). The Royal Commission's findings in relation to the experiences of the two brothers known as Kaleb and Jonathon, as reported in *Public Hearing Report: Public hearing 33 Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study)* (Public Hearing 33 report), shared similarities with aspects of several child death cases reviewed by the Board. Specifically, these were, cases of children with quality-of-life concerns, parents struggling to meet their needs despite the involvement of government entities, and the influence of unconscious and conscious bias on child protection practice.

In the case study of the 16-year-old, Child Safety was focused on gaining additional in-home disability support to keep him at home and assist his parent, who was recognised to be "not coping but doing their best". The Board considered that this approach did not place sufficient weight to the young person's experiences of harm while in the care of his parent.

The Royal Commission made the following recommendation:

The State of Queensland should provide training and resources to its employees and agents who have any responsibilities relevant to children and young people with disability directed, but not limited to:

a. the influence of unconscious and conscious bias, and
b. how discrimination occurs

in responses, actions and decisions concerning children and young people living with disability at risk of experiencing violence, abuse and neglect.[86]

The Royal Commission delivered its final report to the Australian Government in September 2023 and made 222 recommendations to improve laws, policies, structures and practices to ensure a more inclusive and just society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation. Some recommendations called for the improvement of child protection responses to First Nations parents, children and young people with disability as well as improved data capture, data linkage and continued funding of the National Disability Data Asset (NDDA). The Royal Commission recommended that a specific data project using the NDDA be undertaken to demonstrate the outcomes and experiences of people with disability transitioning between systems, including the justice, housing, employment, education and child protection systems.

The Australian Government released its response to 172 of the 222 recommendations that were within the Australian Government's primary or shared responsibility, on 31 July 2024. It did not include responses to the 50 recommendations within state and territory governments' primary responsibility. One hundred and thirty of the 172 recommendations were accepted or accepted in principle, 36 recommendations were for further consideration and six recommendations were noted.

The Queensland Government's response was also published on 31 July 2024, addressing 130 recommendations that were directed to the Queensland Government. Of the recommendations accepted or accepted in principle, implementation will progress in a staged approach alongside the necessary NDIS reforms and the ongoing implementation of actions under *Australia's Disability Strategy 2021-2031* and existing commitments under *Queensland's Disability Plan 2022-27: Together, a better Queensland*. Further, the Queensland Government developed the *Disability Reform Framework: The Next Chapter* that sets out Queensland's disability reform agenda, that provides a cohesive and structured approach for considering disability reform in the context of the Queensland Government response to the Royal Commission.

86 Commonwealth, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Public hearing 33 Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study) Public Hearing Report, 5 September 2023.

Recommendations in relation to First Nations people with disability in the context of child protection were accepted and accepted in principle jointly by the Australian Government and states and territories. The Queensland Government referred to *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families (2017-2037)* and the *Breaking Cycles 2023–25* plan as contributing mechanisms for addressing these recommendations.[87] The recommendation in relation to the NDDA was accepted in principle jointly by the Australian Government and states and territories with the NDDA to continue to be in operation in 2024–25 with future funding to be determined.[88]

Case example: Mismanagement of medication as a child protection risk

In one case, a community notifier reported that a child's medical care needs were not being met by their parents in relation to their condition as the child had a seizure and was not taken to hospital. The child reported that at times, their parents had mismanaged the medication that was essential to appropriately manage their condition. A decision was made to record the notified concerns as a CCR with the included rationale that the information was third hand and required further context. The notifier was not recontacted to further confirm or explore the information they had provided.

Mismanagement of medication as a child protection risk

The Board reviewed cases that involved parents mismanaging or failing to administer their child's prescribed preventative medications. This was often due to a lack of full understanding of the medication and how to provide it. When one young person, was in the care of both his parents, medical practitioners repeatedly reported to Child Safety, via notified concerns and the SCAN team, that his parents were not treating his seizures and had stopped giving him his epilepsy medication because they thought it was not working. In other cases, there were examples of parents missing scheduled doses of medication, not commencing medication at all, and an inability to administer the correct dose of medication to their child.

For children with chronic medical conditions controlled by prescribed medications, it is critical for the child protection system to consider appropriate medication management and provision as an essential care need of the child. For some chronic medical conditions, the impact for the child of not receiving consistent preventative or treating medication can be significant harm. If the child does not have a parent able and willing to protect them and meet their medical and medication needs, they may be in need of protection – however it is also true that the health system has an obligation to ensure children in Queensland have their health needs met.

In assessing risk to children with disability and/or chronic medical conditions where medication mismanagement exists, Child Safety must work in collaboration with the treating teams and medical professionals engaged with the child. This would help ensure there is a clear understanding about the child's diagnosis, treatment, management and/or medication plans, the impacts on the child if these are not followed and the parent or caregiver's engagement with and comprehension of the plans.

87 Queensland Government response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, p 106-7, 31 July 2024 https://www.dcssds.qld.gov.au/__data/assets/file/0011/14321/queensland-government-response-disability-royal-commission.pdf]

88 Queensland Government response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, p 148, 31 July 2024 https://www.dcssds.qld.gov.au/__data/assets/file/0011/14321/queensland-government-response-disability-royal-commission.pdf]

Case example: Dilution of risk mitigation by support services

The Board considered the case of a young person with multiple complex needs including brain damage, and a vision impairment. He was non-verbal, percutaneous endoscopic gastrostomy fed and wheelchair dependent. His primary carer was his single parent and NDIS in-home supports were reported to be in place. A notifier reported that the parent of the young person was missing his medication and feeds. Child Safety did not identify the missed feeds and medication as possible medical neglect and did not contact the young person's medical team to gather information about the impact of these alleged missed medication and feeds.

The Board was concerned that child protection concerns were minimised, and that safety was reassured by the involvement of NDIS supports and the presence of the young person's adult sibling who was acting protectively, however, the assessment did not recognise that NDIS supports alone may not be sufficient to mitigate the risk of harm by a parent where the parent's capacity may be impacted by carer stress, substance use and mental health issues.

Culturally competent service delivery

In Australia, CALD groups are defined as cultural groups from outside the dominant Anglo Australians (Anglo Saxon and Celtic) population segment. The distinction is because of their ethnicity, including race, culture, language, and religion. CALD groups are also distinct from Indigenous Australians based on their migration histories. CALD people typically come to Australia from non-English speaking backgrounds, and often from countries where collectivism is prioritised over individualism, and where the family, rather than the individual, forms the basic unit of society.

The Board reviewed approximately 10 cases where the agency review records indicated the child and/or one or both parents had a CALD background, however, it was not possible to ascertain the exact number because of the children (and their families) having differing levels of engagement with agencies. This resulted in limited awareness of those agencies and/or a lack of information available to the Board. In some cases, the CALD status of a child was recorded as unknown.

"Culture is the acquired knowledge that people use to interpret experience and generate behaviour.[89] Cultural knowledge exists at two levels of consciousness. Explicit culture makes up part of what we know, a level of knowledge people can communicate about with relative ease.[90] At the same time, a large portion of our cultural knowledge remains tacit, outside of our awareness."[91]

89 J Spradley, 'Ethnography and culture', In J Spradley and D McCurdy (eds), *Conformity and Conflict: Readings in cultural anthropology*, 14th edn, Pearson, 2012, p 9.

90 J Spradley and D McCurdy (eds), *Conformity and Conflict: Readings in cultural anthropology*, p 10.

91 J Spradley and D McCurdy (eds), *Conformity and Conflict: Readings in cultural anthropology* p 10.

Cultural competence is the ability to understand, communicate and effectively interact across cultures. It is commonly defined as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professional; enabling that system, agency or those professionals to work effectively in cross-cultural situations."[92] Cultural competence is important as it offers a framework through which to improve service delivery to clients from culturally and linguistically diverse backgrounds. Poorly designed services mean that CALD Australians may be prevented from accessing opportunities available to many other Australians because:

- individuals or communities do not know that the service exists or is available to them
- services do not consider or meet the needs of families with limited English proficiency
- services do not consider or meet cultural needs
- services do not consider the needs of families with low digital proficiency or who cannot access digital services
- insufficient consideration is given to how the migration experience impacts CALD families (e.g. a lack of trust of authority creating barriers to access or difficulties for migrants in meeting documentation requirements meaning delayed or no access to services).[93]

Awareness of difference also allows for proactive monitoring. Healthcare that is provided in a culturally blind way might disregard this contextual evidence and treat everyone individually and uniformly. The American Psychological Association defines cultural blindness as:

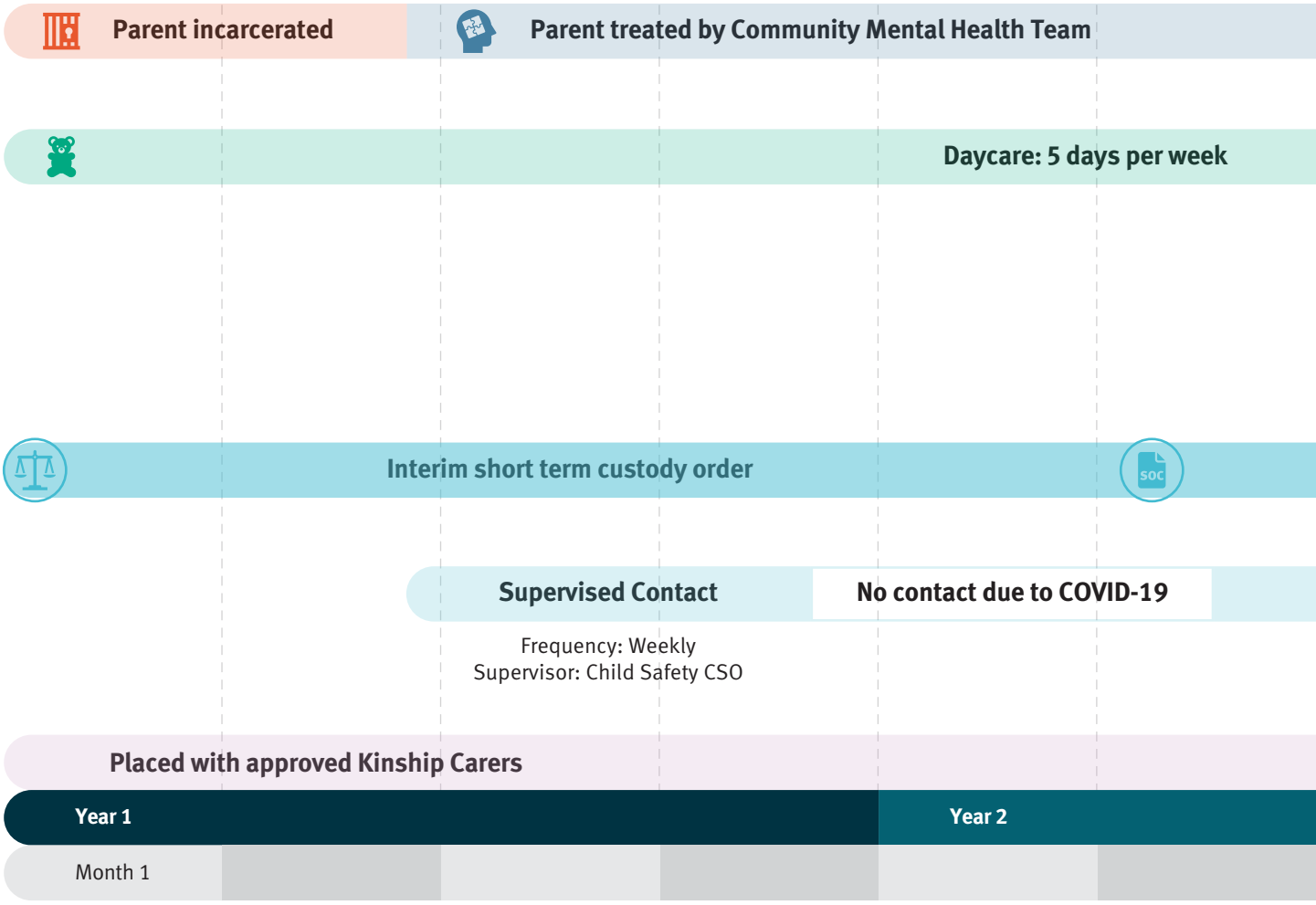
> "The inability to understand how particular matters might be viewed by people of a different culture because of a rigid adherence to the views, attitudes, and values of one's own culture or because the perspective of one's own culture is sufficiently limiting to make it difficult to see alternatives."[94]

92 Centre for Culture, Ethnicity & Health, A framework for cultural competence, March 2012.

93 Federation of Ethic Communities' Councils of Australia, Cultural Competence in Australia: A Guide, n.d., p 5.

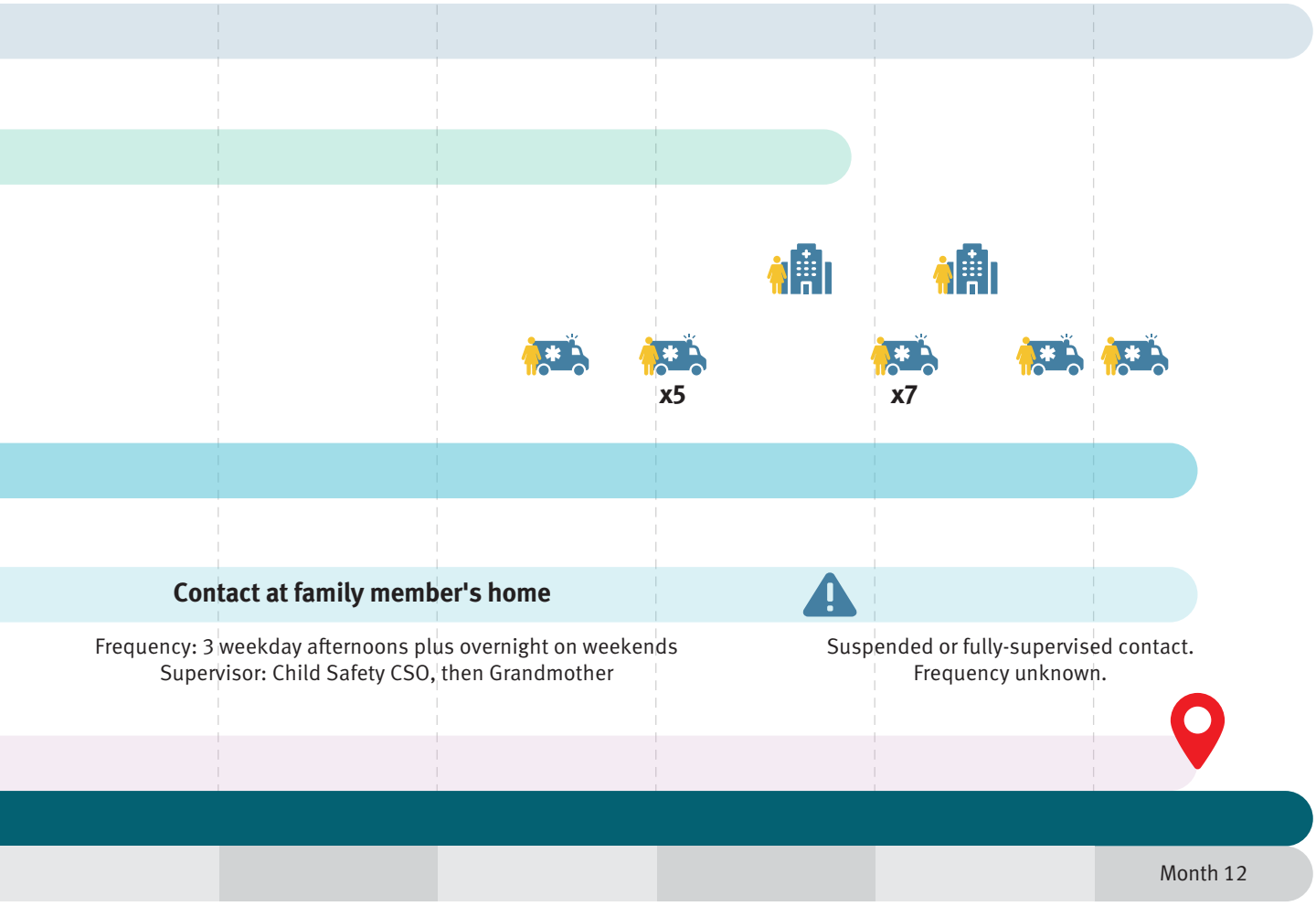
94 APA Dictionary of Psychology, https://dictionary.apa.org/cultural-blindness

Figure 21: Timeline of system touchpoints



Legend

- Child Protection Order granted
- Incarcerated
- Mental health services accessed
- Standard of care review following missing persons' report
- Daycare
- QAS Response



Hospital admission

Hospital reports concerns to child safety

Child Protection Order

Arrangements for contact with Parent

Day of death

Case example: The impact of language and understanding in the context of medical literacy and child safety

The Board reviewed the case of a young boy who's mother had been pregnant with him when she arrived in Australia on a humanitarian visa. The family's country of origin and CALD background remained unclear with the boy's family noted to have spent periods of time in prison camps and refugee camps. The boy and his family spoke at least three languages, and it was noted that the boy's mother could speak conversational English but required an interpreter for more detailed information.

Child Safety determined that the boy's mother was unable to care for him due to significant mental health concerns, arising from the trauma she was subjected to as a refugee. The boy was removed at birth by Child Safety and was at first placed in foster care and then in a kinship care arrangement.

At age two, the boy was taken to hospital by ambulance after experiencing seizures on 15 occasions. He had six inpatient admissions, predominantly accompanied by and discharged to, his mother.

Despite the kinship placement with his grandparents, it was difficult to understand who was caring for the boy. This is possibly because not one single person was responsible and there was discrepancy between what the grandparents were reporting to Child Safety and what the hospital was recording. From health records the mother was the most consistent person present with the boy at the hospital and appeared to be the person who made decisions and received information about administration of medications. Discussions and instructions about assessment and treatment of the boy's seizures, including medication management, were predominantly with his mother. From the records this seemed to happen mostly in English.

Senior medical officers became concerned that the boy was being underdosed with his medication. Communication and language difficulties and a lack of understanding by health staff about the care arrangements for the boy, including who his primary carer or carers were, were impediments to diagnosing and treating his medical condition. The boy's grandparents said that his mother was not responsible for medication, which is why his mother did not know how to do it properly. The hospital said that the family did know how to look after medication.

Ultimately, the medical condition remained uncontrolled. A clear gap was the lack of regular communication and verification between Queensland Health and Child Safety. This communication gap is critical because Queensland Health does not see itself responsible for the safety of a child with disability, and the child safety system does not see itself responsible for the child's medical care. When combined with a complex family dynamic and the imposition of kinship care arrangements, responsibility for meeting the child's needs became highly complex.

Assessing and supporting the health literacy of parents and guardians

According to the Australian Commission on Safety and Quality in Health Care, *"health literacy is about how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it"*.[95] There are two aspects to health literacy – the individual level and the health literacy environment.[96] Consideration must be given to the health literacy environment, particularly for CALD families and populations where individual health literacy is known to be poor and the mortality rate is higher. Poor health literacy must not remain the problem of individual children and families, although they certainly bear the burden of higher morbidity and mortality.

In child protection work, it is necessary to understand how a particular family uses cultural repertoires. This helps to identify if, when and how culture relates to child rearing practices generally, and child protection matters more specifically.[97] This is particularly important when the household arrangements and functioning align more with a communal child-rearing model, more typically associated with collectivist cultures, which are more likely in families with CALD heritage.

Concerted effort is needed to be taken by Child Safety practitioners, and other service providers, to determine each family's unique way of functioning. Different cultures often have different approaches to household management and child rearing. This view was reflected by a young person at the Youth summit held by the QFCC in April 2024. Huda, a young person who is a member of the Multicultural Australia Future Leaders Advocacy Group and the Queensland Program of Assistance to Survivors of Torture and Trauma spoke about identity and culture.

In her speech to the summit, Huda said:

> "Culturally and linguistically diverse families encounter numerous challenges including a deficiency in understanding and education concerning healthy family relationships. Parents often confront language barriers when navigation the child protection services system … These system gaps perpetuate a cycle of mistrust and reluctance among culturally diverse families to seek help when needed… It is imperative that we move beyond band-aid solutions and instead cultivate a culture of empathy and understanding when working with families … We must recognise and celebrate the rich tapestry of cultural values that underpin family life."

In reviewing these types of cases, it is important that service providers are conscious of the risk of cultural blindness when they are dealing with families and children from diverse ethnic and cultural backgrounds.

95 Australian Commission on Safety and Quality in Health Care, Health Literacy, ACSQHC Website, 2014, accessed 4 July 2023.

96 Australian Commission on Safety and Quality in Health Care, Health Literacy

97 P Sawrikar P *Working with Ethnic Minorities and Across Cultures in Western Child Protection Systems,* Routledge, 2016, p 215.

Language, interpreting and translating

Language is a key element of a person's ethnicity, and their identification as a CALD person. The Board identified in several cases that agency records did not uniformly record the child's and parent's language/s. In the communication of multifaceted information, such as management of illnesses, complex disability, and child protection matters, the use of interpreter and translation services, and the provision of resources in languages other than English is vitally important. The provision of interpreting and translating services is made more difficult for service providers when information about children's and parent's/carer's language preference is not captured other than in the detail of case notes (sometimes incorrectly).

In a number of these cases a family's cultural background and English as a second language were recorded but not their language preferences. There were also examples of families and agencies not being able to access interpreters due to limited availability. At times agency staff relied upon bilingual staff and family friends to step in as interpreters. There was limited evidence that information, including complex health information, was translated when provided to families.

Some of the families had mistrust and suspicion towards interpreters due to their experiences of trauma and discrimination. Others had poor experiences with interpreters. For example, in one case an interpreter told the mother of a child to stop crying when she spoke of the violence perpetrated against her by her partner. In another case the parent of a child and an interpreter were arguing and yelling at each other.

The *Queensland Health Refugee Health Policy and Action Plan 2022-2027*[98] acknowledges there is limited data in Queensland on the health of refugees because health systems don't often consider a person's migration status or cultural background. People from refugee backgrounds are more likely to face challenges when navigating a different health system. The Board welcomes the priorities and actions set out in this Plan, particularly in the areas of improving interpreter services, building the capability of the language services sector and improving visibility of health outcomes for people with CALD backgrounds. The cases examined support the need for improved data collection on people from CALD backgrounds including the recording of CALD status and language preferences.

A health needs assessment project conducted by Queensland Health between 2009 and 2011 revealed significant health inequities among Pacific Islanders in Queensland, finding poorer health outcomes compared to the total Queensland population. *One key finding was that health literacy among Pacific Islander communities was notably low, with limited knowledge about health services due to challenges in navigating the system, disengagement from mainstream health campaigns and services, and cultural reluctance to seek help.*[99] Consideration must be given to the health literacy environment, particularly for CALD families and populations where individual health literacy is known to be poor and the mortality rate is higher.

Case example: Medical support for families

The Board reviewed the case of a boy that had asthma resulting in multiple emergency department presentations. The boy and his family were from a CALD community. Different agencies recorded that English was not the family's first language, but the family's language preferences were not recorded. Queensland Health records noted that the family of the boy had very poor health literacy and during one of the presentations he was kept overnight as staff assessed it was unsafe to discharge him to go home. It was also noted that prescribed medications had not been administered in line with medical advice.

There was a lack of recorded evidence that a parent/carer had an asthma education checklist or that an asthma action plan had been completed. Recorded directions for a handover to the boy's GP, requesting monitoring of his asthma, change of medication dosage, and a referral to a Paediatric Clinic, was not completed. Queensland Health staff contacted the family by phone and spoke to the boy's parents. Both advised their son was fine and they had no concerns. A few days later the boy was brought unconscious to a hospital emergency department and he was later declared deceased.

98 Queensland Government and Refuge Health Network Queensland, Refugee Health and Wellbeing Policy and Action Plan 2022-2027, November 2022.
99 Queensland Health, Queensland Health response to Pacific Islander and Maori health needs assessment, Queensland health, Brisbane, December 2011.

Improving culturally safe service delivery to First Nations families

The Board's examination of the gaps in culturally competent service delivery to CALD families also provides opportunity to make recommendations on improving culturally safe service delivery for First Nations families and their children. In the child death cases reviewed by the Board, where there was evidence a child or young person had disability and/or chronic medical condition/s, several of these children and young people were Aboriginal and/or Torres Strait Islander.

Although the term "cultural competency" is referred to above in relation to CALD families, for First Nations families the practice of cultural safety is more appropriate. This is because it acknowledges and seeks to address the inequalities that First Nations people face due to the impacts of colonial history, including dispossession and institutionalisation.[100] The *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* states:[101]

Cultural safety is about how care is provided, rather than what care is provided. It requires practitioners to deliver safe, accessible and responsive health care that is free of racism by:

- recognising and responding to the power imbalance between practitioner and patient
- reflecting on their knowledge, skills, attitudes, practicing behaviours, and conscious and unconscious biases.

This approach can inform both Queensland Health and Child Safety in their service delivery to First Nations families with children who have disability and chronic medical conditions. Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care.[102]

Health literacy levels of Aboriginal and Torres Strait Islander peoples are poorly understood and insufficiently researched. It is, however, believed that First Nations peoples' health literacy is lower than that of non-Indigenous Australians.[103] Culturally safe practices can play a role in assessing and supporting the health literacy of First Nations families.

100 Australian Human Rights Commission, Cultural safety for Aboriginal and Torres Strait Islander children and young people: A background paper to inform work on child safe organisations, January 2018, accessed 25 August 2023.

101 AIHW, Cultural safety in health care for Indigenous Australians: monitoring framework, AIHW Website 7 July 2023, accessed 25 August 2023.

102 AIHW, Cultural safety in health care for Indigenous Australians: monitoring framework.

103 W MacAskill, R Marrion Rolleston, K Brumpton and J Pinidiyapathirage, 'Assessing health literacy of Aboriginal and Torres Strait Islander peoples presenting to general practice', *Australian Journal of General Practice*, August 2022, 5(8), doi: 10.31128/AJGP-07-21-6100.

Addressing health concerns for siblings in child protection cases

Case example: Medical processes and Child Safety interpretation of medical needs

The Board reviewed the case of a toddler, aged two years, who lived with her parents and sibling. She came to the attention of Queensland Health during an appointment for her sibling with a child development service. The toddler was noted to be pale in complexion, having minimal interest in toys or the clinician. The toddler's parents told the clinician their daughter did not speak, displayed repetitive movements and was unable to eat solid foods. They were worried she may be autistic. Upon observing the toddler, the clinician outlined their concerns in a GP letter which requested an assessment of her development be completed, and support be provided to the family to access the Early Access Scheme, through the NDIS, for speech pathology and feeding support. The clinician also requested the GP refer the toddler to a child development service. These referrals were necessary as there was no process in place at that time for siblings of children being seen by the child development service to be directly referred into the service.

As the family did not have a family doctor, the GP letter was provided to the toddler's parents. It is unknown if her parents saw a GP and passed the letter on, and the toddler was never referred to or seen by a child development service.

Concerns about the family were reported to Child Safety by the school of the toddler's sibling after staff became concerned about the sibling's low attendance and presentation. The concerns also included that the family was experiencing significant emotional and financial stress and were facing eviction from their home. The school was aware of the GP referral letter and advised Child Safety that the parents had not taken the toddler to see a GP. In response Child Safety staff visited the family as part of an investigation. The toddler's presentation was interpreted by Child Safety as developmental concerns and not medical (or both). A medical assessment was not sought during the investigation to inform Child Safety's decision-making despite knowledge of the request by the child development service for her to be seen by a GP, and additional concerns were received that she was underfed and possibly anaemic. The toddler was taken to hospital unresponsive 10 days after she had been sighted by Child Safety. Attempts made to revive her were unsuccessful and she was declared deceased.

Prompted by their internal review of this case, Queensland Health made a recommendation for the development of a procedure to ensure the follow-up of potential patient appointments, when children (i.e. siblings) who are not currently engaged with a child development service are identified as requiring follow-up. Part of this recommendation included the development of a fast-tracked referral process for siblings who were identified as requiring input.

Health assessments and expert advice to inform investigation and assessments

The Board reviewed three cases where there were examples of missed opportunities to seek further information or request assessments about a child's medical condition or concerns that could inform risk assessments. In the toddler's case, Child Safety's internal review queried whether she may have needed urgent medical attention. The review revealed that staff had interpreted her presentation as non-medical and, although there seemed to be something going on for the toddler, it was assessed as development-related rather than her being physically unwell or neglected.

Child protection practitioners are not expected or supposed to make health and development related assessments, nor decide on whether a child is experiencing medical, health or developmental issues. The Child Safety Practice Manual directs that during an investigation, a medical examination or assessment by a health professional may be considered necessary to inform the investigation outcome.[104] In determining whether neglect is occurring and/or a child is experiencing medical, developmental or health issues, seeking expert advice is essential to inform risk assessments. Ultimately, the toddler was assessed as safe, despite her meeting all of the vulnerability criteria and some of the immediate harm indicators. Child Safety's Systems and Practice Review Committee (SPRC) identified that Child Safety needs to help staff to identify vulnerabilities and risks including the difference between medical and developmental concerns.

Child Safety and the NDIS

> NDIS funds *"reasonable and necessary"* disability supports for eligible people with intellectual, physical, sensory, cognitive or psychosocial disability. Participant's reasonable and necessary supports take into account any informal supports already available to the individual (informal arrangements that are part of family life or natural connections with friends and community services) as well as other formal supports, such as health and education.[105]

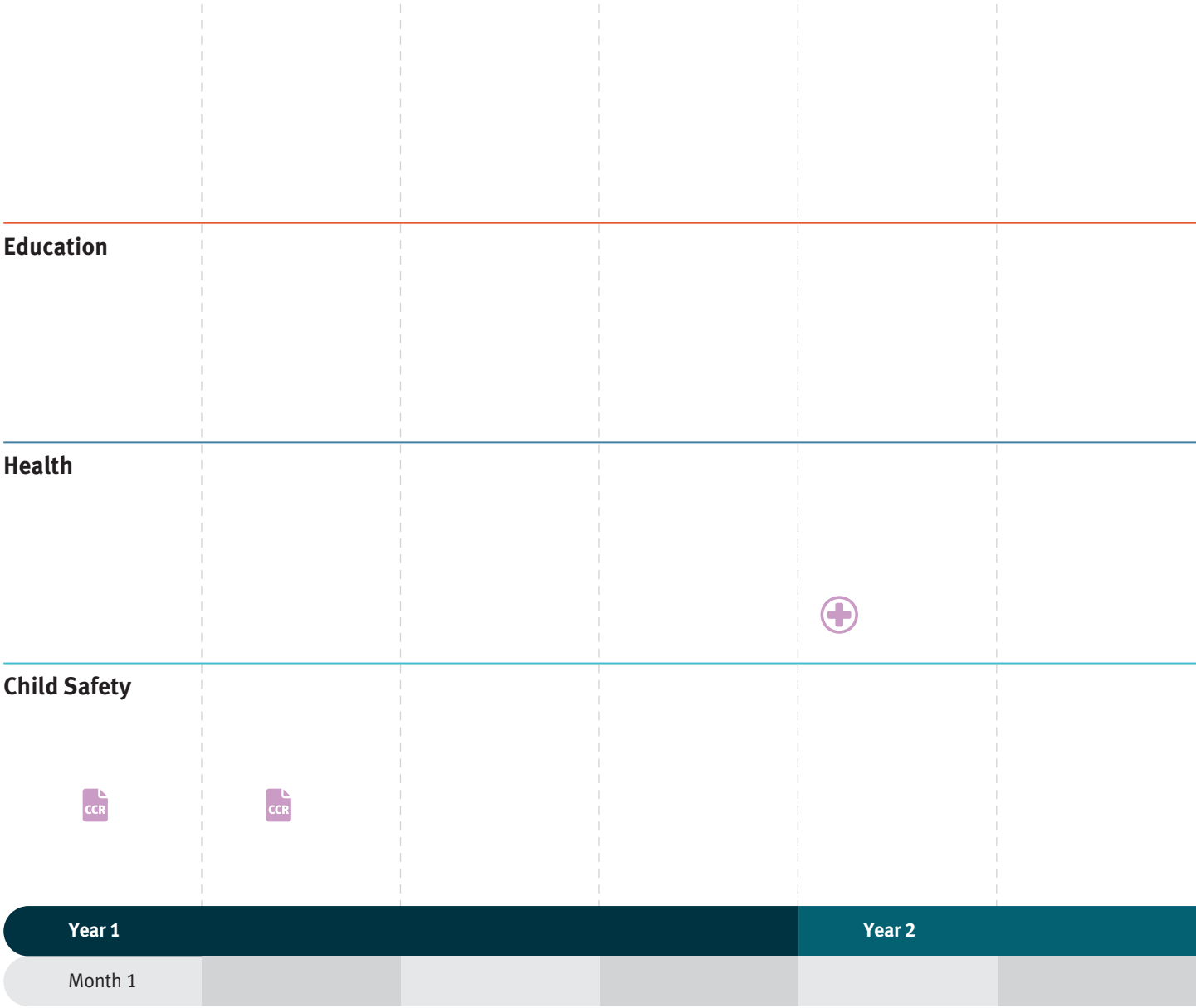
In several cases reviewed by the Board it was identified that the child had an NDIS plan in place and was accessing NDIS supports but the level or type of supports were unclear or unknown from the information provided. The Board noted evidence of tensions in relation to the role and responsibility of Child Safety versus perceptions about the sufficiency of NDIS plans and supports.

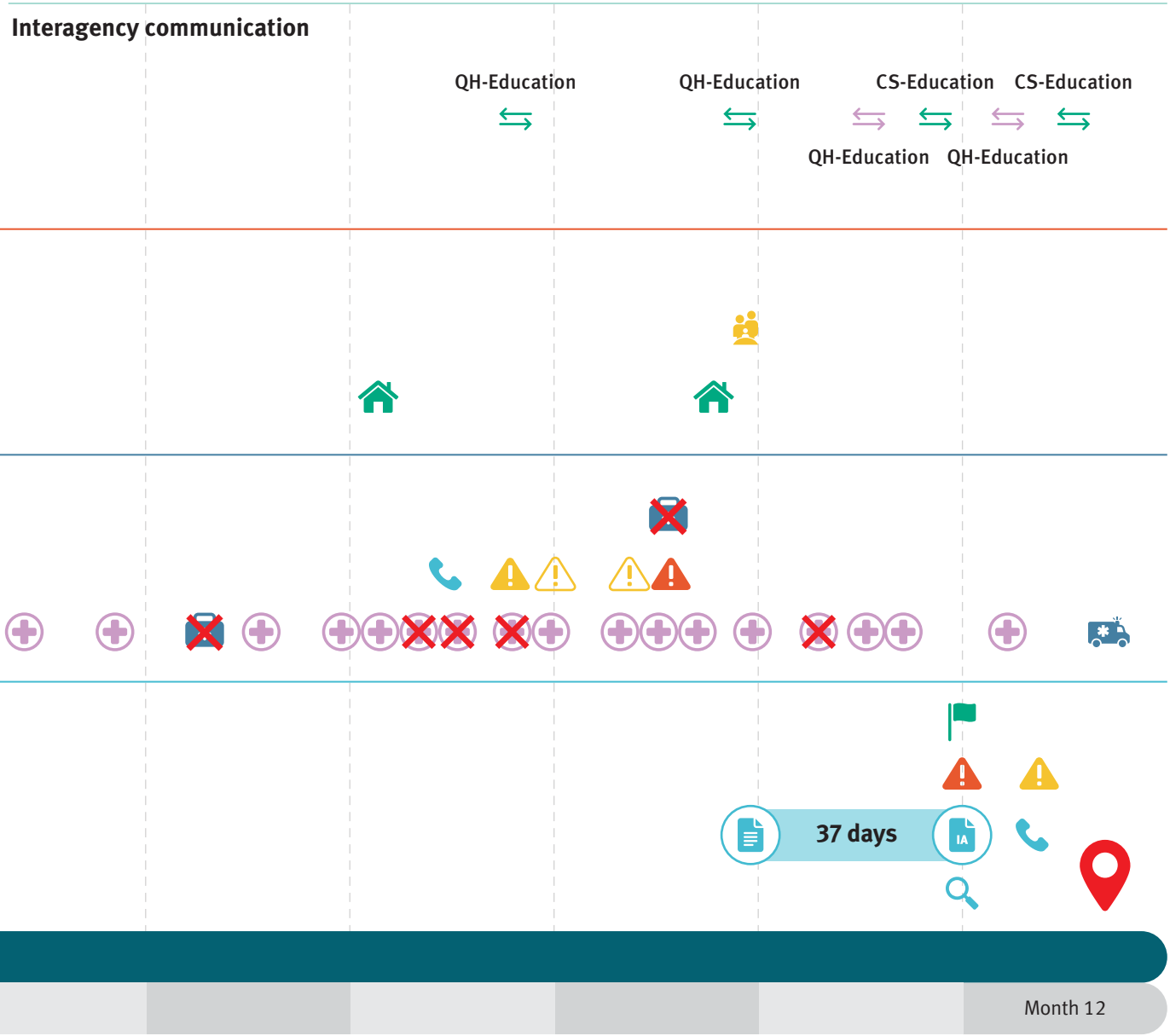
In considering whether a child needs protection, Child Safety must assess whether a child has a parent both able and willing to protect them. In Child Safety's assessments of these children and families, it seemed involvement with NDIS was perceived as a safety mechanism (rather than being considered a protective factor). The default position was that issues within the family related to the child's disability and inadequate NDIS funding to support the parent's care of the child.

In one case, Child Safety staff were of the view that lack of support provided by the NDIS was the greater issue, rather than the concerns about his parent's behaviours and the impact on the young person. The NDIS-funded disability support staff working in the home advised Child Safety that the parent was medically neglecting him. They reported his parent disagreed with medical advice and did not acknowledge the importance of medical appointments or emergency treatment. They spent a significant portion of their role managing the parent's behaviours and his capacity to respond to the young person's needs, which they advised was not the role of the NDIS.

104 DCSSDS, Child Safety Practice Manual Consider a medical examination, DCSSDS Website 7 May 2024, accessed 27 July 2023.
105 National Disability Insurance Scheme (NDIS), Reasonable and necessary supports, NDIS Website 24 September 2019, accessed 14 August 2023.

Figure 22: Timeline of system touchpoints





Phone call

Information sharing – regarding toddler

Information sharing – regarding brother

Concerns about toddler recorded

Toddler sighted

Toddler present but not sighted

Education home visit due to absence of siblings

Queensland Ambulance Service responds

Child Safety home visit

Day of death

In 2019, the Queensland Government completed the transition of former disability service clients to the NDIS. Since then, Disability Service's role has shifted to supporting and advocating for people with disability, working in partnership with the disability sector to create an all-abilities Queensland, and monitoring the NDIS to ensure it delivers the outcomes we all expect for Queenslanders with disability. Since May 2023, at an organisational level the Machinery of Government arrangements and departmental structure have built closer connections between the senior executives with responsibility for child safety and disability, as well as driven greater awareness of disability related issues including interface.

The interface between the child protection system and the NDIS is an ongoing issue of concern for the Board. In its 2021–22 Annual Report, the Board made the recommendation (Recommendation 6) for the Queensland Government and Commonwealth Government to improve access for vulnerable children and families to the NDIS. It said this should happen through improved mechanisms by which children and families could enter and access, as well as focus on Queensland based support positions. Further information is provided, including government's most recent response in Chapter 8 of this report titled Monitoring Recommendations.

Actions taken by government

In response to the recommendations from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Public hearing 33 – Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study), Queensland Health is strengthening the health system's capability to provide services to people with disability by providing staff with disability training and resources. The Queensland Ombudsman is also conducting an independent review of the powers and responsibilities of all agencies that engaged with Kaleb and Johnathon.

Queensland Health has also advised that it is strengthening the health services provided to culturally and linguistically diverse communities. This includes:[106]

- developing a new Multicultural Health Action Plan, which is due for release in 2024. The plan will set the priorities to improve outcomes for Queensland's culturally and linguistically diverse communities. Actions will aim to address the health needs of priority populations, including children, and service interfaces such as disability and the NDIS, mental health and settlement services
- funding the Multicultural Health Coordination Program since 2023. The program is delivered by Mater Refugee Health, which supports people and families from multicultural backgrounds who have complex health and wellbeing needs free of charge, regardless of visa status, and
- working in partnership with the University of Queensland to review Queensland's refugee health services, including a focus on health service funding arrangements and service delivery for children from refugee backgrounds.

Queensland Health and [the then, Department of Child Safety, Seniors, Disability Services and Multicultural Affairs] have also committed to improving inter-agency coordination to enable timely responses to medical neglect concerns. This includes a multi-agency Master Sharing Agreement to exchange relevant health information about vulnerable children and young people across government, social services and justice sectors in a timely manner. Queensland Health is also working with Child Safety to improve information sharing and consideration of expert medical advice when reviewing cases related to medical neglect. This aims to strengthen the systems that protect, improve outcomes, and act on opportunities to prevent the deaths of, or serious injury to, vulnerable children and young people.

106 Letter to the Chair, CDRB from Michael Walsh, Director-General, Queensland Health, dated 6 February 2024.

Concluding comments

There is a need to continually improve the way the child protection system responds to children with chronic medical conditions and disability. The cases reviewed by the Board show that:

- More can be done to support families to develop health literacy that can improve their understanding of preventative health measures, recognise symptoms early, and help them navigate the healthcare system more effectively. Where a deficit in a parent or caregiver's health literacy or understanding is identified, parents and caregivers should be offered education to improve their knowledge. This can support quality care, encourage adherence to treatment plans and ultimately leads to better outcomes for individuals and communities alike.
- Concerted effort is needed by Child Safety practitioners, and other service providers, to determine each family's unique way of functioning. Different cultures often have different approaches to household management and child rearing. In a number of these cases a family's cultural background and English as a second language were recorded but not their language preferences. There were also examples of families and agencies not being able to access interpreters due to limited availability. At times agency staff relied upon bilingual staff and family friends to step in as interpreters. There was limited evidence that information, including complex health information, was translated when provided to families.
- There should be a specific focus on supporting CALD and Aboriginal and Torres Strait Islander children and families through culturally competent and culturally safe and inclusive service delivery.
- Child protection practitioners need to apply critical thinking even when families are open and engaging because the risk of neglect or harm to a child may still be present. A parent or guardian's willingness to seek or accept support does not equate to actively receiving support that over time will lead to increased safety and wellbeing for children, young people and their families. Child Safety's SPRC identified that workers can be overly optimistic about a parent or caregiver's capacity to recognise the needs of their children when the parent or caregiver is engaging and actively seeking help. A family that is presenting as friendly and open may be engaging in *"disguised compliance"*.

Recommendations

Recommendation 5

Improving risk assessments of children with disability and chronic medical conditions

The Board recommends that Queensland Health take action to provide clear guidance that will support Child Safety to better assess the safety of children living with disabilities and/or chronic medical conditions with a specific focus on distinguishing between intentional parental neglect or maltreatment compared to deficits in the health literacy or competency of the parent that should be addressed through health and/or disability support services.

Recommendation 6

Coordinated health service delivery for sibling groups

The Board recommends that Queensland Health develop guidelines for clinicians to promote a family-centred approach to the provision of health services to children and young people, such that clinicians consider the wellbeing of siblings and can directly refer siblings into the health service, or to the clinician, if risks or health concerns are identified.

CHAPTER 5

Responding to families experiencing domestic violence

Domestic and family violence are broad terms covering a range of different behaviours that can include physical, verbal, emotional and sexual abuse, and coercive control. There are differing preferences and perspectives on the use of terms "domestic violence" and "family violence". For clarity and brevity, the Board has used the terms domestic violence and intimate partner violence interchangeably because this chapter is focused on the violence that occurred in the relationship of the child's parents, or the relationship between the child's mother and her partner/ex-partner. The use of these terms is not intended to diminish the impact violence had on the families.

Domestic and family violence has been prevalent in a high number of child death cases that have come before the Board. The Board's consideration of such cases and its focus on system responses to domestic and family violence resulted in a number of recommendations in its annual reports in 2020–21 and 2021–22, and a commissioned research report in 2022. The Board has sought to contribute to the existing reform program by making recommendations that focus on the specific wellbeing and safety of children and young people who are victims in their own right.

This year the Board considered the child protection system response to seven children where domestic and family violence was present in the child's life. The children ranged in age from eight weeks to three years and nine months at the time of their deaths. Coercion and control, physical violence, verbal and emotional abuse and sexual abuse were evidenced throughout these cases.

A child's exposure to domestic and family violence, along with the presence of, and exposure to, other risk factors is likely to be cumulative – the more risk factors in a child's life, the greater the chance that they will experience maltreatment.[110] Multiple risk factors were recorded in relation to these children.

Information provided by agencies indicated the following:

- In all seven cases the child's father or mother's partner/ex-partner perpetrated domestic violence towards the child's mother.
- In all seven of the cases Domestic Violence Orders were in place, with the child's father or mother's partner listed as the respondent, and the child's mother listed as the aggrieved.
- In five of the cases, the records state that the child or their sibling/s were present during the incidents and/or were in the home when it occurred.
- In three of the cases, the mother, while pregnant, was subjected to physical violence by the child's father.
- In three of the cases, the child's mother was recorded to have perpetrated domestic violence towards the child's father or her partner.
- In one case, cross Domestic Violence Orders were in place, with father and mother listed as both the aggrieved and the respondent.

Case example: Responding to domestic and family violence in a serious manner

In one child's case reviewed this year there were three CCRs during the review period. These related to repeated concerns of a lack of parental supervision of the child's siblings, who had been located alone, outside of their home and property. Other concerns included the parents arguing, pushing and shoving each other, parental problematic drug and alcohol use (which also affected parental supervision), the children's mother struggling to care for the children, and allegations that she was smacking and hitting them. The mother had made threats of self-harm when in contact with a government agency, that resulted in a police welfare check.

The father perpetrated violence towards the child's mother. There was a DVO in place, with the mother listed as the aggrieved and his father as the respondent. A notifier advised Child Safety that there was significant domestic violence that resulted in attendance by QPS and there was evidence of coercion to the extent that "Father did not allow Mother to do much".

Of the three CCRs, the first noted as a strength that the mother was seeing a psychologist and was linked with a family support service. The next two were recorded as not meeting the threshold for a Child Protection Notification.

110 Australian Government, Australian Institute of Family Studies, Risk and protective factors for child abuse and neglect: the interaction of risk and protective risk factors, May 2017

In reviewing the seven cases the Board noted that significant work was underway to address the prevalence of domestic and family violence as well as the recommendations made by the Board in relation to improving how the system responds to domestic and family violence.

In Queensland, the domestic and family violence reform program (an outcome of the 89 recommendations of the *Not Now, Not Ever* report) has been in place since 2015. In December 2023, the Queensland Government released the annual evaluation of *Queensland's Domestic and family violence prevention strategy 2016-2026*, titled *Year 8 Highlights Card 2022-23*. The *Fourth action plan 2022–23 to 2025–26* of the strategy was released in November 2022.

The Women's Safety and Justice Taskforce provides oversight of the reform program, having made 277 recommendations across its two reports *Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland* and *Hear Her Voice – Report Two – Women and girls' experiences across the criminal justice system*.

The *Independent Commission of Inquiry into Queensland Police Service responses to domestic and family violence* handed down its report *A Call for Change* in November 2022 and made 78 recommendations. These recommendations address the capability, capacity and structure of the QPS to respond to domestic and family violence, and the adequacy of the processes for dealing with complaints about police officers to ensure the community confidence in the QPS. The Inquiry was a key recommendation made by the Women's Safety and Justice Taskforce. In March 2023, Ms Cathy Taylor was appointed as the Independent Implementation Supervisor to oversee implementation of the Government Response to recommendations made by the Women's Safety and Justice Taskforce, including the implementation of the recommendations made by the Inquiry.

Recognising and responding to cumulative harm

Assessing and responding to cumulative harm has been a focus of the Board because of multiple case reviews that evidenced an ongoing issue of child protection staff not adequately considering cumulative harm in risk assessments.

Two recommendations were made in the Board's 2020–21 Annual Report:

2020–21 Recommendation 2

The Board recommends: 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 CCR 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.

COMPLETE

In 2021–22, Child Safety undertook a Multiple Event Review trial where a third consecutive intake received within 12-months would prompt four additional questions to aid an officer's decision making. Staff reported the trial had a positive impact on their ability to understand the cumulative impacts of child protection history.

For the 2022–23 Annual Report, Child Safety advised that mandatory and non-mandatory cumulative harm training had increased. It also advised that its forthcoming IT system, Unify, would aim to illustrate and increase the visibility of cumulative impacts of harm on children, young people and their families by presenting departmental history as a timeline to assist staff in identifying cumulative harm.

The Board considered the recommendation 'complete' noting the launch of Unify in 2024.

2020–21 Recommendation 3

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs develops 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.

COMPLETE

In 2021–22, Child Safety:

- Revised practice and guidance training resources following an internal review paper on cumulative harm
- Risk assessment guidance for staff was updated in mid-2022 and included strengthened content on cumulative harm (in context of the discontinuation of Structural Decision Making Tools).

In 2022–23, Child Safety advised that mandatory and non-mandatory cumulative harm training had increased and its forthcoming IT system, Unify would generate a prompt if a third (or higher) intake has been generated for a child or young person within 12 months.

The Board considered the recommendation 'complete' noting the launch of Unify in 2024.

In some of the cases reviewed this year, there was repeated reporting of concerns to Child Safety centred on domestic violence perpetrated by the child's father or mother's partner, as well as repeated callouts by police in relation to domestic violence incidents. At times, children were present, either having witnessed the violence or having been in the home when the domestic violence occurred. Agencies in their reviews, noted limited consideration of the risk of cumulative harm to children in families when there were repeated concerns about, and incidents of, domestic violence. In one child's case Child Safety's review identified the importance of assessing cumulative harm with a focus on the cumulative impact of recurring conditions, circumstances or incidents and the effect of this harm on children.

Child Safety's Review Team queried whether the issue of cumulative harm had been considered due to the family's child protection history of eight CCRs and one investigation since 2018, which included the same concerns noted in the three most recent CCRs. The concerns outlined in the most recent CCRs may not have met the threshold for a Child Protection Notification, however, the information did indicate that the family's circumstance had not improved and there was the potential for the children to be at risk of cumulative harm.

> Assessing cumulative harm requires a focus on the cumulative impact of recurring conditions, circumstances or incidents, which may not have met the threshold for tertiary child protection involvement previously. These conditions, circumstances or incidents may be the same in nature, such as ongoing neglect, or may be comprised of different abuse types.[111]

111 Department of Child Safety, Seniors and Disability Services, Child Safety, Child Safety Practice Guide - Assess harm and risk of harm, 8 August 2022, p 1

QPS in its review of another case, suggested that although suspected reports of harm could have been submitted on several occasions, police officers had difficulties in their dealings with the child's mother, which potentially affected their ability to appropriately assess the child's safety. The QPS *Operational Procedural Manual* directs that "*officers should consider the wellbeing of children at every job they attend, and a child may or may not be present to form a concern for a child.*"[112] A child does not need to witness domestic violence to be affected by it. Children who grow up in families where domestic and family violence occurs are more likely to experience abuse, including physical, sexual, emotional abuse, and maltreatment.[113] The Board reviewed cases where the mother was described as *'non-cooperative'* and *'uncooperative'* in her interactions with police.[114] The language used to describe victim-survivors is explored further elsewhere in this report.

The Board notes that initiatives are currently underway by QPS, as part of its domestic and family violence reform, to improve police responses to domestic violence. The QPS is currently working to address the recommendations set out by the *Independent Commission of Inquiry into Queensland Police Service responses to domestic and family violence*. In December 2023, the inquiry's first annual report was released. The *Domestic and family violence reform: a pathway forward for change* provides an update on the progress of the recommendations.

Recommendations included establishing a 24 hour-per-day response capability by creating and expanding domestic and family violence liaison officer and coordinator roles, and establishing domestic and family violence vulnerable persons units in each police district.[115]

Case example: Understanding that harms are likely and should be reported

The Board reviewed a case where the parents had reportedly perpetrated domestic violence towards each other that included arguments, verbal abuse, threats of violence and physical altercations. There was repeated conflict in their relationship, and they struggled with shared care of their children and housing arrangements. From the records it appears that the child's parents separated and reunified several times.

At times, other family members would witness the parents arguing, as the mother and father would reside with different family members (together and separately). On four occasions different family members called police for assistance in removing the mother from different residences due to disturbances caused by the conflict between the parents, and other family members. During the review period, police had interacted with the parents on multiple occasions in relation to domestic violence. Attending police at times offered referrals and, on occasion, these were accepted by each of the parents. Child harm reports were not always made.

A DVO was made after police, who had been attending a neighbouring property, witnessed the father being verbally aggressive toward the mother and wiped food in her face, while she held the child. A child harm report was made in relation to this incident. The risk of emotional harm to a child may not be clear when assessing individual incidents, but cumulative harm and the need for a child harm report becomes clearer when the history of domestic violence and familial stressors are considered.

112 Queensland Police Service, Operational Procedures Manual, Chapter 7.3.1 Initial action for reports of child harm, Issue 97 Public Edition, 15 December 2023, p 6

113 Australian Government, Australian Institute of Family Studies, Children's exposure to domestic and family violence, 2015; Most children who experience multi-type maltreatment experience exposure to domestic violence, Higgins DJ, Mathews B, Pacella R, et al. The prevalence and nature of multi-type child maltreatment in Australia. Med J Aust 2023; 218 (6 Suppl): S19-S25.

114 Our Watch, Changing the picture, Background paper: Understanding violence against Aboriginal and Torres Strait Islander women and their children, 2018 p 21

115 The State of Queensland, Commission of Inquiry into Queensland Police Service responses to domestic and family violence, A *Call for Change*, Annual Report 2022-23, p 15-16

One of these recommendations was for improved training that specifically considers the unique experiences of First Nations peoples and communities. This includes misidentification of victims, and communication with First Nations peoples and communities to ensure conditions of protective orders are contextually appropriate and clearly understood. QPS advised that a suite of training products had been designed for officers, based on their roles, and had been rolled out in 2022–23, with roll out continuing through 2023–24.[116] At a local level, one recommendation called for embedded domestic and family violence support workers in police stations in areas where domestic and family violence services were available.[117]

In response to recommendations of both the Commission of Inquiry and the Women's Safety and Justice Taskforce, a mobile co-response trial will occur in Cairns in which police callouts will also involve government funded domestic and family violence specialist services. The co-response trial will adopt a crisis intervention and early intervention approach for call outs to incidents enabling domestic and family violence specialist services to respond at the same time as the intervention by QPS.[118] The trial began early in 2024 and will continue until mid-2026.[119] These reform initiatives will allow for police officers to be supported by skilled specialists and, ideally, this will improve responses and increase the safety of victim-survivors and their children.

The Board noted that the reform work to be undertaken by QPS is significant, requiring a major shift in police workplace culture and practice, and potentially specialist and/or additional recruitment. It is likely this reform will take time.

Case example: Appropriately assessing individual incidents in the context of a child's lifetime experience

In one case reviewed this year, the Board considered the case of a child that was born into a family with a history of violence. Specifically, the father perpetrated violence towards the child's mother, including physically assaulting her while she held her oldest child. A DVO was made, followed by a further order nine months later that prohibited the father from approaching or being within 100 metres of both the mother and the oldest child. The mother had limited supports and was reliant on family in her home country for financial support as well as the family of the father, and a friend. While the mother was pregnant with the child, she had difficulty obtaining accommodation and could not work. At this time the mother was seeking to have the DVO amended as she was looking to reunify with the father.

An investigation was in progress at the time of the child's birth in relation to reported concerns that the father, while on parole, perpetrated violence towards the mother in front of her oldest children. Child Safety assessed a high probability that the child and his sibling would experience abuse or neglect in the future, in relation to prolonged exposure to domestic and family violence. The investigation was closed (as a 'high risk closure') a few days after the child's birth with an outcome of 'unsubstantiated' and the child and his sibling were assessed as not being in need of protection. Their mother was assessed as both willing and able to protect them from future harm and risk of harm. No support referrals were offered or made for the family. Four weeks after the closure of the investigation, concerns were received from two professional notifiers (a hospital social worker and QPS) about the father physically assaulting the mother, and the parents living together despite the no contact condition of the DVO. The social worker advised of concerns of ongoing domestic violence and the risk of physical and emotional harm. An investigation assessed the children as being at risk of emotional and physical harm due to exposure to domestic and family violence.

The investigation was transferred to the appropriate office but did not commence prior to the child's death.

116 A *Call for Change*, Annual Report 2022-23, p 19 and p 33
117 A *Call for Change*, Annual Report 2022-23, p 17
118 Queensland Government, Media Statement, Domestic and family violence co-response trial to start in cairns, 9 May 2023
119 Queensland Government, Media Statement, DFV specialist service provider wanted for Cairns co-response trial, 9 November 2023

Assessing risk of future harm and neglect

Exploration and understanding of the risk factors being experienced by a family informs not only whether there is cumulative harm but also informs assessment of the likelihood of future harm and/or neglect.

In the above case example Child Safety's Review Team questioned the process of closing the first investigation, noting there was no information to indicate that the father's behaviour would change and the assessment of the mother's willingness and ability to protect her children from future risk of harm did not adequately consider this, nor the limited supports she had which caused her to be reliant on the father and his family.

The application of perpetrator pattern-based approaches and the role of fathers and fathering for behaviour change intervention has been a previous focus of the Board. Two recommendations in the first year of the Board were made in respect to these issues:

2020–21 Recommendation 4

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs builds 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:

[for brevity only related points have been noted here]

- 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)

The findings of the Board and the QFCC's systemic review of IPAs may be used to develop this training.

COMPLETE

In 2021–22, Child Safety advised that several training programs had been updated, particularly training for Child Safety Officers in their first year of practice and training in domestic and family violence-informed practice.

In 2022–23, Child Safety completed its review of mandatory training for the Child Safety Officer role. The training is now three weeks in duration and includes a dedicated day focusing on domestic and family violence-informed practice. Non-mandatory training on domestic and family violence-informed practice is also available to all staff.

The Board considered the recommendation as 'complete', though caveats that quality risk assessment is essential to child protection practice and is likely to be an ongoing matter for continuous monitoring and improvement.

2021–22 Recommendation 4

The Board recognises there is significant reform occurring in the area of domestic and family violence. The Board recommended 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.

COMPLETE

Department of Justice and Attorney-General (DJAG) completed a number of actions including:

- Revising the *Domestic and Family Violence Common Risk and Safety Framework* so children are recognised as victims in their own right
- Enhancing High Risk Teams to improve the safety of victim-survivors including three new teams in Townsville, Redlands and Rockhampton
- The *Domestic and Family Violence Protection (Combatting Coercive Control) and Other Legislation Amendment Act 2023* commenced on 1 August 2023
- Funding to organisations for counselling children impacted by domestic and family violence
- Administrating funding over 2020–25 for Legal Aid Queensland Youth Legal Advice Hotline for the Legal Aid Queensland and Aboriginal and Torres Strait Islander Legal Service Youth Justice Legal Advocacy Program to deliver free youth specific legal assistance
- From 1 July 2023, staged trials of specialist perpetrator intervention programs including a second youth perpetrator intervention program and programs designed for Aboriginal and Torres Strait Islander peoples
- From 2023–24, $2.5 million per annum allocation to Men's Support Services to provide culturally appropriate support to Aboriginal and Torres Strait Islander men to address concerns related to the use of violence

DJAG has several additional activities underway including establishing three new High-Risk Teams in Townsville, Redlands and Rockhampton. The new teams will have a First Nations Cultural Advisor embedded in each. A standalone Domestic and Family Violence Perpetrator Strategy is currently being developed. The whole-of-government strategy will be the first of its kind in Australia. DJAG also intends to facilitate a community-led project to design and pilot a perpetrator intervention program specifically tailored to meet the needs of Aboriginal and Torres Strait Islander peoples through an embedding healing approach.

The Board considered the recommendation as "complete" on the basis that focus has been given to the issues raised to the extent possible within the reforms to date.

Although this recommendation is considered complete, quality risk assessment is expected to be an ongoing focus for continuous monitoring and improvement. Missed opportunities and gaps in domestic violence informed child protection practice continue to be identified across child death cases that come before the Board.

> Perpetrator behaviours can be subtle and insidious, and individually targeted and tailored to the individual victim, making the manipulative and coercive nature of the behaviour only visible to the perpetrator and victim, and further isolating for the victim.[120]

120 Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Bill 2023 Explanatory Notes

Case example: Child Safety in the context of domestic and family violence

In one case reviewed by the Board, the father perpetrated verbal and physical violence towards the mother that included striking her in the head and body, pulling and dragging her by her hair, and kicking her while she lay on the floor, which resulted in her attending hospital on multiple occasions. Physical abuse continued to occur when she was pregnant, and when the child's sibling was present. There were cross-order DVOs in place.

In the 12 months prior to the child's passing, there were nine domestic violence incidents that police attended. In addition to the police reports to Child Safety from these incidents, concerns were also received from professional notifiers. The reported concerns centred on the verbal abuse and physical violence perpetrated by the father towards the mother, and the children being exposed to domestic violence. Some of the reported concerns were recorded as two CCRs. The rationale for the first CCR included the mother acting protectively by attending hospital, calling on her family and ending the relationship. The second CCR noted that the parents had reunified, and if Child Safety should receive further concerns and the family declined support, then *consideration can be given to more intense intervention from child safety*.

Further concerns were reported from a professional notifier who advised that the recently born child and his sibling were at risk of neglect and emotional abuse *"due to an ongoing pattern of significant harm characterised by domestic violence, family conflict, parental volatility, poor coping skills and maternal mental health issues"*. A pre-notification check with Queensland Health showed that the mother had presented to hospital five times in relation to assault and mental health concerns. Eight days after the child's birth, his mother was observed to have a bruised eye which she informed staff had resulted from a family member assaulting her. A notification was recorded, and an investigation commenced. Child Safety interviewed the parents together and during this interview the mother indicated that her bruising resulted from self-harm, and that she *"also took responsibility for fighting with Father and him hitting her"*. According to the records the father acknowledged what he had done, that he was trying to get help, and that he had learned to walk away as a strategy.

Assessing the pattern of perpetrator violence and behaviour over time, as opposed to an incident-by-incident assessment, supports accurate assessments and strengthens understanding about the intent of violence (for example, control versus self-defence). Child Safety's perpetrator pattern-based approach directs that characteristics of domestic violence-informed child protection practice includes recognising the perpetrator's pattern of behaviour and choices are the sole source of harm to children caused by domestic violence. The approach also requires the ability to describe the specific behaviours of the domestic violence perpetrator and the impact on child and family functioning.[121]

During the investigation, in the case study above, the child's parents were not spoken with or interviewed separately. The mother is noted to have spoken of the violence in terms of it being her fault. Similar self-blame and minimisation of the violence was also noted in the cases of three other children. Interviewing separately, when it's safe for the victim-survivor to do so, could have possibly provided more insight into the father's behaviours and the impact on the mother.

On two occasions the father had taken the children to the home of paternal family during incidents of violence. It is unclear whether this was a protective action, or a way of controlling their mother. As noted, perpetrator behaviours can be subtle and consequently hard to recognise, so every opportunity needs to be taken, when it's safe to do so, to speak with the victim-survivor separately. In the cases of three children, their fathers were not engaged or had limited involvement in the child protection process. The reasons for this included refusal to engage or they were excluded at the request of the victim-survivor.

121 Department of Child Safety, Seniors and Disability Services, Child Safety Practice Manual, Perpetrator pattern-based approach, 17 March 2022

Case example: Appropriate recognition of parents in a domestic and family violence relationship

This child's family came to the attention of Child Safety when a professional notifier reported concerns of possible medical neglect of the child's sibling. There was concern that he was not being supported to address the pain of his medical condition or assisted with his mobility. There were concerns that his mother needed support with the care of three young children, two of whom had additional medical care needs, as the parents had recently separated.

It was recorded that the father perpetrated violence towards the mother who told Child Safety that she had left him because he was not contributing, spent all their money and smoked cannabis in front of the children. She also said he had been violent to her when she was pregnant.

Child Safety's Review Team noted that specifics about the violence was not recorded in their department's records. The father was not contacted as part of an investigation as the mother asked Child Safety staff not to, as she had not heard from him for some time and was worried that if he was contacted it would cause problems for her. The mother was also concerned about her own family knowing, and advised of significant family conflict, including family members making threats to take her children away.

In the above case study Child Safety's Review Team agreed with the approach of not including the father, however, in reflecting on the practice with the CSOs involved with the case, the Review Team noted that it would have been beneficial to still have worked further with the mother to understand the father's patterns of behaviour, and his impact on family functioning.

This child's case highlights the complexity and challenge that child protection practitioners face when having to navigate keeping the victim-survivor and their children safe while still needing to examine perpetrator behaviours and holding perpetrators accountable.

Where adult survivors (the non-offending parent) are noting safety concerns in relation to contact with fathers, the best-practice response to this is explore exactly what this means for the mother and her children, and whether there is any risk mitigation that can/should be undertaken to maximise safety. This step should be taken to ensure that domestic and family violence perpetrators can be and still are engaged, in their role as parents, as much as feasibly possible.

Coercive control

Coercive control is a component of perpetrator behaviour. It involves a perpetrator using a pattern of abusive behaviours over time in a way that hurts, humiliates, isolates, denies liberty and autonomy, and frightens and threatens another person in order to control or dominate them. It is almost always an underpinning dynamic of family and domestic violence.[122]

Child Safety's practice guide on assessing harm and risk of harm explains that coercive control may make it more difficult for practitioners to recognise acts of protection. The guide emphasises the importance of fully understanding perpetrator patterns of behaviour and the protective and safety strategies of the victim-survivor to understand the potential harm and future risk of harm.[123]

The Board noted that legal and First Nations advocates have voiced concern around the potential negative impact criminalising coercive control will have on First Nations women. One of these concerns is the misidentification of victim-survivors as perpetrators which could increase child protection intervention and threat of child removal.[124]

Of the cases included in this report, three mothers were recorded to have perpetrated domestic violence with one mother also listed as both the aggrieved and the respondent in a DVO. The Board is not suggesting in these cases the mothers were misidentified as perpetrators, however the Board acknowledges that misidentification is a known issue. Further, the language used by police to describe a victim-survivor can have an impact on the type, and level of police response. A recent study of domestic violence fatality reviews/coronial files for a whole-of-population study of First Nations women killed by male partners across several Australian jurisdictions between 2006 and 2016, examined the use of terminology. It found in nearly three quarters of the domestic violence homicides (60 women), police had used terminology such as *"uncooperative"* and *"unwilling"* to work with police to describe the victims during prior police involvement in relation to domestic violence.[125]

In our reviews this year, the mothers of three children were described as uncooperative in their interactions with police. In one child's case, his mother was noted as not wanting to cooperate with police because she would not provide information about the incident. In another case this was put forward as a possible reason for attending police not being able to assess the safety of a child and his siblings. In a third case, this was listed as part of the rationale for a child harm report – *"Mother was not acting protectively given her disregard for the DV order, lack of cooperation with Police and remarks to remove (Child) from intensive care before returning home."* In this case the child's mother had contravened the no contact conditions of the order, on which she was listed as the aggrieved, by living with the father.

Concluding comments

In reviewing the seven cases the Board noted that significant work was underway to address the prevalence of domestic and family violence as well as the recommendations made by the Board in relation to improving how the system responds to domestic and family violence.

The Board also notes that initiatives are currently underway by QPS, as part of its domestic and family violence reform, to improve police responses to domestic violence. The Board noted that the reform work to be undertaken by QPS is significant, requiring a major shift in police workplace culture and practice, and potentially specialist and/or additional recruitment.

The Board advised in its 2022–23 Annual Report that ongoing improvements to responses to, and prevention of, domestic and family violence would continue to be an area of consideration by the Board. At that time, we recommended 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"*. Further in this report we note the actions taken by government in response to last year's recommendation and accept its closure whilst also continuing to assert that the prevalence and seriousness of family and domestic violence demands ongoing prioritised response.

The cases reviewed by the Board in 2023–24 have again reinforced both the epidemic of violence in Queensland homes, and the complexity of government responding to the issue. It is clear to the Board that numerous reviews, inquiries, strategies and funding announcements have occurred in response to family, domestic and sexual violence. The Board considered its role, and the value it can have in making further recommendations. In engaging in this discussion the Board acknowledged, regrettably, that changing the culture of violence in relationships will take time and require the sustained effort of all community leaders to ensure that change occurs.

122 Queensland Government, About domestic and family violence, 11 December 2023; Australian Government, Attorney-General's Department, Coercive control, Understanding coercive control.

123 Child Safety, Practice Guide, Assessing harm and risk of harm, 8 August 2022

124 Buxton-Namisnyk, E, Gibson, A and MacGillivray, P, Opinion: Unintended, but not unanticipated: coercive control laws will disadvantage First Nations women, University of NSW, 29 August 2022

125 Emma Buxton-Namisnyk, Domestic Violence Policing of First Nations Women in Australia: 'Settler' Frameworks, Consequential Harms and the Promise of Meaningful Self-Determination, The British Journal of Criminology, Volume 62, Issue 6, November 2022, Pages 1323–1340

Recommendations

Recommendation 7

Maintaining action on reducing family and domestic violence

The Board recommends that Queensland Government continue to prioritise its response to the impact of family and domestic violence on Queensland children, and continue to implement the past recommendations of the Board and the following reviews:

- The *Not Now, Not Ever report, the Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland*
- The *Hear Her Voice – Report Two – Women and girls' experiences across the criminal justice system*
- The *Independent Commission of Inquiry into Queensland Police Service (QPS) A Call for Change*.

CHAPTER 6

Recognising and responding to disclosures of harm

"Participating is about children and young people having a voice, being listened to, and taken seriously within their family and community. It means having a say in decisions that impact them."[126]

Parents and guardians have a legal responsibility to protect children. Besides providing children and young people under the age of 18 years with basic necessities, such as adequate food, lodging, medical treatment and care, this requires parents to take precautions that are reasonable in all circumstances to avoid danger to the child's life, health or safety, and remove the child from such danger (ss 285, 286 *Criminal Code Act 1899 (Qld)*.[127]

The ACMS, which published its findings in April 2023, found that nearly two-thirds (62.2 per cent) of the 8,500 Australians interviewed reported having been abused, neglected, or exposed to domestic violence before they turned 18. The most prevalent form of maltreatment was exposure to domestic violence (39.6 per cent).[128]

In 2023–24 the Board considered the cases of 39 children and young people who were exposed to significant domestic and family violence with multiple related challenges. This included physical, verbal and emotional abuse.

When a child or young person discloses that they have been abused, it is essential that adults believe them and act to protect them from further abuse. The harm suffered from abuse can be mitigated greatly by the actions of a protective and safe adult who tells the child they believe them and then acts to stop further abuse from happening.

Indicators that children display about abuse can be physical, behavioural, and emotional, and may best be considered holistically. Disclosures can be purposeful or accidental and can occur ongoing over time as part of a process. Non-verbal disclosures are more common, especially for younger children. As they get older and their ability to vocalise distress increases, children and young people's statements about experiences of abuse, feeling unsafe at home or fearful of their caregivers may become more distinct and urgent.

126 Australian Research Alliance for Children and Youth (ARACY), What's in the nest?, ARACY Website n.d., accessed 26 January 2024.

127 Caxton Legal Centre Inc, The Queensland Law Handbook, Parental responsibilities, Caxton Legal Centre Inc Website, September 2022, accessed 7 March 2024.

128 Australian Child Maltreatment Study (ACMS), The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study ACMS Website, 2023, accessed 11 March 2024.

Case example: Disclosures to school staff

In the year before he died, the young person disclosed to his school Guidance Officer and teachers that his parent often hit him with a belt, which hurt and left bruises. At school, he showed staff a large bruise to the back of his leg, which was still visible a week later. As mandatory reporters, teachers must make a report to Child Safety if they form a reasonable suspicion that a child has suffered, is suffering or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect them.

On this occasion, the school did not report these disclosures to Child Safety. While the Principal and Guidance Officer agreed that the young person's disclosures and bruising suggested he had suffered significant harm, *both staff recorded they suspected a parent was able and willing to protect him from harm*.

This lack of referral to Child Safety silenced the young person's voice and his need for a trusted, safe adult to believe him.

Subsequently, the young person made further disclosures of physical harm to school staff. He had been in trouble at school on consecutive days for minor misdemeanours. Upon being told that his parents were going to be called, the young person exhibited fear and distress and clearly said he would be hit if the school called the parents. The parents were called and informed of the incidents. There was no evidence of any immediate action taken to promote the young person's safety and wellbeing in response to his disclosures. The following day, the young person was found hanging. The school made a Student Protection Report the following day.

This case highlights that staff need to be cautious about making assumptions about a parent's ability and willingness to protect as a reason not to refer to Child Safety, given the contextual information they may not be privy to. In the young person's case, there was a long-standing history of domestic and family violence that had been perpetrated in the young person's household, which likely would have impacted a parent's ability to protect him at home.

Apart from using words, infants and young children tend to communicate in a myriad of ways, as they are learning to talk.[129] Often, distressing things that have happened to children will signal through their behaviour and their play as well as, and sometimes more than, their words.[130] The "voice of the child" encompasses verbal disclosures by children but also other ways of "telling". Indicators that children display about abuse can be physical, behavioural, and emotional, and may best be considered holistically.[131]

Knowledge about disclosures of abuse is based largely on research findings from the literature about child sexual abuse. However, many of the identified issues and dynamics are also likely to be relevant to disclosures of other types of abuse.[132] The following section discusses how children and young people typically show their distress, fear, feeling unsafe or worry for their or their loved ones' safety.

129 Government of Western Australia, Child Development and Trauma Guide, Government of Western Australia Website 2021, accessed 11 March 2024.

130 Australian Institute of Family Studies (AIFS), What is child abuse and neglect?, AIFS Website, September 2018, accessed 16 February 2024; Felicity Blake (host) (n.d.,) 'Silent all these years: Disclosure' [Podcast] *SAMSN's Stronger Podcast*, Survivors & Mates Support Network, accessed 12 February 2024.

131 C Esposito, 'Child sexual abuse and disclosure: What does the research tell us?' *New South Wales Government Family & Community Services*, Communities and Justice Website, n.d., accessed 16 March 2024.

132 AIFS, Responding to children and young people's disclosures of abuse.

But then it's only beneficial if the person that hears it understands what's being said. And a lot of people didn't understand what was being said. One of the most interesting things is, when we did research about disclosure, most people said they had actually disclosed as a child, but they did so in a way that either the adults rejected, or more significantly, didn't understand it. They couldn't understand the gravity of what was being disclosed. *Because no child says, "I've just been … abused."* And so we didn't even have the vocabulary, the language, the understanding, when children were disclosing to us.[133]
-Robert Fitzgerald AM, former Commissioner of the Royal Commission into institutional responses to child sexual abuse

Case examples: Trusting the observations of those next-closest to the child

Over seven months, a childcare provider formally notified Child Safety on more than 10 occasions about significant concerns for the boy's welfare. Staff had noticed a pattern of injuries that could have resulted from physical abuse, with some inconsistent explanations by the boy's caregivers in relation to how he had been injured. The caregivers explained the boy's bruises and injuries were accidental and were a result of the boy's clumsiness, however, staff at the childcare said that the boy was not a clumsy or accident-prone child.

The childcare reported that the child had made repeated disclosures that his caregiver had caused the injuries they observed, and that the child had appeared *timid and withdrawn, scared, on alert, very reserved and really quiet* in the presence of his caregiver. Staff also reported that they had observed the child start crying when he became aware that his caregiver had arrived to collect him.

In another case, in the course of a month, a child's childcare provider contacted Child Safety on several occasions to report concerns for the boy. Staff had observed his behaviours had become increasingly aggressive, violent and dysregulated towards his peers and staff members. This had resulted in the boy being sent home early on multiple occasions. On one occasion, staff witnessed the boy's caregiver grab him by the ear and shoulder and drag him, with the boy vocalising pain. The caregiver was also witnessed smacking the boy, while looking *"really angry"*. Childcare reported that the boy had made verbal disclosures about being hit, smacked and kicked and feeling afraid of his caregiver.

The boy had told staff not to ring home because he did not want to go home. He was seen crying when collected, and on another occasion was clinging to an educator's leg and saying *"I don't want to leave here. I don't want to go"*.

Child Safety recorded a Child Protection Notification seven weeks after the concerns were reported. The boy died five months later. The I&A was not commenced.

The Board has reviewed cases where injuries to children had been reported, often by professional notifiers. Some of these injuries could not be easily explained as non-accidental, and were noticed repeatedly, such as bruises, swelling, burns, scratches, blisters, abrasions, haematoma, and conjunctival haemorrhages. At times, the children's caregivers' accounts of how the injuries happened were inconsistent.

133 Felicity Blake, 'Silent all these years: Disclosure'.

The Board noted that in some cases, children had tried to tell the adults around them they were being hurt or feeling unsafe and scared. The disclosures, however, were at times at odds with accounts from other family members.

Competing narratives about what occurred in the home can be difficult to assess.[134] When it comes to children's voices that are contradicted by others in their family, doubt and hesitation can interfere with efforts to protect children and result in efforts that are ambivalent and hesitant. Rather than having access to the voice of the child directly, disclosures made by children to others are often conveyed via the voice of a mandatory reporter.

Children and young people can demonstrate significant incongruity in relation to telling an adult about their maltreatment. Telling an adult about not feeling safe in the care of the people who are supposed to love them can be incredibly daunting, making children and young people's attempts at telling look tentative, full of self-doubt, half-hearted and hesitant. The final report from the Royal Commission into institutional responses to child sexual abuse noted that the biggest inhibitor of telling someone about abuse was *"fear of not being believed"*.[135]

The Australian Childhood Foundation has been engaged in the world's longest running community tracking research that investigates the attitudes and beliefs of Australians about child abuse and child protection. Findings from its fourth interim report confirmed that *"nothing has changed in terms of public attitudes towards child abuse"*.[136]

The study found that two thirds of respondents believed that children made up stories about child abuse and neglect and were uncertain whether to believe children when they told them about having been abused. Put another way, this means that children only have a one in three chance of finding an adult who will believe them and so it is *far more likely that children will not be believed or in fact perceived as lying*.[137]

In addition to the lack of community confidence regarding the believability of children's disclosures, research on patterns of disclosure consistently notes children's own attempts to cover for abusive parents and caregivers. This includes trying to keep their abuse a secret. Apart from fear of not being believed and inadvertently making things worse, possible reasons for children and young people's reticence to talking about being hurt by those who are supposed to love them include:

- loyalty to the parent/s
- shame
- self-blame and feelings of responsibility
- fear for their and their siblings' safety.

Developmentally, children are self-centred and consequently likely to believe the reason they are suffering abuse is because there is something wrong with them and that they deserve to be treated badly and punished. This can trigger feelings of shame and low self-worth.[138] Often, abusers will tell a child directly that they deserve what they got. Children and young people might also have been taught that what they are experiencing is not unusual, and therefore they might not recognise that the way they are being treated is harmful and not acceptable. Development delay, impacted by cumulative trauma[139] and disabilities[140], creates further impediments to making disclosures.

Case example: Youth mental health, parenting and child protection

At 12 years old, the young person was reported missing by his parent. Police found him a short time later. They *"disclosed to police that he had been fighting with his parent and felt that he was always being told off for being bad"*. He *"felt that life was a little tough at home but gave no indications of any abuse"*. There had been a child protection history for him from before he was born. The concerns included exposure to significant domestic and family violence. The young person died by suicide about four weeks later.

134 A Whitaker, Independent expert report concerning professional decision making following the death of Mason Jet Lee held in the Coroner's Court of Queensland, Australia, May 2020, doi: 10.13140/RG.2.2.28645.01767.

135 Commonwealth, Royal Commission into institutional responses to child sexual abuse, Final Report, Vol 4: Identifying and disclosing child sexual abuse, 15 December 2017, p 77, accessed 25 March 2024.

136 J Tucci and J Mitchell, Still Unseen & Ignored: Tracking Community Knowledge and Attitudes about Child Abuse and Child Protection in Australia.

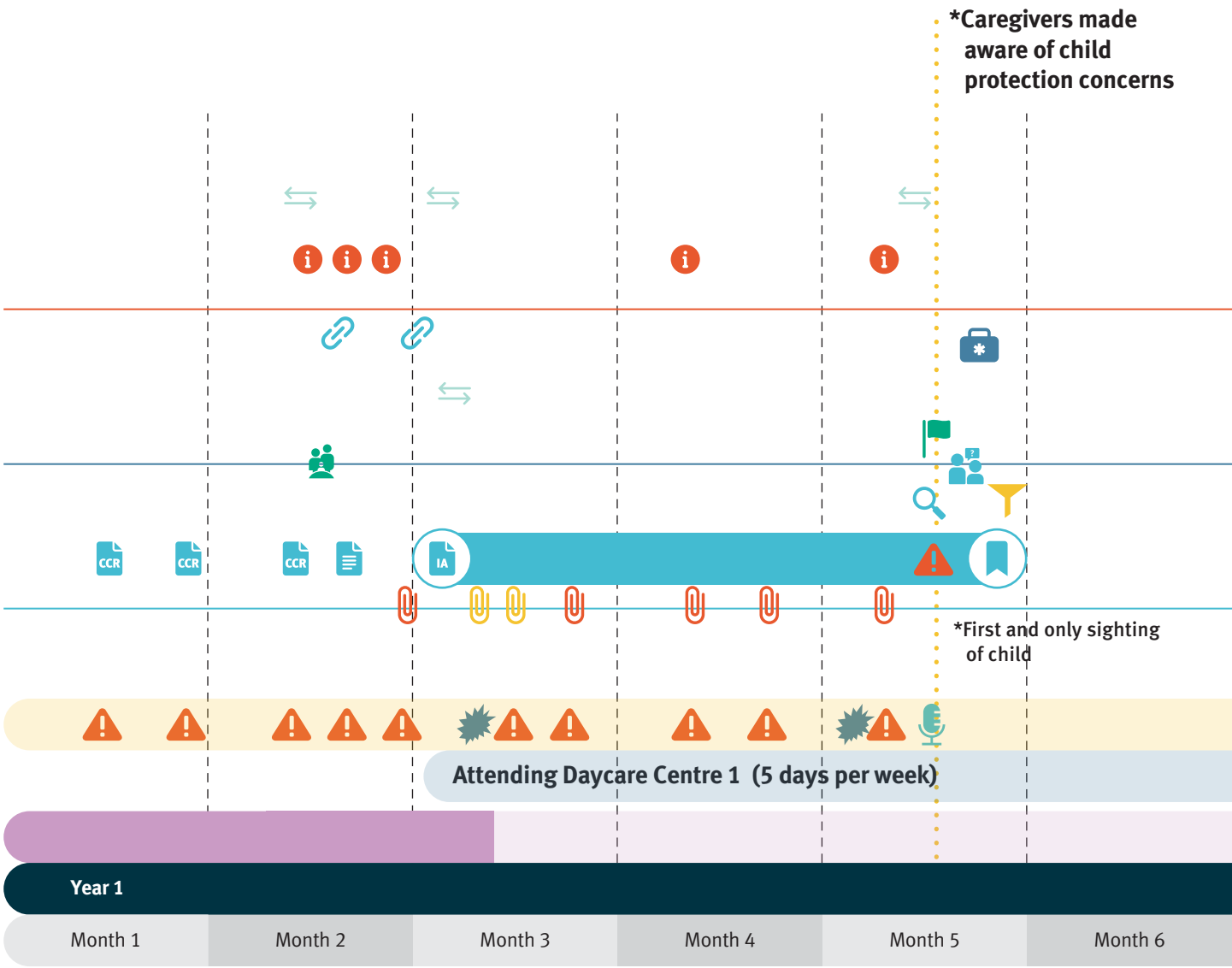
137 J Tucci and J Mitchell, Still Unseen & Ignored: Tracking Community Knowledge and Attitudes about Child Abuse and Child Protection in Australia.

138 Government of Western Australia, Child Development and Trauma Guide.

139 D Hughes, *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children*, J Aronson, University of Michigan, 1997.

140 Kellogg and Menard, 2002; Finn, 2011; Mulryan, Cather & Fagin, 2004 in C Esposito, 'Child sexual abuse and disclosure: What does the research tell us?'

Figure 23: Timeline of system touchpoints

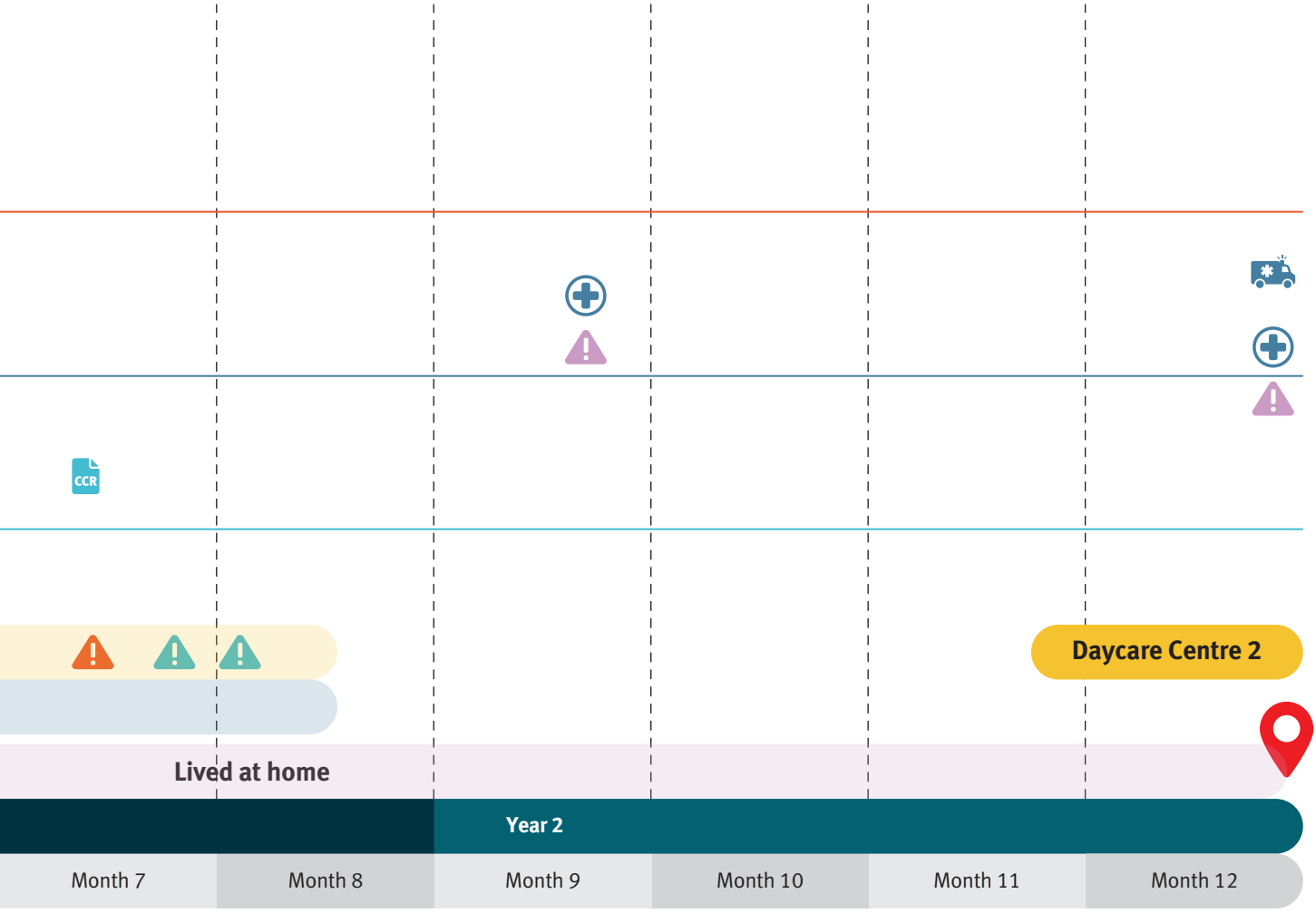


Child Safety

- CCR
- Notification
- I&A
- Information request/ sharing (under CPA)
- Additional notified concerns (ANC) CCR/CPN
- Home visit (NB: Child never sighted in home)
- I&A outcome (unsubstantiated)
- Family Risk Evaluation (moderate)
- Safety Assessment (safe)
- Senior Practitioner consult
- FaCC referral

Health

- GP visit
- Emergency presentation
- Injuries observed
- QAS response



Police

- Referral from Child Safety pursuant to section 14(2) of the Act (possible criminal offence)
- Child Safety request joint investigation with QPS

Daycare

- Injuries observed and worries reported to Child Safety
- Child interviewed by Child Safety at daycare
- Behavioural change observed
- Daycare advised one parent in hospital
- Injuries observed and not reported to Child Safety
- Day Of Death

Risk Assessment: Child-centred responses to disclosures about harm

For child protection practitioners, regardless of whether it is a purposeful or accidental disclosure of abuse, believing the child when they show in their behaviour and verbal statements that they have been hurt becomes the first crucial step towards taking action to protect the child.

Risk assessment is a combination of the art (knowledge, skills and professional judgement of practitioners, leaders and managers) and the science (the tools and practice guidance).[141]

While identifying and assessing risk, child protection work seeks to plan for the safety, development, needs and wellbeing of children, young people and their families.[142] All child protection assessments are meant to consider context as far as is possible. With this, it becomes critical to take a child-centred approach to risk assessments that is responsive to the child's needs while considering in detail the probability the child has suffered harm or is likely to suffer harm in the future, and whether they have a parent who is able and willing to protect them.

The additional vulnerabilities of young and non-verbal children may necessitate a tailored response to risk assessment. This might include seeking additional corroborating evidence and/or greater consideration of their non-verbal disclosures.

Serious physical abuse…should be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma.[143]

Bruising is the most common injury from physical abuse and the most common injury to be overlooked or misdiagnosed as non-abusive before an abuse-related fatality or near-fatality in a young child.[144]

Physical abuse of children can cause injuries, some of them serious and potentially lethal. The younger the child, the higher the risk of death due to their vulnerability and almost total dependence on their caregiver for protection.[145]

There is a strong correlation between physical injuries to children, inconsistent accounts of how the injury occurred and physical abuse.[146] There is also a distinct link between suspected non-accidental injuries to children and the child protection system. In 2017, the Australian Institute of Family Studies published a policy and practice paper on child deaths from abuse and neglect, and found that in Australia, almost 33 per cent of children admitted to hospital with an unintentional injury were known to child protection authorities.[147] The literature also evidences that some hospital admissions likely to be due to maltreatment are not recognised as such.[148]

As a priority, in cases of suspected physical abuse, child protection workers need to assess any injuries and the child's signals that show they might be suffering harm and feeling unsafe indicating that the child's primary caregiver is not in a position to protect them from harm.

141 Victoria State Government, Department of Families, Fairness and Housing, SAFER children framework guide: The five practice activities of risk assessment in Child Protection, 20 November 2021, accessed 12 March 2024.

142 Victoria State Government, Department of Families, Fairness and Housing, SAFER children framework guide: The five practice activities of risk assessment in Child Protection.

143 CH Kempe, FN Silverman, et al., 'The Battered-Child Syndrome', Journal of the American Medical Association (JAMA), 7 July 1967, 181(1): 17–24, doi: 10.1001/jama.1962.03050270019004.

144 MC Pierce, K Kaczor, et al., 'Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics', JAMA Network Open, 14 April 2021, 4(4), doi: 10.1001/jamanetworkopen.2021.5832.

145 AIFS, Child deaths from abuse and neglect, AIFS Website, October 2017, accessed 7 March 2024.

146 A Kemp et al., 'Bruising in children who are assessed for suspected physical abuse', Archives of Disease in Childhood, February 2014, 99(2): 108–113, doi: 10.1136/archdischild-2013-304339; CH Kempe, FN Silverman, et al., 'The Battered-Child Syndrome'.

147 McKenzie, Scott, Fraser and Dunne (2012) in AIFS, Child deaths from abuse and neglect, AIFS Website, October 2017, accessed 7 March 2024.

148 AIFS, Child deaths from abuse and neglect.

Domestic discipline and physical abuse

Physical abuse of a child can happen under the guise of discipline or punishment. The World Health Organisation observes:

> Much physical violence against children in the home is inflicted with the object of punishing.[149]

For child protection workers tasked with assessing harm and risk, it can be difficult to determine whether a disclosure from a child is describing physical abuse or legal levels of domestic discipline. The Board debated the legality of physical discipline of children at two of its Board meetings this year, revolving around more than three concerning cases. The Board was inclined to make a recommendation that the Queensland Government consider removing this legislation permitting physical discipline however it noted that the Queensland Law Reform Commission is currently undertaking a review of particular defences in the *Criminal Code (1899)*, including the defence of domestic discipline in section 280. S280 currently allows physical discipline of children, including the use of *"force"* as is deemed *"reasonable"* under the circumstances for the purpose of correction, discipline, management or control of a child. In their Terms of Reference for the *Review of particular criminal defences*, the law reform commission asserts that the defence has attracted criticisms, including that:

- The defence is unclear and open to different views about what is "reasonable".
- Physical (corporal) punishment of children is undesirable, is not effective and can result in long-term harm.
- The defence is out of step with contemporary views against the use of violence and with the protection of the best interests and human rights of children, including their right to equal protection under the law.[150]

The Board Chair and the staff of the QFCC have met with the law reform commission and have provided information into their review. The Board intends to monitor this further in 2024–25.

The negative impact of corporal punishment, often used as domestic discipline, can be significant and long-lasting on children. Research shows that children who experience corporal punishment are at a higher risk of exhibiting aggressive behavior and becoming involved in violent relationships as adults. Decades of research including systematic reviews and meta-analyses have shown corporal punishment is associated with a range of adverse outcomes including aggression, externalising problems, internalising problems, mood disorders, lower moral internalisation and decreases in cognitive ability, and even neurological changes. The primary benefit of corporal punishment is immediate compliance, an outcome that not only is short-term, but which research demonstrates can also be achieved with alternative non-violent parenting strategies that are sustainable.

In 2023 the Australian prevalence of childhood experiences of corporal punishment across all ages was 62.5 per cent. This was outlined in the research report The prevalence of corporal punishment in Australia: Findings from a nationally representative survey undertaken to build upon the ACMS.

Communities can be strengthened by promoting alternatives to corporal punishment. These alternatives focus on non physical discipline, encouraging desirable behaviour, fostering communication, empathy, and mutual respect within families. By shifting away from forceful discipline, communities can reduce violence, increase emotional security, and create healthier relationships. Positive parenting practices encourage problem-solving and emotional regulation in children, which contributes to stronger familial bonds and a more supportive social environment.

149 AIFS, Child deaths from abuse and neglect.

150 Queensland Law Reform Commission, 'Review of particular criminal defences: Our terms of reference', *Background paper 1*, November 2023, p 11-12, accessed 1 July 2024.

Evidence based parenting programs that promote non-violent disciplinary methods, coupled with community education, can help break the cycle of violence. They empower parents with tools to discipline effectively without causing harm, while also helping children develop social and emotional skills. This not only nurtures safer family environments but also builds a community culture that values the well-being of children and promotes long-term stability and resilience. The Board suggests that the government should invest in a public campaign that:

1. educates on the harmful effects of corporal punishment
2. promotes positive parenting techniques
3. offers practical tools and strategies for parents
4. highlights community support resources
5. encourages cultural shifts towards non-violent discipline.

Child protection, medical and care professionals need to be adept at differentiating abusive bruising and injuries from childhood everyday activity or unintentional injury.[151] The TEN-4-FACESp is a bruising clinical decision rule that has been developed and continually validated by Dr Mary Clyde Pierce and her colleagues to assess probability of physical abuse.[152]

The acronym specifies a way of screening bruising in infants and children under the age of four years to identify when a bruise is more likely to result from abuse than by an accidental injury. It stands for **T**orso, **E**ars, **N**eck, **F**renulum, **A**ngle of the jaw, **C**heeks, **E**yelids or **S**ubconjunctivae, **"4"** represents infants 4 months and younger with any bruise, anywhere, and **"p"** represents the presence of patterned bruising ("TEN-4-FACESp").[153] Prevalence of linear or patterned bruises (such as slap marks, fingertip bruising or matching an implement or object) is evidently higher for physically abused children, and all locations that are not typically injured in falls, such as the ears, cheeks, neck, torso, front of thighs, upper arms, buttocks and genitalia have been associated with a much higher prevalence of physical abuse.[154] Figure 24 shows the core aspects of the TEN-4-FACESp Clinical Decision Rule.[155]

151 A Kemp et al., 'Bruising in children who are assessed for suspected physical abuse'.

152 MC Pierce et al., 'Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics', *JAMA Network Open*, 4(4), doi:10.1001/jamanetworkopen.2021.5832.

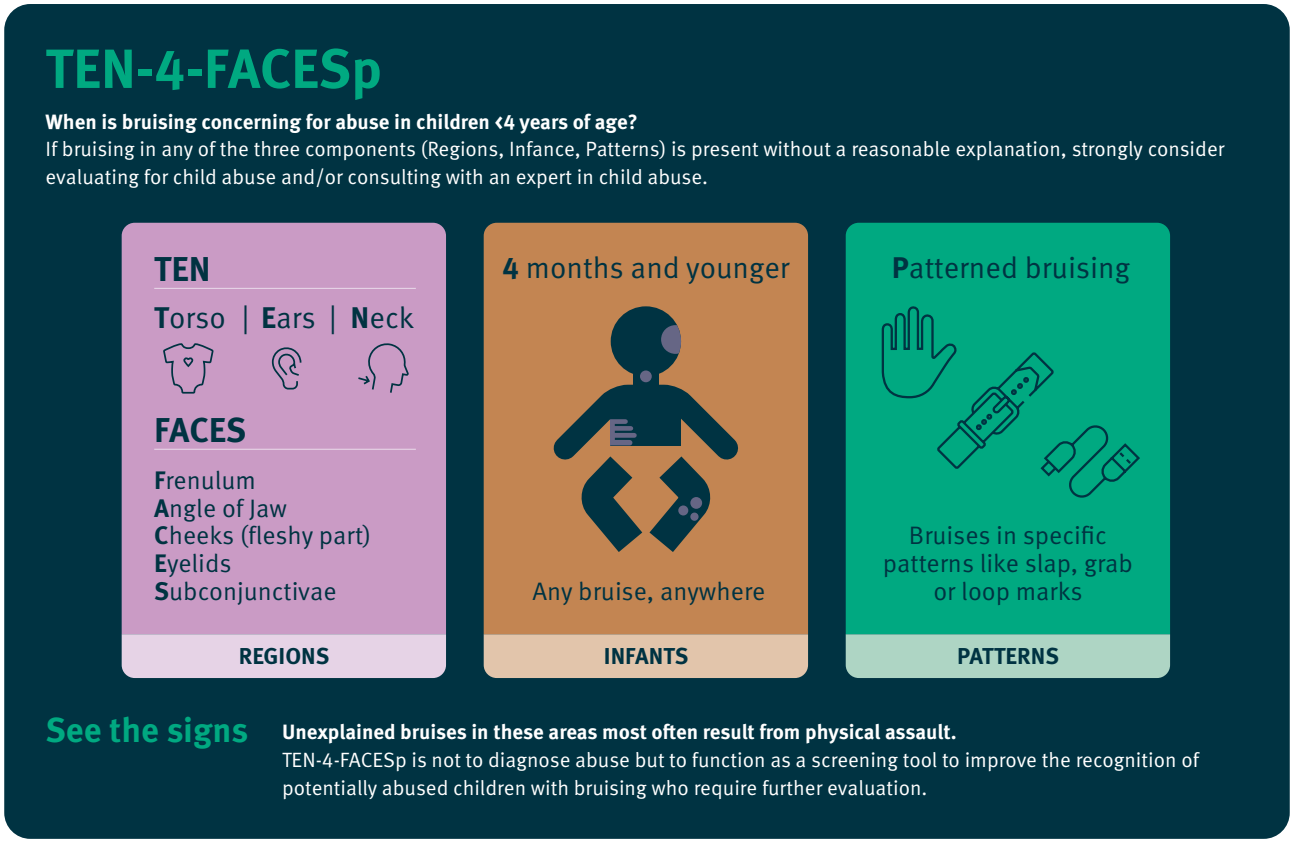
153 Stanley Manne Children's Research Institute, TEN-4-FACESp, Ann & Robert H. Lurie Children's Hospital of Chicago Website, n.d., accessed 16 March 2024.

154 A Kemp et al., 'Bruising in children who are assessed for suspected physical abuse'; Stanley Manne Children's Research Institute, TEN-4-FACESp.

155 Stanley Manne Children's Research Institute, TEN-4 Infographic (Social Media), Ann & Robert H. Lurie Children's Hospital of Chicago Website, n.d., accessed 16 March 2024.

Figure 24: The TEN-4-FACESp

The TEN-4-FACESp Clinical Decision Rule is a key part of the "red flag examination" outlined in the *Clinical Practice Guidelines: Child Abuse* at the Royal Children's Hospital Melbourne[156] (which hosts the Victorian Forensic Paediatric Medical Service). Gold Coast Health refers to using the TEN-4-FACESp rule in its physical abuse assessments[157] however, after a search of publicly available information, the Board noted that the extent of the awareness and use of this tool among professionals across Queensland appears inconsistent.



Case example: Multiple injury patterns as a key indicator

The Board reviewed the case of a child that presented to the Emergency Department of a large public hospital. His parent provided an account of how he had fallen out of a tree and landed with the side of his head against a concrete garden bed. He was reported to have red spots on the white of his eye and grazes to his face. Staff also noted older injuries, including a rash on the face, an abrasion to the abdomen, and bruising to the jawline. The boy was found to have a minor head injury and discharged home with a fact sheet, request for GP follow up regarding the rash, and advice on when to return to the Emergency Department.

At the time of presentation, an administrative error prevented Emergency Department clinicians from accessing information provided earlier by Child Safety, which had expressed concerns about *"the ongoing pattern of multiple injuries over a short span of time that are suggestive of physical harm."*

156 The Royal Children's Hospital Melbourne, Clinical Practice Guidelines, RCHM Website, November 2021, accessed 16 March 2024.
157 Queensland Government, Gold Coast Health, Physical abuse assessment, Gold Coast Health Website, 16 July 2021, accessed 16 March 2024.

Medical examinations in cases of suspected abuse: The importance of context and collaboration

Physicians have a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trauma will be permitted to occur. [158]

The Queensland Child Safety Practice Manual states that during an investigation, a medical examination can be arranged if considered necessary, to *"ensure the child's immediate health and safety"* or to *"inform the investigation and assessment outcome"*.[159] When this is to occur, child protection practitioners need to speak to the child about the upcoming medical examination, preferably in a relaxed environment, and share with the medical practitioner *"any disclosure made by the child"*.[160]

The organisational policies and procedures currently available to child protection practitioners do not specify exactly the process by which a medical referral ought to be made. The Board has reviewed cases where the need for a medical examination had been established by child protection practitioners. Rather than Child Safety organising a medical appointment with a practitioner with child protection expertise, the Board noted that at times, parents independently organised a GP appointment with a practitioner of their choosing. Typically, the child attended this appointment without Child Safety present, and little information was available as to the depth of the medical examination that occurred.

Some cases also showed significant time delays between the first reported injury observed on a child, subsequent reported injuries, and the medical examination. Acute injuries might have had time to heal during this delay.

158 A Kemp et al., 'Bruising in children who are assessed for suspected physical abuse'.

159 Queensland Government, Child Safety Practice Manual, Consider a medical examination, Child Safety Practice Manual Website, 7 May 2024, accessed 1 July 2024.

160 Queensland Government, Child Safety Practice Manual, Consider a medical examination.

Challenges when making decisions

Making decisions about harm or risk of harm to children is a complex task. In addition to paying careful attention to patterns of injuries over a period of time, practitioners need to gather information from multiple sources for a comprehensive risk assessment and carefully weigh up the information they are gathering for balance and rigour. While conversations with parents and carers usually form the starting point for discussions, extended family and professionals who know the child and their family well should be included in assessment processes as a valuable source of information.[161]

From about the age of five years, child protection professionals tend to interview children as part of an investigation, asking them directly about their experiences and their feelings of safety. For developmental reasons, interviews of this format are not typically done with young children. Rather than formally interviewing them, child protection staff will often sight and observe children of pre-school age, preferably in interactions with their caregivers, to assess the quality of their attachment to the adults who are meant to keep them safe. These observations are important and can be telling about impact from abuse, including trauma responses.[162]

The Board noted that, at times, children had been observed not to appear scared or distressed when close to an alleged abuser or asked about abuse. This, however, does not mean the abuse did not occur.

Research has found that children who have been abused may not appear emotionally distressed and may even respond warmly towards the alleged abuser. Children may mask their emotions for several reasons and may hold conflicting views about the person harming them. This could be due to fear, attempts at self-protection that include not aggravating the person of whom they are scared, or other ambivalent feelings.[163]

Given that much of what constitutes child abuse and neglect happens under the guise of secrecy, a lack of evidence that abuse has occurred, does not mean that it did not occur.

Concluding comments

Society must listen to and appropriately respond to children and young people's disclosures of harm. This includes behavioural and verbal disclosures of abuse and/or neglect and can lead to further assessments of non-accidental injuries and decision-making about the parent or guardian's ability and willingness to protect them.

Competing narratives about what occurred in the home can be difficult to assess.[164] When it comes to children's voices that are contradicted by others in their family, doubt and hesitation can interfere with efforts to protect children and result in efforts that are ambiguous and hesitant. Rather than having access to the voice of the child directly, disclosures made by children to others are often conveyed via the voice of a mandatory reporter.

To make good decisions, professionals require sufficient access to information and training about recognising and responding to signs of abuse in children and young people, and contextual information accompanying requests for medical examinations. The integration of disclosures, observations, collateral information provided by the child's family, carers and professionals, and a review of relevant sources of information will support rigorous and balanced decision-making.

Helping children to safely disclose what has happened to them becomes paramount. Harm can be mitigated greatly by the actions of a protective and safe adult who tells the child they believe them and then acts to stop further abuse from happening.[165]

Child protection, medical and care professionals need to be adept at differentiating abusive bruising and injuries from childhood everyday activity or unintentional injury.[166] In this regard, medical assessments are important to ascertain whether patterns of observed injuries are non-accidental. They also aid in properly documenting the observed injuries.

161 L Bromfield and R Miller, 'Cumulative Harm: Best interests case practice model specialist practice resource', *Victoria State Government*, 2012, accessed 4 March 2024.

162 L Bromfield and R Miller, 'Cumulative Harm: Best interests case practice model specialist practice resource'; BA Van der Kolk, *The body keeps the score: mind, brain and body in the transformation of trauma*, Viking, 2014.

163 C Esposito, 'Child sexual abuse and disclosure: What does the research tell us?'

164 A Whitaker, Independent expert report concerning professional decision making following the death of Mason Jet Lee held in the Coroner's Court of Queensland, Australia, May 2020, doi: 10.13140/RG.2.2.28645.01767.

165 C Esposito, 'Child sexual abuse and disclosure: What does the research tell us?'; AIFS, Responding to children and young people's disclosures of abuse; J Tucci and J Mitchell, Still Unseen & Ignored: Tracking Community Knowledge and Attitudes about Child Abuse and Child Protection in Australia.

166 A Kemp et al., 'Bruising in children who are assessed for suspected physical abuse'.

Recommendations

Recommendation 8

Enhanced awareness of, and improved response to, the additional vulnerabilities of young and non-verbal children

The Board recommends that:

1. the Queensland Government invest in a public campaign to assist parents understand childhood behavior development, positive parenting techniques and the consequences of corporal punishment; and
2. all child protection agencies (Child Safety, Queensland Health, Education, QPS and Youth Justice) enhance staff awareness of additional vulnerabilities of young (under five years) and/or non-verbal children. This may include how to interpret and seek corroborating evidence in response to verbal and non-verbal disclosures. It is recommended that this includes:
    - consideration of implementing a bruising clinical decision rule, such as the Ten-4-Faces-P material, to ensure that it is captured in their current guidance on indicators of physical abuse to increase their capacity to identify non-accidental injuries
    - consideration of the need to seek information from a broader range of sources who know the child than might otherwise be required for verbal children. This would include early childcare workers, support workers, neighbours and extended family
    - improving how agencies facilitate and receive medical assessments of children including how they provide relevant context as to why the review has been requested, contact the medical practitioner prior to the review, and nominate an independent medical professional.

CHAPTER 7

Assessing the impact of parental substance use on the child

Problematic family alcohol and drug use can increase the risk for multi-type maltreatment of children.[167] In 2023–24 the Board reviewed a number of cases where parental substance abuse was a significant factor in the child's household.

The sample eight cases outlined in this chapter highlight that problematic drug and alcohol use, in combination with other challenges (such as domestic and family violence, poor parental mental health, housing instability, etc.) can pose a significant risk to children. For example, six of the eight cases involved parental mental illness, five involved domestic and family violence, and two involved housing instability and homelessness (see Figure 25 below). It is important to consider all risk factors holistically to accurately assess the ongoing risk of problematic substance use to children.

The challenge of assessing the impact of problematic parental substance use on children, particularly infants and young children, has been previously identified across Board reviews. Chapter 5 of the *Child Death Review Board Annual Report 2022-23* highlighted the need to strengthen child safety practices in response to parental substance, including methamphetamine use. That report identified that of the 170 cases reviewed by the Board from 1 July 2020 until 30 June 2023, methamphetamine use was present in nearly a third of cases. Data collated in March 2021 showed that an estimated 42 per cent of children in out-of-home care in Queensland had at least one parent who had a record of methamphetamine use.[168]

Problematic substance use by parents of any substance, including alcohol, can result in negative impacts on children in both direct and indirect ways. Direct exposure can significantly harm a child's physical, emotional and mental health. Impacts on physical health include children's exposure to substances in utero, unsafe environments with poor ventilation, parental driving under the influence, unsafe sleeping practices, access to drugs or drug paraphernalia, a lack of adequate supervision and basic needs not being met (i.e., nutrition, hydration, hygiene, clothing, housing, and medical care).

Emotional harm can occur through the exposure of a child to inconsistent and unpredictable parenting behaviours ranging from impulsive and overly attentive behaviours to emotional withdrawal, flat affect, and limited to no responses to the child.[169] Lack of emotional regulation can substantially impact a child's developing ability and competency to regulate their own emotions and significantly disrupt attachments to parents and caregivers.[170]

Young children are particularly vulnerable to emotional harm, with exposure to parental substance use before age three linked to insecure and disorganised attachment[171] and delayed speech and language development.[172] Even minor exposure can have compounding effects over time, resulting in cumulative harm.[173] Infants and very young children, due to their absolute dependence on their caregivers, are especially vulnerable to the harms of problematic alcohol and drug use, however children of all ages feel the negative impacts of parental drug and alcohol misuse.

Figure 25: Common features in the life trajectory of the 8 children reviewed in this report.

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Parental substance use	•	•	•	•	•	•	•	•
Domestic and family violence		•	•	•	•	•		
Parental mental health concerns	•		•	•	•	•	•	
Housing instability	•		•					

167 Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 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, The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: 2023 Brief Report - The Australian Child Maltreatment Study (ACMS)

168 The Queensland Cabinet and Ministerial Directory 2021, *Demand increases for family support and Child Protection,* https://statements.qld.gov.au/statements/92939

169 Child Safety 2023, *Living with alcohol and other drugs use*. Accessed 5 October 2023, Living with alcohol and other drugs use | Child Safety Practice Manual (csyw.qld.gov.au)

170 Shadur J and Hussong A 2020, 'Maternal Substance Use and Child Emotion Regulation: The Mediating Role of Parent Emotion Socialization', *Journal of Child and Family Studies* 29, 1589–1603, Maternal Substance Use and Child Emotion Regulation: The Mediating Role of Parent Emotion Socialization | Journal of Child and Family Studies (springer.com)

171 Barnard M and McKeganey N 2004, 'The impact of parental problem drug use on children: what is the problem and what can be done to help?', *Addiction*, 99(5), 552-559

172 Dunn MG, Tarter RE, Mezzich AC, Vanyukov M, Kirisci L & Kirillova G 2002, 'Origins and consequences of child neglect in substance abuse families', *Clinical Psychology Review*, 22(7), 1063-1090

173 Broadley K 2014, 'Equipping Child Protection practitioners to intervene to protect children from cumulative harm: Legislation and policy in Victoria, Australia', *Australian Journal of Social Issues*, 49(3), 265-284

Assessment issues in the presence of problematic parental substance

The Board, in Chapter 5 of the *Child Death Review Board Annual Report 2022-23*, identified the following issues in child protection risk assessments and the associated impacts on children from parental drug use:

- **Challenges identifying cumulative harm** – chronic emotional abuse and neglect caused by repeated exposure to parental drug use often remained unaddressed. Cumulative harm is often less visible and takes additional effort to identify, including direct observations of the child. In consideration of resourcing constraints, the Board noted that practitioners do not always have the resources to pursue this.
- **Difficulty recognising impacts on children from patterns of problematic substance use by parents** – behaviours were evaluated as individual incidents rather than repeated habits.
- **Missed opportunities to investigate extent and type of drug use and associated impacts** – where parents disclosed polysubstance use, follow up conversations about the extent and type of drug use often did not go beyond eliciting superficial information and did not sufficiently explore the impacts on children.
- **Acceptance by workers when parents advised they were unwilling to address their substance use** – many parents were pre-contemplative about addressing their alcohol and drug use and denied any negative impacts on their child/ren.
- **Acceptance of information from parents at face-value** – working with parents who use substances at levels that present harm to their children requires practitioners to use a level of scepticism.[174] Accounts from the parents were often given more weight than the accounts from members of the safety and support network.
- **Overreliance on inadequate family arrangements or support networks** – informal arrangements with family members or friends were considered sufficient to care for a child when their parent was intoxicated. Often practitioners did not confirm that people who had agreed to care for a child were safe and sober to do so.
- **Overly optimistic practice** – a parent's ability and willingness to adhere to established safety plans was frequently overestimated. Some safety plans did not sufficiently take into account a parent's past behaviour in the context of problematic substance use.

The Board made the following recommendation in an effort to support improved risk assessment in the face of parental substance misuse.

"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:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services must be implemented to ensure a child's safety."

The government's actions in response to this recommendation is outlined further in this report, and is accepted by the Board to be closed given the sufficiency of action taken. In closing this recommendation, the Board recognises that parental substance use remains an ongoing threat to the safety of Queensland children.

The Board also noted that of the eight children discussed in this chapter, two of the children died by SUDI, with another young infant's cause of death pending. This highlights the ongoing need to promote safe sleep education, and the issues raised by the Board in Chapter 4 of the 2021–22 Annual Report.[175] Chapter 4 of the report reveals that just under half of the infant deaths reviewed by the Board in 2021–22 were classified as SUDI (11 cases), with many of these occurring in the infant's regular sleep environment.

All SUDI events in 2021–22 occurred in the child's home (rather than in out-of-home care), suggesting the need for strengthened support and education for families at home. In recognition of this, the Board commissioned the Queensland Paediatric Quality Council to deliver a research report on risk factors for SUDI and to inform system improvements to reduce SUDI deaths among families known to the child protection system.

"The review noted that the majority of SUDI in families known to the child protection system occurred in highly hazardous sleep environments, including sharing a sleep surface, particularly in the context of parental smoking and alcohol and other substance use."

A range of other sociodemographic factors were also more frequently reported among this cohort – alcohol and substance use during pregnancy, experiencing domestic and family violence or poor mental health, intergenerational child protection involvement, criminal offending, and limited social support.

174 Hader Clinic Queensland, *Why addicts lie and how to deal with it*. Accessed 5 October 2023. https://haderclinicqld.com.au/why-addicts-lie-andhow-to-deal-with-it/

175 Child Death Review Board, Queensland Family and Child Commission, *Annual Report 2022-23*, Child Death Review Board Annual Report 2021–22 (parliament.qld.gov.au)

The research considered that families experiencing social vulnerabilities have fallen behind in their uptake of safer infant care and safer sleep recommendations, and many experience barriers to implementing SUDI risk reduction strategies. However, effective strategies to increase uptake of safer sleep recommendations are lacking and research about how to achieve this, specifically among families known to the child protection system is limited.

Instead, research about families at higher risk of SUDI and strategies for improving service engagement provides useful guidance on interventions for families known to the child protection system—such as programs that:

- address broader social and economic inequalities
- offer long-term face-to-face support
- establish strong collaborative relationships between services
- are tailored to families' individual circumstances
- involve whole-of-family/social network approaches
- incorporate multimodal interventions which provide a safe infant sleep space, coupled with a comprehensive education program.

In the *Child Death Review Board Annual Report 2021–22*, the Board made recommendations (Recommendation 5), that the Queensland Government:

Extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to:

- supporting and monitoring the wellbeing and development of an infant within the family home
- addressing families' health and psychosocial needs and wellbeing as they arise
- implement or expand initiatives to create 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.

The Board notes that the government's *Putting Queensland Kids First* strategy includes increased investment and expansion of the home visiting and safe sleeping programs for children. This strategy is built around helping youngest Queenslanders have access to positive and healthy pathways for life and supporting people to get back on track when they face challenges. Funding under the strategy includes $65.52 million for more sustained health home visiting and antenatal support, $11.09 million to connect parents with essentials for thriving babies and $4.1 million to expand weekly text messaging to support child development and parental wellbeing.

Concluding comments

Young children are particularly vulnerable to emotional harm in households where parental substance abuse is present. Even minor exposure can have a significant impact over time. In fact, children of all ages feel the negative impacts of parental drug and alcohol misuse.

The Board has previously made recommendations on this issue and the more recent cases reinforce the ongoing need for the child safety system to recognise the risk of parental substance abuse.

The Board also notes that the majority of SUDI in families known to the child protection system occurred in highly hazardous sleep environments and more work is needed to identify and mitigate the likelihood of an infant experiencing these environments.

Recommendation 9

Revisiting 2022–23 Recommendation 5: Strengthening child safety practice in response to parental substance and methamphetamine use.

The Board recommends that Queensland Government outline the work it is doing to further embed the practice guidance it created in response to the *Child Death Review Board 2022–23 Annual Report Recommendation 5: Strengthening child safety practice in response to parental substance and methamphetamine use*, noting cases reviewed by the Board in 2023–24 confirmed the ongoing need to support frontline practitioners in their risk assessments of children whose parents' substance use is problematic.

CHAPTER 8

Recommendation monitoring

The primary purpose of the Board is to identify systemic improvements that will improve the safety of Queensland's children. This relies on us making realistic and actionable recommendations to government for their implementation.

2022–23 Recommendation 1

Assessing the safety of children who are registered for home education

The Department of Education

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 Pursues 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.

Government Response

All Queensland children are entitled to be safe wherever they live and learn. The Queensland Government is committed to ensuring that home educated children are safe and thriving. The Queensland Government respects the right of parents to educate their child at home and acknowledges the importance of ensuring effective regulation of home education, while supporting parents and children.

The Minister for Education has announced a review of the Queensland Home Education Unit, supported by a stakeholder led Home Education Expert Group. The review will:

- consider the diverse experience and needs of home educating parents
- identify gaps and areas for improvement in the approach to regulation, education and support of home educators; and
- provide recommendations, where appropriate, to enhance the effectiveness of regulation, including supports for parents, options to engage more broadly with home educators in the absence of a peak body, and other supportive activities within the existing legislative framework of the *Education (General Provisions) Act 2006*.

The outcomes of the Home Education Unit Review will inform how Education can support home educating families, so children and young people can access a high-quality education. Amendments to the home education legislative framework under this education Act will require further consideration by government following completion of the Home Education Unit Review and consultation with relevant stakeholders. Home education regulation will be considered in the context of the existing child safety legislative framework for the oversight of safety and wellbeing of children.

The Home Education Unit Review is expected to be completed in 2024. Any additional changes required to be made to legislation will be addressed in future reviews of the *Education (General Provisions) Act 2006* proposed from 2025 onwards.

The QFCC has established a cross-agency working group (including Child Safety and QPS) to review the prevalence of home education in high-risk home environments. An aspect of this review includes working with agencies to match data to identify the number of home educated children who are living in high-risk home environments (including those with concerning child protection and domestic and family violence histories). As part of the review, Education will participate in an information sharing trial led by QFCC to match 500 home-schooled student records with Child Safety data about children found to be in need of protection and resulting in an intervention. A similar information sharing trial is being developed with Queensland Catholic Education Commission and Independent schools Queensland. The review outcomes will inform development of options for proposed ongoing data sharing between agencies, giving consideration to associated legislative and system implications.

Further the QPS Child Abuse and Sexual Crime Group will undertake a full review of Chapter 7 (Child Harm) of the *QPS Operational Procedures Manual*. This will include reviewing supporting guidelines to ensure a continued focus on appropriate child harm reporting, including the risk to children in domestic and family violence contexts, and ongoing consideration of emotional and accumulative harm. This review may include updating reporting and information sharing guidelines.

The *Child Protection Act 1999* allows the Child Protection chief executive to request information from QPS and to enter into an information sharing arrangement. However, regular sharing of data between Education, Child Safety and QPS would require legislative amendment to enable data sharing, development or alterations to information technology systems, and development of operational protocols. Authorising and operational matters will need to be further considered following the outcomes of the Home Education Unit Review, and the QFCC review's findings.

Board Observations

The Board acknowledges the participation of Education, Child Safety and QPS in the QFCC's cross-agency working group to review the prevalence of home education in high-risk home environments. The Board, however, cautions that the implementation of Recommendation 1.1 to increase the visibility and available supports for vulnerable children enrolled in home education should occur whether this affects many children or one child. The intent the of Recommendation 1.1 is to improve information sharing between child protection agencies, particularly between Education, Child Safety and QPS. Improved collaboration would not only benefit vulnerable children enrolled in home education but is likely to increase the visibility of other vulnerable children as well.

The Board notes QPS intends to undertake a full review of Chapter 7 (Child Harm) of the QPS Operational Procedures Manual. As the review progresses, the Board would ask QPS to provide specific advice on how the planned changes to the QPS Operational Manual are expected to improve collaboration between Education and Child Safety and improve child harm reporting.

The Board acknowledges that the implementation of Recommendation 1.2 is largely dependent on outcome of the Home Education Unit Review. This Board awaits the review's findings. It is hoped that Education will continue to consider the findings from Board's review of child enrolled in home education (as presented in Chapter 1 of the 2022–23 Annual Report) inclusive of the comparison of the regulatory scheme to those already in operation in other Australian jurisdictions.

2022 23 RECOMMENDATION 1: OPEN IN PROGRESS

2022–23 Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice (Youth detention operating model)

The Department of Youth Justice, Employment, Small Business and Training

2.1 Takes 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.

Government Response

The Queensland Government is committed to reforming the youth justice system to strengthen the prevention, early intervention and rehabilitation responses to youth crime and make communities safer.

Since this recommendation was made, Youth Justice has added new information to the Youth Justice website, including a new services map[176] and a dedicated page on separation[177] in youth detention centres. Youth Justice will continue to publish comprehensive information about the youth detention operating model, philosophy, and policy and procedure frameworks on its website.[178]

Youth Justice has developed a comprehensive plan to promote sustained workforce growth to support frontline youth detention service delivery. Strategies include ongoing investment in staff training, utilising recruitment and retention analytics to refine processes, strengthening applicant supports, defining the Child Safety's Employee Value Proposition, improving staff compensation, building a diverse workforce, redeploying staff as required and partnering with a range of education and employment service providers to build an ongoing applicant pool for scheduled recruitment cycles. This plan also includes specific regional initiatives relevant to Queensland's new youth detention centres.

The Youth Justice *Reframing the Relationship and Youth Detention Reform Action Plan* outlines that Youth Justice is committed to developing strategies to improve workforce recruitment with Aboriginal and Torres Strait Islander people in consultation with the First Nations Action Board and First Nations Action Groups, and local stakeholders. The cultural capability workplan consists of intensive training designed to build the capability of the workforce employed within Youth Justice.

The Minister for Education and Minister for Youth Justice has announced a new Youth Justice peak body that will work with justice representatives and the government to inform policy that improves community safety. One of its priorities is to develop strategies to deliver a capable and effective Youth Justice workforce. This work will enhance Youth Justice's workforce strategy.

In September 2024 Youth Justice advised that "with the agency updates provided the Department (Youth Justice) would consider recommendation 2.1 to be completed." It also confirmed that the Department is developing a strategic workforce plan. The project involves review of current workforce capabilities, forecasting future workforce supply and demand trends, identifying and prioritising workforce gaps and developing strategies to bridge those gaps. This will inform operational and tactical workforce planning activities across the department.

Further, Youth Justice has allocated internal resourcing to undertake a Service Model Refresh. The Service Model Refresh is examining current functions, service models and needs and identify options for service design and delivery that can improve community safety and engagement and the effectiveness and efficiency of youth justice services. Consultation is occurring with front-line departmental staff and government and non-government partners to inform decision making. The aim of the program of work is to better meet the needs of the community, young people, families, and our workforce now and into the future.

176 https://desbt.qld.gov.au/__data/assets/pdf_file/0027/23868/services-youth-detention-centres.pdf

177 https://www.qld.gov.au/law/sentencing-prisons-and-probation/young-offenders-and-the-justice-system/youth-detention/about-youth-detention/separation

178 https://desbt.qld.gov.au/youth-justice/resources

Board Observations

The Board acknowledges that Youth Justice has provided additional information on its website in regard to services available to children in youth detention, philosophy of youth detention services, and use of separation, however these do not present as a single guiding framework as recommended by the Board, and as of 13 August 2024, several policies listed in the Youth Detention Centre operational policy and procedure framework are not publicly available, including Youth Justice's policy on separation: YD-3-8 Separation. Nor was the Youth Detention Centre Operational Manual publicly available as of 13 August 2024.

As per the intention of Recommendation 2.1, the Board re-iterates the need for Youth Justice to create and publish a Queensland's Detention Centre Operating Model in its entirety. The opportunity this would present would be a clear articulation of the "purpose of detention" as now legislated by the government through its 2024 reform to the Youth Justice Act.

The Board recognises that Youth Justice has developed a plan to promote workforce growth. Youth Justice's cultural capability workplan is also recognised for the intention to bolster the workforce's cultural capability.

The Board awaits the work of the announced youth justice peak body, particularly its input into Youth Justice's workforce strategy. The Board intends to request to view Youth Justice's enhanced workforce strategy at this time.

2022 23 RECOMMENDATION 2: OPEN IN PROGRESS

2022–23 Recommendation 3

Reappraising the response to youth crime and the purpose of youth justice (Youth detainees time out of cells)

The Queensland Government

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.

Government Response

Recommendation 3.1

Youth Justice will 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 will champion this measure for inclusion in nationally consistent reporting with other jurisdictions.

Recommendation 3.2

This recommendation is supported in principle noting that the intent of the recommendation will be addressed through other work already underway across government. Young people on the Serious Repeat Offender Index (SROI) are considered by Multi-Agency Collaborative Panels (MAC-Ps) as a tier 2 response to address challenges and barriers in the delivery of case management. There is significant work underway to implement recommendations for changes to MAC-P responses. Review or evaluation of responses to young people on the SROI prior to the implementation of these recommendations would not provide results in line with new practice. Work is also underway as part of the Youth Justice Senior Officers Reference Group to identify systemic issues escalated from MAC-Ps.

The Queensland Audit Office (QAO) has recently published the performance audit report *Reducing serious youth crime*[179] (tabled 28 June 2024). It assessed whether Youth Justice strategies and programs are effective in reducing crime by serious repeat offenders. Overall, the report found that oversight and coordination of the Youth Justice system has improved, including through the creation of committees that enable departments to coordinate and prioritise their responses to young people in the system. However, there remain long-standing issues across the system, including detention centre capacity. The QAO report makes 12 recommendations, eight of which are directed to Youth Justice, four to QPS and two to the DPC. Agency responses to the recommendations have been published along with the report and recommendations are agreed or agreed in principle.

Significant reform has occurred across the system while the audit was undertaken from May 2023. Youth Justice has implemented five of eight recommendations with the remaining three currently being implemented to address the findings. The Queensland Government is also investing more than $500 million for prevention and early supports for children and families to set young people on a positive pathway for the future and to reduce the growing demands on more costly tertiary interventions later in life. Responses to young people on the SROI were also considered by the Youth Justice Reform Select Committee in its interim report[180] which made 60 recommendations, of which government has accepted 23 in full and 37 in principle.

- In 2024 Youth Justice improved its reporting – including daily public data on young people in detention and watchhouses, and a public website for the evaluation reports on its programs. This is a significant step and the leadership is to be congratulated. Youth Justice noted that the following information regarding young people in watchhouses is now available publicly:
  - » watchhouse data - Watch-house data I QPS (police.qld.gov.au);
  - » the report has been added to the bottom of the Reports and publications - Reports and publications I QPS (police.qld.gov.au); and
  - » the report has also been added to Quick links on right hand side of the Maps and statistics - Maps and statistics | QPS (police.qld.gov.au)

Board Observations

The Board acknowledges the improved reporting released by Youth Justice throughout 2024. While the Board acknowledges that Youth Justice has taken action to date to publish information on youth detainees' time out of cells on its website, the webpage provided in the government response (as accessed on 13 August 2024) does not state the maximum time a young person can be kept in separation or the process for approving and managing separation that occurs longer than the maximum time allowed. The webpage does not provide information to parents and guardians on how to escalate concerns if they are concerned that their young person is experiencing prolonged separation. As of 13 August 2024, Youth Justice's policy on separation (YD-3-8 Separation) is not included as one of the public policies available of the Youth Justice website. Recommendation 3.1 will remain in progress until this occurs.

In relation to recommendation 3.2 the Board does not accept that the intention of Recommendation 3.2 has been achieved through the review of young people on the SROI by MAC-Ps. Recommendation 3.2 was specifically designed to enable a process of cross-government learning regarding the missed opportunities for government in young people's lives. The Board's review of the young people in chapter 3 of the 2022–23 Annual Report uncovered profound opportunities for preventative justice – including the role of housing, education, employment, mental health services, health, and other portfolios in impacting a young person's trajectory. When a child known to Child Safety dies, we take the time to understand the missed opportunities for government service delivery in their life, and we improve our policies and programs for the future. When a child commits serious and significant crime, we also have this opportunity.

2022 23 RECOMMENDATION 3.2: OPEN IN PROGRESS

179 https://www.qao.qld.gov.au/reports-resources/reports-parliament/reducing-serious-youth-crime?mc_cid=ec61aae37e&mc_eid=1175ce1e5
180 https://documents.parliament.qld.gov.au/tp/2024/5724T725-B9B9.pdf

2022–23 Recommendation 4

Improving research on the needs of First Nations communities

Recommendation

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.

Government Response

Queensland Government agencies commit to strengthening their research policies to ensure that research seeking to understand the needs of First Nations children, young people and families is designed, procured, coordinated and conducted through working with First Nations professionals. Agencies will continue to work towards developing and strengthening policies that align with the:

- National Health and Medical Research Council's *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders*
- Australian Institute of Aboriginal and Torres Strait Islander Studies' *Code of Ethics for Aboriginal and Torres Strait Islander Research*
- National Agreement on Closing the Gap Priority Reform Four: *Shared Access to Data and Information at a Regional Level*
- *Queensland Indigenous Procurement Policy*, which provides a whole-of-government framework to increase procurement with Indigenous businesses and can be applied to ensure that procurement for research projects contracts with First Nations businesses and professionals.

In 2023, Child Safety released the *Child and Family Research* Agenda. Under this agenda, Child Safety prioritises research led by or developed in partnership with Aboriginal and/or Torres Strait Islander researchers. Child Safety requires all proposals for prescribed research to comply with the principles of Indigenous data sovereignty and governance as outlined in the 13 June 2023 *Indigenous Data Governance Communique* of the National Indigenous Data Sovereignty Summit. Further, under the *Our Way* strategy action plan, *Breaking Cycles* 2023–2025, Child Safety has committed to expanding data sharing and ownership capabilities to achieve Aboriginal and Torres Strait Islander Data sovereignty and governance including:

- continuing to expand and develop, through technology, policy and legislation, the data sharing and ownership capabilities delivered through Unify to the Aboriginal and Torres Strait Islander Community Controlled Organisation sector to achieve data sovereignty (ongoing through 2031)
- continuing to support QATSICPP Centre of Excellence to ensure Aboriginal and Torres Strait Islander evidence is at the forefront of driving change in the Queensland child protection system and to ensure culturally strong evidence is utilised in delivering outcomes for Aboriginal and Torres Strait Islander children and families
- using evidence-based research and frameworks produced by the QATSICPP Centre of Excellence to form the basis for increased investment and development of new programs and services by the Queensland Government to support Aboriginal and Torres Strait Islander children and families (ongoing through 2025)
- continuing to monitor and evaluate the implementation, impact and outcomes of the Breaking Cycles phase of the *Our Way* strategy. Monitoring and evaluation activities for *Our Way* prioritise the voices of Aboriginal and Torres Strait Islander peoples in the design, data collection, analysis and reporting processes and will contribute evidence to influence the future design of policy, program and service delivery with and for Queensland Aboriginal and Torres Strait Islander children, families and communities (Reporting in October 2024; Outcomes Evaluation late-2025).

In 2024, Child Safety advised that under Safe and *Supported: the National Framework for Protecting Australia's Children 2021–2031*, work is progressing to establish an Aboriginal and Torres Strait Islander-led, Aboriginal and Torres Strait Centre for Excellence in Child and Family Support, to increase access to research that is grounded in Aboriginal and Torres Strait Islander knowledge and theoretical frameworks, and provide opportunities for Aboriginal and Torres Strait Islander-led research. This work includes an Aboriginal and Torres Strait Islander-led scoping study on the potential functions and scope of the centre, which is due to be finalised by late 2024.

Child Safety continues to encourage research to deliver with the Child and Family Research Agenda, which prioritises work led by or developed in partnership with Aboriginal and/or Torres Strait Islander researchers. Child Safety requires all proposals for prescribed research to comply with the principles of Aboriginal and Torres Strait Islander Data Sovereignty and Governance.

Under the *Our Way* strategy action plan, *Breaking Cycles 2023–25*, Child Safety continues its commitment to expanding data sharing and ownership capabilities to achieve Aboriginal and Torres Strait Islander Data Sovereignty and Governance.

Other research initiatives undertaken in 2024 to benefit Aboriginal and Torres Strait Islander families and communities, include:

- engaging the Indigenous consultancy Winangali to conduct the evaluation of the Family Participation Program. Winangali is engaging service providers across the state in the evaluation process, which is overseen by a Project Working Group involving departmental staff and QATSICPP representatives
- working with QATSICPP to review and replace the client assessment tools used by Aboriginal and Torres Strait Islander Family Wellbeing Services with a new tool designed by and for Aboriginal and Torres Strait Islander peoples. The project is being led by an Indigenous organisation, First Nations Co, with input from Professor Helen Milroy and Professor Pat Dudgeon, both eminent Aboriginal academics and clinicians. The assessment framework will also form the basis for tracking the performance of the program and services, so it is important that the framework reflects the views and interests of Aboriginal and Torres Strait Islander people.

In addition to Child Safety's response

1. The Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts advised the Board that the department is working with the Doomadgee Communities to address local data needs through the local community data project. Doomadgee is also the location in Queensland for a place-based partnership which aims to work in partnership with local leadership to co-design local solutions to Closing the Gap priorities to be identified by the Doomadgee community.
2. Education advised that the research priorities are aligned to the *Equity and Excellence: realising the potential of every student education strategy* and sets clear standards for ethical research practice aligning with the National Health and Medical Research Council's Ethical Conduct in research with Aboriginal and Torres Strait Islander peoples and communities. In 2024–25 this department is funding a dedicated First Nations research round under the Education Horizon Research Grant Scheme.
3. The Department of Health confirmed that its Office of Research and Innovation is working towards developing a targeted First Nations consumer and community engagement plan for research, on the basis that engaging with First Nations consumers to understand their health research priorities is the first step towards improvement. It also confirmed that the *First Nations First Strategy 2032* includes actions to:
    - enable access to world quality data that supports holistic evidence-based decision-making, and promote world-class First Nations health research and evaluation; and
    - focus on building First Nations research and researcher capability and capacity.

4. DJAG advised that the First Nations Justice Office was established in response to Recommendation 1 of the *Women's Safety and Justice Taskforce report: Hear Her Voice - Report One*, to develop and oversight implementation of a co-designed, whole-of-government and community strategy to address the overrepresentation of Aboriginal and Torres Strait Islander peoples in the Queensland criminal justice system and contribute to meeting Queensland's justice targets under the *National Agreement on Closing the Gap*. The Strategy: Better Justice Together. *Queensland's Aboriginal and Torres Strait Islander Justice Strategy 2024-2031 (Better Justice Together)* and the *Foundational Action Plan 2024–2026*, have now been finalised. Priority Reform 4 of the National Agreement, Shared Access to Data and Information at a Regional Level, is reflected in Objective 2.3 of *Better Justice Together*, improve access to data and information and Action 9 of the *Foundational Action Plan*, identify best practice data collection, access, management, local data sharing and decision-making arrangements and explore options to implement data sovereignty principles.
5. QPS confirmed that it is actioning this recommendation through its work on *Our Way*, Breaking the Cycles 2023-2025 Monitoring, Evaluation and Learning Project, and will continue engagement in this area as required.
6. Youth Justice confirmed that the Youth Justice Research Agenda 2023–24 prioritises working with and empowering Aboriginal and Torres Strait Islander communities to deliver culturally-safe and responsive solutions that result in positive futures for First Nations children.

Board Observations

The Board acknowledges the Queensland Government's commitment to ensuring First Nations research is designed, procured, coordinated and conducted through working with First Nations professionals. This commitment is reflected in the above mentioned whole-of-government policies and internal Child Safety, Youth Justice and Education policies.

2022 23 RECOMMENDATION 4: CLOSED COMPLETE

2022–23 Recommendation 5

Strengthening child safety practice in response to parental substance and methamphetamine use

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:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety.

Government Response

The Queensland Government acknowledges the Board's observations that problematic alcohol and drug use by parents or caregivers can have significant impacts on a child's physical, emotional and mental health and, in the cases reviewed by the Board, placed children at harm or at an unacceptable risk of harm. The Queensland Government is committed to supporting communities, families and individuals where substance use, and in particular, methamphetamine use, is a problem.

Child Safety has the *Assess Harm and Risk of Harm* Practice Guide which assists staff to gather and analyse relevant information and form a professional judgement regarding future likelihood of significant harm to inform a decision regarding intervention. Drug use is referenced as a risk factor in this Practice Guide. Additionally, Child Safety staff, including CSOs have current access to training on the following topics:

- Introduction to alcohol and other drugs (mandatory);
- Assessing risk and safety (mandatory 3-day workshop)
- Crystal methamphetamine (Ice) (eLearning)
- Responding to inhalant use in the community (eLearning).

A Drug and Alcohol Practice Kit is also incorporated in *the Child Safety Practice Manual* to provide practitioners with expert advice and guidance to inform their practice with parents who are using drugs and alcohol. Child Safety is currently reviewing the kit to ensure it includes the most contemporary information and advice.

The Practice Guide has also been reviewed and updated in the context of Child Safety's *Enhanced Intake and Investigation Approach* which will be launched with the new Information and Communication Technology case management system Unify.

The Child Safety Office of the Chief Practitioner in Child Safety has recently established a new practice leader position focused on alcohol and other drugs to work alongside other practice leaders with expertise in mental health, sexual abuse and exploitation and domestic and family violence.

Queensland Health will work collaboratively with Child Safety to support the development and implementation of the Practice Guide through providing specialist alcohol and other drug treatment and harm reduction service system, and clinical advice and information. This will be provided through the Queensland Health and statewide service Insight: Centre for alcohol and other drug training and workforce development.

In 2024 Child Safety further confirmed that:

1. they engaged Professor Sharon Dawe to present at the IPA Senior Team Leader Forum. Professor Dawe's presentation was in relation to undertaking assessment, identifying risk and setting goals for parents with substance use problems. Following the success and reception of that presentation, a statewide webinar hosted by Professor Sharon Dawe occurred in February 2024 and is available to all frontline staff.
2. Child Safety staff, including CSOs continue to have access to training on the following topics:
   - Introduction to alcohol and other drugs (mandatory for new CSOs)
   - Assessing risk and safety (3-day workshop mandatory for new CSOs)
   - Crystal methamphetamine (Ice) (eLearning), and
   - Responding to inhalant use in the community (eLearning).

Since the Board provided Recommendation 5 to the government on 31 October 2023, Board-commissioned research from UQ's Poche Centre on how parental methamphetamine use impacts the health and wellbeing of children has been published. The research report Risks for children caused by Methamphetamine use by parents[181], confirms that there is a need to increasing workers' awareness and understanding of the signs that indicate harm and/or unacceptable risk of harm to children.[182]

The Board acknowledges that assessing the safety of children whose parents use illicit substances will remain an ongoing challenge for all child safety systems. These assessments rely on the skill and judgement of professional staff, and whilst frontline practice needs continual improvement, the actions taken by Child Safety meet the requirements of the recommendation.

2022 23 RECOMMENDATION 5: CLOSED COMPLETE

2022–23 Recommendation 6

Assisting workers to recognise and respond to parental deception

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).

Government Response

The Queensland Government is investing $34.7 million over 6 years from 2023–24 to support the implementation of domestic and family violence training in alignment with the Domestic and Family Violence Training and Change Management Framework, including the Domestic and Family Violence Training, Support and Coordination Service, development of prioritised Coercive Control and Legislative Change modules and evaluation.

Domestic and family violence training modules, which will be developed and made available through the service, will include content on how to identify and respond to attempts at parental deception in the context of domestic and family violence and coercive control. This training will be available to all frontline practitioners and government employees online, with some face-to-face training for priority cohorts. Implementation is anticipated to commence in 2025. Establishment of this service (anticipated to commence in December 2024) will support the development and delivery of consistent trauma informed, culturally appropriate and customised domestic and family violence training across the government and non-government sectors that aligns to this framework.

181 Full research report is available on the Board's website at cdrb.qld.gov.au/reports-and-publications/
182 Risks for children caused by Methamphetamine use by parents, p 37.

The framework was developed in response to Recommendation 23 of the Women's Safety and Justice Taskforce *Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland*, which recommended that the Queensland Government develop an evidence based and trauma informed framework to support consistent training and change management across all parts of the domestic and family violence and justice service systems. One of the core learning outcomes identified in the framework is to understand how persons who use violence can use parental deception, or 'image management', and systems abuse to perpetuate violence and control. Child Safety is currently developing a refreshed *domestic and family violence Practice Kit* to guide the work of practitioners (including in relation to coercive control); it will be deployed by July 2024. Topics will include victim and perpetrator presentation, and the guide will address behaviour minimisation, denial, and victim-blaming. Child Safety is also developing a *Domestic and Family Violence Practice Development and Training Strategy*, which will seek to address a range of learning needs for frontline staff, including nuanced assessment of domestic and family violence perpetrator presentation and image management.

Child Safety staff, including CSOs, have current access to training on the following topics:

- Factors impacting decision making including information on parental deception and disguised compliance
- Defining domestic and family violence (mandatory)
- Investigate and assess, including a course component on factors impacting decision making (mandatory)
- Family Violence informed practice (mandatory one day workshop)
- Partnering with survivors of domestic and family violence (two-hour workshop)
- Working with perpetrators of domestic and family violence (two-hour workshop)
- Impact of violent and coercive behaviours on children
- Working with families when violent and coercive behaviours are causing harm, and
- Assessment when domestic and family violence is present.

Education has developed training for staff in schools and regional offices about understanding the indicators of domestic and family violence, identifying risks, sharing information, and providing support for victim-survivors. By December 2024, Education will develop information to support the implementation of this recommendation. These materials will be disseminated to staff through this training and through the suite of domestic and family violence and student protection resources and training materials available to staff.

Queensland Health will explore options to develop the capability of frontline staff to identify and respond to parental deception, including consideration of updates to existing child protection training modules. Queensland Health commits to completing this work by June 2025.

With the introduction of the *Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Act 2024*, the QPS has strengthened domestic and family violence targeted training and introduced the whole-of-picture approach when investigating domestic and family violence. This approach teaches officers to detect coercive control through identifying the patterns of behaviour that one person uses to establish power over another. The domestic and family violence training products also demonstrate how to initiate effective lines of questioning which assist in identifying parental deception.

Specific training on image management is included in domestic and family violence training.

QPS uses the following strategies to ensure officers effectively identify and respond to image management:

- 3-day holistic training, 2-day extension and 5-day specialist training with sections on perpetrator tactics
- Tailored training products for frontline officers that include how to identify and respond to domestic and family violence. The training products also target child protection requirements and the assessment of immediate and short-term safety needs of all children during domestic and family violence related call-outs
- Perpetrator tactics highlighted as a concern to be addressed in the person centred review
- When relevant, ensuring a SCAN report is completed, or children are named on a protection order
- Information exchange between QPS and Child Safety to prevent the use of parental deception tactics used with either agency
- Referrals to the Domestic Violence High Risk Teams to involve other agencies to gather collateral and accurate information to inform QPS's response, and
- Using powers under Part 5A of the Act to share information and detect where parent have used deception tactics.

Board Observations

In 2024 Child Safety confirmed that it had organised a senior staff forum to respond to this issue. The forum covered topics including decision making in practice with links to issues relating to cognitive bias, halo effect, confirmation bias, difficult conversations, variability in decision making and disguised compliance and the interface between domestic and family violence practice and mental health, with a focus on parental deception and the use of systems in coercion and control.

A new practice guide was developed in 2024 in relation to cognitive bias in child protection decision making. This new practice guide aims to assist staff to develop an understanding of how bias influences decision making and details strategies to assist with recognising and mitigating their effects through the use of practical strategies and processes. The development of this practice guide contributes to addressing findings from recent coronial matters and will be used to support the rollout of the Enhanced Intake and Assessment Approach.

Child Safety staff, including CSOs, continue to have access to training on the following topics:

- Investigate and assess (eLearning; mandatory for new Child Safety Officers)
- Cognitive bias (eLearning)
- Factors impacting decision making (eLearning; mandatory for new Child Safety Officers who work in I&A). This course includes information on parental deception and disguised compliance.
- Domestic and family violence informed practice (one-day, mandatory for new Child Safety Officers)
- Defining domestic and family violence (eLearning; mandatory for new Child Safety Officers)
- Impact of violent and coercive behaviours on children (eLearning)
- Working with families when violent and coercive behaviours are causing harm (eLearning)
- Assessment when domestic and family violence is present (eLearning)
- Partnering with survivors: Domestic and Family Violence (two-hour workshop)
- Working with people who use violence: Domestic and Family Violence (two-hour workshop)

Information pertaining to cognitive bias is also interwoven within mandatory Child Safety Officer role-specific training.

- The Board was also further advised that:
- The Department of Education has established a network of domestic and family violence trainers across all regions. These staff will continue to deliver training and information to staff in schools and regional teams.
- DJAG advised that within Courts Services Queensland, trauma informed service delivery training is being developed for court staff across the State. The training introduces the concepts relating to coercive control and will provide court staff with linkages to departmental policy and procedures. This training will build upon the already available mandatory domestic and family violence training module for court staff which provides foundational knowledge on domestic and family violence, coercive control and the gendered nature of violence. Additionally, following the release of the domestic and family violence Training and Change Management Framework, funding has been allocated to establish a Training Support and Coordination Service (TSCS) early in 2025. The TSCS will be providing a suite of foundational domestic and family violence training modules. The content to assist workers to improve their knowledge on parental deceptions in the context of domestic and family violence and coercive control will be included in a relevant foundational training module.
- The QPS has implemented a new training course for domestic and family violence, 'Unpacking coercive control' which provides further training to recognise perpetrator tactics and image management which commenced in October 2024.
- Youth Justice is finalising a Youth Justice Domestic and Family Violence Practice Framework. The evidence-based framework will articulate a shared understanding, language, and common approach to recognising, assessing, and responding to domestic and family violence and provides best practice approaches for frontline Youth Justice staff. The Framework will also include tools to assist frontline officers identify and respond to domestic and family violence and assess risk of lethality or serious harm. In addition, Youth Justice have implemented a Domestic and Family Violence Community of Practice to support the development of workforce capability and enhanced practice, and are working collaboratively with the broader integrated system in the enhancement of system responses for young people and families that sit outside the role of the department.

The Board acknowledges the above outlined implementation actions to support staff in better identifying and responding to parental deception taken by Child Safety, Education, Queensland Health and QPS to date. The Board also recognises the Queensland Government's whole-of-government implementation of domestic and family violence training and looks forward to its implementation from 2025. Acknowledging the current and schedule efforts towards implementation of this recommendation, the Board will record this recommendation as complete.

2022 23 RECOMMENDATION 6: CLOSED COMPLETE

Annual Report 2021–22 recommendations

Workforce reform to ensure service accessibility and delivery (Recommendation 1: 2021–22)

The Board recommended that the Queensland Government implements 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.

2024 Update

In its original response the Queensland Government supported Recommendation 1 in principle, acknowledging the key role played by both government and the non-government sector in the human services workforce. The government committed to considering how best to implement the recommendation, particularly with respect to addressing overlaps and competition between departmental portfolios. It aims to ensure children, families, and carers receive quality support, while also considering the current industrial relations framework outlined in the *Industrial Relations Act 2016*, which emphasises collective bargaining as the primary method for setting wages and conditions. The government noted that wage parity already exists across some Queensland Government agencies.

The Queensland Government highlighted its *Good People. Good Jobs Queensland Workforce Strategy 2022–32*, the state's first whole-of-government workforce strategy. The strategy identifies pressures on the workforce and outlines three multi-year action plans for addressing them. It emphasised that at a national level, the Queensland Government is collaborating with other Community Services Ministers to address workforce issues in child protection and family support systems through the *Safe & Supported: National Framework for Protecting Australia's Children 2021–2031*.

In September 2023, when the Board sought an update on the implementation of Recommendation 1, it received workforce actions from individual agencies. While these actions were deemed important, they fell short of the recommendation's call for a holistic, whole-of-government response to workforce shortages.

In August 2024, when the Board sought an update, Youth Justice confirmed that it:

- is developing a strategic workforce plan. The project involves review of current workforce capabilities, forecasting future workforce supply and demand trends, identifying and prioritising workforce gaps and developing strategies to bridge those gaps. This will inform operational and tactical workforce planning activities across Youth Justice.
- has allocated internal resourcing to undertake a Service Model Refresh. The Service Model Refresh is examining current functions, service models and needs and identify options for service design and delivery that can improve community safety and engagement and the effectiveness and efficiency of youth justice services. Consultation is occurring with front-line departmental staff and government and non-government partners to inform decision making. The aim of the program of work is to better meet the needs of the community, young people, families, and our workforce now and into the future. The Service Model Refresh will also focus on the First Nations workforce and career pathways, cultural safety needs, and engagement and partnership with local communities.

Furthermore, Child Safety advised that it is proactively addressing the workforce challenges of its Child and Family workforce through a combination of strategies and initiatives. This included:

- the uplift of entry level classification for CSOs from PO2 to PO3 through Enterprise Bargaining. This increased Child Safety's competitiveness in the job market against other child protection agencies (both in Queensland and interstate).
- The Child Safety *Strategic Workforce Plan 2023–26* articulating the priority areas of focus targeting of labour market challenges and service delivery demands. Actions focuses on: Leadership and Talent Engagement; Capability and Future of Work; Safety and Wellbeing and Culture.

Child Safety also confirmed that the strategic workforce plan is being implemented through place-based workforce plans, which have been developed by regional leadership teams with support from People and Culture. The *regional workforce plans* contains place-based strategies and

initiatives to better address workforce priorities unique to the regions. The plans are reviewed annually to ensure place-based approaches are current, relevant and effective. Under the strategic workforce plan, a Retention Strategy for Child and Family has been developed and is being implemented. Deliverables of the Retention Strategy aim to help the department attract quality talent aligned to our values and service delivery needs, and to improve staff retention to enhance workforce capability and capacity.

Furthermore, as part of Roadmap for Residential Care in Queensland, Child Safety is working with peak bodies, the non-government sector, and other stakeholders, to promote place based approaches and address workforce issues. This includes:

- commissioning PeakCare to develop a workforce strategy to meet current and future needs of the residential care sector. PeakCare is consulting with Queensland Government and non-government partners, consulting with Australian state and territory governments, and conducting international jurisdiction analysis to support best practice workforce planning strategies, particularly regarding residential care.
- developing new training to provide foster and kinship carers with foundational skills and ongoing learning opportunities to better equip them for their caring role.

Board Observations

The Board does not consider that this portfolio approach to human-services workforce development and retention is sufficient to meet the intent of the Board's recommendation. We remain concerned about the negative impacts on children and parents when systems compete for limited specialist resources rather than working holistically.

The Board will ask government to formally reject or alternatively respond to the recommendation with a whole-of-government approach in the next reporting round.

2021 22 RECOMMENDATION 1: OPEN IN PROGRESS

Workforce reform to ensure service accessibility and delivery (Recommendation 2: 2021–22)

The Board recommended that the Queensland Government implements 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 deliver holistic family support and early intervention.

2024 Update

In its original response the Queensland Government supported Recommendation 2, acknowledging the importance of local, community-based, and culturally safe responses in strengthening the human services workforce to ensure accessible service delivery. For Aboriginal and Torres Strait Islander communities, this involves partnering with First Nations peoples and organisations to design and deliver services that meet their specific needs and priorities. It identified that key initiatives supporting this recommendation include:

- **Local Decision Making Bodies:** Established as part of the Local Thriving Communities reform by the Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities, and the Arts, these bodies empower First Nations communities to influence and co-design how services are delivered. Engagement with LDMBs across Queensland will guide the development of regional and remote workforce strategies.

- **Paving the Way – First Nations Training Strategy:** As part of the *Queensland Workforce Strategy 2022–32*, this initiative supports the development of Queensland's Aboriginal and Torres Strait Islander workforce through training and skills development, aimed at improving employment outcomes for First Nations peoples.
- ***Our Way Strategy*:** Implemented by Child Safety, this generational strategy (2017–37) for Aboriginal and Torres Strait Islander children and families ensures participation and control over decisions that impact First Nations children. It includes building the capacity of community-controlled organisations, supporting participation in decision-making, delegating statutory child protection functions, and empowering communities to drive local solutions.
- **Access to Aboriginal and Torres Strait Islander Community Controlled Organisations:** The Queensland Government committed to ensuring that First Nations families can access supports through these organisations if they choose. A 10-year plan is in place to transition investment to this sector. The government will work with QATSICPP and other stakeholders to develop a workforce strategy for this sector.
- **First Nations Economic Strategy:** Expected to be released in 2023–24, this whole-of-government strategy will support the economic participation and self-empowerment of Aboriginal and Torres Strait Islander Queenslanders. It will be developed in collaboration with a First Nations Economic Committee, linking workforce, skills, and training strategies to support workforce development at regional and community levels.

In 2023 the Board welcomed these efforts but encouraged further attention to how these initiatives will address workforce shortages in regional and remote communities. The Board also suggested exploring the repurposing of unspent funds from long-term vacant positions for place-based service design, as part of the upcoming First Nations Economic Strategy.

In 2024, Child Safety confirmed that Queensland is committed to actions under the *Safe and Support Action Plans (2023–26)*, led by the Commonwealth Department of Social Services:

- Under Action 3 of the **First Action Plan**, Queensland has committed to support a national approach or strategy for a sustainable and skilled children and family services workforce.
- Under Action 5 of the **First Action Plan**, Queensland has committed to improve lifetime outcomes for children and young people in and leaving care through strategies that support proactive access to universal services e.g. housing, education, income support, health.
- Under Action 6 of the **First Action Plan**, Queensland has committed to improving support for carers. This includes reviewing carer payments for adequacy, consistency and accessibility, and exploring ways to take national action to improve carer recruitment. Actions to increase Child Safety's financial supports will be informed by, and will leverage, this national research wherever possible.
- Under Action 2 of the **Aboriginal and Torres Strait Islander First Action Plan**, Queensland has committed to investing in the community-controlled sector and shifting towards adequate and coordinated funding of early, targeted and culturally safe supports for First Nations children and families. The plan is delivered and overseen in partnership with the Aboriginal and Torres Strait Islander Leadership Group including the QFCC's Commissioner, Natalie Lewis, and the QATSICPP Chief Executive Officer, Garth Morgan.
- Under Action 4 of the **Aboriginal and Torres Strait Islander First Action Plan**, Queensland has committed to developing a national approach to continue building a sustainable Aboriginal and Torres Strait Islander child and family sector workforce. The department is working with QATSICPP to develop and implement a workforce strategy for the Aboriginal and Torres Strait Islander community-controlled sector.

Child Safety also confirmed it is working with QATSICPP to develop a workforce strategy to meet current and projected workforce pressures in the Aboriginal and Torres Strait Islander Community Controlled Organisations sector. The strategy will support the recruitment, retention and skills development for workers in direct service delivery, management and administrative roles within organisations. Resources have been allocated to support implementation of the strategy. The strategy will take account of the differing workforce dynamics and pressures evident in different parts of the state.

Child Safety supports community-led redesign of services to better respond to local needs and circumstances for Aboriginal and Torres Strait Islander peoples. Child Safety is developing a community engagement model to support the involvement of local communities in service design, and there are several examples of local community needs analysis and planning processes that have been funded through departmental resources. Discussions are occurring in several communities regarding the reshaping of funded services to better meet the needs of Aboriginal and Torres Strait Islander children and families, with some of these efforts considering joint commissioning processes across departments.

The Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and Arts advised the Board that on 13 June 2024 the Under Treasurer announced new Best Practice Industry Conditions for Social Services Procurement. The conditions are underpinned by nine principles that will support the sustainability of the social services sector in Queensland. These principles will:

- promote greater certainty and efficiency in service delivery, through the provision of default five-year initial terms for social services contracts and new and amended contractual arrangements
- ensure the social services industry can attract and retain a highly skilled workforce through strengthening employment security and ensuring adequate funding is provided to support training and award conditions
- enable the sector to deliver high quality outcomes for the Queensland community.

Further, this department continues to support the implementation and function of Local Decision-Making Bodies, and the delivery of coordinated and integrated services through the facilitation of interagency/service delivery meetings in remote and discrete communities.

Board Observations

The Board welcomes this work, and has indicated that it will close this recommendation subject to the above work progressing throughout 2024–25.

2021 22 RECOMMENDATION 2: OPEN IN PROGRESS

Continuity of care for children with complex needs (Recommendation 3: 2021–22)

The Board recommended that the Queensland Government develops 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:

1.1 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.

1.2 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.

1.3 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
- 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
- integrating ongoing access for the child to family, culture and education.

2024 Update

Originally the Queensland Government designated Recommendation 3 for further consideration, recognising the need for specialised support for children exhibiting high-risk behaviours and the importance of early intervention to address their social, emotional, health, and wellbeing needs before behaviours escalate to a crisis level. The government stated that it currently provides various supports for children with complex needs through the health, education, child protection, and youth justice systems. Several initiatives are underway to enhance responses to these children from a continuum of care perspective, while acknowledging that further improvements are necessary.

The Queensland Government explained that Child Safety continues to utilise Intensive Family Support (IFS) services for managing cases of children at risk of entering the child protection system or families with complex support needs. Some IFS providers are trialling evidence-based models, such as Functional Family Therapy-Child Welfare and Functional Family Therapy-Case Management, with positive outcomes reported in three trial sites for families requiring therapeutic responses to address multiple challenges. In addition, the government was reviewing the authorisation framework for the use of restrictive practices with NDIS participants under the *Disability Services Act 2006* (Qld), including expanding its application to children. Furthermore, Child Safety is also working with Youth Justice and other agencies to explore improved support for children with disabilities who are at risk of interacting with the Youth Justice system.

In 2023, the Board noted the government's concerns regarding restrictive practices and agreed on the importance of safeguarding the rights of children with disabilities by limiting these practices, however, the Board also emphasised that many children exhibit high-risk behaviours due to trauma, maltreatment, and adverse childhood experiences, which may not be related to disabilities or mental health concerns and therefore require alternative support mechanisms outside of NDIS provisions that featured prominently in the government response.

In 2024, Child Safety confirmed that in response to this recommendation:

1. The Office of the Chief Practitioner is reviewing health and wellbeing programs and services currently available to children and young people in residential care placements in response to a recommendation from the residential care review. The review highlighted a range of programs and services available to children in care that supports their ongoing physical health, psychological health, adolescent health and educational needs. Each child and young person in care should receive a comprehensive health assessment completed by a GP annually, have access to specialised Paediatricians and nurses through child protection units, and access to clinicians who support children with severe or complex mental health needs and children with disabilities.
2. The Roadmap for residential care in Queensland includes the following actions:
    - 2.1 (year 1 commencement): Trial new models of residential care and build an evidence base of what works to meet the needs of Queensland children and their families. In response, Child Safety has contracted a professional service to develop an evaluation framework and test the efficacy of trialled models of care and support. These models may include short stay residential care with assertive outreach, specialist residential care for young people with complex mental health needs and/or disability, and models delivered by Aboriginal and Torres Strait Islander Community Controlled Organisations.

- 2.3 (year 1 commencement): Design a specialist services project to support a trial of intensive therapeutic care and support for young people with disability, mental health and behavioural support needs. In response, Child Safety is partnering with Queensland Health to review and update the ETS Memorandum of Understanding with focus on e.g. the needs of children and young people and service delivery requirements, and a contract has been executed with a professional service to evaluate and contemporise the Counselling and Intervention Support service type. This action supersedes the previous advice provided on 18 September 2023 advising that, 'Child Safety is partnering with Queensland Health on a project to identify specialist support needs, including assessment, treatment and behavioural support for children and young people within the child protection system presenting with complex mental health needs, complex disability support needs, psychological needs and high-risk behaviours.'
- 3.3 (year 2 commencement): Redesign of the youth support program to deliver outreach services that strengthen connections to family and community-based supports. The revision of the programs will ensure that the services have the capacity to respond to the needs of young people experiencing significant levels of vulnerability, and their families. The redesigned youth services will complement the department's investment in 31 Indigenous Youth and Family Workers, based within Aboriginal and Torres Strait Islander Family Wellbeing Services. These positions seek to address the familial factors that contribute to young people's involvement in high-risk behaviours including offending.

3. In 2022–23, Child Safety partnered with PeakCare to design and make available the master class modules on understanding positive behaviour support and managing high risk behaviours for residential care staff. The four master class modules align with departmental policies and procedures and best practice in therapeutic care with focus on:
   - trauma informed care
   - understanding positive behaviour support
   - prohibited practices, and
   - managing high risk behaviours.

   Residential care staff are encouraged to complete these modules to support ongoing learning and to continue to provide the highest standards of care and support to improve the health, safety and wellbeing of young people.

Board Observations

The Board notes the commitments made in the Residential Care Roadmap and their alignment with aspects of the Board's recommendation. The Board does not consider that sufficient action in relation to the 2021–22 recommendation has been taken, as is further outlined in chapter 2 of this year's Annual Report that continues to show the systems impact on children and young people requiring specialised accommodation and support that meets their needs.

This recommendation remains in progress and is further emphasised by new recommendation 1 and 2 of the 2023–24 Annual Report.

2021 22 RECOMMENDATION 3: OPEN IN PROGRESS

Promoting the safety of infants and unborn children (Recommendation 5: 2021–22)

The Board recommended that the Queensland Government:

- extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to: – supporting and monitoring the wellbeing and development of an infant within the family home; and – addressing families' health and psychosocial needs and wellbeing as they arise
- implements or expands initiatives to create 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.

2024 Update

The Queensland Government supported Recommendation 5 in principle, noting the alignment with the existing First 2000 Days program. It reported that as of August 2023, there are two Hospital and Health Services that have been funded to execute a home visiting program. These programs demonstrated increased parental capacity to support their child's early development. It also confirmed that two safe sleeping initiatives (Connecting2U and Pepi-pod) have been trialled and further roll-out is being considered.

Board Observations

In 2024 the Queensland Government released the *Putting Queensland Kids First Strategy*. This strategy included increased investment and expansion of the home visiting and safe sleeping programs for children. This strategy is built around helping youngest Queenslanders have access to positive and healthy pathways for life and supporting people to get back on track when they face challenges. Funding under the strategy includes $65.52 million for more sustained health home visiting and antenatal support, $11.09 million to connect parents with essentials for thriving babies and $4.1 million to expand weekly text messaging to support child development and parental wellbeing.

The Pepi-Pod® Program, was identified as a priority initiative under the Putting Queensland Kids First Package. Queensland Health commenced work to ascertain how this safe sleeping program will be implemented in Queensland. In July 2024, following the Putting Queensland Kids First funding announcement, Queensland Health commenced expansion of a Sustained Health Home Visiting program in Queensland. This will be delivered by Child Health Nurses and Social Workers, ensuring Queensland's most vulnerable families are identified antenatally and supported with an evidence based program of home visiting up until the child is two years of age. $65.52 million has been allocated to expand sustained health home visiting and antenatal support. This service is currently being delivered in Children's Health Queensland and Gold Coast Hospital and Health Service. Sunshine Coast Hospital and Health Service has recently commenced roll out, with the first families to be home visited in August 2024. This will be followed by Townsville and West Moreton Hospital and Health Services, with full implementation in all Queensland Hospital and Health Services over the coming four years.

Child Safety confirmed that a review of Child Safety Practice Manual guidance in relation to safe sleeping practice was conducted and identified that current guidance is contemporary and links to expert guidance provided by Queensland Health and Red Nose Australia.

Child Safety also confirmed that it will continue to work with Queensland Health to ensure department officers support families to access enhanced home visiting and the Pepi-pod program. The Office of the Chief Practitioner has also worked with Queensland Health to deliver a webinar to Senior Team Leaders about vulnerable infants. Child Safety staff are able and encouraged to undertake a one-day training course on Unborn children and infants at high risk.

2021 22 RECOMMENDATION 5: CLOSED COMPLETE

Promoting the safety of children with disability (Recommendation 6: 2021–22)

The Board recommended that the Queensland Government engages 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 Board expects the outcomes of the engagement to be reported back to it by August 2023.

2024 Update

In 2022, the Queensland Government supported Recommendation 6 in principle, acknowledging that access to the NDIS is primarily the responsibility of the Commonwealth Government and that implementation of the recommendation depends on collaboration with the Commonwealth on this national program. The government noted the potential for significant recommendations to arise from the Independent Review of the NDIS, expected in October 2023, which may impact NDIS access processes. Consequently, a report back to the Board by August 2023 could not be achieved.

The Queensland Government highlighted its commitment to improving NDIS access, including the ongoing support provided through the Assessment and Referral Team (ART) Program. This program assists at-risk children and young people in accessing the NDIS and helps build the capacity of government agencies to navigate the NDIS access pathway more effectively. The government continues to work with the Commonwealth and other NDIS governing partners to simplify and improve access processes for vulnerable and complex groups.

Further, as part of the 2023–24 Queensland Budget, the government allocated $16.2 million over four years, with $2 million per annum ongoing, to:

- support at-risk children and young people in accessing the NDIS until December 2024
- establish a specialist disability assessment team from January 2025 to help individuals with complex needs navigate multiple service systems to access NDIS services.

In 2023 the Board observed that the Queensland Government's advocacy for simpler NDIS access processes was ongoing, and it welcomed the allocated funding, while noting its time-limited nature. The Board emphasised the importance of tracking this expenditure and evaluating the cost-benefit or return on investment, in line with its recommendation. The Board also agreed that the outcomes of the Independent Review of the NDIS will influence the government's approach to supporting vulnerable children and families. Continued strong advocacy for improving NDIS access mechanisms for children and families with complex needs will fulfill the Board's recommendation.

In 2024 Child Safety advised that $16.2 million has been committed to continue the existing operation of the ART until December 2024 and from January 2025 ongoing, a small specialist team will support eligible people with complex needs navigating multiple mainstream services to access the NDIS. As part of this, $4.669 million is committed to continue the work of the ART in 2024–25 to support at-risk and disadvantaged Queenslanders to access the NDIS.

At 31 July 2024, 1,475 people have been supported by ART's intensive case management and clinical services model to access the NDIS since July 2022.

In response to changes to the National Disability Insurance Agency's access pathway in late 2023, the Assessment and Referral Team refocused its efforts from 18 December 2023 to support Queenslanders aged seven to 64 years who live in remote or very remote locations where their partner services do not operate. In addition, ART has continued to support the following vulnerable cohorts of people regardless of where they live in Queensland:

- young people connected to the Youth Justice Stronger Communities Initiative or who are identified as a serious repeat offender children or young people in the child protection system
- adults living in community and connected to offender support programs
- adults living in Level 3 Supported Accommodation
- people who identify as culturally and linguistically diverse and are engaged with resettlement and refugee programs.

The government also confirmed it was engaging with Commonwealth Government to improve the mechanisms by which children and parents with complex needs can enter and access the NDIS. Specifically:

- The Independent Review of the NDIS considered the Scheme's design, operations and sustainability. The NDIS Review final report was published on 7 December 2023 and made 26 recommendations and 139 supporting actions. The Review included recommendations to reform access to the NDIS, including specific recommendations to reform the pathway for all children under 9 to enter the NDIS under early intervention requirements and to introduce a more consistent and robust approach to assessing developmental delay. The NDIS Review also recommended National Cabinet jointly design, fund and commission foundational supports for people with disability outside of the NDIS. This recommendation includes investment in capacity building programs for families and caregivers of children with development concerns and disability; and in early supports for children with emerging development concerns and disability.
- On 6 December 2023, National Cabinet, as an initial response to the Review, committed to work together to implement legislative and other changes to improve the NDIS, including to commission and fund additional foundational supports.
- Throughout 2023–24 the Queensland Government has continued to work closely with the Commonwealth and other state and territory governments to negotiate implementation of the National Cabinet agreement. Queensland contributed to a Council for the Australian Federation submission to the Commonwealth Senate setting out collective state and territory concerns about the Bill, with the primary concern being that the amendments must only commence once a foundational support system has been established and all rules that detail how the NDIS will be changed have been developed jointly with all stakeholders.
- The Commonwealth introduced a NDIS Amendment (Getting the NDIS Back on Track No. 1) Bill in March 2024, which proposes a process to change how people access the NDIS, including assessments, management of plans and funding.
- the Commonwealth Government tabled the Disability Royal Commission Final Report in the Australian Parliament on 29 September 2023. Of the 222 Royal Commission recommendations, 130 were directed to state and territory governments. The Queensland Government continued to work with other jurisdictions to prepare a joint response to the recommendations.
- Queensland also continued work to develop a Queensland Disability Reform Framework to provide a cohesive approach to responding to the royal commission and NDIS Review.

Board Observations

Based on the above, the Board considers that its recommendation has been actioned, and the circumstances of the system that led to the recommendation no longer exist. This does not mean that the Board is confident that parents of children with disabilities will find it easier to access disability support. The Board continues to hold concerns that the disability, health and child safety systems continue to create service system gaps and barriers that make it difficult for parents (especially those with intersecting vulnerabilities) to access support for their child. This is affirmed in recommendation 5 in this year's annual report.

2021 22 RECOMMENDATION 6: CLOSED NOT COMPLETE

2020–21 Recommendation 5

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs and Queensland Health addresses 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 Board, 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 services 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.

2024 Update

The Queensland Government accepted Recommendation 5, acknowledging Child Safety and Queensland Health's commitment to improving inter-agency coordination for children and families with specific health needs. It explained that in 2021–22, the agencies established a cross-agency working group to define and implement activities aligned with the recommendation. In 2022–23, the working group facilitated a focus group session on the four priority areas at the Queensland Health Child Protection Liaison Officer Conference. The resulting paper, *Seeking, Weighting and Engaging Health Findings*, was released internally in December 2022 to promote local awareness among Hospital and Health Services and Child Safety Service Centres.

Queensland Health also undertook several activities to improve inter-agency coordination, including:

- Publishing an interactive child protection contact list to streamline communication between Queensland Health employees and Child Safety Units,
- Updating the *Responding to an Unborn Child High Risk Alert* guideline and accompanying forms to improve coordination for unborn children suspected to be at risk,
- Launching the *Supporting all Families Everyday* child protection online education modules in September 2023 to address child protection training for Queensland Health staff,
- Continuing collaboration to implement Child Safety's Unify system.

In 2023, the Board recognised the progress made in improving relationships and coordination between Child Safety and Queensland Health but emphasised the need for evidence of strengthened practices before closing the recommendation. Specific areas requiring further action include:

- Encouraging greater engagement with Aboriginal and Torres Strait Islander community-controlled health services and embedding cultural expertise into practice,
- Addressing changes to Child Safety Officer (Health Liaison) roles, particularly in promoting stakeholder relationships with Aboriginal and Torres Strait Islander health services

In 2024 the Department of Child Safety confirmed that:

- the Child Safety Practice Manual was updated to strengthen the requirements in relation to comprehensive health assessments for children in departmental care. Current practice guidance explicitly requires departmental officers to give Aboriginal or Torres Strait Islander children the opportunity to attend an Aboriginal and Torres Strait Islander community-controlled health service. The availability of '715 Health Checks' funded under Medicare are also promoted in associated practice guidance.
- SCAN teams are in place across the state and are a partnership between the department, QPS, Queensland Health and Education. SCAN teams meet regularly to discuss complex cases requiring a multiagency response and are required to invite key stakeholders involved with the child or family to attend meetings, including Aboriginal and Torres Strait Islander community-controlled health services. The responsibility to invite key stakeholders, in particular Aboriginal and Torres Strait Islander community-controlled health services where there is current involvement with a child and family has been promoted to SCAN teams.

- Child Safety regions work closely with Aboriginal and Torres Strait Islander community-controlled health services to ensure pathways for services for Aboriginal and Torres Strait Islander children and their families. Child Safety would not be able to provide data on how many referrals are made to services run by Aboriginal and Torres Strait Islander community-controlled health services as this is not data held by Child Safety.
- In 2024, the Senior Health Liaison Officer role profile was updated to explicitly include the additional responsibilities recommended by the Board. Child Safety and Queensland Health continue to partner to strengthen local liaison role and Health and Hospital Services relationships.

Board Observations

Based on these actions the Board is satisfied sufficient action and attention has been taken in response to the 2020–21 recommendation.

2020 21 RECOMMENDATION 5: CLOSED COMPLETE

Schedule of Closed Board Recommendations

2021–22

Recommendation 4: The Board recognises there is significant reform occurring in the area of domestic and family violence. The Board recommended 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.

2020–21

Recommendation 1: 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 QFCC's evaluations of the reform program could also inform this work.

The Board also recommends: The Department of Children, Youth Justice and Multicultural Affairs strengthens its model of funded secondary services and:

1.2 develops and implements best practice and culturally responsive strategies to improve outcomes for children and families

1.3 supports and strengthens 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

Recommendation 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 CCR are recorded
- patterns of parental behaviour (acts or omissions)
- cultural factors.

To support this, Child Safety's Workload Management Manual should include guidance on reasonable workloads for intake.

Recommendation 3: The Department of Children, Youth Justice and Multicultural Affairs develops 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.

Recommendation 4: The Department of Children, Youth Justice and Multicultural Affairs builds 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 I&A, 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: – limited supply of, and timely access to, supports and services in regional and remote areas – (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 Board and the QFCC's systemic review of IPA may be used to develop this training.

Recommendation 6: The Queensland Mental Health Commission's Shifting minds Strategic Leadership Group, as the senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland, developed 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 Board 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 for consumers who currently do not have their needs met by child and adolescent mental health services or ETS
- 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.

Recommendation 7: The Department of Children, Youth Justice and Multicultural Affairs:

7.1 immediately examines why less than 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 one developed.

7.2 reviews its 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
- 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

Recommendation 8: The Queensland Mental Health Commission and the QFCC 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.

Recommendation 9: The Department of Education undertakes 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.

Recommendation 10: The Board recommended 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.

CHAPTER 9

Governance

The Board held five meetings in 2023–24. Principal Commissioner Luke Twyford presided as Chair at four meetings. The Deputy Chair, Ms Simone Jackson, presided as Chair at Meeting #20. A quorum[183] was present at all meetings. Meetings were:

Meeting 18 — 19 September 2023. At this meeting, the Board reviewed 13 cases.

Meeting 19 — 29 November 2023. At this meeting:

- the Board reviewed nine cases.
- Deputy State Coroner Stephanie Gallagher, Coroners Court of Queensland and Chairperson of the Domestic and Family Violence Death Review Board attended as a guest observer. The Board collaborates with this board to reduce duplication and share learnings.
- the Board received a presentation on Positive Behaviour Support, a PeakCare Queensland masterclass on the appropriate use of restrictive practices and secure care for staff working with young people in residential care with complex behaviours. This virtual presentation was by Mr Tom Allsop, Chief Executive Officer and Ms Jennifer Inoue, Innovation Lead, PeakCare Queensland.
- the Board received a presentation regarding the findings of the QFCC's *Growing Up in Queensland* project by the manager and principal advisor of the Analysis, Insights and Reporting team.

Meeting 20 — 29 February 2024. At this meeting, the Board reviewed 16 cases and received a presentation on Enhanced Intake and Assessment approach from Board member, Dr Meegan Crawford, Chief Practitioner and Ms Sandra Tucker, Director of Statewide Operations, Child Safety.

Meeting 21 — 17 April 2024. At this meeting, the Board reviewed 13 cases and received a presentation on Gillick Competency from Board member, Dr Stephen Stathis, Medical Director of CYMHS, Children's Health Queensland. An additional out-of-session meeting was held on 29 May 2024, between meetings 21 and 22. The Chair presided over the meeting and eight of the eleven members were in attendance. The duration of the meeting was one hour.

Meeting 22 — 19 June 2024. At this meeting, the Board reviewed 19 cases.

The Board hosted an induction meeting on 6 September 2023 for the new non-government members that had been appointed by the Attorney-General in July 2023. Four non-government members and the Chair were in attendance.

Child Death Review and Advisory Board members

The Board consists of a Chair and eleven members. Members include both government and non-government persons with a requirement that government members not constitute a majority. The *Family and Child Commission Act 2014* sets out requirements for the Board's composition, such as the appointment of an Aboriginal or Torres Strait Islander person as the Chair or Deputy Chair, and membership that comprises specialist knowledge in relevant fields.[184]

Recruitment

Board members are appointed for a term of three years. The current three-year appointment terms commenced on 1 July 2024. In preparation for the appointments, the QFCC partnered with DJAG between January and June 2023 to undertake a significant recruitment process. There was a strong aspiration to increase Aboriginal and Torres Strait Islander membership on the Board. The QFCC led a digital and media campaign to encourage applications from across Queensland and provided to DJAG a list of applicants together with their expertise and knowledge.

In 2023–24, the Attorney-General appointed five new non-government Board members: Mr Murray Benton, Associate Professor Divna Haslam, Ms Elizabeth McNamara, Ms Carly Jacobitz and Dr Marlene Longbottom. The new members bring expertise in child and adolescent mental health, child sexual exploitation prevention, housing and homelessness, domestic and family violence support, frontline child protection, and child maltreatment research.

Sitting non-government Board member, Simone Jackson, was appointed to the role of Deputy Chairperson, recognising her significant experience across Queensland's human services sectors and her commitment to reducing the over-representation of First Nations children involved with youth justice and child protection systems.

The five government Board representatives (either individual or positional appointment) from within Child Safety, Youth Justice, Queensland, Education and QPS were reconfirmed in 2023–24.

183 See *Family and Child Commission Act 2014*, s. 29ZF.
184 *Family and Child Commission Act 2014*, s. 29W-29Y.

Members

The Child Death Review Board Chair: Commissioner Luke Twyford

Luke Twyford was appointed as the Board Chair in March 2022. Luke's career spans more than 20 years across Commonwealth, New South Wales and Northern Territory governments in the areas of reform, research and evidence, integrity, audit, governance and complaints management. Prior to joining the QFCC, Luke worked for nine years with the Northern Territory Government, leading critical reform of the child protection and youth justice system and its legal frameworks.

Luke holds a Bachelor of Laws with Honours from the University of Wollongong. He has extensive experience providing evidence to courts, inquiries and commissions. Luke's parents fostered a number of children throughout his childhood, with his own lived experience and those of his foster brothers and sisters profoundly shaping the perspective he brings to his work and his passion in advocating for the safety and wellbeing of children and young people.

Deputy Chair: Simone Jackson

Simone Jackson is a proud Kamilaroi woman from Southwest Queensland and an accomplished Government Executive with over 20 years' experience as a public servant and over the past 11 years has worked in Senior Government roles. Simone has worked in roles relating to justice and human services across two jurisdictions (Queensland and Northern Territory). Simone is currently the Chief Executive Officer, Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health) and is responsible for the Aboriginal community-controlled health response operating across West Moreton, over three clinical sites, Ipswich, Booval and Laidley. Kambu Health also has Amaroo Kindergarten and a Long Day Centre, Children, and family services as well as operating programs funded through numerous state and commonwealth departments. Simone has been a member of the Queensland Parole Board since 2017.

Murray Benton

Murray Benton is a proud Aboriginal Barkindji Koori man from Central West New South Wales. He is a valued part of the team at Q Shelter, Queensland's peak body advocating for housing solutions and addressing homelessness. Murray leads Community Housing Futures Queensland, driving initiatives with community housing providers to meet housing needs across the state.

Murray brings extensive experience in the not-for-profit community sector, with particular expertise in specialist homelessness services, and the child, youth, and family space. His background spans crisis response and specialist homelessness services, intensive case management, emergency relief, primary health and antenatal care, sexual and reproductive health, natural disaster recovery, domestic and family violence including refuge settings, multicultural migrant support, community housing and the development of Queensland's first local housing action plan. He has a proven track record of successful public advocacy on issues impacting young people, and Aboriginal and Torres Strait Islander peoples.

Dr Marlene Longbottom

Dr Marlene Longbottom is a Yuin woman, from Roseby Park mission (Jerrinja) on the South Coast of NSW and is an Associate Professor with the Indigenous Education and Research Centre at James Cook University.

Marlene's research experience spans over fifteen years where she has collaboratively designed, implemented community-based research and evaluation projects of benefit, that are priority driven by the Indigenous community in both Aboriginal and Torres Strait Islander communities in urban, regional and remote communities in New South Wales, Queensland. She has expertise in research in service systems and service provision to Indigenous communities in both Community Controlled and government sectors.

Dr Longbottom is frequently requested to provide expert opinion and advice to government on Indigenous issues in areas related to her work in violence, trauma and social justice matters.

Associate Professor Divna Haslam

Associate Professor Haslam is a registered clinical psychologist with a PhD in the field parenting. She is a childhood adversity researcher based at the University of Queensland. Her work aims to ensure all children have access to the safe, loving, violence-free childhoods they need to thrive. This has involved a broad range of work from substantial work in field of evidence-based parenting supports through to epidemiological work in child maltreatment and adverse childhood experiences, most notably on the Australian Child Maltreatment Study. She is currently co-leading the Third Australian Survey of Child and Adolescent Wellbeing known as Young Minds: Our Future. Associate Professor Haslam has served as a consultant to the Australian Government for multiple projects in the field of child maltreatment and child and adolescent wellbeing, and to governments internationally about population-based prevention programs that target modifiable family-related risk and protective factors. She has published extensively in leading international journals. Associate Professor Haslam has a strong belief in the importance of prevention and is committed to conducting and using gold standard scientific research to improve the lives of children and families. Associate Professor Haslam is also a Director of the Parenting and Family Research Alliance and an Associate Editor for the Australian Journal of Social Issues, a policy masthead in Australia.

Carly Jacobitz

Carly is the current Deputy Chief Executive (Child, Youth and Family) at Life Without Barriers. She brings a unique perspective derived from experience in both front line statutory child protection and nationally with one of Australia's largest out of home care providers. Carly has developed a strong understanding of child protection systems across all states and territories and has a deep commitment to evidence-based practice.

Carly has undergraduate qualifications in business and postgraduate qualifications in psychology and is a registered psychologist with the Australian Health Practitioner Regulation Agency. She is a graduate of the Australian Institute of Company Directors and a Non-Executive Director with both PeakCare and DVConnect. Previously, Carly has served on Queensland's Truth, Healing and Reconciliation Taskforce working to embed the recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse.

Beth McNamara

Beth McNamara is a qualified social worker. She has worked in violence prevention for over 15 years, specifically in the areas of child sexual abuse and domestic and family violence. Her career started in the Western Sydney suburb of Mt Druitt where she worked for seven years as a child sexual assault and domestic and family violence counsellor. A career highlight was working at the Royal Commission into Institutional Responses to Child Sexual Abuse, from its inception in 2013 to its conclusion in 2017, as a counsellor and lead policy writer.

In her current role as National Education Manager for the Daniel Morcombe Foundation, Beth oversees a number of primary prevention projects which aim to enhance national approaches to child safety education. Through the Daniel Morcombe Foundation's Walk Tall Therapy program, Beth also provides trauma-informed counselling to child victims of crime and their caregivers, one to two days a week. Working alongside children and their families and witnessing their resistance to violence, keeps Beth grounded in the work that matters most.

Government members

Government appointments to the Board can either be a personal appointment of a specific person or based on a relevant position within an agency. As different officers occupy the agency's nominated position, they automatically become the agency's Board member.

Child Safety

The Board position within Child Safety is the Chief Practitioner. Dr Meegan Crawford is the Chief Practitioner of Child Safety, Queensland. After graduating as a social worker, Meegan commenced her career over 30 years ago as a CSO. Meegan has worked in a variety of roles in the department including Senior Team Leader, Senior Training Officer, Manager, Director, Executive Director and Regional Executive Director and has worked as an academic and research assistant for Griffith University. As the Chief Practitioner Meegan reports directly to the Director General and has oversight of the teams responsible for child death and serious injury reviews; child safety complaints; child safety training; operational policy, practice development and guidance; delegated authority; NDIS interface; sexual abuse and exploitation, and partnerships and projects.

Youth Justice

The Board position within Youth Justice is the Senior Executive Director, Youth Justice Workforce and Practice. Mr Darren Hegarty occupies this position. Darren has led a number of positive and significant reforms for children and young people in both the youth justice and child protection systems. These include the Youth Justice Strategy and Action Plans, Out of Home Care Reinvestment program, including Queensland's first Mental Health Recovery Residential, improved service delivery frameworks within Child Safety, targeted outcomes for Aboriginal and Torres Strait Islander families, stronger engagement with community Elder groups and Aboriginal and Torres Strait Islander service providers, and the re-focused investment in Intensive Family Support for children and young people. Darren has extensive experience in providing innovative approaches to solving complex problems within the human services sector.

Queensland Health

The Board representative for Queensland Health is Dr Stephen Stathis. Dr Stathis is the Medical Director of CYMHS, Children's Health Queensland. Stephen obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child and Adolescent Psychiatry and Forensic Psychiatry. Stephen is currently the Medical Director of CYMHS, Children's Health Queensland. He also acts as the Clinical Advisor to the Mental Health Alcohol and Other Drugs Branch for child and youth mental health. Stephen has extensive experience working among vulnerable and marginalised young people within the community. His clinical interests include 'bridging the gap' between paediatrics and psychiatry, mental health policy and strategic planning, gender dysphoria, consequences of early childhood trauma and abuse, and adolescent forensic psychiatry.

Department of Education

From July 2023 to May 2024 the Board representative for the Department of Education was Ms Hayley Stevenson. Ms Stevenson was Assistant Director-General. In May 2024, the Department of Education's representation on the Board became the position of the Assistant Director-General, Disability, Inclusion and Student Services. Ms Robyn Albury occupies this position. Prior to this position, Robyn held the position of Executive Director, Governance Strategy and Planning. As the Assistant Director-General, Disability, Inclusion and Student Services, Robyn is responsible for leading the policy development and implementation of key initiatives relating to student engagement, mental health and wellbeing, student protection, support and resourcing for students with disability, student behaviour and inclusion. Robyn is committed to supporting the Department of Education's policy and operational alignment to the implementation of the Equity and Excellence strategy to realise the full potential of every student.

Queensland Police Service

The Board position within the QPS is the Detective Superintendent Child Abuse and Sexual Crime Group. Detective Superintendent Denzil Clark occupied this position for the first Board meeting in 2023–24, followed by Detective Acting Superintendent Stephen Blanchfield who occupied this position for subsequent meetings.

Stephen has over 30 years policing experience, with more than 20 years as an investigator. Stephen has worked in regional two-person stations and in challenging urban areas. He commenced in the specialised field of child protection in 1991. He worked in Homicide, Child Abuse and Sexual Crime and other areas within Crime and Intelligence Command. He was awarded a Commissioners Certificate for his role as Investigations Leader into the murder of Daniel Morcombe.

In December 2015 he was promoted to Detective Inspector, Major and Organised Crime Squad, South Eastern Region. In October 2018 he returned to child protection as Operations Manager, Child Trauma and Sexual Crime Unit, Crime and Intelligence Command.

Attendance

Figure 26: Attendance at Board meetings in 2023–24.

Member (person or position)	Agency	Meeting 18 19/09/2023	Meeting 19 29/11/2023	Meeting 20 29/02/2024	Meeting 21 17/04/2024	Meeting 22 19/06/2024
Luke Twyford	QFCC (Chair)	Present	Present	Present	Present	Present
Simone Jackson	Non-government (Deputy Chair)	Present	Present: (Chair)	Present	Apology	Present
Murray Benton	Non-government	Present	Present	Present	Present	Present
Divna Haslam	Non-government	Present	Present	Present	Present	Present
Carly Jacobitz	Non-government	Present	Present	Present	Present	Present
Beth McNamara	Non-government	Present	Present	Present	Present	Present
Marlene Longbottom	Non-government	N/A – Position appointed 14 March 2024			Present: via video call	Present: via video call
Chief Practitioner	Child Safety	Present: Charmaine Matebau	Present: Meegan Crawford	Present: Meegan Crawford	Present: Meegan Crawford	Present: Victoria Van Houdt
Hayley Stevenson	Education	Apology Proxy: Lisa Shield	Present	Present	Apology Proxy: Robyn Albury	N/A
Assistant DG, Disability, Inclusion and Student Services	Education	N/A – Position appointed 7 May 2024				Present: Robyn Albury
Stephen Stathis	Queensland Health	Present	Present	Present	Present	Apology Proxy: Dylan Hampson
Senior Executive Director, Youth Justice Workforce and Practice	Youth Justice	Present: Darren Hegarty	Apology	Present: Darren Hegarty	Present: Darren Hegarty - via video call	Apology
Detective Superintendent CASCG	QPS	Present: Glen Donaldson	Present: Stephen Blanchfield	Present: Stephen Blanchfield	Present: Stephen Blanchfield	Present: Stephen Blanchfield - via video call

Conflicts of interest

The Board members disclosed a personal interest relating to a review as required by legislation[185] on one occasion. The interest disclosed involved a non-government member who was employed by a child and family support organisation that had provided services to two children being discussed by the Board at that meeting. After consideration of the disclosure, the Board agreed that the member would not participate in the case review discussion.

Stakeholder engagement and partnerships

The Board continued to maintain professional relationships with a range of stakeholders throughout 2023–24. Stakeholders supported the Board by:

- undertaking internal agency reviews and providing insights into relevant legislation, policies, procedures and practices
- providing insights into the experiences of individuals, families or communities or contributed expertise on matters that affect them
- contributing data, research or expertise to inform the Board's work
- carrying out similar review functions in other Australian jurisdictions
- implementing, or assisting in the implementation of, system changes recommended by the Board
- sharing the Board's key messages to a wider audience.

A cross-agency working group was established in 2020 to develop operational guidelines for agency reviews following the death or serious physical injury of a child. Chaired by the Board Secretariat, the group met on four occasions during 2023–24 to monitor the number of upcoming internal agency reviews and discuss death review processes and emerging issues.

The Board is also a member of the Australian and New Zealand Child Death Review and Prevention Group. Through this group, the Board is able to engage and share learnings with similar interstate entities.

Commissioned research

In 2022–23, the Board commissioned research to better understand how parental methamphetamine use impacts the health and wellbeing of children, particularly on children under three years of age. This research followed observations from the about the increase in methamphetamine use among parents involved with child cases reviewed by the Board.

The research, conducted with the University of Queensland's Poche Centre for Indigenous Health, identifies potential opportunities for system improvements to respond to and reduce the risk of harm to children known to the child protection system. It includes an analysis of 32 de-identified cases where there was evidence of parental methamphetamine use in the 12 months prior to a child's death. It serves as a critical piece of awareness raising and will be shared with frontline workers to provide additional guidance on better responding to and supporting parents who use methamphetamine.

The research report, *Risks for children caused by Methamphetamine use by parents*, was published in May 2024. The full research report is available at www.qfcc.qld.gov.au/board/publications.

Promoting our work

The Board maintains a web presence at www.qfcc.qld.gov.au/board, which provides information about its structure, functions and work.

Between 1 July 2023 and 30 June 2024, the Board and its work featured in 493 media items, with a combined potential audience reach of 22.9 million across Australia. Media items comprised:

- 431 online items (estimated audience reach 20 million)
- 8 print items (estimated audience reach 2.5 million)
- 50 radio items (estimated audience reach 391,000)
- 4 TV items (estimated audience reach 120,000)

185 Family and Child Commission Act 2014, s. 29ZJ.

Media items focused on:

- the Final Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, handed down in September 2023
- the release of the Annual Report 2022–23, with particular interest in chapters about youth justice and home schooling
- the release of the research report commissioned by the Board, *Risks for children caused by Methamphetamine use by parents*, and its discussion during a coronial inquest into the death of two young siblings in May 2024.

During the same period, the Board and its work featured in seven posts on LinkedIn, which reached a combined audience of 68,125. The social media posts included:

- First Nations highlights (10,369 views)
- Risks for children caused by Methamphetamine use by parents (13,999 views)
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (16,899 views)
- Home education (1,936 views)
- Annual Report 2022–23 (19,988 views)
- Common trajectories (5,367 views)
- New Board members (367 views).

Information requests

Pursuant to s29P of the *Family and Child Commission Act 2014*, the Board Chair is able to request information to support the Board to carry out its reviews.

The Chair used s29P information request powers on three occasions in 2023–24 to request additional information about services provided to a child from non-government entities. On all occasions, the entities supplied the requested information within a timely manner.

Coronial information requests

Some child deaths reviewed by the Board are reportable to the Queensland Coroner[186]. Where a reportable death has been reviewed by the Board, the Queensland Coroner may submit a *Requirement by Coroner for Information* request, identified as a Form 25 request, as per section 16(2) of *Coroners Act 2003* (Qld), to obtain a copy of the Board's review and findings.

During the 2023–24 reporting period, the Board complied with eight Form 25 requests.

The Board is committed to reducing duplication through regular collaboration with the Coroners Court of Queensland, including the Domestic and Family Violence Death Review and Advisory Board[187].

Risk management

The Secretariat, on behalf of The Board's, maintains the Board strategic risk register in compliance with the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*. These require that all accountable officers and statutory bodies establish and maintain appropriate systems of internal control and risk management. The Board's strategic risk register captures and monitors strategic and operational risks for the Board. For purposes of accountability, it is presented six-monthly to the QFCC's Audit and Risk Management Committee.

186 Requirements for a reportable death is available from Coroners Court of Queensland's website at https://www.coronerscourt.qld.gov.au/about-our-court/reportable-deaths

187 Learn more about the Domestic and Family Violence Death Review and Advisory Board at https://www.coronerscourt.qld.gov.au/dfvdrab

Appendices

Appendix 1
Glossary of terms and acronyms

Term or acronym	Meaning
Agencies and organisations	
Board members/ members	Members of the Child Death Review Board
the Board	Child Death Review Board
CYMHS	Child and Youth Mental Health Services
Child Safety	Department of Child Safety, Seniors and Disability Services. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.
DPC	Department of the Premier and Cabinet
DJAG	Department of Justice and Attorney-General
Education	Department of Education
ETS	Evolve Therapeutic Services
ODCPL	Office of the Director of Child Protection Litigation. The ODCPL supports the functions of the Director of Child Protection Litigation (DCPL) including by conducting the child death and serious physical injury reviews.
QAO	Queensland Audit Office
QATSICPP	Queensland Aboriginal and Torres Strait Islander Child Protection Peak
QFCC	Queensland Family and Child Commission
QH/Health	Queensland Health (includes hospitals and health services)
QMHC	Queensland Mental Health Commission
QPS	Queensland Police Service
Review agencies	These are the agencies required to undertake reviews following the death or serious physical injury of a child as defined in section 245B – see *relevant agency* - of the *Child Protection Act 1999*. These are: the Department of Education (Education), the Department of Child Safety, Seniors and Disability Services (Child Safety), the Department of Youth Justice (Youth Justice), Queensland Health (includes Hospital and Health Services) and the Queensland Police Service. The term 'review agencies' also includes the Director of Child Protection Litigation defined in section 245J of the *Child Protection Act 1999* (noting its review scope is different to that of the other review agencies).
Youth Justice	The Department of Youth Justice, Employment, Small Business and Training. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.
Child protection terms[188]	
Child Concern Report (CCR)	A Child Concern Report is a record of child protection concerns received by Child Safety that does not meet the threshold for a notification.
Child in need of protection	This is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering from harm, and does not have a parent able and willing to protect the child from the harm (*Child Protection Act 1999*, section 10).
Aboriginal and Torres Strait Islander Child Placement Principle	The Aboriginal and Torres Strait Islander Child Placement Principle aims to keep children connected to their families, communities, culture and country and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children's care and protection. The Principle centres on five elements: prevention, partnership, participation, placement and connection.

188 See Glos ary | Child Safety Practice Manual (csyw.qld.gov.au)

Term or acronym	Meaning
Child Safety Officer (CSO)	A Child Safety Officer is authorised, under the Child Protection Act 1999, to: • deliver statutory child protection services, such as investigating and assessing allegations of suspected child abuse and neglect • intervene to ensure the safety and wellbeing of children subject to ongoing intervention, in accordance with legislation, policies and procedures.
Cumulative harm	This refers to harm to a child caused by a series or combination of acts, omissions or circumstances that may have a cumulative effect on the child's safety and wellbeing. The acts, omissions or circumstances may apply at a particular point in time or over an extended period, or the same acts, omissions or circumstance may be repeated over time.
Domestic and family violence	Domestic and family violence is behaviour by a person towards another person with whom the person is in a relevant relationship. It includes behaviour that is: physically or sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the other person and causes them to fear for their safety or wellbeing or that of someone else.
Family and Child Connect (FaCC) service	Family and Child Connect are funded non-government community-based intake and referral services that helps families to care for and protect their children at home. Family and Child Connect support vulnerable families by assessing their needs and connecting them with appropriate support services.
Family Wellbeing Service (FWS)	The Aboriginal and Torres Strait Islander Family Wellbeing Service is a program co-designed with the community-controlled sector and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak. Family Wellbeing Services are designed to make it easier for Aboriginal and Torres Strait Islander families across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and to build their capacity to safely care for and protect their children.
Harm	In this context, harm refers to any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation. Harm can be caused by a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances (*Child Protection Act 1999*, section 9).
Indigenous Program Coordinator (IPC)	Coordinates Indigenous programs
Intake	Intake refers to the process by which Child Safety receives and gathers information about harm or risk of harm to a child or an unborn child who may be at risk of harm after he or she is born, and determines the appropriate response to the information received. Intake processes are initiated when professionals, family members or members of the public contact a Regional Intake Service or a Child Safety Service Centre with concerns about a child.
Intake enquiry	An intake enquiry may be a request for information or relate to child wellbeing issues or child protection concerns. It is one type of departmental response to information received at the intake phase.
Intensive Family Support (IFS) programs	Intensive Family Support programs provide case management to families at risk of entering the statutory child protection system.
Intervention with parental agreement (IPA)	This refers to ongoing intervention with a child who is considered in need of protection, based on the agreement of the child's parent/s to work with the department to meet the child's safety and protection needs.
Investigation and assessment (I&A)	Investigation and assessment is the second phase of the child protection continuum. An investigation and assessment is the departmental response to all notifications and is the process of assessing the child's need for protection where there are allegations of harm or risk of harm to a child (*Child Protection Act 1999*, section 14).

Term or acronym	Meaning
Multi-Agency Collaborative Panels (MAC-Ps)	The Multi-Agency Collaborative Panels involve relevant government and non-government organisations who work together to coordinate service delivery and address systemic barriers that contribute to high-risk young people's offending, including young people engaged in serious repeat offending.
Non-government organisation	In this context, this refers to a not-for-profit organisation that receives government funding specifically for the purpose of providing community support services.
Notification	A notification is recorded when information is received about a child who may be harmed or at risk of harm that requires an investigation and assessment response. A notification is also recorded on an unborn child if there is reasonable suspicion that they will be at risk of harm after they are born.
Out-of-home care / care	This refers to placements of children, subject to statutory child protection intervention, using the authority of the *Child Protection Act 1999*, section 82(1). Out-of-home care includes placements with a licensed care service, an approved or kinship carer, or another entity.
Parent able and willing	This refers to a parent who has both the ability and willingness to protect their child from harm (*Child Protection Act 1999*, section 10). A parent may be willing to protect a child, but not have the means or capacity to do so. For example, a parent with a diagnosed mental illness may express a willingness to protect their child; however, due to factors related to the mental illness, may not be able to do so. Alternatively, a parent may have the means and capacity to protect a child but may not do so. A Child Safety Officer must clearly assess the parent's motivation and ability to protect the child. In circumstances where a child resides across two households, the ability and willingness of both parents to protect the child needs to be assessed.
Placement	This refers to when a child is placed in an out-of-home care living arrangement due to intervention by the department.
Regional intake service	This is the contact point for reporting concerns about a child. There are seven regional intake service locations across Queensland. They receive incoming calls and reports, assess the information and decide how to respond.
SCAN	Suspected Child Abuse and Neglect
Serious Repeat Offender Index (SROI)	This refers to an index to identify serious repeat offenders based on a range of factors, including number of charges over the last 2 years, severity of offences, time spent in custody, and the offender's age.
SPRC	Systems and Practice Review Committee
Other	
Adverse childhood experience (ACE)	Adverse childhood experiences can include abuse, neglect and household dysfunction. 'Adverse childhood experience' is generally seen as a mental health term, where the more a child experiences, the greater the likelihood of negative impacts on the child's physical and mental health. These include negative impacts on gene function and brain structure.
Assessment and Referral Team (ART)	Refers to the assistance team for Queenslanders aged seven to 64 with disability to join the National Disability Insurance Scheme (NDIS).
ADHD	Attention Deficit Hyperactivity Disorder
Child Death Register	The Queensland Child Death Register records the deaths of all children and young people who die in Queensland. It is maintained by the QFCC.
CALD	Culturally and Linguistically Diverse
DVO	Domestic Violence Order
GP	General Practitioner
NDDA	National Disability Data Asset
OPG	Office of the Public Guardian

Term or acronym	Meaning
Post-traumatic stress disorder (PTSD)	Post-traumatic stress disorder is a treatable anxiety disorder that occurs when fear, anxiety and memories of a traumatic event remain and interfere with how people cope with everyday life.
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
Roadmap	A Roadmap for Contemporary Residential Care in Queensland - a Queensland Government review led by Child Safety and overseen by the QFCC Principal Commissioner and Board Chair Luke Twyford.
Sudden unexpected death in infancy (SUDI)	Sudden unexpected death in infancy is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause.
The Royal Commission	The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability - established by the Australian Government In April 2019.

Appendix 2
Remuneration of the Child Death Review Board

Child Death Review Board (the Board)					
Act or instrument	*Family and Child Commission Act 2014*				
Functions	Undertake systemic reviews following the deaths of children connected to the child protection system and make recommendations to improve the child protection system and to prevent the deaths of children.				
Achievements	The Board met on five occasions in 2023–24. A total of 70 child deaths were reviewed in this period. One research project was commissioned.				
Financial reporting	The Board is audited as part of the QFCC. Accounts are published in the annual report.				
Remuneration					
Position	Name	Meetings attended	Approved annual fee	Approved sub-committee fees if applicable	Actual fees received
Chair (government)	Luke Twyford	5	$0	N/A	$0
Deputy Chair (non-government)	Simone Jackson	4	$4500	N/A	$4500
Member (non-government)	Murray Benton	5	$4500	N/A	$4500
Member (non-government)	Divna Haslam	5	$4500	N/A	$4500
Member (non-government)	Carly Jacobitz	5	$4500	N/A	$4500
Member (non-government)	Beth McNamara	5	$4500	N/A	$4500
Member (non-government)	Marlene Longbottom	2	$4500	N/A	$1125
Member (government)	Meegan Crawford	3	$0	N/A	$0
Member (government)	Charmaine Matebau	1	$0	N/A	$0
Member (government)	Victoria Van Houdt	1	$0	N/A	$0
Member (government)	Hayley Stevenson	2	$0	N/A	$0
Member (government)	Lisa Shields	1	$0	N/A	$0
Member (government)	Robyn Albury	2	$0	N/A	$0
Member (government)	Stephen Stathis	4	$0	N/A	$0
Member (government)	Dylan Hampson	1	$0	N/A	$0
Member (government)	Darren Hegarty	3	$0	N/A	$0
Member (government)	Glen Donaldson	1	$0	N/A	$0
Member (government)	Stephen Blanchfield	4	$0	N/A	$0
Number of scheduled meetings/sessions	5				
Total superannuation paid (non-government)	$2598.75				
Total out-of-pocket expenses	$0 (accommodation, meal allowances and member taxi fares/parking)				

Queensland
Government

Child Death Review Board

Queensland **Family & Child** Commission