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

Annual Report 2024–25

Systemic findings, insights and recommendations of the Queensland Child Death Review Board

Queensland
Government

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Contact for enquiries

For enquiries or further information about this annual report (including to receive a hard copy) please contact:

Secretariat, Queensland Child Death Review Board

Level 8, 63 George Street

PO Box 15217, Brisbane City East QLD 4002

Email: cdrb@qfcc.qld.gov.au

Website: www.qfcc.qld.gov.au/board

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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 we 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 helping 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: DOC25/3904

The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice and Minister for Integrity
Department of Justice GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29J of the *Family and Child Commission Act 2014* (Qld), I am pleased to provide for presentation to the Parliament the 2024–25 Annual Report for the Queensland Child Death Review Board (the Board).

The work of the Board brings attention to the circumstances of children within families for whom there is insufficient focus on promoting access to existing services which could have helped but were sadly out of reach at crucial times. In some instances, it highlights the family's inability or reluctance to seek support for their children; in other instances it reflects an inability to prioritise children, young people or families who we know needed help.

In 2024–25, the Board reviewed the deaths of 64 children. This annual report details the key system issues identified in those child death reviews and offers the Board's insights and recommendations to improve the system in the areas of:

- **Our window of opportunity: supportive responses for mothers with unborn children (Chapter 2)**
- **Stability begins at home: supporting young parents with infants and children (Chapter 3)**
- **Finding a better path forward for teenagers with high-risk behaviours (Chapter 4)**
- **Identifying domestic and family violence in risk assessments: connecting families through child protection (Chapter 5)**
- **Better outcomes for children through interagency collaboration and information sharing (Chapter 6)**
- **Addressing two persistent gaps in supporting vulnerable families (Chapter 7)**

We also include our monitoring of the recommendations made in the four previous annual reports that were open (not yet implemented) at the start of the reporting period (1 July 2024).

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

31 October 2025

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Message from the Chair

I am pleased to present the Child Death Review Board Annual Report 2024–25, which provides an analysis of 64 deaths of children reviewed by the Board during this period.

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.

This report underscores the critical responsibility we have as a society to protect our most vulnerable children. It highlights the ongoing challenges in addressing systemic failures across various support structures.

The Board acknowledges 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.

In response to the insights gained in 2024–25 and learnings from past years, the work of the Board this year focused on:

- **Our window of opportunity: supportive responses for mothers with unborn children (Chapter 2)**
- **Stability begins at home: supporting young parents with infants and children (Chapter 3)**
- **Finding a better path forward for teenagers with high-risk behaviours (Chapter 4)**
- **Identifying domestic and family violence in risk assessments: connecting families through child protection (Chapter 5)**
- **Better outcomes for children through interagency collaboration and information sharing (Chapter 6)**
- **Addressing two persistent gaps in supporting vulnerable families (Chapter 7)**

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. The recommendations in this report seek to strengthen the focus of our child safety system. In particular we highlight the importance of:

1. Boosting access to antenatal health support to priority (and vulnerable) mothers during pregnancy to achieve better birth outcomes without relying on infant removals.
2. Placing greater priority on young mothers (families) with infants to access suitable housing to help them build their parenting within supportive communities.
3. Stepping in to help teenagers who are heading down a track of high-risk-taking behaviour.
4. Better recognising the significance of risks posed to children by family violence and strengthening the use of safety planning to stop the violence.
5. Ensuring multi-agency collaboration is an effective and essential part of a child safety system rather than seeing it as an option or nice to have.
6. Addressing barriers that prevent families known to the system from receiving timely and coordinated support.

Finally, the Board notes that on 4 December 2024 the Attorney-General referred the matter of Ashley Paul Griffith to the Board and requested a review under section 29I of the *Family and Child Commission Act 2014* (Qld). In response the Board approved the Terms of Reference for a review into the System Responses to Child Sexual Abuse. This major undertaking has been a key feature of the Board's efforts this year. The Board's findings will be presented in a separate report.

I want to sincerely thank our Board members and Secretariat staff for the complex and often challenging work they undertake with diligence and care. Your expertise, thoughtful judgement and steadfast commitment to the rights and wellbeing of children underpin everything we do. It is through your collective effort—balancing rigorous oversight, nuanced decision-making, and tireless behind-the-scenes work—that we are able to contribute meaningfully to systems that protect and support children and families.

Luke Twyford
Chairperson
Child Death Review Board

31 October 2025

"When a child enters the child protection system, they have already experienced loss, trauma, and uncertainty. It is our responsibility, as a society and as a system, to ensure that every child in care does not just survive but thrives—knowing they are valued, feeling loved, and living in safety."- Living experience advocate

Introduction

This report has been prepared under section 29J of the *Family and Child Commission Act 2014* (Qld). It describes the work of the Board in 2024–25 in carrying out its reviews and other functions under Part 3A of the *Family and Child Commission Act 2014* (Qld) and the Board's Procedural Guidelines.

Chapter 1 provides an overview of key characteristics of the 64 children and young people whose cases are reviewed in the reporting period. It looks at the children's causes of death, basic demographics and cultural status.

Chapters 2 to 7 discuss the key themes and service system issues identified by the Board in 2024–25. The chapters also share relevant case studies of children's lived experiences. Each of the 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 — Our window of opportunity: supportive responses for mothers with unborn children
- Chapter 3 — Stability begins at home: supporting young parents with infants and children
- Chapter 4 — Finding a better path forward for teenagers with high-risk behaviours
- Chapter 5 — Identifying domestic and family violence in risk assessments: connecting families through child protection
- Chapter 6 — Better outcomes for children through interagency collaboration and information sharing
- Chapter 7 — Addressing two persistent gaps in supporting vulnerable families
- Chapter 8 — Monitoring recommendations: This chapter revisits Board recommendations made in the previous four annual reports and provides an update on their implementation. 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, 2022–23 and 2023–24.
- Chapter 9 — Governance: outlines the structure and governance of the Board.

Recommendations made in this report

The Board recommends that:

Recommendation 1

The Minister for Families should urgently review and reset the Queensland Government's policy and responsibility for responding to reports about the safety of unborn children. This should shift the focus from collecting evidence for future statutory child protection intervention towards a stronger, health-led outreach and support approach. As part of this reset, the Department of Families, Seniors, Disability Services and Child Safety, in partnership with Queensland Health, should:

- implement and document responsive pathways for young and care-experienced parents, including dedicated early parenting programs and peer support networks
- enhance the provision of supportive, culturally safe antenatal healthcare services to ensure early engagement and continuity of care for pregnant women, particularly those at risk, leveraging Family Led Decision Making processes and early family engagement wherever possible
- ensure infant care practices during removal proceedings prioritise the infant's immediate health and bonding needs, including opportunities for breastfeeding and physical closeness with the mother where safe and appropriate.

This integrated approach should prioritise health and wellbeing outcomes for unborn and new infants and their parents, reduce the adversarial nature of statutory intervention, and foster earlier, more culturally responsive supports.

Recommendation 2

The Department of Housing and Public Works, in collaboration with the Department of Families, Seniors, Disability Services and Child Safety, should establish and articulate a dedicated housing pathway for young parents (particularly mothers raising infants). This pathway should prioritise access to safe, stable and developmentally supportive housing environments that enable young families to build parenting capacity. It should be supported by strengthened assessment and planning processes that enable temporary and crisis accommodation options to adequately meet the safety and wellbeing needs of this vulnerable cohort.

Recommendation 3

Given the high prevalence of housing issues in the child death cases we see, the Board recommends that the Government pursue legislative amendment to the *Child Protection Act 1999* (Qld) to include the Department of Housing and Public Works in the Child Death Review Model. This approach could be the same as the current requirements for the Director of Child Protection Litigation: Housing would be legislated to complete child death reviews but would not be a member of the Board.

Recommendation 4

The Minister for Families should commission work that will enhance the operational capacity, accountability and cross-agency collaboration of Suspected Child Abuse and Neglect (SCAN) teams (or another legislated, multi-agency committee) such that it delivers a legislated accountability mechanism that works across portfolios to ensure timely and coordinated responses to complex risk indicators in children and families. Specifically, an improved multiagency case management process should include:

a. a strategic mechanism for targeting pre-emptive support to families to ensure they are engaging the right cohorts—particularly unborn children, infants, and young people with cumulative risk factors as explored through the chapters in this report—and not duplicating or misdirecting resources
b. joint case management reviews for any child in care who has more than two placement moves in a 12-month period, or any child below the age of 12 who is in residential care
c. a structured framework that triggers mandatory involvement from the Department responsible for Child Safety or Youth Justice when a young person presents with a cluster of high-risk indicators such as intergenerational trauma, care experience, cognitive impairment, developmental delays, school disengagement and early contact with the justice system
d. expanded eligibility to include children with significant unmet needs who may not yet meet the Department responsible for Child Safety's threshold but may benefit from a coordinated system response, including those with chronic health conditions, high health service usage or complex medical discharge needs who require multi-agency coordination and planning.

Recommendation 5

The Department of the Premier and Cabinet should lead a project alongside the Department of Education, Queensland Health and the Department responsible for Child Safety to develop a strategy to further integrate health and family services within early childhood education and care (ECEC) settings and public schools. This strategy should include consideration of:

a. providing the necessary infrastructure, resourcing and workforce to deliver on the service needs of children and their families, across the spectrum of universal supports to timely, targeted and tailored interventions and support
b. reviewing accessibility and availability of services, both government and non-government, to build parenting capacity and improve how the system can better connect children and parents to these services
c. reviewing the Healthy Kindy Kids program to ensure the mechanism will be sufficiently robust to identify and coordinate diagnostic screening of children, not just for potential speech, hearing and visual impairments, but more broadly children with developmental delays, behavioural concerns and/or other undiagnosed disabilities that, when otherwise unaddressed, may increase a child's likelihood of later disengaging from education
d. creating integrated referral points to ensure children and their parents/caregivers identified with additional areas of need are connected to appropriate early childhood interventions, therapy or behavioural supports, including where applicable supporting families with access to the National Disability Insurance Scheme (NDIS) and ensuring they are supported while waiting for assessments and/or diagnoses
e. implementing a targeted rollout that prioritises specific communities/local government areas/schools with the greatest need in response to its disadvantage measure.

Recommendation 6

The Queensland Government should review emerging and existing applications of technology and artificial intelligence to enhance the effectiveness and efficiency of child protection functions. This review should prioritise opportunities to reduce administrative burden and streamline case management processes, with the goal of freeing up practitioner time for direct engagement with children and families. The review should also consider how technology can support timely, accountable and coordinated responses across agencies without displacing the critical role of human judgement in assessing and responding to risk. This review could include, but is not limited to, exploration of tools and systems that can:

- Facilitate seamless, secure information exchange and interoperability across government agencies to support coordinated and timely responses to risks to children, while addressing long-standing barriers to effective information sharing and clarifying lines of accountability.
- Incorporate predictive algorithms and machine learning to help practitioners in identifying and contextualising risks, needs and protective factors; support prioritisation of cases and resource deployment; and guide targeted, integrated referrals (for example, to the SCAN team). These tools should be positioned as productivity aids that enhance – not replace – professional judgement and responsibility.
- Automatically compile and synthesise child protection history and relevant case data to support robust risk assessments, inform decision-making and streamline court documentation. This includes surfacing the most recent and relevant information from across multiple plans across multiple organisations and multiple portfolios to reduce duplication and improve clarity.
- Reduce administrative burden by converting audio records of interviews or home visits into structured written documentation to support timely and accurate record-keeping.
- Enable real-time feedback loops between service providers and case managers, including automated updates on the status of outreach or scheduled services. This would support timely follow-up, clarify who is accountable for next steps and help identify and address barriers to service engagement (for example missed paediatric or mental health appointments).

Recommendation 7

The Queensland Government should produce a Statement of Intent outlining how it will enable and empower cross-portfolio accountability and information-sharing to keep children who are known to the Department responsible for Child Safety safe. This statement should embed a whole-of-system approach that recognises the shared responsibility of all agencies – not just the Department responsible for Child Safety – for identifying and responding to early risk in infants and young children. It should articulate how modern information-sharing systems and clear governance mechanisms will ensure accountability for the safety of children. This Statement of Intent should be produced by March 2026 to enable consideration by the Commission of Inquiry in its final report.

Recommendation 8

The Department of the Premier and Cabinet conduct a review of remote service delivery models, focusing on equity across health, education, domestic and family violence and family support services.

Recommendation 9

The Department of Families, Seniors, Disability Services and Child Safety should work with cultural authorities to provide greater consistency and understanding of how to monitor and respond to a child's safety during Sorry Business, including through greater partnership with local community-controlled organisations, community leaders and families to ensure place-based approaches.

CHAPTER 1

Cases reviewed by the Board in 2024–25

The Board is responsible for conducting system reviews following the death of a child who was known to the child protection system in the 12 months before their death. This report largely focuses on 64 new deaths reviewed this year. Parts of this report reconsider the details of child death cases that the Board reviewed in earlier reports, where relevant to the theme under discussion.

The Board's reviews are not intended to investigate the cause of death. Instead, they are intended to identify system improvements that can increase children's safety and prevent future child deaths.[1]

It should be noted that the cause of death for almost half of the 64 new cases reviewed this year was natural causes. It is also important to note that 94 per cent of the children were living with family or friends or independently at the time of their death. Only six per cent of reviewed cases related to children who were in the care of the child protection system at the time of death.

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

- the Department of Education (Education)
- the Department of Families, Seniors, Disability Services and Child Safety (Department responsible for Child Safety)
- the Department of Youth Justice and Victim Support (Youth Justice)
- Queensland Health (includes Hospital and Health Services)
- the Queensland Police Service (QPS)
- the Director of Child Protection Litigation.[2,3]

Secondly, agency reviews are provided to the Board's staff, who read all internal agency reports relating to a case and assess the presence and degree of system issues. The Board's staff recommend a review categorisation level based on the presence and degree of system issues identified in the preliminary review and note the case alignment with thematic issues identified across multiple cases to the Board. The Chairperson approves the categorisation level and system issues identified in the preliminary review and notes potential upcoming thematic reviews within which the case may be included. Each Board meeting provides an opportunity for the Board to question and revisit the categorisation level and system issues identified in the preliminary review briefing notes.

In 2024–25 the Board received 57 notices of the death of a child known to the child protection system, and completed reviews of 64 cases.

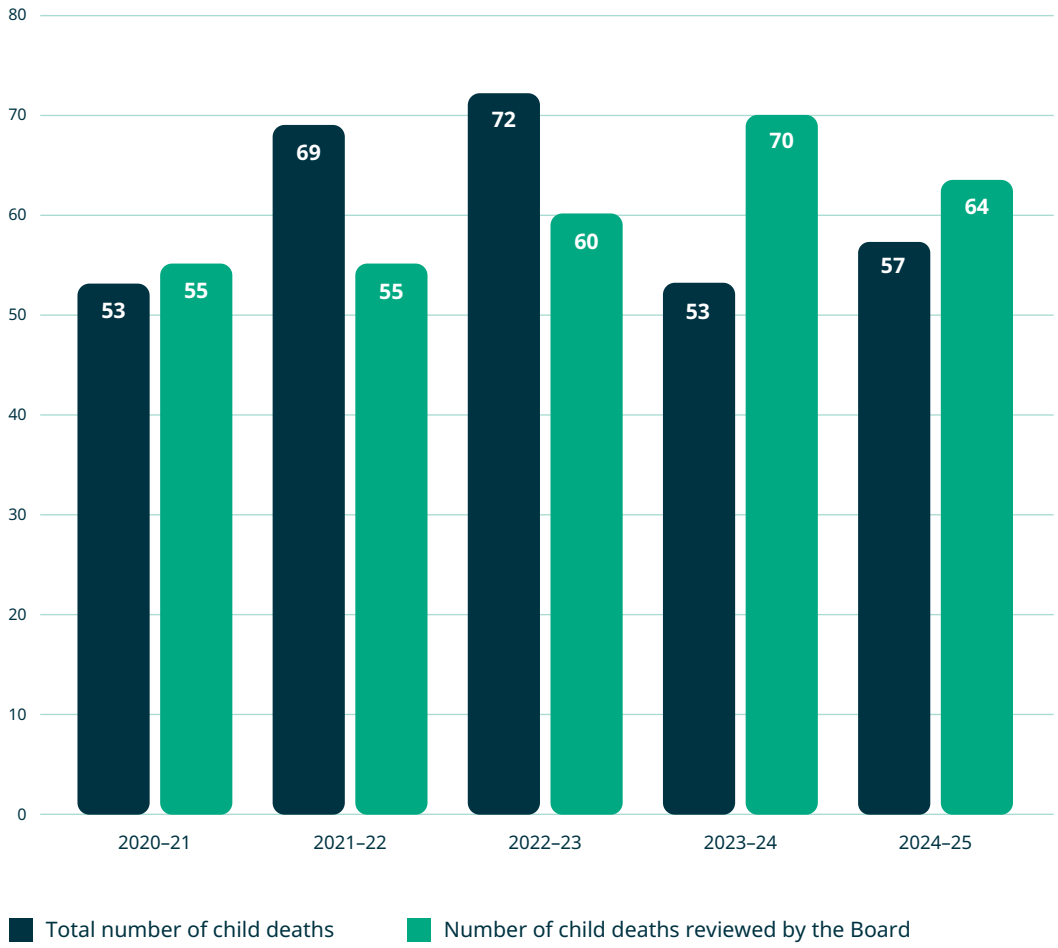
This year, in completing the 64 reviews, the Board assessed 215 agency reviews (see Figure 1).

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 245K for further details on the scope of relevant agency review.

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

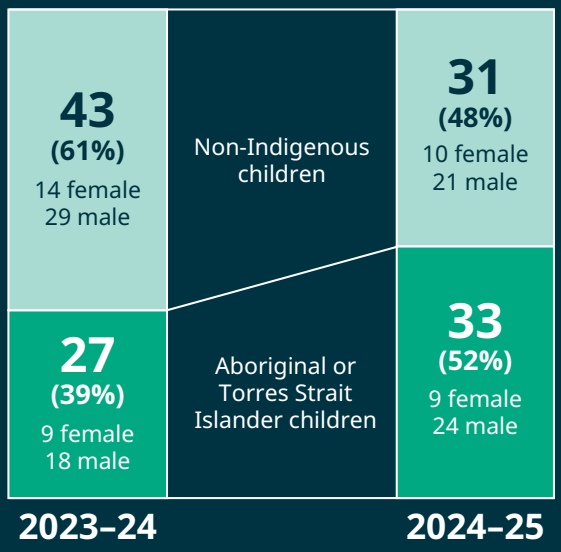
Figure 1: Number of child deaths of children who were known to the Queensland child protection system in the 12 months before death, and deaths reviewed by the Board by year, 2020–21 to 2024–25[4]



4 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 2024–25, the Board considered the deaths of 64 children

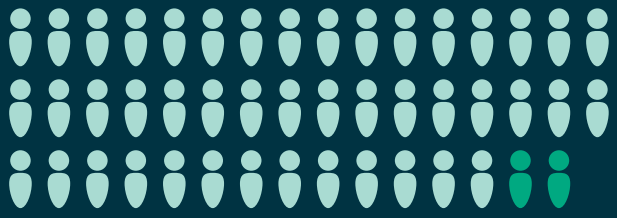
Demographics



19 female (30%)

compared to 23 (33%) last year

45 male (67%)



compared to 47 (67%) last year

The number of deaths reviewed in each age group

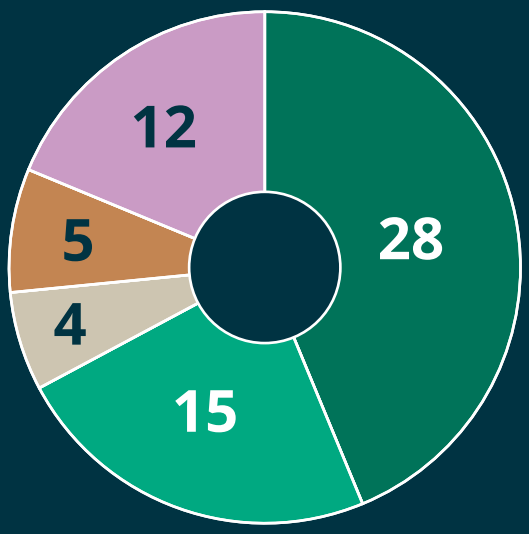
28 **Under 1 year** (44%)
16 Aboriginal or Torres Strait Islander/ 12 Non Indigenous) (9 female/19 male)

15 **1–4 years** (23%)
(5 Aboriginal or Torres Strait Islander/ 10 Non Indigenous) (4 female/11 male)

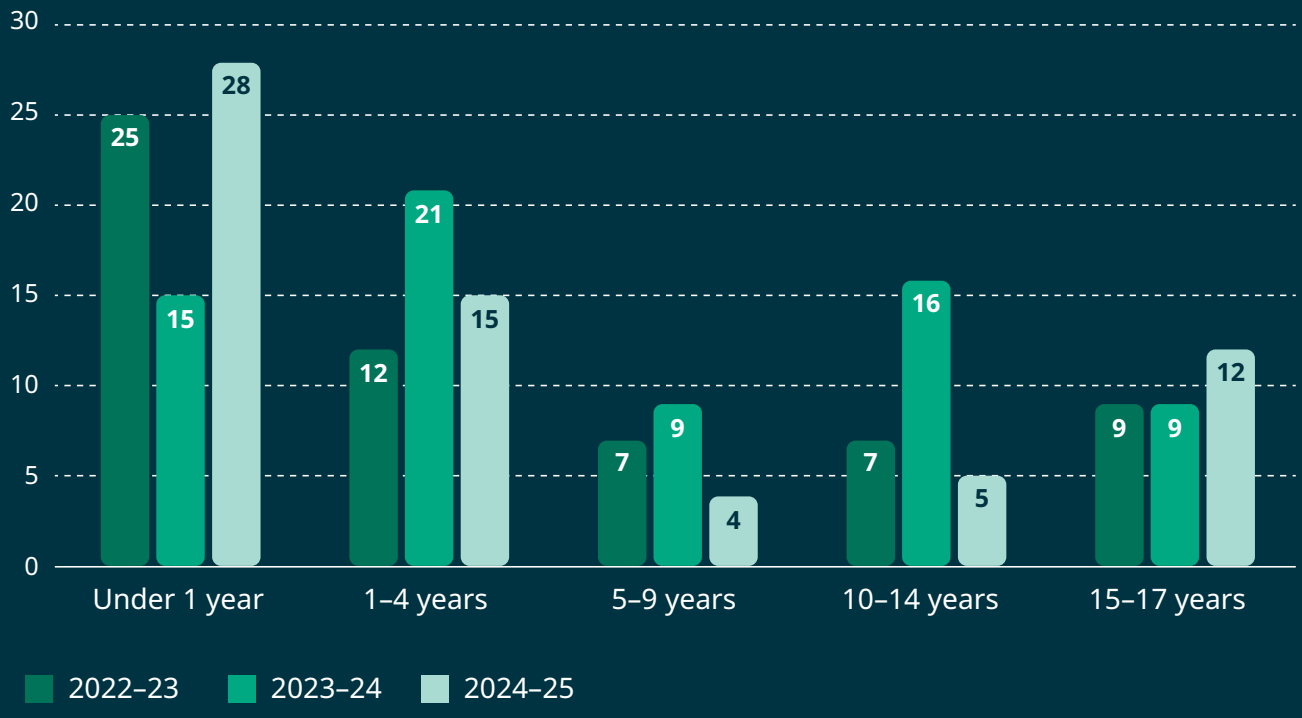
4 **5–9 years** (6%)
(2 Aboriginal or Torres Strait Islander/ 2 Non Indigenous) (1 female/3 male)

5 **10–14 years** (8%)
(2 Aboriginal or Torres Strait Islander/ 3 Non Indigenous) (0 female/5 male)

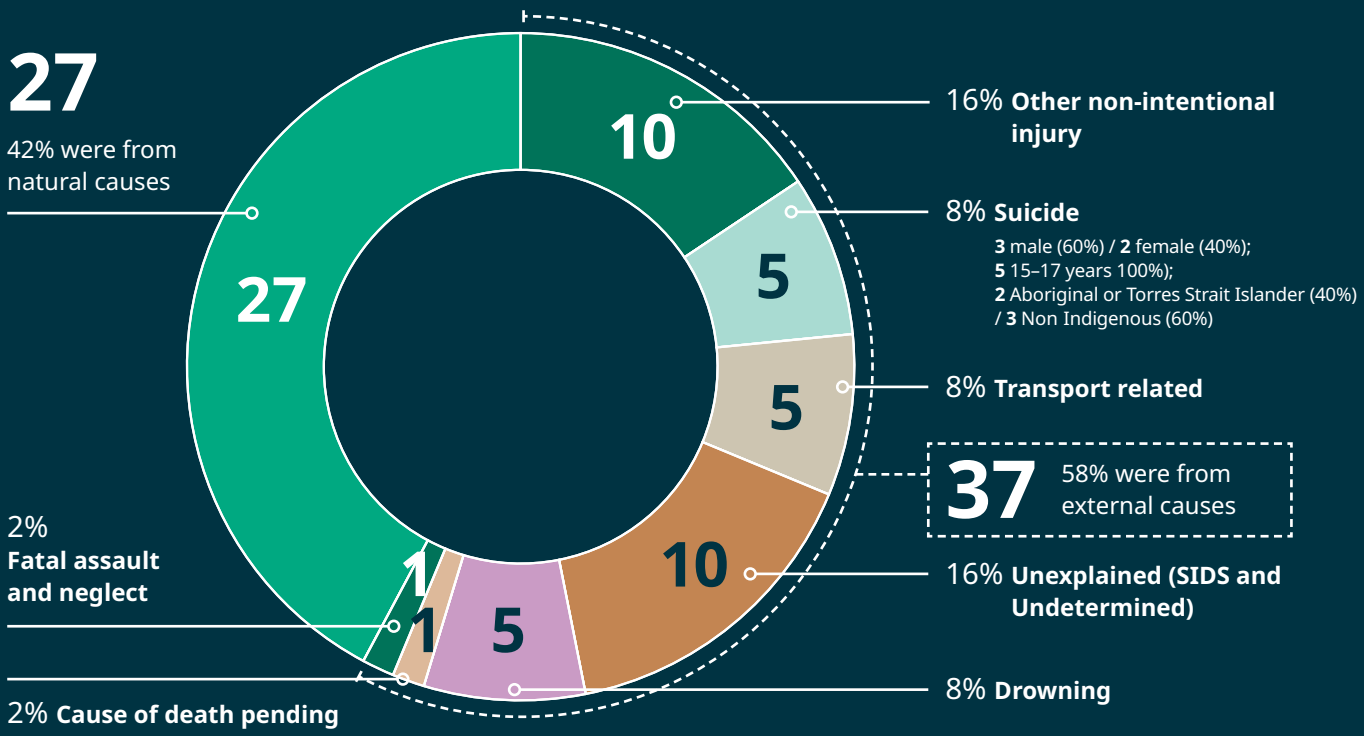
12 **15–17 years** (19%)
(8 Aboriginal or Torres Strait Islander/ 4 Non Indigenous) (5 female/7 male)



Age of children's cases reviewed by the Board



Category of deaths reviewed by the Board



Sudden Unexpected Death in Infancy

13 (20%) deaths fell within the Sudden Unexpected Death in Infancy (SUDI) research classification[5]

7 Aboriginal or Torres Strait Islander

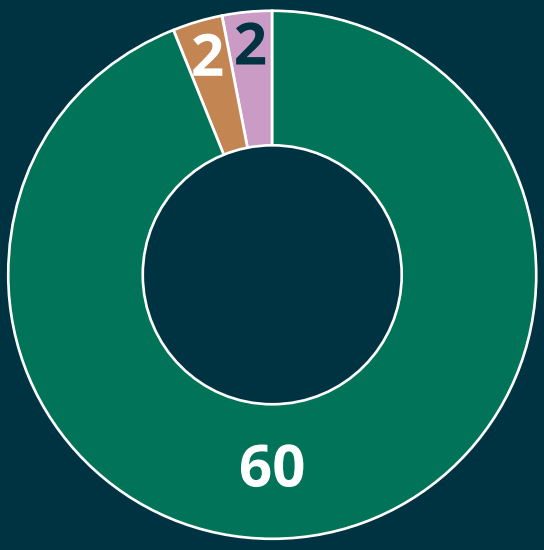
6 Non-Indigenous

Care circumstances

60 (94%) were living with family or friends or independently at the time of their death[6]

2 (3%) were in foster or kinship care or on a permanent guardianship order

2 (3%) were in residential care[7]



Agency reviews considered by the Board (215)

64 The Department responsible for Child Safety

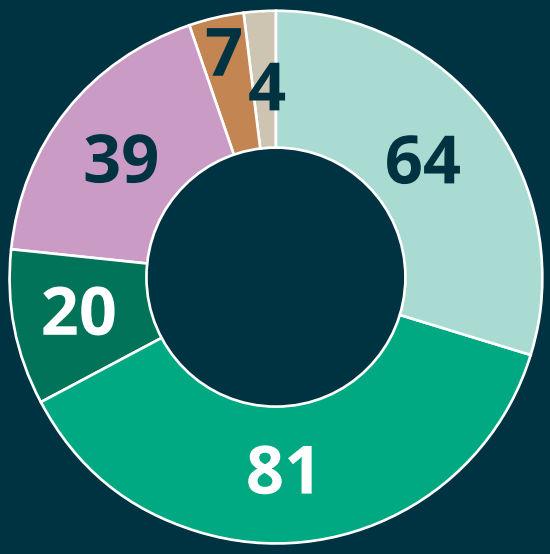
81 Queensland Health[8]

20 Education

39 QPS

7 Youth Justice

4 The Director of Child Protection Litigation



Case Review Classification

Level 1	23	36%
Level 2	25	39%
Level 3	16	25%

5 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.

6 Two children were born prematurely and placed on a Child Protection Order granting short-term custody to the Chief Executive, but they died while in hospital before discharge to any residence

7 One child was in residential care with parental consent.

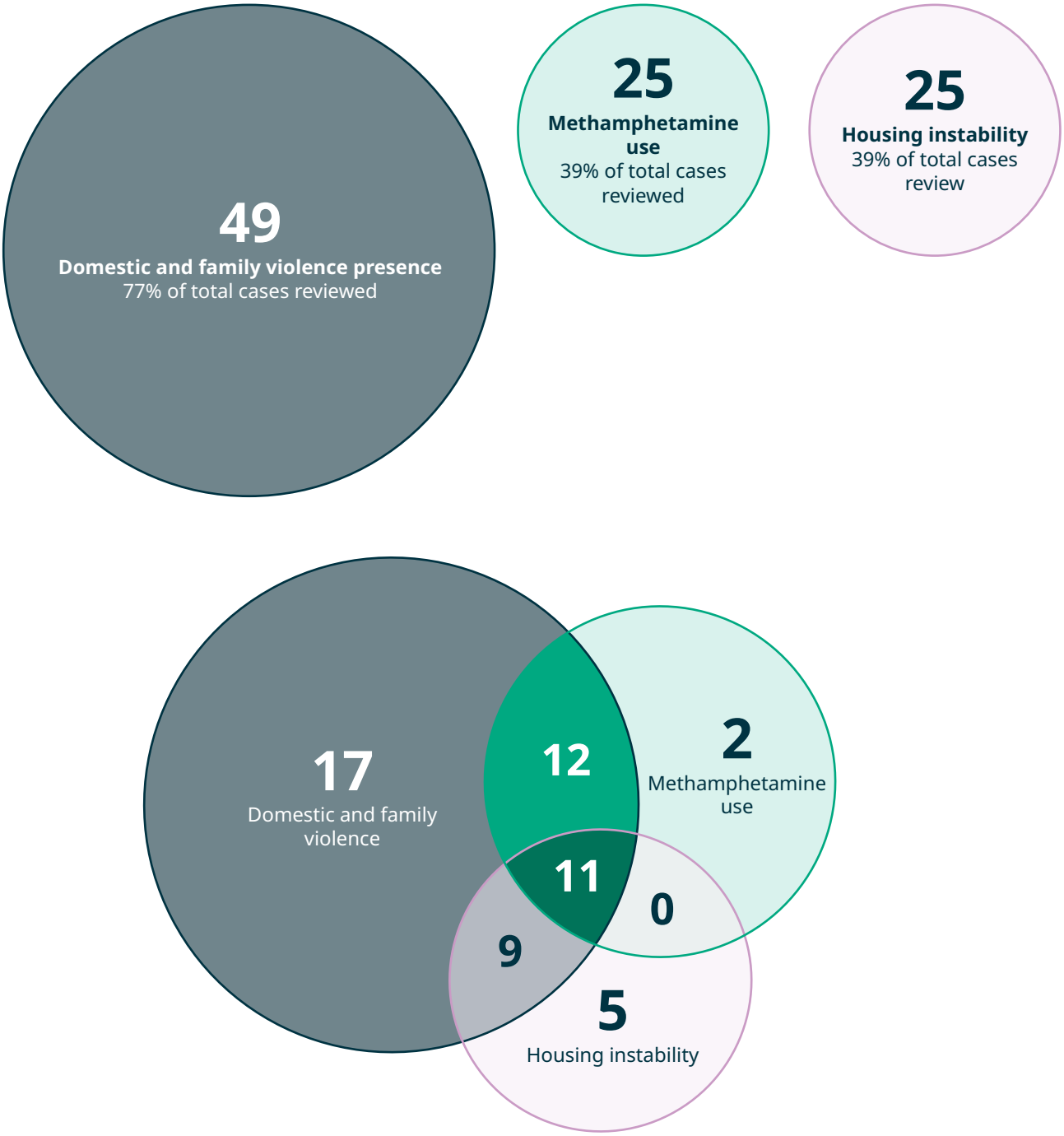
8 The number of review reports from Queensland Health is higher than the number of child deaths because multiple Hospital and Health Services undertook reviews for some children.

Case characteristics 2023–24

In the financial year 2024–25, the Board reviewed a number of cases where three select characteristics were noted. Three primary characteristics were widely recorded across the 64 cases, often in combination: presence of domestic and family violence; methamphetamine use; and housing instability.[9]

This reporting continues to show 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: Key characteristics of cases reviewed by the Board in 2024–25



9 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

Our window of opportunity: supportive responses for mothers with unborn children

"Young babies are particularly vulnerable to abuse and work carried out in the antenatal period can help minimise any potential harm through early assessment, intervention and support… The antenatal period provides a window of opportunity for practitioners and families to work together."[10]

The removal of an infant from their parent, particularly at or shortly after birth, is one of the most consequential actions the government can take in the name of child protection. This year the Board turned its attention to infants and specifically considered the child protection system response to children who were subject to an unborn child Notification. This chapter explores the service system response to four infants, while also drawing on insights from 45 additional cases examined in previous years who were also the subject of concerns reported to the Department responsible for Child Safety before their birth.

The response to child protection reports about unborn children engages the most profound of human rights questions: how to safeguard a child from harm while also upholding the rights of the mother. The child protection system is charged with a sacred responsibility: to act in the best interests of children, ensuring that their right to safety, care and development is upheld. Where there is an immediate and significant risk to an infant, such as exposure to harmful substances, serious violence, neglect, or unsafe environments, there may be no alternative but to intervene. In those moments decisive, proportionate and rights-respecting action is needed. The complexity lies in the fact that decisions are often made in environments of incomplete information, intergenerational trauma, service system failure and deep structural inequality. While framed as individual risk assessments, these decisions are shaped by a system that often responds more swiftly to visible disadvantage than to its underlying causes.

The Board's 2021–22 annual report identified helping mothers during pregnancy as a missed opportunity for early intervention. It highlighted limited education on infant safety, gaps in antenatal care services, and fragmented assessments between agencies. That report acknowledged positive steps taken by the Department responsible for Child Safety, QPS and Queensland Health to improve early risk response and support for vulnerable families. However, the Board called for further action, including targeted investment in health and social services to support families during pregnancy and early childhood, particularly where multiple risk factors exist; extended home visiting programs; and consistent, culturally appropriate messaging around infant safety and wellbeing.

This year the Board considered four cases that were investigated this year and reconsidered 45 unborn child cases that had previously been reviewed by the Board between January 2022 and June 2024. These cases highlight that risks identified before a child's birth were often overlooked or minimised within the formal child safety system investigation process.

Despite ongoing involvement from the Department responsible for Child Safety and other agencies, in cases reviewed this year risks identified before a child's birth were not a central feature in risk assessments or decisions regarding supportive interventions. Additionally, patterns of ongoing neglect not considered holistically across all children in the family.

Over half of the children in this cohort of 45 cases (56%) were born prematurely, with many experiencing low birth weight and associated complications. This aligns with earlier findings that the majority of mothers (71%) had substance use issues, alongside high rates of domestic and family violence and mental health concerns. It is well established that these factors are associated with low birth weight, and in this cohort, they have translated into significant neonatal health challenges with most infants were born in respiratory distress, requiring breathing support, and spending multiple days or weeks in hospital.

Understanding these health outcomes in the context of the identified risk factors reinforces the need for early, targeted supports for mothers before birth. These issues not only reflect inconsistencies in practice, but also point to a systemic gap in antenatal support for mothers who are known to the Department responsible for Child Safety and pregnant, particularly for Aboriginal and Torres Strait Islander mothers and their families.

The cases reviewed by the Board highlight circumstances of women and families with multiple young children, seven or more, who face multiple challenges with their own health and parental responsibilities.

10 Hampshire Safeguarding Children Partnership (UK), The Unborn/New Born Baby Protocol, 2025, accessed 19 January 2025.

Case example 1: The limitations of child protection responses for unborn children

Unborn Baby A

Unborn Baby A was the youngest of several children born to Mother. Mother and Father had a significant child protection history in multiple states with concerns relating to domestic and family violence, mental health, parental drug use, psychological abuse and neglect of the children. At the time of the relevant report to the Department responsible for Child Safety, Mother lived in different refuges or with friends and two of her children were in care. Concerns reported to the Department responsible for Child Safety related to the safety of the siblings (The Department responsible for Child Safety was unaware of unborn Baby A at this time).

During the investigation and assessment (I&A), Baby A was included as an unborn subject child, when the Department responsible for Child Safety became aware that Mother was pregnant. During the I&A there were a further 10 Additional Notified Concerns recorded as Child Concern Reports or Notifications with five or 10-day response priority timeframes. Concerns related to ongoing domestic and family violence perpetrated by Father, and Mother's mental health and drug use.

The I&A was finalised prior to the birth with an outcome of 'Substantiated – child in need of protection' for all three subject children. A pre-emptive support case was opened for unborn Baby A after the I&A closed and a Parental Strengths and Needs assessment was completed.

Baby A was born extremely premature and died shortly after birth.

Unborn Baby B

Unborn Baby B was the youngest of Mother's several children. Mother did not have the siblings in her care. Some were subject to Family Law Court orders while others were living with an aunt. Information provided to the Department responsible for Child Safety stated that Mother did not attend antenatal care and was seen drinking to the point of intoxication. There were ongoing worries about Mother's problematic alcohol and possible intravenous drug use, poor mental health, history of neglect, transience and experiences of domestic and family violence. As a result of these concerns the Department responsible for Child Safety recorded an unborn child Notification 13 days before the birth of Baby B. Pre-notification checks with a hospital were undertaken.

Safety plans were completed after the birth of Baby B while still in hospital. Initially, Mother had supervised contact with Baby B while staying at the homes of Aunt and Grandmother. Mother and Baby B were supported to move back to living independently under a further safety plan, and mother was reported to be making good choices. However, within three weeks Aunt reported that Mother had regressed, and the family had taken Baby B back into their care. The I&A was finalised as 'Unsubstantiated – child not in need of protection' on the basis was being cared for by Grandmother (primary carer) and Aunt under a family arrangement. The rationale noted: Mother was unwilling and unable to be the primary parent to Baby B and that if placed in Mother's primary care Baby B would be at significant risk of future harm.

Grandmother died unexpectedly months later. Her death was not reported to the Department responsible for Child Safety, who therefore did not have oversight of who was caring for the baby. Baby B later died while in the care of extended family.

Unborn Baby C

Unborn Baby C was one of several children to Mother. All of Baby C's siblings were subject to Child Protection Orders and their parents had been unable or unwilling to address the child protection concerns over the course of several years. The Department responsible for Child Safety's concerns included exposure to domestic and family violence, Mother's current transience with no stable housing, and concerns that Mother was still using illicit drugs. There were concerns that her partner had a long history of drug use and was perpetrating violence. The concerns were screened in as a 'notification for an unborn child', with a 10-day response priority timeframe assigned and an unborn Child High Risk Alert was completed and sent to three hospitals.

Mother had not received any antenatal care, and the child was born at 26 weeks gestation following at least two incidents of domestic and family violence in the 12 days prior. The Department responsible for Child Safety was advised of the birth. The baby was born critically unwell and was transferred to the Intensive Care Unit. Before the transfer, Mother had discharged herself against medical advice and was recorded by the hospital as absconded. Staff at both hospitals struggled to contact Mother and regular updates were provided to the Department responsible for Child Safety. Emails between the Department responsible for Child Safety and a hospital social worker noted that a Temporary Assessment Order would not be pursued but that transparent conversations were intended to occur with Mother in relation to the child entering departmental care.

Baby C's condition deteriorated and Mother and family were supported in making visits during this time. Mother attended at times with her partner, for whom there was a Domestic Violence Order in place. A Queensland Police Domestic Violence Officer became involved as there were ongoing concerns that Mother was a potential victim and was being influenced by her partner during hospital visits, as he was possibly prohibiting Mother from accessing services and stopping QPS from contacting her.

Baby C passed away in hospital.

Supporting pregnant mothers offers a 'window of opportunity'

One of the most important things a child needs is a secure attachment with their parent or caregiver. But if no one teaches you about attachment, if you've never had a safe and nurturing experience as a child, how would you know how to provide it?[11]

The antenatal period presents a critical window of opportunity for practitioners to work collaboratively in supporting families. This stage allows for early identification of risks and the provision of timely interventions that can positively influence long-term outcomes. The importance of antenatal care for parents, particularly those with experiences of care, will be further explored in Chapter 3.

Research consistently indicates that women generally reduce risk-taking behaviours during pregnancy to prioritise foetal health. One prominent study from the Australian Longitudinal Study on Women's Health highlights noticeable behavioural changes, such as decreases in alcohol consumption and smoking.[12]

Women are also more receptive to health messages and motivated to adopt healthier behaviours during pregnancy. The emotional significance of pregnancy and the desire to protect the unborn child often lead to increased openness to change, making this period ideal for initiating supportive interventions.[13]

Pregnancy and early infancy, often referred to as the 'first 1,000 days' or the 'first 2,000 days', are foundational to a child's development. Evidence shows that this period significantly impacts health, wellbeing and developmental outcomes.[14] It is also a time when women may be more open to making lifestyle changes and more receptive to professional advice.[15]

The First 2,000 Days initiative by Queensland Health highlights the critical importance of pregnancy and early childhood in shaping lifelong health and development outcomes. This period is also a time when many women are more open to support and behavioural change.

Improving birth outcomes is a key target under Australia's Closing the Gap initiative, which aims to increase the proportion of Aboriginal and Torres Strait Islander babies born with a healthy birthweight to 91 per cent by 2031.[16] Engagement during pregnancy is a central part of the *Child Protection Practice Framework*. Achieving these outcomes requires active, culturally appropriate support to help families stay together and thrive.

A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaging with parenthood provides an opportunity to explore with that parent, their feelings towards the child and any risks that this might pose.[17]

11 Shantelle. (2025). QFCC Youth Summit 2025 speakers Rachel and Shantelle (Healthy). https://www.youtube.com/watch?v=48Zxw4mrlmg.

12 Magnus MC, Hockey RL, Håberg SE et al. Pre-pregnancy lifestyle characteristics and risk of miscarriage: the Australian Longitudinal Study on Women's Health, *BMC Pregnancy Childbirth*, 2022, 22(169).

13 Rockliffe L, Peters S, Heazell AEP, Smith DM, Understanding pregnancy as a teachable moment for behaviour change: a comparison of the COM-B and teachable moments models, *Health Psychology and Behavioural Medicine 10*(1): 41–59.

14 Ingham Institute for Applied Medical Research, *Empowering families to detect development problems in the first 2,000 days (from pregnancy to start of school)*, 2025.

15 Royal Australasian College of Physicians, *Early Childhood: The Importance of the Early Years – Position Statement*, 2019.

16 Australian Institute of Health and Welfare, *Closing the Gap targets: key findings and implications – Born healthy and strong*, 2025.

17 Brandon M, Sidebotham P, Bailey S & Belderson, *Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014*. Department for Education (UK), 2016.

Initiative improving outcomes for mothers, babies and families in South East Queensland: Birthing in Our Community

Birthing in Our Community (BiOC) is an Aboriginal and Torres Strait Islander-led service for mums, bubs and families in South East Queensland. This program has been supporting Aboriginal and Torres Strait Islander families since 2013 and continues to provide:

- midwifery services throughout pregnancy, birthing and the postnatal period
- an Aboriginal or Torres Strait Islander family support practitioner service to support pregnant women throughout pregnancy and after.

Australian research shows women who received care through BiOC were only one third as likely to have their newborn removed by child protection services as women who received standard maternity care.[18]

Child protection data shows that children under four account for about 30 per cent of Child Protection Notifications (CPN) and substantiated outcomes in Queensland.[19] Among these, neglect and physical harm are the most common types of harm reported. This underscores the need for early, coordinated responses.

Queensland has established policies and procedures to guide how the child safety system responds to children after they are born without a parent able and willing to protect them. This includes protective responses for unborn children, recognising the importance of early intervention. Section 13A of the *Child Protection Act 1999* (Qld) allows any person to inform the Chief Executive if they reasonably suspect that an unborn child may be in need of protection after birth. A Notification is recorded about an unborn child where there is reasonable suspicion that the baby will be at risk of significant harm after birth. The Child Safety Practice Manual outlines a standard response process, which aims to offer help and support to pregnant women to reduce the likelihood of the child requiring protection after birth.[20]

While the manual notes that formal risk considerations apply once the child is born, it also emphasises that risks identified during pregnancy should trigger supportive actions to enhance the newborn's safety. This aligns with the principle of working collaboratively with people during pregnancy, respecting their rights while ensuring the safety of the child.

Child Safety Practice Manual: Unborn child

The purpose of an I&A and assessment before the birth of a child is to assess concerns about the risk of significant harm that the unborn child may experience after birth. If the risk is identified, the pregnant woman will be offered help and support to increase the newborn baby's safety. The role the Department responsible for Child Safety is to:

- assess the likelihood that the unborn child will need protection after birth
- decide what help and support can be offered to the pregnant woman and, if relevant, her partner or the father of the unborn child.

18 B. O'Dea et. Al, Breaking the cycle: Effect of a multi-agency maternity service redesign on reducing the over-representation of Aboriginal and Torres Strait Islander newborns in out-of-home care: A prospective, non-randomised, intervention study in urban Australia, 2024

19 Child Safety, *Infants at high-risk*, Practice Guide, September 2019, p 1.

20 Queensland Department responsible for Child Safety, Seniors and Disability Services, *Undertake a standard response for an unborn child*. Child Safety Practice Manual, 2025. Child Protection Act 1999.

Child Safety's *Practice Guide: Infants at high risk*[21] helps to identify infants at high risk of abuse or neglect. The practice guide highlights and explores the following risk and protective factors for infants at high risk:

Risk and protective factors for infants at high risk[22]

Parental risk factors

- Age of the parent (under 20 years)
- Previous child protection history
- Problematic alcohol and other drug use
- Domestic and family violence
- Childhood experience of abuse (of the parent)
- Mental illness
- Intellectual impairment
- Negative perceptions of child
- Limited parenting skills
- Poor impulse control
- Poor attachment to newborn

Child risk factors

- Premature and low birth weight
- Prenatal exposure to alcohol and drugs
- Disability
- Unintended pregnancy
- Feeding difficulties or prolonged or frequent crying

Environment risk factors

- Isolation
- Poverty
- Household composition (unrelated adults)
- Chaotic or unsafe home environments

Protective factors for infants at high risk

- Social support
- Good health care and nutrition
- Good quality care arrangements
- Healthy spousal relationship
- Understanding of basic child development and parenting skills
- Safe sleeping practices

These factors should be considered in assessments and planning, especially during the antenatal period when early intervention can significantly improve outcomes. Careful consideration must be given to the risk factors that are used to inform the Department responsible for Child Safety's involvement for unborn children and infants. Jurisdictions across Australia follow a different set of parental risk factors. The use of wider parental risk factors raises concerns that higher rates of child protection responses will result, particularly for specific families including those with disability, intergenerational trauma, and previous childhood experiences in care.

The Board has observed that current responses are often centred within the Department responsible for Child Safety, with limited evidence of joint action obligations with Queensland Health. This raises questions about how an unborn child report balances service responses and information gathering for the health and safety benefit of the mother and unborn child compared to the safety of the child after birth.

21 Child Safety, *Practice Guide: Infants at high risk*, 2019, pp. 2–6

22 Child Safety, *Practice Guide: Infants at high risk*, 2019, pp. 2–6

What the data tells us: the prevalence of risks to unborn children and infants in Queensland

In 2021, it was estimated that three per cent of Australian pregnancies are the subject of prenatal reporting to child protection agencies.[23]

In recent years, Australian and international jurisdictions have seen an increasing rate of families being reported to child protection services during pregnancy and in the period following birth. Each year, about 1,500 unborn children in Queensland are the subject of CPNs.[24] Among the Australian states and territories Queensland has the second highest number of Aboriginal and Torres Strait Islander children subject to unborn reports.[25]

In the year ending June 2024, 1,564 unborn children were reported in Queensland. About 39 per cent of these were Aboriginal and Torres Strait Islander children, although Aboriginal and Torres Strait Islander people are only 4.6 per cent of the Queensland population. This highlights a significant overrepresentation and underscores the need for culturally responsive and early intervention strategies.

Figure 3 shows the trend in the number of unborn children who were the subject of a Notification.

Figure 3: Number of unborn children in Queensland subject to a CPN, from 2020 to 2024.

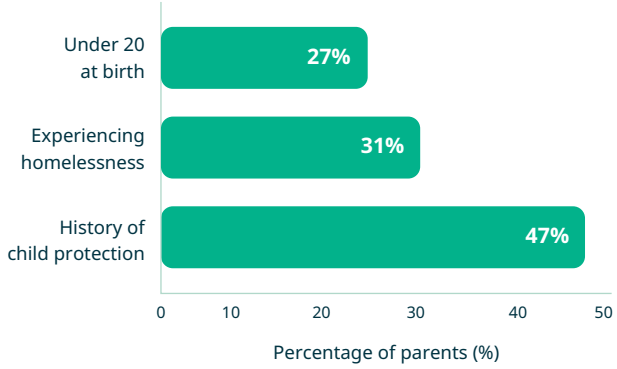
23 J Meiksans, F Arney, R Flaherty, O Octoman, A Chong, F Ward, C Taylor, Risk factors identified in prenatal child protection reports, Children and Youth Services Review, 122, 2021.

24 Queensland Government, Child Safety, Our Performance Concerns received by Child Safety | Our Performance, 2025, accessed 7 February 2025

25 SNAICC – National Voice for our Children, *Family Matters Report 2024*, 2024.

The review also found that 47 per cent of the parents had a history of child protection involvement during their own childhood; 31 per cent of their parents were experiencing homelessness; and 27 per cent of their parents were under 20 years of age at the time of the child's birth (see Figure 4).

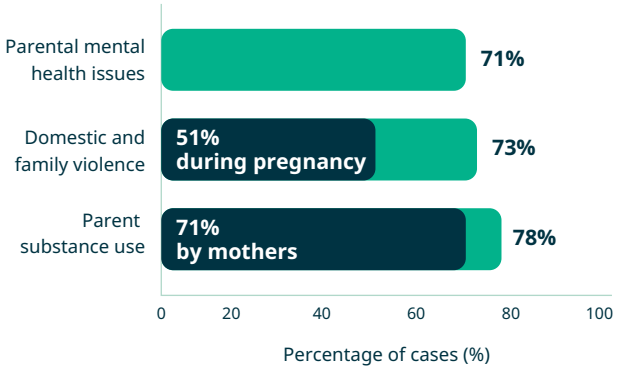
Figure 4: Parental risk factors for infants who were the subject of a Child Concern Report or Notification before birth

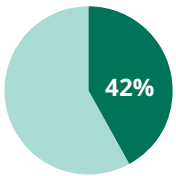


Families of these infants faced multiple and complex challenges. The data shows that 78 per cent of the parents had substance use issues during pregnancy, with 71 per cent of mothers affected. The presence of domestic and family violence was recorded in file notes in 73 per cent of cases, including incidents during pregnancy in 51 per cent of the cases. Additionally, 71 per cent of parents had mental health issues. See Figure 5.

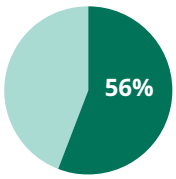
Alarmingly, 19 of the 45 infants were born into families facing co-occurring issues of domestic and family violence, substance misuse and mental health concerns, indicating a high level of vulnerability and need for coordinated support.

Figure 5: Prevalence of key risk factors among families of deceased infants

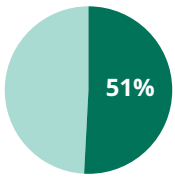




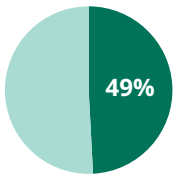
19 were born into families facing co-occurring issues of domestic and family violence, substance misuse and mental health concerns



25 were born prematurely at less than 37 weeks gestation



23 were born very prematurely at 32 weeks or less gestation



22 never left hospital after their birth

The significant rate of premature births highlights for the system the importance of responding to unborn child Notifications in a timely manner and making the most of the opportunity of pregnancy to promote safety for the unborn child.

A profound rights question: getting the right balance between "protection" and prevention

"The removal of an infant from their parent, particularly shortly after birth, is one of the most consequential actions the government can take in the name of child protection. It engages the most profound of human rights questions: how to safeguard a child from immediate or future harm, while also upholding the rights of that child to family, identity, culture and belonging."[26]

Shona Reid, Guardian for Children and Young People

The inclusion of unborn children in child protection considerations is a relatively recent development in Australia. This shift has emerged in response to growing concerns about prenatal neglect and exposure to harm during pregnancy. As awareness of these risks has increased, child protection agencies have begun to monitor and respond to situations where unborn children may be at risk. Legally, the status of unborn children varies across Australian jurisdictions. While some regions may have specific provisions addressing prenatal risk, the overarching legal principle affirms a woman's right to make decisions about her reproductive health. This includes choices that may be perceived as potentially harmful to the unborn baby. The legal framework generally prioritises maternal autonomy, which can create complex ethical and legal tensions when considering the welfare of the unborn child.

In Queensland the Department responsible for Child Safety outlines in its practice manual: "Any action taken by Child Safety to investigate and assess the safety of an unborn child after birth must not interfere with the rights and liberties of the pregnant woman."[27]

The assessment of risk to unborn children also differs across states and territories. Each jurisdiction may use distinct criteria and processes to evaluate potential harm, reflecting variations in policy, legal interpretation and professional practice. These differences can influence how cases are managed and the types of interventions that are considered appropriate. Child protection agencies often classify unborn children as at risk based on factors such as parental substance use, domestic and family violence, and prior engagement with child protection services. While these indicators can help identify potential harm, they may disproportionately target vulnerable women, particularly those experiencing poverty, mental health challenges, housing instability or histories of trauma. In many cases, infant removals occur due to cumulative concerns rather than isolated incidents, reflecting broader systemic issues. This approach can also miss important aspects of risk to unborn children, such as inadequate prenatal care or environmental stressors, which may not be captured by standard risk indicators.

The use of child protection responses during pregnancy must be carefully balanced with recognition of the significant harms caused by infant removal, including long-term emotional, health, psychological and cultural impacts. Equally important is the recognition that "infant removals are so serious that the threshold for such interventions must be high, and a process must be conducted with the utmost care, transparency and humanity."[28] It is essential to uphold the rights of pregnant women and consider evidence that highlights the value of supportive interventions during pregnancy, a time when many are open to making positive changes.

Additionally, there is a risk of applying disproportionate scrutiny to Aboriginal and Torres Strait Islander parents, disabled parents and those with care experience, further entrenching systemic inequality. A briefing paper by the South Australian Guardian for Children and Young People notes that "changing the trajectory of infant removals in Australia is not a matter of tweaking policy settings or adjusting statutory thresholds alone. It requires a deliberate courageous reorientation of our systems, values and collective expectations."[29]

The Board supports these concerns and reinforces the need for more equitable, culturally safe and supportive approaches to prenatal child protection.

26 Shona Reid, *Initial Paper on Infant Removal in Australia*, Office of the Guardian for Children and Young People, South Australia, 2025.

27 Department responsible for Child Safety, Seniors and Disability Services (Queensland), *Undertake a standard response for an unborn child*. Child Safety Practice Manual, 2025.

28 Shona Reid, *Internal Briefing Paper on Infant Removal in Australia*, Office of the Guardian for Children and Young People, South Australia, 2025.

29 Shona Reid, *Internal Briefing Paper on Infant Removal in Australia*, Office of the Guardian for Children and Young People, South Australia, 2025.

"... removals occur not because there is no time to act differently, but because the systems around families have not invested in acting early, relationally or respectfully. Poverty is mistaken for neglect. Disability is equated with incapacity. Cultural difference is perceived as deficit. In these moments, government intervention risks becoming less about protection and more about control."[30] Shona Reid, Guardian for Children and Young People

Interstate example: Victoria Child Protection

In some jurisdictions there are broader and more prescriptive guidelines in relation to when an unborn child report is considered appropriate. For example, the Victorian Child Protection Manual states:

There may be multiple factors present that can impact a child's safety, development and wellbeing after the birth. An unborn child report to child protection is particularly appropriate in the following circumstance:

- another child has previously suffered significant abuse or neglect while in the care of either parent or another adult in the household
- another child has previously suffered life threatening injuries or a condition as a result of abuse or neglect while in the care of either parent or another adult in the household
- another child has previously died as a result of abuse or neglect, or the circumstances of the death are unclear, while in the care of either parent or other adult in the household
- another child has been previously removed from the care of either parent by a court order following a period of service provision and no significant change has occurred in the interim
- a mother will likely give birth to a child with complex medical needs and/or disability and may encounter difficulties providing the requisite level of care to that child
- a parent or other adult in the household has been convicted for a sexual offence or any offence against a child
- parental substance abuse is likely to significantly impact on the child's safety, development and wellbeing after the birth
- parental mental health illness or impairment is likely to significantly impact on the child's safety, development and wellbeing after the birth
- family violence is likely to significantly impact on the child's safety and development in utero and after the birth
- there are significant concerns about a parent's capability to care for the child after the birth, such as a parent who has a significant intellectual disability or an unsupported young person who is under 20 years of age.

30 Shona Reid, *Internal Briefing Paper on Infant Removal in Australia*, Office of the Guardian for Children and Young People, South Australia, 2025.

Internal Briefing Paper on Infant Removal in Australia

In the *Internal Briefing Paper on Infant Removal in Australia*, by Shona Reid, Guardian for Children and Young People in South Australia, a bold and compassionate framework is proposed to shift the focus of child protection from surveillance to support.

The paper advocates for a system that prioritises helping families rather than policing them, beginning with investment in both universal and targeted antenatal support. It emphasises the importance of co-designing services with families and communities, and it calls for the elimination of pre-birth risk assessments that rely on bias, assumptions or previous system contact.

To strengthen families' agency, the paper recommends:

- embedding family-led decision making as standard practice across child protection systems
- creating responsive pathways for young and care-experienced parents, including dedicated early parenting programs, peer support networks, and the discontinuation of automatic notifications to child protection services
- reforming the practice of infant removal to ensure that there is culturally appropriate planning; to mandate that mothers are allowed to hold, feed and say goodbye to their child; and to develop clear post-removal therapeutic and reunification pathways
- human rights be embraced as a lived practice, not merely a guiding principle, and calls for civil society to be actively engaged in this transformation.

Together, these recommendations reflect a deliberate and courageous reorientation of systems, values and collective expectations to change the trajectory of infant removals in Australia.

Learning from our children: has a reliance on a protection-based response let us down?

From these 45 cases, this chapter explores the service system response to four infants who were the subject of reports to the Department responsible for Child Safety before their births. These unborn children came to the attention of the Department responsible for Child Safety due to the multiple complex issues being experienced by their parents.

All four children (three families) were impacted by parental substance use, domestic and family violence and parental history of abuse and/or neglect as a child. Parental mental health diagnoses and criminal history were also factors for two families. For two families there was also significant child protection history in relation to the siblings of the unborn children, while for the other family young parental age combined with a harmful childhood and complex mental health concerns were identified as concerns. These unborn children were highly vulnerable, and concerns received while they were in utero were appropriately screened as Notifications. It was after the recording of the Notification that the difference in system response became apparent.

For two families, the child protection system made the most of the opportunity that was the mother's pregnancy and completed the I&A before birth, participated in interagency communication and collaboration and started intervention during pregnancy via Support Service Cases. After birth, plans were in place to meet the care and protection needs of the children: planning for Child Protection Orders, and an Intervention with parental agreement (IPA).

In contrast, the service delivery to one child, whose timeline is shown below, went virtually silent after the Notification was recorded. The I&A did not start before birth; no Unborn Child High Risk Alert was raised; an IPA case about their siblings due to chronic neglect remained without any case plan in place (meaning the Department responsible for Child Safety had not collaborated with the mother to establish safety goals); and there was no evidence of the Department responsible for Child Safety discussing the mother's pregnancy or what her support needs might be. After birth, the child was not sighted by the Department responsible for Child Safety until three days before their death.

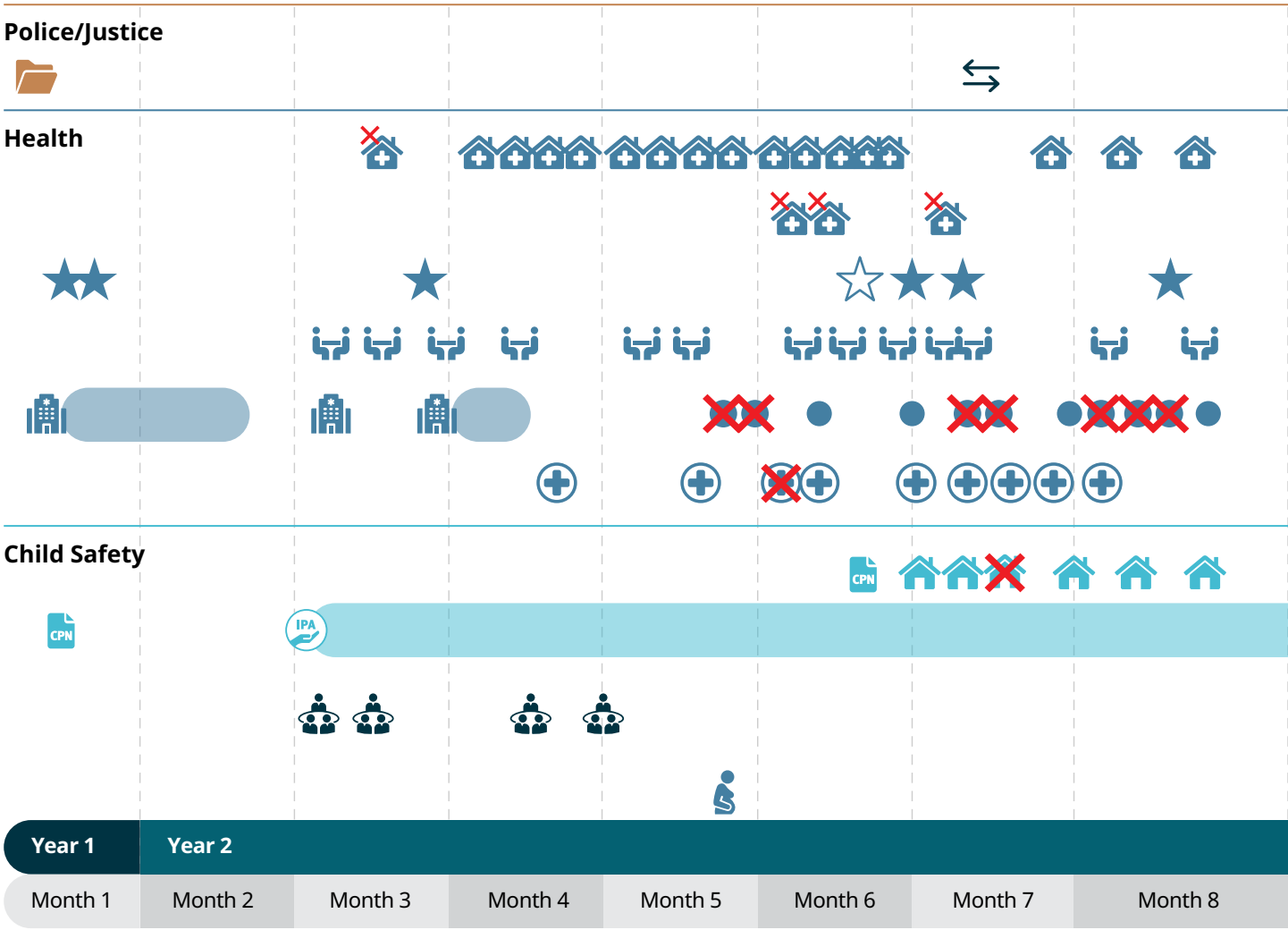
Case example 2: Inconsistencies in key practices and an inability to engage the family

Two professional notifiers reported concerns to the Intake Service in relation to an unborn child and ongoing worries about the health and care of the sibling. The Department responsible for Child Safety had a current IPA case in relation to the siblings. Both notifiers reported that Mother was four months pregnant, and they were worried about unborn Baby due to the significant neglect that had occurred to the sibling. One of the notifiers advised that the sibling "had been admitted to hospital five times… with infected scabies, pneumonia, faltering growth, microcytic anaemia, otitis media, rickets, nits, global developmental delay and refeeding risk." These health conditions and developmental delays were identified by health practitioners as non-organic, and due to the care received at home.

An I&A did not start before Baby's birth; no Unborn Child High Alert Risk was raised and an IPA for the sibling, due to chronic neglect, remained without any case plan in place.

The timeline of interventions for Baby and sibling is shown in Figure 6.

Figure 6: Case example 2: service to an unborn child – timeline of system touchpoints

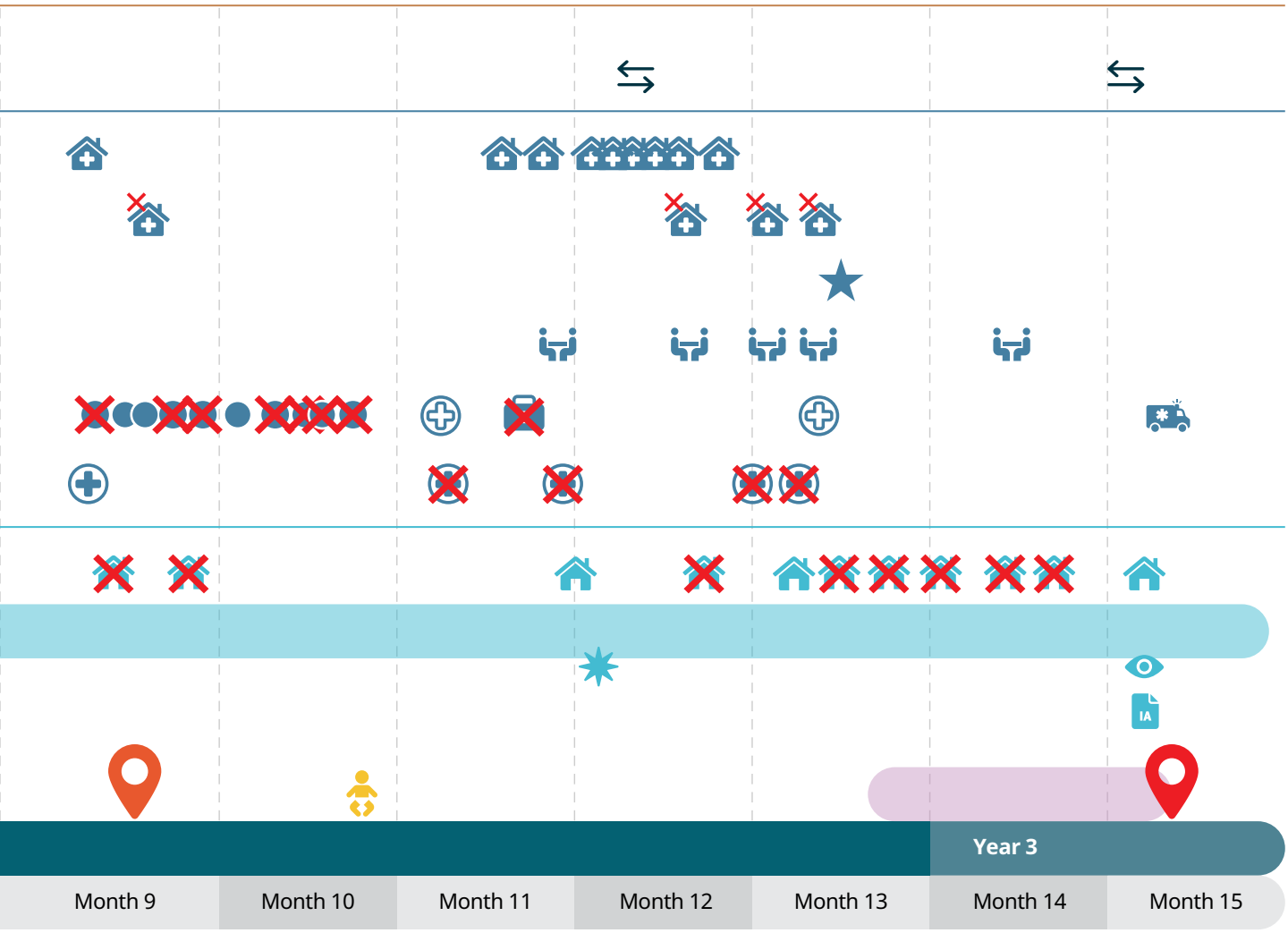


Child Safety

- CPN
- I&A
- Home visit
- Attempted home visit
- Intervention with parental agreement (siblings)
- Baby sighted
- Child safety aware of birth

Health

- Hospital admission (sibling)
- Report to Child Safety (sibling)
- Nurse home visit (sibling)
- Unsuccessful nurse home visit (sibling)
- Paediatric intake and planning meeting (sibling)
- Allied/specialist health service accessed (sibling)
- FTA appointment
- Pregnancy known (unborn child)
- Antenatal care (unborn child)
- Antenatal care (unborn child): failed to attend



- Report to Child Safety (unborn child)
- Child health home visits – cancelled x 3
- Health service accessed: baby
- Queensland Ambulance Service (QAS) response

Police/Justice

- Domestic Violence Order

Other key events

- Information shared
- SCAN Meeting
- Day of birth
- Residing intrastate
- Parent death
- Day of death

"A new baby brings significant changes to any family. It is critical to consider the impacts of a new baby on family functioning and factor in the significant vulnerability of newborns. This should be considered in both casework for siblings in the care of the department, and risk assessments in relation to the unborn/newborn sibling. The additional stressors that can be experienced in the antenatal and perinatal period may require adjustments to family supports, contact arrangements and/or reunification schedules to meet the safety and wellbeing needs of both siblings and the newborn."[31]

Case example 2 of the unborn child in the timeline highlights inconsistencies and limitations in child protection and health service responses, particularly in their ability to engage meaningfully with the family. Despite multiple actions taken by the Department responsible for Child Safety and Queensland Health, coordination was ineffective, and risk planning did not adequately address the unborn child or the sibling despite clear signs of neglect.

While existing policies support timely intervention during pregnancy, a period when mothers may be open to change, these policies are not consistently followed. The presence of multiple risk factors, including domestic and family violence, substance abuse, and intergenerational neglect, calls for more attention to implementing a well-planned and coordinated response.

The ability to identify an unborn child and implement a planned, coordinated response is crucial, yet in this case this opportunity was missed. This case highlights the importance of, but also the limitations of, the Unborn Child High Risk Alert and the IPA which are available to support mothers of unborn children.

This case highlights the implications of practice guidance and tools being applied inconsistently and without impact. The Department responsible for Child Safety outlines in its practice manual:

"IPAs are designed to be intrusive in nature and parents are expected to be able to actively work with Child Safety to reduce the risk of harm to the child."[32]

The case review highlights that there were insufficient efforts to establish a meaningful case plan and provide effective support to the family. Although a non-government organisation was involved in family-led decision making and an IPA was active, an appropriate and tailored case plan was not developed. Families, particularly mothers, need support strategies that they perceive as helpful and relevant to their circumstances.

Support must be delivered in ways that reflect the family's capacity and context, including their adjustment to pregnancy and the arrival of a newborn. The Board identified that previous experiences in care, intergenerational trauma, disability and mental health challenges negatively impacted parenting ability. Despite considerable activity and attempts to engage, actual connection with the family was limited. While practical supports like reminders and transport were offered, the family did not attend appointments, which limited the opportunities for health service provision.

In the same case, an IPA was initiated in relation to the family with known child protection concerns, requiring a family-led decision-making process and the development of a case plan within a set timeframe. Although a provider was engaged to facilitate this process, there was a significant delay in finalising the case plan. Communication from child protection staff indicated uncertainty about the plan's status, and by the time of the child's death the case plan had not been obtained or implemented. The mother expressed that the IPA process was not working for her and that she did not feel supported, highlighting a breakdown in engagement and service delivery.

31 Child Death Review Board, *Collective review report: Housing struggles of infants, children, and their young parents*, 2024, held on 26 September 2024.

32 Department responsible for Child Safety, Seniors and Disability Services (Queensland), *Intervention with parental agreement*. Child Safety Practice Manual, 2025.

These issues were compounded by severe workforce shortages, with a large number of vacant caseworker positions leading to unmanageable caseloads. Despite the family's history of neglect, malnutrition and health concerns, support was insufficient and health service involvement was minimal.

The child was seen by a caseworker and the parents were advised to seek medical attention, but there is no evidence this occurred before the baby's death. The case also revealed specific health issues, including vitamin D deficiency linked to rickets, which were not adequately addressed. This situation underscores the need for timely, coordinated and family-centred responses, especially in cases with clear indicators of risk.

Cases of this sort also highlight how parenting capability concerns manifest as neglect, particularly in the context of intergenerational disadvantage. In the case explored above, a sibling of an unborn child presented with developmental delays due to malnutrition, while the mother's low vitamin D levels placed her unborn child at risk of deficiency and rickets – conditions already observed in siblings. The Board expressed a desire for this case to inform more effective targeting of services and interventions, especially for pregnant women from priority populations. This includes recognising health vulnerabilities early and delivering support in ways that are responsive to the lived realities of families.

Considering the safety and protection needs of unborn children while there is ongoing intervention occurring with older siblings

In this review period, the Board reviewed previous cases of unborn children with siblings in care. The Board considered the safety and protection needs of unborn children while there was ongoing intervention occurring with other siblings. In both cases, the Department responsible for Child Safety identified a need to refine decision-making and strengthen practice guidance for staff when case work is occurring with siblings in care and there is the safety of a newborn to be considered.

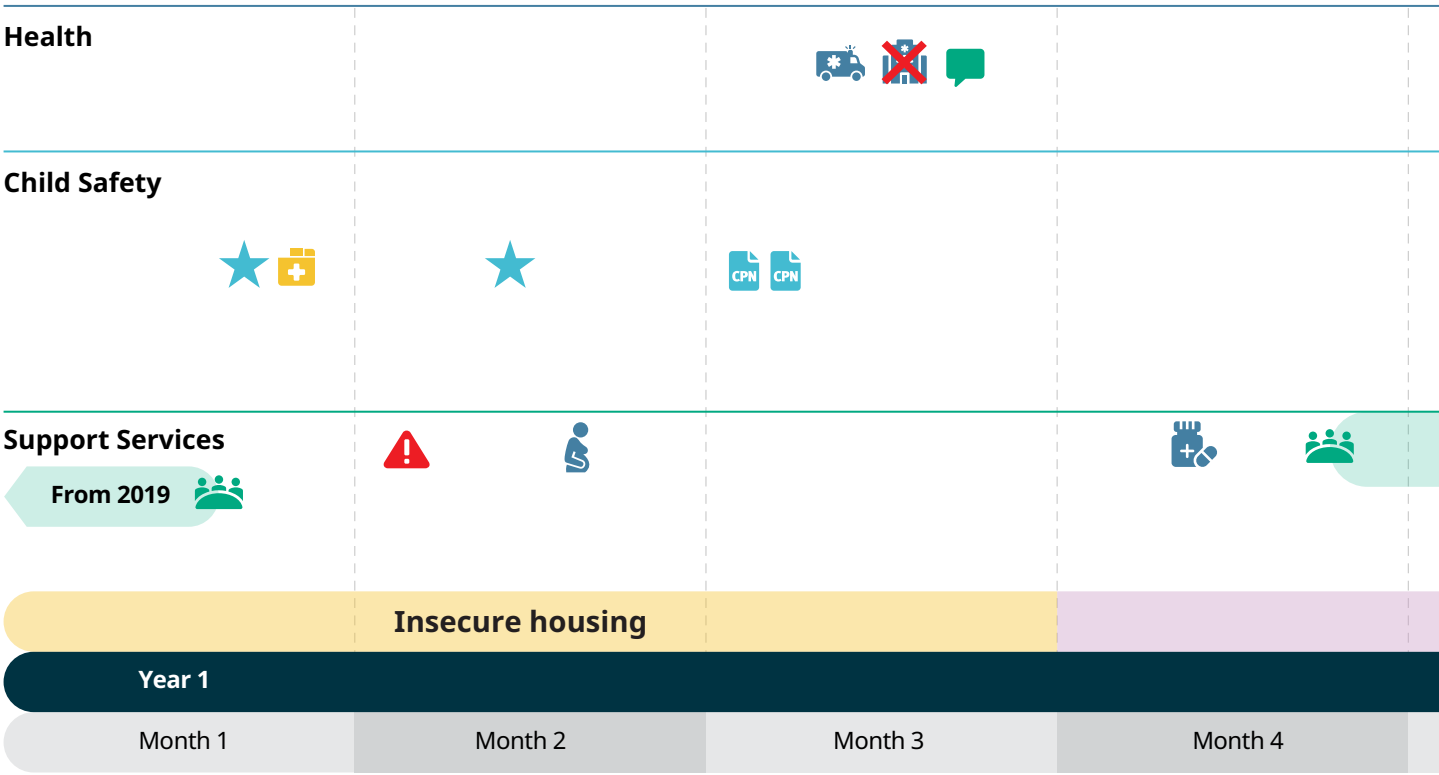
A new baby brings significant changes to any family. It is critical to consider the impacts of a new baby on family functioning and factor in the significant vulnerability of newborns. This should be considered in both casework for siblings in the care of the department and risk assessments in relation to the unborn/newborn sibling. The additional stressors that can be experienced in the antenatal and perinatal period may require adjustments to family supports, contact arrangements and/or reunification schedules to meet the safety and wellbeing needs of both siblings and the newborn. It is also important to recognise that parents who have had their children in out-of-home care will once again be parenting full-time, while continuing to navigate intervention for their older child, reunification planning and contact. These competing stressors could heighten risks associated with historical or current vulnerabilities, including parental mental health issues, substance use or domestic and family violence.

Case example 3: Safeguarding an unborn child in the context of intergenerational risk and systemic delay

The Board reviewed the case of an unborn child who was a second child. The first-born child was removed from the parents' care as an infant and subject to a Short-Term Custody Child Protection Order, living in a kinship care placement. The concerns that led to the first-born child's removal related to their parents experiencing homelessness and living in a car while Mother was pregnant, parental substance use, unaddressed mental health concerns, and Mother's suicidal ideation and self-harming behaviours. Both parents had child protection histories as subject children, including concerns about child sexual abuse and youth sexual offending.

The Department responsible for Child Safety became aware of the pregnancy. Concerns were submitted for approval as a Notification two months later but not approved until four months later after a significant delay.

Figure 7: Case example 3: housing struggles of infants, children and young parents – timeline of system touchpoints

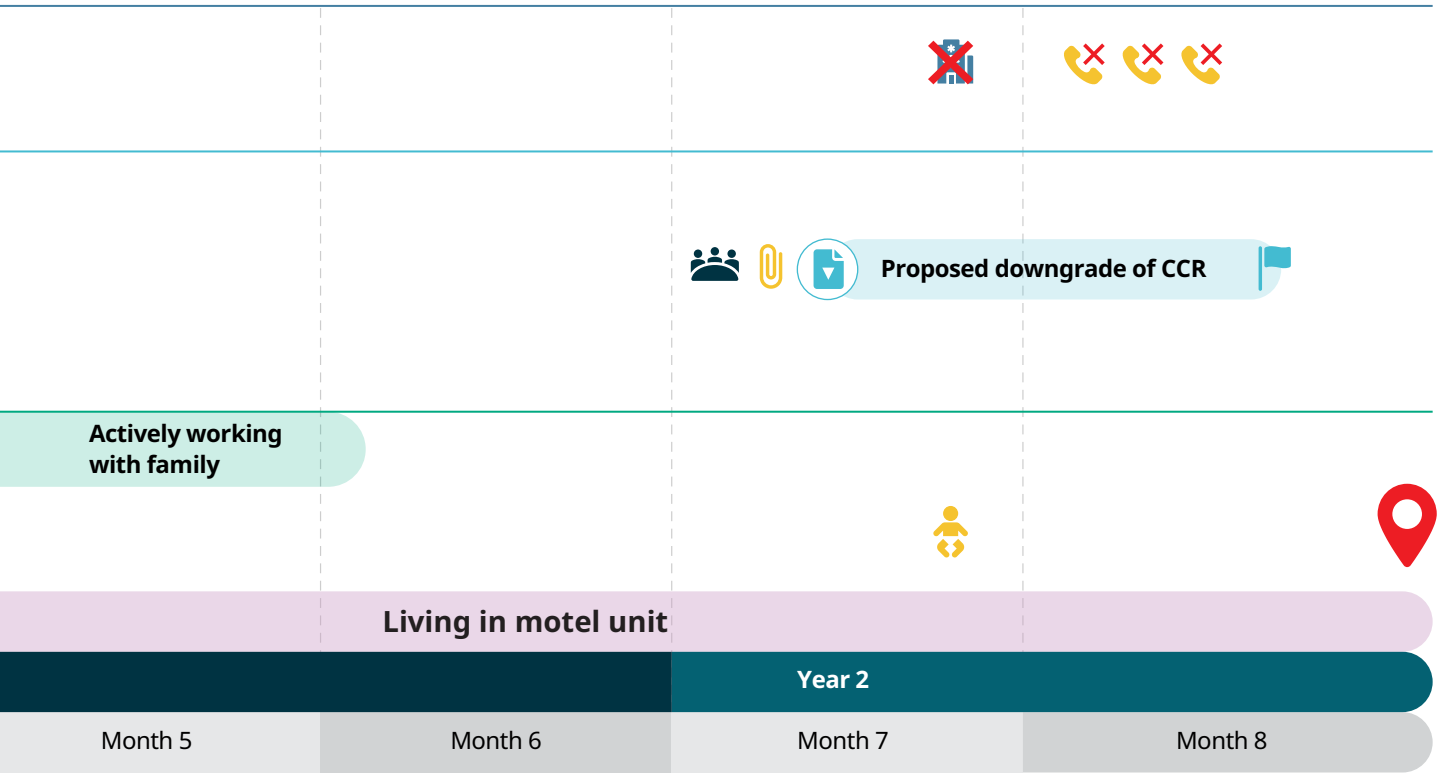


At this time the parents continued to experience prolonged bouts of homelessness, with housing options very limited. Mother was approximately 21 weeks pregnant with the unborn child when Mother and Father secured temporary motel accommodation.

The Department responsible for Child Safety recorded that services were providing ongoing support regarding psychoeducation and parenting skills, while helping Father to secure employment and Mother to access antenatal care. The motel accommodation was initially set to expire but it appears it was extended while the family was trying to secure long-term accommodation. The intake was reopened and the CPN was downgraded to a Child Concern Report following consultation with a non-government organisation, the Department responsible for Child Safety Service Centre's Cultural Practice Advisor and a Senior Practitioner. The rationale noted there were good supports in place including a service for mums, bubs and families.

At the time the child subject to the unborn child report was born.

The timeline of interventions for this child is shown in Figure 7.



Case example 4: Early intervention and risk assessment in the context of infant vulnerability

The Board reviewed the case of an unborn child with two older siblings placed in care. Both older siblings were subject to interim Child Protection Orders granting short-term custody to the Chief Executive. The siblings were placed into the care due to child protection concerns that included Father perpetrating domestic and family violence, Mother's poor emotional regulation and significant parental poly-substance use.

In the months prior to the birth, both parents were working towards reunification with their first two children. In the last month before the birth, they were having overnight contact with the children one night per week and 20 additional hours of contact per week. Through the ongoing intervention for the siblings, the Department responsible for Child Safety became aware of Mother's pregnancy but did not record a separate unborn intake event. The Department responsible for Child Safety staff reportedly discussed the pregnancy with the parents and provided education about the risks of co-sleeping.

A case plan conducted in the week before birth identified that the family's two-bedroom holiday rental was not suitable for reunification with the older siblings. Baby was born prematurely at 35 weeks gestation. Baby was admitted to the neonatal unit due to respiratory distress and required breathing support and antibiotics in their first two days of life. Baby remained in hospital for 12 days before being discharged to the parents. Five days after leaving hospital, Baby, parents and siblings were co-sleeping on a large mattress on the floor of the main bedroom. It was noted there were multiple soft bedding items on the mattress. During the night the parents awoke to find Baby unresponsive and cold to the touch.

The Department responsible for Child Safety's Review Team identified the following high value learnings:

- It is important to recognise that infants are at increased risk due to their age-related vulnerability. Clear documentation is necessary to demonstrate any assessment and decision making that has occurred in relation to how their care and protection needs will be met in their parents' care.
- Early intervention and support with a pregnant woman are critical especially when numerous and complex child protection concerns are present. There needs to be a systems response to a pregnant woman that crosses the secondary and health sectors. Access to early supports and interventions can inform future assessment of how the unborn child's care and protection needs will be met upon their birth if required.

Case example 4 raises consideration of whether risk assessment of unborn children and newborns who have siblings already subject to child protection intervention should be strengthened. Determining whether there is sufficient practice guidance for the Department responsible for Child Safety Officers who undertake ongoing intervention-type case management of siblings, to engage with and support a pregnant woman, once they become aware of the pregnancy, could also be considered. This could include the potential impact the pregnancy has on a family, including the need for changes to case plans and goals.

Enhancing maternal support through early risk identification and outreach

Recent developments in child protection and maternal support services include the introduction of the Enhanced Intake and Assessment Approach, which aims to improve early identification and response to risks.[33] This model is designed to strengthen coordination and ensure timely, appropriate interventions.

33 The Enhanced Intake and Assessment Approach was introduced in April 2025.

A key focus of these improvements is on enhancing antenatal service delivery, particularly through outreach and warm referral pathways. Rather than placing the burden on women to seek out services, the new approach emphasises that services must proactively reach out to women, especially those from vulnerable or priority populations. This shift reflects a commitment to accessibility, equity and responsiveness, ensuring that support is not only available but actively offered in ways that meet women where they are.

Shifting to a more supportive approach or revising risk assessment

The cases underscore the need to rethink how risk is assessed and responded to in cases involving unborn children and their siblings. The cases revealed opportunities to improve how cumulative risk is identified and addressed through supportive interventions that enhance birth and child health outcomes.

While several options were considered to strengthen the system's response, each has distinct implications. One proposal was to broaden the scope of risk assessment to align with other jurisdictions. However, this approach risks reframing the issue as a child protection matter prematurely, potentially undermining maternal rights and reinforcing a compliance-based model of intervention. Instead, the importance of recognising cumulative risks, such as neglect, was highlighted as a critical lens for early identification and support. Another approach is to rely on reforms within the child protection jurisdiction itself. Yet this approach alone may not address the broader systemic gaps that contribute to missed opportunities for early intervention.

The most promising direction identified was to adopt a more systemic view, one that draws on learnings from South Australia and other jurisdictions. This approach reframes the issue from one of surveillance to one of support, advocating for a shift in practice that prioritises antenatal engagement and family-led decision making. It calls for boosting universal and targeted antenatal supports, recognising pregnancy as a critical window to strengthen protective factors and reduce long-term risk.

Concluding comments

The cases reviewed by the Board highlight the importance of supporting families during pregnancy. They show a need to identify risks associated with neglect and physical harm, which are the most frequently reported factors for concern reports. The consideration of cases of unborn children this year points to improvements in using the care of siblings as a pointer to the likely risks to the newborn and providing the right response for unborn children.

Evidence from other jurisdictions and the cases reviewed cautions us against responding by widening risk factors to enact a child protection response. This will further impact the pregnant woman's rights and place certain groups under greater scrutiny.

The greater opportunity to improve outcomes for unborn children, their siblings and families, is to ensure a more consistent and effective approach to identifying and supporting mothers and families. The cases reviewed by the Board show the importance of effective family-led decision making; but also show that this requires vastly better coordination to ensure that the engagement of families aligns with intensive and appropriate supports, particularly antenatal and other health services.

Most powerfully, these cases highlight the importance of enacting a harm prevention focus to offer targeted early intervention with antenatal services to reduce negative birth and child health outcomes for mothers who have had care experiences, parents who have childhood experiences of neglect or abuse, and parents with disability. The impacts of intergenerational disadvantage mean that Aboriginal and Torres Strait Islander families will be over-represented among mothers in these priority groups and who are subject to unborn child risk alerts more generally.

The Board's 2021–22 annual report reiterated the critical importance of early intervention and wraparound services for families with unborn children, particularly in situations involving parental substance use or domestic and family violence. The Board emphasised that these risk factors can significantly compromise the safety and wellbeing of children even before birth, and called for proactive, coordinated responses that engage families during pregnancy. This includes expanding health home visiting programs, integrating culturally safe supports, and ensuring frontline services are equipped to identify and respond to complex needs such as methamphetamine use and coercive control. By intervening early and holistically, agencies can help stabilise families, promote safer environments and improve outcomes for both parents and their unborn children.

Recommendations

The Board recommends that:

Recommendation 1

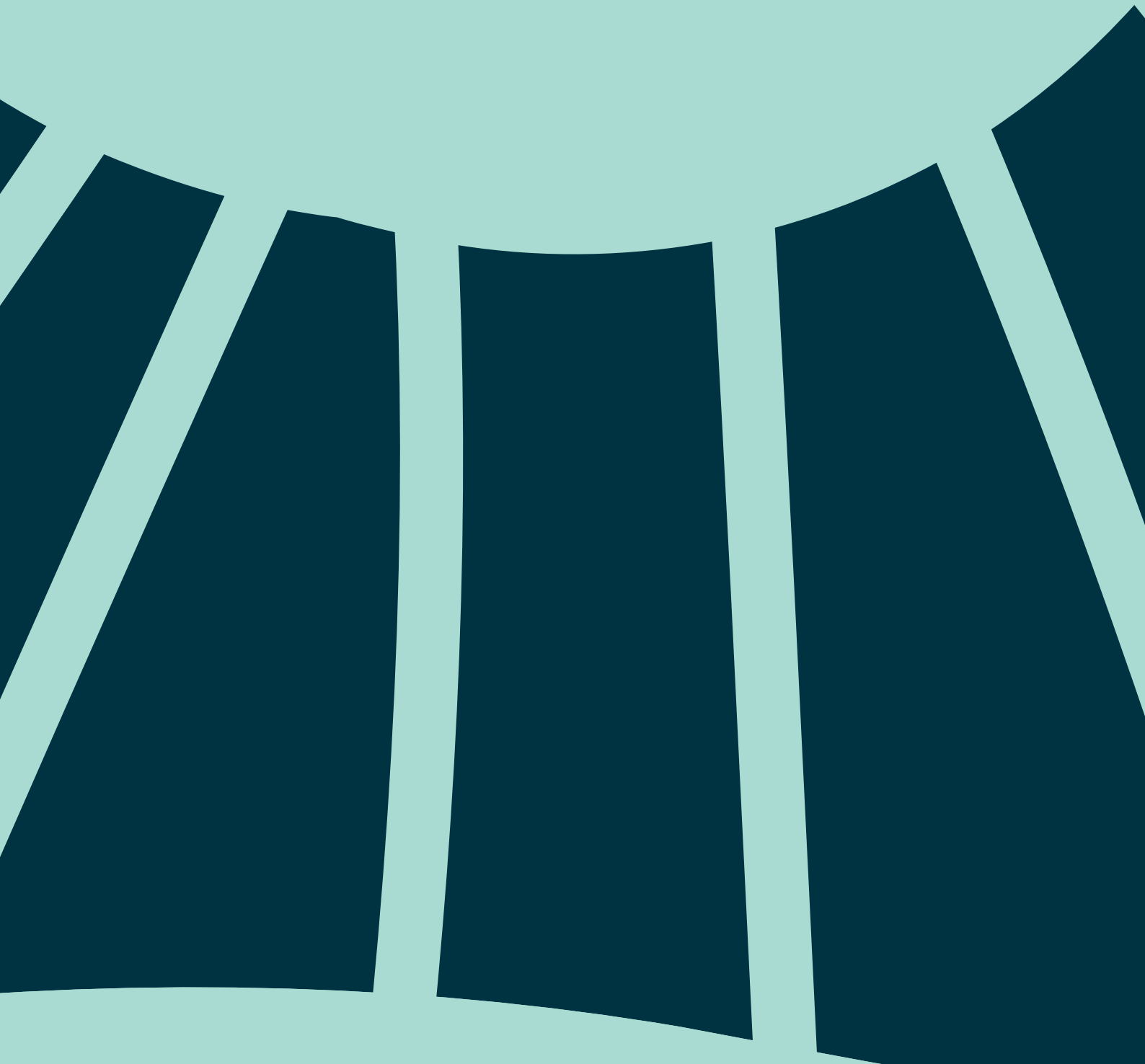
The Minister for Families should urgently review and reset the Queensland Government's policy and responsibility for responding to reports about the safety of unborn children. This should shift the focus from collecting evidence for future statutory child protection intervention towards a stronger, health-led outreach and support approach. As part of this reset, the Department of Families, Seniors, Disability Services and Child Safety, in partnership with Queensland Health, should:

- implement and document responsive pathways for young and care-experienced parents, including dedicated early parenting programs and peer support networks
- enhance the provision of supportive, culturally safe antenatal healthcare services to ensure early engagement and continuity of care for pregnant women, particularly those at risk, leveraging Family Led Decision Making processes and early family engagement wherever possible
- ensure infant care practices during removal proceedings prioritise the infant's immediate health and bonding needs, including opportunities for breastfeeding and physical closeness with the mother where safe and appropriate.

This integrated approach should prioritise health and wellbeing outcomes for unborn and new infants and their parents, reduce the adversarial nature of statutory intervention, and foster earlier, more culturally responsive supports.

CHAPTER 3

Stability begins at home: supporting young parents with infants and children



Nationally, the proportion of young mothers aged under 20 has more than halved since 2010 (3.8% in 2010 compared with 1.6% in 2023). Despite this downward trend, in 2024–25 a comparatively high percentage of Queensland child deaths were in this group. Of the 64 cases reviewed this year, 10 (16%) involved the young parent cohort. This suggests that young parenting warrants specific attention and strategic focus in policy and practice responses.

In 2022, about 4,649 women under 20 (1.5% of all mothers) gave birth across Australia, with Queensland contributing a significant portion.[34] Young mothers as a proportion of all mothers is somewhat higher in Queensland, at 2.4 per cent, than the Australian average. A subset of these young mothers in Queensland parent together with a partner, and some of these partners are also under the age of 20, though exact numbers for partnered parenting under age 20 are not specified in public data.[35] The *Queensland Maternal and Perinatal Quality Council Report 2023* highlights that younger mothers are at increased risk of adverse outcomes and often face complex social circumstances.[36]

This year the Board considered the circumstances of young parents. Specifically, the Board reviewed the child protection system's response to young parents (aged 16 to 24 at the birth of their first child) and their 10 infants or young children who were aged between 18 days and eight years. The Board's consideration of these cases brought attention to the impact of housing instability and homelessness on these younger families. In reviewing these cases, the Board also considered the interplay between domestic and family violence and housing instability and homelessness. This chapter examines the multifaceted, compounding impacts on infants and children of homelessness and housing instability, both immediate and long term, with a particular focus on young parents and families with co-occurring risk factors such as domestic and family violence.

It takes a village to raise a child: housing as an essential link to community

"Housing is the pivotal, critical thing that we need to get right as quickly as possible… Once you've got the housing in place you can start to get in the other services."[37]

Access to safe, stable and adequate shelter is a fundamental human need and a critical determinant of a child's health, development and wellbeing. Children in stable housing environments are more likely to experience positive emotional development (including enhanced self-esteem and self-identity), maintain strong relationships, and achieve better educational outcomes.[38]

Drawing on the Australian Research Alliance for Children and Youth (ARACY) Nest Wellbeing Framework (see Figure 8), housing is a critical component of a child's safety and wellbeing. Stable housing enables families to establish routines, build connections and participate in education, employment and community life.[39] It also underpins the provision of material basics such as adequate space, safe child-appropriate furnishings, nutritious food and access to transport and medical services.[40]

34 Australian Institute of Health and Welfare (AIHW), *Australia's mothers and babies: Summary*, 2025.

35 Queensland Government, *Support for young parents and carers*, n.d.

36 Queensland Maternal and Perinatal Quality Council (QMPQC). *Queensland Mothers and Babies 2020–2021: Report of the Queensland Maternal and Perinatal Quality Council 2023*, Clinical Excellence Queensland, Queensland Health, 2025.

37 ANROWS, *Barriers preventing Aboriginal and Torres Strait Islander women reporting domestic violence*, 2020.

38 Australian Institute of Health and Welfare (AIHW), *Australia's children*, 2022.

39 Australian Institute of Health and Welfare (AIHW), *Australia's children*, 2022.

40 R Goodhue, P Dakin, and K Noble, *What's in the Nest? Exploring Australia's Wellbeing Framework for Children and Young People*, Australian Research Alliance for Children and Youth (ARACY), Canberra, 2021, p 2.

For families with infants, one critical aspect of suitable housing is bedding. Evidence links the absence of safe infant sleeping environment to increased risk of SUDI.[41] This reinforces the importance of housing not only as a structural condition but as a protective factor in early childhood development and survival. Without secure housing, families face compounding risks that can undermine their ability to thrive.

Figure 8: ARACY's Wellbeing Wheel

41 The Child Safeguarding Practice Review Panel (United Kingdom), *Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm*, 2020, p.18.

Increased demand is placing a squeeze on social housing (and those who need it)

People experiencing homelessness, or those at risk of becoming homeless, are among the most socially and economically disadvantaged groups in Australia. Homelessness, within the context of the Census of Population and Housing, is defined as the absence of one or more elements that constitute a sense of 'home'.[42] The Australian Institute of Health and Welfare's Specialist Homelessness Services collection further identifies a person as homeless if they are living in non-conventional settings (such as sleeping rough) or in temporary or emergency accommodation (such as couch surfing or staying with friends).[43]

Queensland has felt the impact of the current housing crisis more than other states and territories. As measured by the average monthly caseload of Specialist Homelessness Services agencies, homelessness in Queensland increased by 22 per cent, compared to only eight per cent nationally, in the four years to 2021–22.[44] On any given day in Queensland in 2023, an estimated 3,900 children (0 to 17 years old) present with their family to an Specialist Homelessness Services agency for housing support. A further 1,600 young people (15- to 25-year-olds) present alone.[45]

Social housing allocation prioritises need over wait time, ensuring those at higher risk (for example, rough sleepers) are prioritised. Crisis housing focuses on immediate safety and stability, transitioning individuals into long-term solutions when possible. The Department of Housing and Public Works prioritises cases based on urgency but cannot provide immediate long-term housing solutions due to supply constraints.

Queensland's social housing system supports over 74,000 properties, with more than 64,500 under direct state ownership.[46] These dwellings serve a wide range of vulnerable groups, prioritising:

- people experiencing homelessness or at risk of homelessness
- women and families affected by domestic violence
- people with disabilities
- Aboriginal and Torres Strait Islander communities
- older people and young people needing crisis support.

However, rapid population growth, soaring property prices, and a private rental market with vacancy rates below 0.08 per cent have outpaced the limited construction of new social housing.[47, 48] The *Queensland Housing Strategy 2017–2027* aims to address this shortfall by delivering 10,000 new social and affordable dwellings over its first eight years.[49]

42 Australian Bureau of Statistics, *Estimating Homelessness: Census methodology*, 2021.

43 Australian Institute of Health and Welfare (AIHW), *Homelessness and homelessness services*, 2025.

44 H Pawson, A Clarke, J Moore, R van den Nouwelant and M Ng, *A blueprint to tackle Queensland's housing crisis*, Queensland Council of Social Service, Brisbane, 2023, p 4. Accessed 1 July 2024.

45 Australian Institute of Health and Welfare (AIHW), *Specialist homelessness services: On any given day, across Queensland 2023*, AIHW, Australian Government, Canberra, 2024, accessed 1 July 2024.

46 Department of Communities, Housing and Digital Economy, *Queensland Housing Strategy 2017–2027*, Queensland Government, 2017.

47 In Queensland, the statewide vacancy rate for the March 2025 quarter was 0.9%, while in areas of Pine Rivers, Redcliffe, and Moreton Bay was between 0.6% and 0.7%. In areas of Maryborough, Toowoomba, Caloundra Coast, and the Southern Downs the vacancy rate was 0.5%, and in Cook and Goondiwindi the vacancy was 0.0%. Real Estate Institute of Queensland, *Queensland's rental market: A New Year, even fewer options*, 8 May 2025.

48 Department of Communities, Housing and Digital Economy, *Queensland Housing and Homelessness Action Plan 2021–2025*, Queensland Government, 2021.

49 Department of Communities, Housing and Digital Economy, *Queensland Housing Strategy 2017–2027*, Queensland Government, 2017.

Other recent Queensland Government initiatives are noted below:

Recent Queensland Government initiatives:

- A commitment to deliver one million homes by 2044, including **53,500 new social and community homes.**
- A trial of a new Master Agreement with community housing providers to cut red tape and accelerate delivery.
- A $365.4 million investment in homelessness funding this financial year to support more than 92 frontline organisations.
- A 20 per cent uplift in funding for Specialist Homelessness Services throughout this term.

Queensland housing policy and supports:

- **Homes for Queenslanders:** Queensland's current housing policy, Homes for Queenslanders, was launched in February 2024. The 2024–25 Queensland Budget committed $3.1 billion to housing and homelessness initiatives.
- **Putting Queensland Kids First:** Queensland Government released the *Putting Queensland Kids First* final plan which included a number of funding commitments relevant to children and families experiencing, or at risk of experiencing, homelessness and housing instability.
- **Closing the Gap Target 9:** Outcome 9 of the *National Agreement on Closing the Gap* is *People can secure appropriate, affordable housing that is aligned with their priorities and need.*

Despite recent investment and reform announcements, demand for social housing continues to outstrip supply, with a 65 per cent increase in the social housing waitlist over the past three years. Vulnerable groups, including young parents and single mothers, face significant barriers to securing housing due to low income, lack of rental history and the limited availability of affordable private rental options for young people on youth allowance or for single parents on parenting payments.[50]

This means that many young families are left without stable accommodation at a time when safety and support are most critical. These cohorts often lack protective factors to help counter 'life shocks' such as unemployment, changes in health and relationship breakdown. This further increases their risk of experiencing homelessness.[51]

Housing stress is related to overcrowded housing

The housing crisis also further drives overcrowded housing, which poses significant risks to young families and children.[52] These risks are especially pronounced for families in low socioeconomic areas and those who are fleeing domestic violence. Aboriginal and Torres Strait Islander children are disproportionately affected: they experience overcrowding at more than four times the rate of non-Indigenous children.[53,54]

Overcrowded housing increases the transmission of respiratory, ear, and skin infections, and is linked to higher risk of SUDI due to limited access to safe infant sleeping environments.[55,56] Further, children living in overcrowded housing have an increased risk of emotional and behavioural problems and reduced school performance, as overcrowded living arrangements may disrupt their sleep and their ability to concentrate and reduce space for study.[57]

50 Queensland Family and Child Commission, *Parenting as a young person*, 2024, p 18.

51 National Housing Supply and Affordability Council, *State of the Housing System 2024*, 3 May 2024.

52 Solari C and Mare R, 'Housing crowding effects on children's wellbeing'; Lowell A, Maypilama L, Fasoli L, Guyula Y, Guyula A and Yunupiju M, 'The "invisible homeless" – Challenges faced by families bringing up their children in a remote Australian Aboriginal community'. *BMC Public Health*, 2018, 18(1):1–14.

53 Easthope H, Stone W and Cheshire L, *The decline of 'advantageous disadvantage' in gateway suburbs in Australia: The challenge of private housing market settlement for newly arrived migrant*. Urban Studies 0:0042098017700791; Mission Australia (2019), *Out of the shadows—Domestic and family violence: A leading cause of homelessness in Australia*. Sydney: Mission Australia, 2017.

54 Australian Institute of Health and Welfare, *Overcrowding*, 2022.

55 Solari C and Mare R, 'Housing crowding effects on children's wellbeing'; Lowell A, Maypilama L, Fasoli L, Guyula Y, Guyula A and Yunupiju M, 'The "invisible homeless" – Challenges faced by families bringing up their children in a remote Australian Aboriginal community'. *BMC Public Health*, 2018, 18(1):1–14.

56 The Child Safeguarding Practice Review Panel (United Kingdom), *Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm*, 2020, p.18.

57 Australian Institute of Health and Welfare (AIHW), *Australia's children*, 2022.

Young parents starting out with little support

"Young parents are highly motivated to be good parents, to have a home and a good education and to do well in life. Specialist services that support young parents in these endeavours play an essential role in improving education, employment, health and safe parenting outcomes."[58]

In Queensland, young parents are often defined as parents aged between 15 and 24 years.[59] The cases reviewed by the Board involved mothers aged between 16 and 24 at the birth of their first child and fathers aged between 16 and 35 at first birth.

Becoming a parent at a young age can be both overwhelming and transformative. Young parents often navigate the demands of caregiving while facing significant social and economic challenges, including disrupted education, reduced access to stable housing, and limited income.[60] For many, the absence of safe, appropriate accommodation and consistent support networks can compound stress and isolation, making it harder to provide a stable environment for their children. These vulnerabilities are not a reflection on their capacity to parent; they reflect the systemic gaps that leave them unsupported at a critical time in their lives.

Although teenage pregnancy rates in Queensland have declined significantly, more than halving from 3,158 births in 2001 to 1,482 in 2021, certain groups remain disproportionately affected. Pregnancy rates for vulnerable cohorts, such as those with care experiences, remain disproportionately high.[61] These families often face multiple, intersecting challenges with all nine families investigated by the Board experiencing two or more additional complex issues and vulnerabilities, which increased the risks for children in the home, including:

- domestic and family violence (seven of nine families)
- parental substance use (seven of nine families)
- parental mental health issues (seven of nine families)
- parental criminal history (six of nine families)
- parent with a history as a subject child in the child protection system (six of nine families).

The intersection of domestic and family violence and housing instability presents particularly complex challenges for young parents. Domestic and family violence is a leading cause of homelessness among women and children in Australia and is a major driver of housing insecurity. Further, young parents are significantly more likely to experience intimate partner violence than their non-parent peers. A seven-year analysis by Brisbane Youth Service (2015–2022) found that 63 per cent of young parents reported past experiences of domestic and family violence, compared to 33 per cent of young people without children.[62] Issues to do with identifying domestic and family violence and the risk to families will be further discussed in Chapter 5.

The *National Plan to End Violence against Women and Children 2022–23* noted that inadequate housing options limit women's and children's ability to leave violent situations and present barriers to accessing help and support.[63] The plan recognised that access to safe, affordable housing is critical to ending violence against women and children, especially for those in the child protection system who face compounded risks from domestic violence and housing instability.

The challenge of securing stable housing can significantly impact young parents' ability to provide a safe, healthy and nurturing environment for their children. Young parents may be excluded from housing support due to restrictive eligibility criteria or service contracts. For example, some Specialist Homelessness Services are contractually required to cease support for pregnant or parenting young women if they are known to or suspected of being involved with the Department responsible for Child Safety. Fear of being reported to the Department responsible for Child Safety may also discourage young parents from seeking help.

58 Australian Human Rights Commission, *Children's Rights Report 2017*, 2017, p. 154.
59 Queensland Government, *Support for young parents*, 2023.
60 Queensland Family and Child Commission, *Parenting as a young person*, 2024, p 18.
61 Queensland Family and Child Commission, *Parenting as a young person*, 2024, p 5 & 12.
62 Brisbane Youth Service, Young People and Family and Intimate Partner Violence, 2024.
63 Australian Government, First Action Plan and implementation, 2022.

Keeping Women Safe in their Homes is an Australian Government initiative under the National Plan to End Violence against Women and Children 2022–2032. The initiative funds state and territory governments and selects providers to deliver programs where the victim-survivor parent and children remain in their existing home and the person using violence is excluded.

Case example 5: The impact of domestic violence as a driver of homelessness for young parents

Young Mother, in her twenties at the birth of first child, was homeless during her pregnancy, couch surfing between the homes of her parents, Father, and his parents. Father perpetrated significant violence before and after Baby's birth, including physically assaulting Mother while she held the infant. During her pregnancy, Mother reported to Queensland Health staff that she used methamphetamine as a coping strategy in the context of Father's behaviours and actions towards her.

After the birth of Baby, Mother had made attempts to leave and had stayed in emergency accommodation and domestic violence refuges.

One of these refuges helped Mother with finding long-term accommodation. She was reluctant to make reports to the QPS for fear of retaliation, as Father had threatened to send videos of her to the Department responsible for Child Safety that showed her in a heightened state.

When Baby was five months old, Mother was sub-renting a room in a share house for her and the baby. Despite a Domestic Violence Order in place, Father was living with Mother on the night of the baby's death. An unsafe sleeping environment (co-sleeping with both parents with soft bedding and pillows) was identified as a factor in Baby's death. At the time of Baby's death, there was an open I&A underway.

Opportunities for early intervention and support

Preventing early pregnancies occurring without adequate support through education and social support should be the first approach so that young people are fully informed of the implications of early and/or unwanted pregnancies. The CREATE Foundation argues that such education should be included in transitioning to independence planning for young people aging out of care.[64]

As recommended in the Queensland Family and Child Commission's (the Commission) insights paper *Parenting as a young person*, intervention strategies for infants and children of young parents need to focus on addressing the multidimensional needs of young people. This includes stable accommodation, coordinated services to address parenting needs, and support for their mental health and wellbeing. The Commission recommends that interventions and supports must also recognise, encourage and foreground young parents' inherent capabilities and strengths in raising children wherever possible.[65]

"Early intervention works. Prevention works. We know this because we lived it. When young parents have access to the right support, they find each other. They find friendships, they kick goals, and they raise children who thrive."[66] - Living experience youth advocate

64 CREATE Foundation, *Young Parents with a care experience*, 2022.

65 Queensland Family and Child Commission, *Parenting as a young person*, 2024, pp 29–31.

66 Rachel. (2025). QFCC Youth Summit 2025 speakers Rachel and Shantelle (Healthy). https://www.youtube.com/watch?v=48Zxw4mrlmg

"… sometimes you feel like people are going to judge you because of how young you are, and because you're not married, you're not with your baby daddy [sic] or whatever they're called. So, you have that resentment of coming to somewhere where people are going to stare at you be like what the hell. Why are you here so young?"[67]

Young parents are statistically less likely than older parents to access adequate antenatal care, despite its well-established role in improving pregnancy and child health outcomes, particularly for adolescent parents. Regular antenatal care supports early identification of health risks, strengthens maternal wellbeing and promotes safer birth outcomes.[68] Women who are engaged in antenatal care receive vital information to support informed choices about maximising the safety of unborn babies and reducing risks such as SUDI.[69]

However, many young women face significant barriers to accessing and engaging with antenatal care. These barriers are more acutely felt by those who are experiencing disadvantage including homelessness, housing instability and family violence.[70]

The *Parenting as a young person* paper identifies the following factors as impacting the level of engagement of young mothers with antenatal care:

- young mothers not being made aware of the supports that are available to them and not knowing how to access antenatal services
- fractured and disconnected services and inconsistency in services being delivered across regions (including age range for services delivered, that is differing age thresholds across regions)
- a lack of culturally appropriate, trauma informed services for young Aboriginal and Torres Strait Islander mothers.[71]

A lack of antenatal care substantially limits the ability of the healthcare system to form meaningful relationships with, and provide supportive care to, those mothers who are at greatest risk when they need it most.

The cost of housing instability and transience for young families

Pregnant and parenting young people are more likely to be highly mobile and often live in vulnerable and unstable situations. They are also more likely to experience difficulty securing safe, stable, and long-term accommodation. When a young parent becomes homeless or is required to move residence, there are inherently complex personal and systemic difficulties associated with accessing services across service delivery regions, particularly Hospital and Health Service locations.[72]

Homelessness and transience disrupt consistent service delivery, as families face frequent moves, unstable housing and fragmented support systems. When families are transient, services struggle to maintain continuity. This increases risk to children due to missed opportunities for early support. The Board has observed cases where children with chronic conditions required ongoing care, but housing instability made it hard to keep appointments, follow treatment plans or stay connected with providers.

67 Wong Shee et al, Accessing and engaging with antenatal care: an interview study of teenage women. *BMC Pregnancy and Childbirth, 2021, 21(693)*, p.3.

68 Wong Shee et al, Accessing and engaging with antenatal care: an interview study of teenage women. *BMC Pregnancy and Childbirth, 2021, 21(693)*, p.3.

69 Queensland Paediatric Quality Council on behalf of Queensland Child Death Review Board, *Issues Paper: Sudden unexpected death in infancy among vulnerable families in Queensland*, 2022, p.17.

70 Penman S, Beatson R, Walker E, Goldfield S and Molloy C, *Barriers to accessing and receiving antenatal care: Findings from interviews with Australian women experiencing disadvantage*, 2023.

71 Queensland Family and Child Commission, *Parenting as a young person*, 2024, p 22

72 Queensland Family and Child Commission, *Parenting as a young person*, 2024, p 18.

Case example 6: Housing instability breaks connections to school and negatively impacts community connections and a young family's ability to manage diabetes for their children

Two young parents, aged in their early twenties at the birth of their first child, were raising five children, including a Child diagnosed with Type 1 diabetes, Autism Spectrum Disorder, and Attention Deficit Hyperactivity Disorder, and a baby. In 2022, the family became homeless while Mother was in early pregnancy with the fifth child. Unable to afford private rental housing, the family couch-surfed between relatives and friends, often confined to a single room. Mother advised the Child's school that they were considering purchasing a tent to live in.

Despite experiencing homelessness, the family had maintained school attendance for their children. However, by early the following year the children ceased attending school, and the family began moving between crisis placements and temporary accommodation. This transience severely disrupted the family's ability to maintain consistent links with education and health services. Health services raised concerns about the management of Child's diabetes, particularly in the context of reported food insecurity and the family's difficulty in regulating his access to high-sugar foods.

Baby was born while the family was still homeless. A couple of months later, Housing Support Services helped the family to access crisis accommodation which was a converted bed and breakfast-style shed with one bedroom, a living area and an ensuite. The only bed, a queen-sized mattress, was shared by the parents and two children. The children slept on a pile of blankets at the foot of the bed, and Baby slept in a bassinet or co-slept with parents.

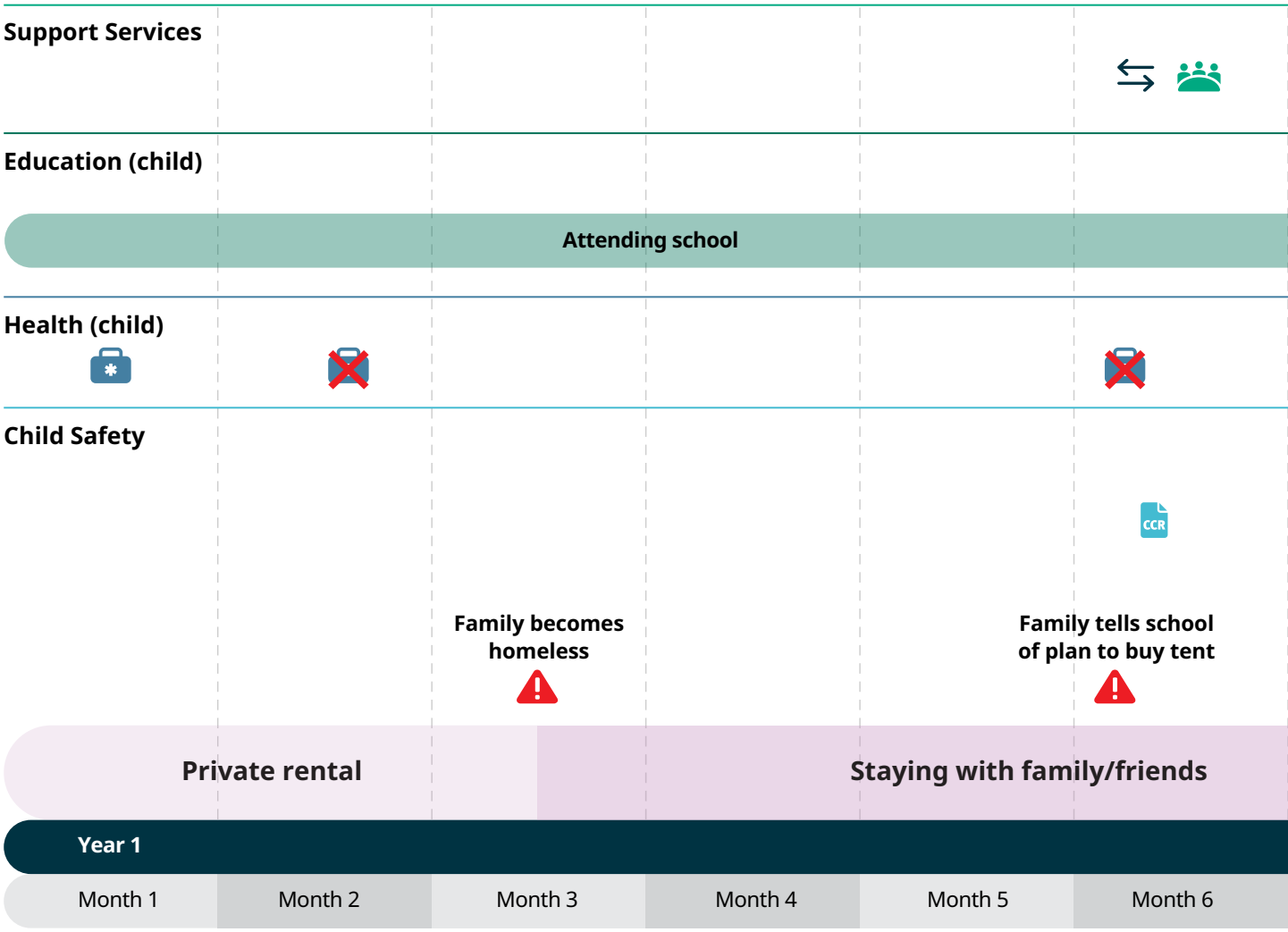
A week later, Baby died from SUDI. The coroner identified unsafe sleep environment as a contributing factor in Baby's death. The siblings were transported to hospital by ambulance where staff observed them to be malnourished, cachexic and small for their age, with elevated blood glucose levels. Although clinicians recommended admission for further diabetes education and monitoring, the decision was made to discharge them the same day to avoid compounding the family's distress.

Following Baby's death, the Department responsible for Child Safety and the Family Wellbeing Service made arrangements for the family to move to a different motel which was located closer to the school. The siblings were re-enrolled at school. Father left the household several days after Baby died, leaving Mother to care for four children on her own.

About two weeks later, a second Child died. The autopsy report identified diabetic ketoacidosis as the cause of death, with evidence of poor long-term glycaemic control and inadequate insulin administration.

The timeline of interventions for Baby and Child is shown in Figure 9.

Figure 9: Case example 6: housing struggles of infants, children and young parents – timeline of system touchpoints



Support Services

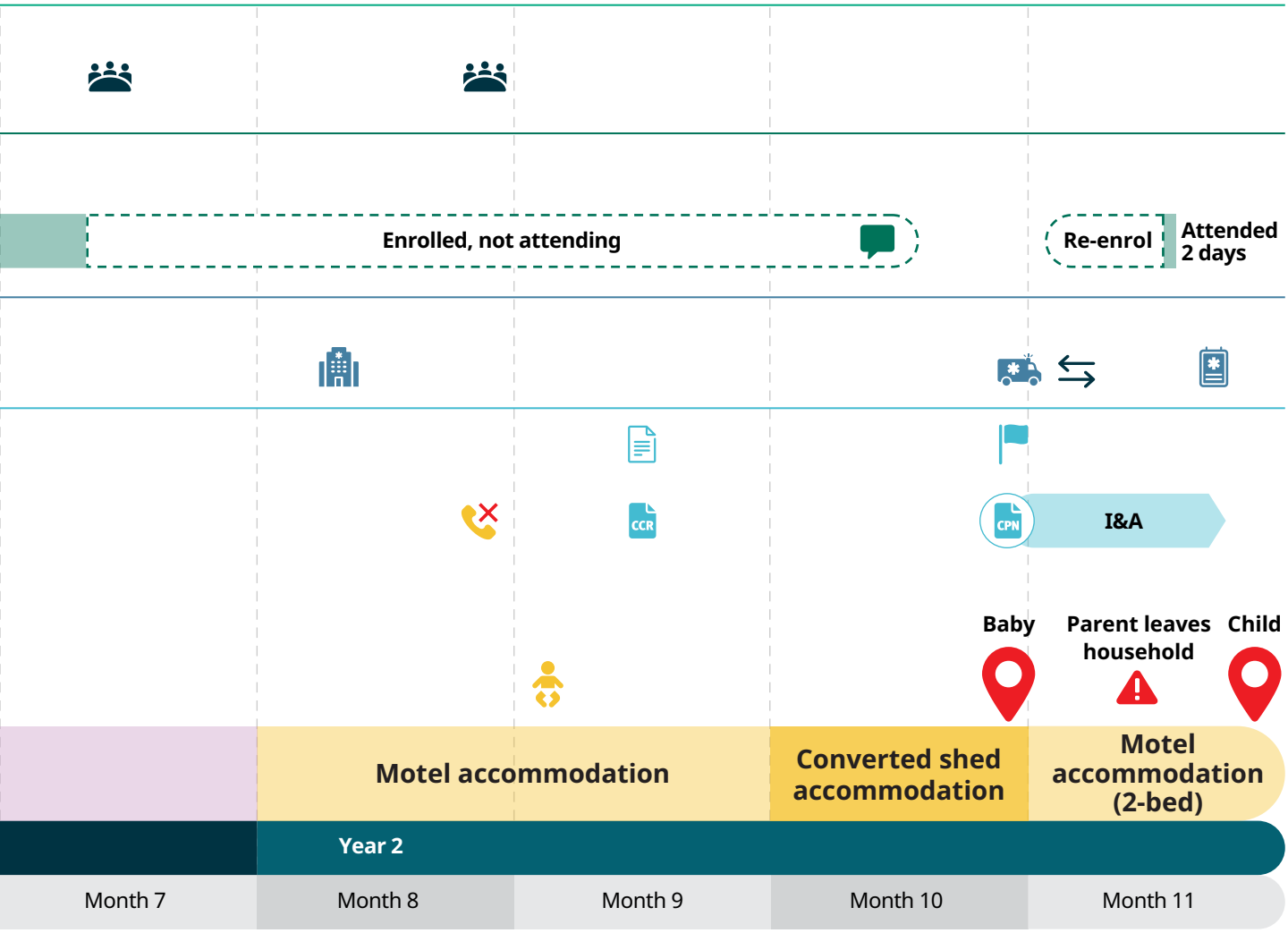
- Family wellbeing service
- Housing support service
- Request for information

Education

- Sharing child protection information from school to QPS
- School attendance / non-attendance

Health (child)

- Medical review (did not attend)
- Medical review (attended)
- Scheduled medical review (post-death)
- Emergency Department presentation
- Hospital admission



Child Safety

- CCR
- Last contact with parent prior to I&A
- CPN
- Student protection report
- Safety Assessment (safe)

Other key events

- I&A
- Significant event
- Baby is born
- Day of death

Case example 6 highlights an important aspect of housing instability: the way it compounds instability in other areas of life. For this family, their housing situation caused them to move away from a school catchment area which was playing an important supportive role. When the child was not attending school, they lost the regular support they had been receiving for their diabetes management and neurodivergence. School was likely a protective factor for the child and their family in managing their diabetes.

Case example 7: The impact of housing instability and transience on the safety of the child

Young Mother, in her early twenties, experienced homelessness and housing instability alongside her three children. The family's living situation was characterised by domestic violence and financial hardship. Mother had a documented history of substance use, which intermittently impaired her capacity to care for the children. During these periods, the children were temporarily cared for by extended family members.

The family's frequent relocations across regions and their reliance on temporary accommodation disrupted access to essential services. This instability made it difficult for child protection and support agencies to maintain consistent engagement. Over time, the family's circumstances became increasingly opaque to authorities, particularly as they crossed state borders and changed housing arrangements rapidly.

The situation culminated in a fatal accident involving Mother and one of the younger children. Both lost their lives, highlighting the compounded risks faced by families experiencing housing insecurity, service fragmentation and limited systemic oversight.

The Board highlights this case to show how housing transience can be a significant barrier to keeping children and families safe. Frequent changes to living arrangements can frustrate efforts made by the Department responsible for Child Safety within or across locations including regions or state borders. While this lack of visibility can be an unintended consequence of housing instability, locational transience can also be used by families to avoid engaging with child protection services.

The reality of raising children in motel rooms

In response to increased demand for Specialist Homelessness Services, there has been an increased use of motel and other holiday-rental-style accommodation for crisis accommodation. Each night about 700 families with infants are placed in temporary hotel or motel accommodation across Queensland. These families typically stay for an average of 27 days, though some remain for extended periods exceeding 90 days, especially when suitable long-term housing is unavailable.[73] Many families are moved multiple times between locations, which can disrupt routines and access to essential services.[74]

Motel accommodation is unlikely to provide families with the appropriate space, furnishing, cooking facilities or amenities to best meet a child's wellbeing. Beyond the physical limitations of motels, there are non-physical risks due to their transient nature and limited to no vetting of the other people living near a child. Some motels may also increase a parent or child's proximity to antisocial people or behaviours.

Families with young parents in motel accommodation

In circumstances where there is no alternative crisis accommodation available, families, including those with very young babies and infants, are sometimes placed in motel rooms. While this option provides an immediate roof over their heads, it is a stopgap measure that raises significant concerns for the safety, wellbeing and developmental needs of children. Unlike purpose-built family shelters or supported accommodation services, motel rooms are not designed to meet the requirements of families raising infants or toddlers. Motels often house a wide variety of tenants, including adults with complex needs, histories of offending or behaviours that may place children at risk. For a young parent navigating the already overwhelming responsibilities of caring for an infant, the proximity to potentially unsafe or volatile neighbours can heighten feelings of fear, insecurity and social isolation. The Department of Housing and Public Works, when placing families in such settings, must consider the heightened vulnerability of young parents, who often lack the protective factors, such as strong family support networks or financial security, that could otherwise help mitigate these risks.

In addition to external risks, the physical environment of motel rooms is fundamentally inadequate for the care of babies and young children. Motel rooms typically lack basic facilities such as kitchens for preparing safe and nutritious food, laundry facilities for maintaining infant hygiene, and appropriate spaces for play and stimulation. For infants and toddlers, these deficits are not minor inconveniences but factors that can directly impact healthy growth and development. The absence of child-safe areas compounds the risk, as parents are left to manage in environments where furniture, fixtures, and layouts have not been designed with children in mind. This can increase the likelihood of accidents or injuries, particularly where parents are fatigued or under stress.

The psychological impact on young parents also warrants attention. Being placed in a motel environment, often at short notice and far from familiar supports, can reinforce feelings of disempowerment and marginalisation. For many, the experience is isolating, with little opportunity to build connections with supportive services or peer networks. The transient and impersonal nature of motel living undermines stability, which is essential for young families working to establish routines and build confidence in their parenting role.

Among the cases reviewed in this chapter, two involved young families living in motels as medium-term and transitional housing, supported through their respective Specialist Homelessness Services. Families placed in emergency and crisis accommodation often find themselves abruptly removed from familiar environments and social networks, leaving them disconnected from the supports that typically help buffer stress. The psychology of crisis highlights that during periods of acute upheaval, people are particularly vulnerable to feelings of loneliness and disorientation, as their usual coping mechanisms and sources of belonging are disrupted. For young parents with infants, this isolation can be profound: the absence of extended family, peers and community connections not only limits access to practical assistance but also deprives them of the emotional reassurance needed to navigate the pressures of early parenting. In this context, crisis accommodation can unintentionally compound distress, with the very setting meant to provide safety becoming a site of isolation and heightened vulnerability.

73 Australian Institute of Health and Welfare (AIHW), *Specialist Homelessness Services: Monthly data*. Australian Government, 2025.

74 Australian Institute of Health and Welfare (AIHW), *Specialist Homelessness Services: Monthly data*. Australian Government, 2025.

For some families, however, entry into crisis accommodation can provide a momentary sense of security and relief. The immediate provision of shelter and safety from violence, instability or homelessness can reduce acute stress and create a stabilising pause in an otherwise chaotic environment. Within this pause, persistent and previously less visible risks often become more apparent. Some parents may, for the first time, feel able to disclose or reflect on challenges such as substance use, mental health struggles or the cumulative impact of trauma. For others, the structured environment of crisis accommodation can provide opportunities for engagement with services that had previously been inaccessible or avoided. In this way, while crisis accommodation can be isolating for some, for others it represents a critical juncture where hidden vulnerabilities are surfaced and supports can be more effectively mobilised.

Policy and research: Improving crisis accommodation for children

Concerned with the availability and delivery of crisis accommodation, a 2023 report by the Australian Housing and Urban Research Institute, *Crisis accommodation in Australia: now and for the future*, made the following recommendations:[75]

- develop minimum quality and safety standards for crisis accommodation
- broaden the range of service offerings provided to meet the scope of clients' needs
- develop a basic set of rules and policies for crisis accommodation services to ensure the safety and comfort of clients, including consideration of a ceiling for co-contributions to ensure affordability, as well as coordinated allocation and entry processes
- enhance integration of primary and allied health services such as mental health support with crisis accommodation
- consider mandatory reporting requirements on crisis accommodation for states and territories, to provide a clear picture of the capacity of the Specialist Homelessness Services-managed crisis accommodation sector.

These risks highlight the need for the Department of Housing and Public Works to adopt a more deliberate and child-focused approach when placing families with young children in emergency accommodation. Assessments must take into account not only the immediate availability of shelter but also the developmental, health and safety needs of infants and young children. Where motel placements are unavoidable, they should be accompanied by safeguards such as regular monitoring, rapid referral to health and parenting supports, and clear planning for transition to more appropriate accommodation. Without these measures, the use of motels as emergency housing risks compounding the very vulnerabilities it seeks to alleviate.

To inform its work this year the Board invited the Department of Housing and Public Works to present. The key points from the presentation included:

- Crisis accommodation is often fully booked due to high demand and market pressures.
- The department prioritises cases based on urgency, but it cannot provide immediate long-term housing solutions due to supply constraints.
- The system lacks capacity to assess the safety of families or accommodation fully. Collaboration with health agencies is suggested.
- Collaboration exists, but housing services are not equipped to assess risk independently. Data sharing could identify risk patterns (for example, young parenting, domestic family violence). Housing teams are open to working with other departments to track and address vulnerabilities.
- Continued collaboration with other agencies and innovative solutions are necessary to address these challenges holistically.

75 Batterham D, Tually S, Coram V, McKinley K, Kolar V, McNelis S, and Goodwin-Smith, Crisis accommodation in Australia: now and for the future, AHURI Final Report No. 407, Australian Housing and Urban Research Institute Limited, Melbourne, 2023.

Rethinking what safe means in temporary living

The Board has previously discussed the need for safety assessments in temporary living arrangements. Children experiencing housing instability or homelessness often move frequently, increasing their vulnerability and necessitating additional safety assessments. However, as shown in case example 7, frequent transience can reduce a child's visibility to the system, making it difficult for the Department responsible for Child Safety to stay informed about changes in their circumstances.

While the Specialist Homelessness Services have established risk assessment protocols for their own accommodation options, these do not extend to broader crisis placements such as motels. This gap highlights the need for system-wide safety assessments that account for all types of temporary housing, particularly for families experiencing homelessness.

To increase shared knowledge about a child's whereabouts in the context of housing instability, a structured and ongoing dialogue is needed between Specialist Homelessness Services and the Department responsible for Child Safety. This imperative also extends to other child protection entities such as Health and Education, as well as secondary services that interact with children and families experiencing homelessness. The Board recognises that housing services are not equipped to assess risk independently. Data sharing between departments could help identify patterns of vulnerability and improve early intervention.

Specialist Homelessness Services and other secondary service providers play a critical role in implementing risk mitigation strategies for vulnerable families. This includes working collaboratively with the Department responsible for Child Safety to conduct safety assessments for crisis and temporary accommodation placements. Embedding these practices into routine service delivery is vital to ensuring that children's safety and wellbeing are prioritised across all service touchpoints.

Experiences of infants and young children in women's refuges

Women and children often remain in refuges for long periods of time while others on the housing register are placed faster. This is due to the perception that women's refuges are a suitable form of accommodation as they are secure and have a bed. However, it is important to highlight that those living in women's refuges are still chronically homeless, with significant safety risks. Strategies to address the need for appropriate long-term safe accommodation options for women and children placed in refuges are a current area of unaddressed need.

There is also concern that infants' needs may be overlooked in some refuges. An Australian Association for Infant Mental Health (AAIMH) paper on infants in women's refuges calls for an 'infant-led' model that recognises that infants do not have the time to wait while their mothers recover from what is often significant and cumulative abuse.[76] The proposed approach emphasises the mother-infant relationship to facilitate recovery for both infant and mother.

An infant-led approach also advocates for the role of fathers and male role models in infant development. The AAIMH is wary of the tendency for mothers and refuge staff to refrain from speaking about fathers and their relationship with the child and their mother. This disrupts an infant's ability to make meaning about their relationship with their father and impacts their emerging sense of self.[77]

The principles behind AAIMH's infant-led refuge model parallels a key theme identified in the Department responsible for Child Safety's system and practice reviews: partnering with mothers cannot be at the expense of identifying risks to an infant, especially when substance use issues are present.

Further discussion on the importance of identifying and responding to domestic and family violence risk in the lives of children is in Chapter 5.

76 Australian Association for Infant Mental Health (AAIMH), *Infants in Women's Refuges/Shelters*, position paper, AAIMH, South Australia, 2024, p 6, accessed 24 July 2024.

77 Australian Association for Infant Mental Health (AAIMH), *Infants in Women's Refuges/Shelters*, position paper, AAIMH, South Australia, 2024, p 7, accessed 24 July 2024.

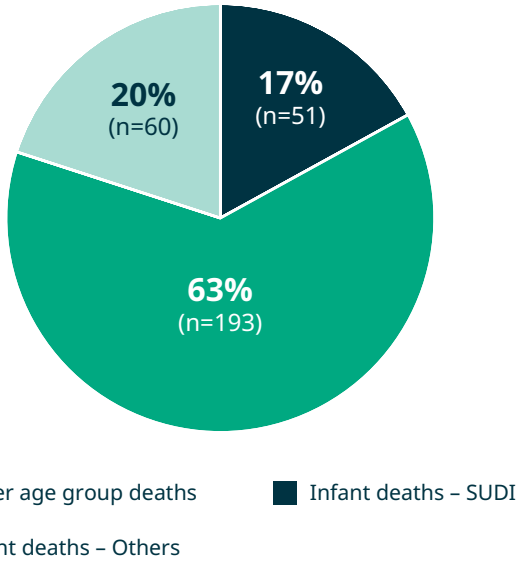
Safe infant sleep challenges for homeless families

"Clearly, poverty and housing circumstances limit opportunities to provide safe/separate sleep arrangements and, we speculate, are also related to broader stresses that affect the own wellbeing of the carer, the ability to access and provide optimal care and make good health-related decisions."[78]

Housing instability and homelessness can compound risks experienced by infants and children, particularly in relation to SUDI. SUDI is a category of death where an otherwise healthy infant dies suddenly and unexpectedly, usually during sleep, without an immediately obvious cause. For infants in families who had contact with the child protection system, most SUDI deaths "occur in highly hazardous sleep environments, frequently while sharing a sleep surface in the context of parental smoking and alcohol and other substance use."[79] There is also evidence that overcrowding is correlated with increased risk of SUDI due to lack of safe infant sleeping equipment.[80]

All eight infants reviewed by the Board were categorised as SUDI deaths. In six of the eight SUDI deaths, unsafe sleeping environments were noted. Since the Board's commencement, the highest proportion of deaths reviewed have related to infants under one year of age: 111 (36%) of 304 cases reviewed between 1 July 2020 and 30 June 2025. Of these 111 deaths, 51 (46%) were categorised as SUDI (see Figure 10). Unsafe sleep factors were identified in many of the Board's SUDI cases.

Figure 10: Proportion of SUDI and other infant deaths reviewed between 1 July 2020 and 30 June 2025



Most of the eight infants' parents in this review had access to a bassinet or cot. The case records considered in this report are less clear on what safe infant sleep education and ongoing support were provided to the parents before and after they left hospital. Best practice models for preventing SUDI emphasise the importance of working with parents beyond the provision of a cot. Evidence suggests that most successful interventions are face-to-face programs with high intensity family contact and close working and co-ordination between agencies and community support.

78 Tipene-Leach D and Fidow JF, *Sudden Unexpected Death in Infancy Prevention in New Zealand: The Case for Hauora – a wellbeing approach*, Ministry of Health, New Zealand Government, Wellington, 2022, p 10.

79 Queensland Paediatric Quality Council on behalf of Child Death Review Board, *Issues Paper: Sudden unexpected death in infancy among vulnerable families in Queensland*, 2022, p. 5.

80 The Child Safeguarding Practice Review Panel (United Kingdom), *Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm*, 2020, p.18.

In 2021, the Board commissioned the Queensland Paediatric Quality Council to provide insights into risk factors surrounding SUDI among vulnerable families in Queensland. The subsequent issues paper, *Sudden unexpected death in infancy among vulnerable families in Queensland*, identified a number of risk factors and recommended strategies to reduce SUDI in families known to the child protection system. Three risk factors which are particularly prominent among families known to child protection, compared with other families, are the presence of domestic and family violence, mental ill-health and substance use.[81] These are also three of the most common vulnerabilities reported by clients of Specialist Homelessness Services.[82]

All eight infant cases considered for this review had at least two of the risk factors for SUDI noted in the report, as shown in Table 1.

Table 1: Presence of SUDI risk factors in the case studies of infant death reviewed for this report

Risk factor	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
Surface sharing	X			X	X	X	X	X
Soft bedding					X	X	X	X
Maternal tobacco smoking during pregnancy	X	X		Unknown	X	X	X	X
Maternal substance use during pregnancy (except tobacco)		X			X	X	X	X
Exposure to environmental tobacco smoke	X	X		X	X	X	X	X
Parental alcohol or substance use at time of death	Unknown	Possible		Possible		Unknown	X	X
Inadequate antenatal care	X						X	X
High parity (3 or more live births)	X						X	X
Young maternal age at first birth (under 20)	X	X	X				X	X
Jobless family	X					Unknown	X	
Domestic violence				X	X	X	X	X
Parental mental ill-health	X	X	X	X	X	X		X
Parental criminal offending							X	X
Parental victim of crime								
Parent known to the Department responsible for Child Safety or Youth Justice as child	X	X		X	X			X
Limited social support	X	X				X		

81 Queensland Paediatric Quality Council on behalf of Child Death Review Board, *Issues Paper: Sudden unexpected death in infancy among vulnerable families in Queensland*, 2022, p 15.

82 Australian Institute of Health and Welfare, *Specialist homelessness services annual report 2022–23: Clients, services and outcomes*, 2024, accessed 20 August 2024.

Case example 8: Addressing housing and health risks in vulnerable families

The Board reviewed a case of an unborn child due to concerns relating to the mother's daily use of methamphetamine, a lack of antenatal care and domestic and family violence perpetrated against the mother by a relative. Mother, aged 17 at the birth of her first child, did not receive antenatal care during her pregnancy. Baby was born at home then brought to hospital by ambulance. Mother subsequently discharged Baby against medical advice but agreed to a home-midwife referral.

Baby was visited at home by a midwife on day one of life, with no concerns noted. Baby was also presented to a child health clinic at four days old, where again there were no concerns identified. Mother was advised about safe sleeping guidelines at this visit.

At eight weeks old, Baby, Mother and three siblings were visiting a family member. Baby, Mother and a sibling were sharing a double foam mattress in the lounge room. Mother disclosed smoking cannabis and drinking two beers over a period of three hours before she went to bed. Baby was found deceased the following morning due to SIDS Category II. The coroner noted unsafe sleeping arrangements and maternal smoking and drug use as risk factors in Baby's case.

Responding to increased risk of SUDI

Among the eight infants reviewed in this chapter, three were discharged from hospital and brought home to accommodation supported by Specialist Homelessness Services. Specialist Homelessness Services are uniquely positioned to form part of the recommended integrated, wrap-around support provided to families with infants. The Board's 2020–21 annual report noted that wrap-around models that combine health, housing, and family support are essential to reduce the risk of SUDI, especially where families face multiple adversities.

The report recommended promoting the safety of infants and unborn children and called for the expansion of health home visiting programs and multimodal safe sleeping initiatives, particularly for families experiencing complex needs. While this recommendation acknowledged the importance of support strategies and culturally appropriate messaging, it did not explicitly address the unique challenges faced by families who are experiencing housing insecurity and homelessness.

The cases reviewed this year demonstrate that unstable housing environments, such as temporary shelters, overcrowded dwellings and transitional accommodation, can severely limit a family's ability to implement safe sleep practices, even when education is provided. These findings suggest that further recommendations are required to ensure that housing and homelessness services are integrated into infant safety strategies.

The first step to help is prioritising housing for vulnerable cohorts

The cases reviewed by the Board underscore the urgent need to prioritise vulnerable cohorts within housing and support systems, particularly young parents and families with multiple co-vulnerabilities. These families often face multiple, compounding challenges: limited capacity, transience and a lack of connection to place or community. When young parents are navigating complex systems without stable accommodation, the risk to their children's safety and wellbeing increases.

Housing instability not only undermines a parent's ability to provide a safe and nurturing environment, but it also intersects with other vulnerabilities such as mental ill-health, substance use and domestic and family violence. These layered risks are particularly acute for young parents, who often lack economic means, educational attainment and access to protective family networks. These issues limit their ability to engage with support systems and build long-term stability.

The lack of stable, safe sleeping environments, often because of transient living arrangements, can undermine even well-intentioned efforts to follow safe sleep guidance. For young families, the challenge is not just awareness of safe sleep practices, but the ability to implement them in environments that are often informal, overcrowded and shaped by crisis.

The Board's preferred position is clear: stable accommodation must be prioritised for young families so they can establish a standard of care and build community connections. Structural drivers such as poverty, systemic racism and lack of income support compound individual challenges like trauma and unemployment. Housing responses are a critical lever to support young families. These responses must be designed with flexibility, dignity and safety in mind, recognising that for young parents housing stability is the gateway to every other form of support including health, education and child protection.

Concluding comments

The cases reviewed by the Board highlight stable housing as a critical protective factor for young families. When housing is safe, stable, and appropriate, it enables other services to engage more meaningfully and support families to meet their children's needs. Conversely, housing instability, especially transience, can disrupt service continuity, increase risk and compound existing vulnerabilities.

Across these cases, the Board identified the need to recognise that housing is more than just a roof, it is a cornerstone of safety, wellbeing and connection. Addressing housing insecurity must be central to any strategy aimed at preventing child deaths and promoting long-term wellbeing.

The Board also calls for improved partnerships between the Department responsible for Child Safety and housing services, with a focus on ensuring safety standards for both children and their accommodation, and increased oversight and visibility of young families experiencing transience.

Further, the Board highlights the need to improve the availability and accessibility of specialist housing services tailored to the needs of young parents and families who are affected by domestic and family violence.

Recommendations

The Board recommends that:

Recommendation 2

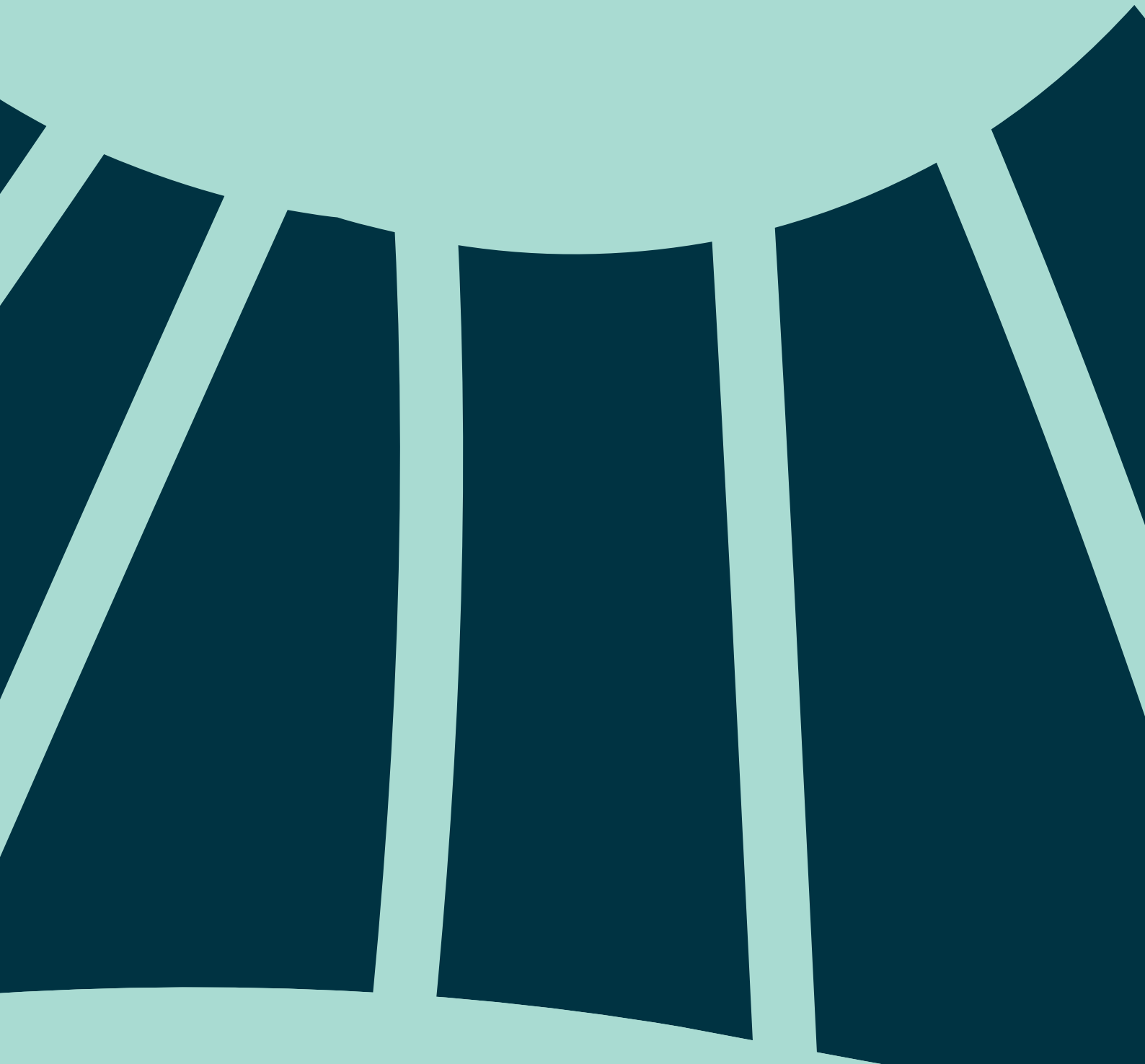
The Department of Housing and Public Works, in collaboration with the Department of Families, Seniors, Disability Services and Child Safety, should establish and articulate a dedicated housing pathway for young parents (particularly mothers raising infants). This pathway should prioritise access to safe, stable and developmentally supportive housing environments that enable young families to build parenting capacity. It should be supported by strengthened assessment and planning processes that enable temporary and crisis accommodation options to adequately meet the safety and wellbeing needs of this vulnerable cohort.

Recommendation 3

Given the high prevalence of housing issues in the child death cases we see, the Board recommends that the Government pursue legislative amendment to the *Child Protection Act 1999* to include the Department of Housing and Public Works in the Child Death Review Model. This approach could be the same as the current requirements for the Director of Child Protection Litigation: Housing would be legislated to complete child death reviews but would not be a member of the Board.

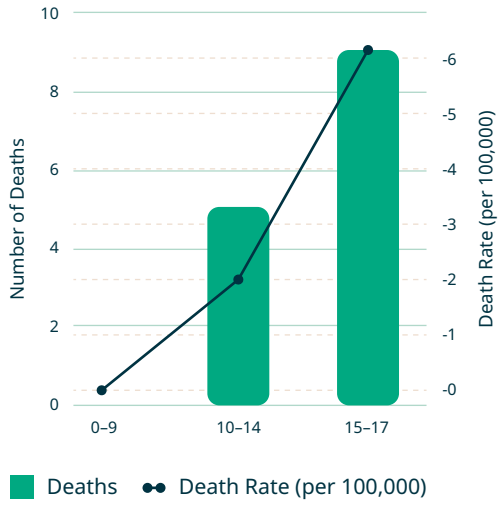
CHAPTER 4

Finding a better path forward for teenagers with high-risk behaviours



Each year, more than 100 of Queensland's young people under 25 years die due to road crashes or suicide. In 2023, intentional self-harm (suicide) was the leading cause of death among young people aged 15 to 24 in Australia, with over 300 deaths nationally in that age group.[83] In Queensland, road fatalities have also remained a significant concern, with around 60 to 70 young people under 25 dying in motor vehicle crashes annually in recent years.[84] In Queensland 20 children and young people aged 0 to 17 died from transport-related incidents in 2023–24.[85] Of these 20, nine were aged 15 to 17, making this age group the most affected, with a transport-related death rate of 6.2 per 100,000 – more than three times higher than the transport-related death rate in the next most affected age group (10 to 14).[86]

Figure 11: Transport-related deaths by age group from 2023–24



This year the Board reviewed the cases of six teenagers aged between 13 and 17 who died in motor vehicle crashes or through suicide. The investigations into the circumstances of these teenagers give insight into the factors that can cause teenagers to adopt a higher form of risk-taking behaviour, which often has its origins in their earlier childhood or intergenerational experiences of disadvantage.

Across its reviews, the Board has observed recurring evidence of children and young people who displayed complex or challenging behaviours often termed 'high-risk behaviours'. In reviewing the teenagers' lives, a connection between their experiences and the adversity they faced is apparent. Their stories highlight shared experiences of childhood trauma, grief, loss and disconnection, and the lasting impacts of intergenerational trauma across their families. The challenges of their childhoods, absence of protective factors, and ineffective system responses contributed to trajectories of school disengagement, risk-taking behaviours, criminal offending, seeking connection with antisocial peer networks, and increasing risk of exploitation by adults.

The cases reviewed this year reflect a broader cohort of children and young people in Queensland who have multiple, high and complex needs that are not being effectively addressed by any single government department. This points to a systemic gap, where the service system does not deliver adequate support or take clear responsibility for this cohort.

83 Australian Bureau of Statistics, *Causes of Death, Australia*, 2023.
84 Queensland Government, *2023 Weekly Road Fatality Report,* Publications Queensland, 2025.
85 Queensland Family and Child Commission, *Annual Report: Deaths of children and young people, 2024, Chapter 3.*
86 Queensland Family and Child Commission, *Annual Report: Deaths of children and young people, 2024, Chapter 3.* Table 1.1, Appendix D.

Teenagers, risk and the underlying drivers of risk-taking behaviour

Teenagers who exhibit high-risk and complex behaviours often intersect with multiple systems—mental health, youth justice, child protection, education, policing and housing. This highlights the breadth of their needs and the challenges faced by service providers. These behaviours exist on a spectrum, ranging from disruptive to highly unsafe. They are shaped by a combination of individual, familial and social factors. Data from the Australian Bureau of Statistics shows that young males are disproportionately represented in deaths due to accidents and intentional self-harm, with road crashes and suicide being leading causes of death among young males aged 15 to 24. Young females, while less represented in fatal outcomes, show higher rates of hospitalisation for self-harm and mental health conditions.[87]

Evidence also points to social determinants, such as economic disadvantage, social marginalisation and unstable housing, as significant contributors to elevated risk-taking behaviour.[88] These factors, when combined with the absence of protective elements like stable caregiving, positive peer relationships and access to mental health support, create environments where risk-taking not only becomes more likely but also more dangerous. At a population level, teenagers are already more inclined toward risk-taking due to developmental factors, but this tendency is amplified in contexts of adversity.

The Department responsible for 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."[89]

The Board has previously reviewed cases involving high-risk behaviours and continues to highlight the urgent need for early identification and intervention. Despite repeated observations, the size of this high-risk cohort remains unknown, and no formal mechanism currently exists to identify or track these young people before they reach crisis point.

87 Australian Bureau of Statistics, *Causes of Death, Australia*, 2023.

88 Centre for Accident Research & Road Safety – Queensland, *Adolescent Risk-Taking: A Fact Sheet*. Queensland University of Technology, 2021.

89 DCSSDS, Child Safety Practice Manual: Positive behaviour support and managing high risk behaviour, DCSSDS website, n.d. accessed 1 July 2024.

High-risk behaviours in youth include:[90, 91]

- substance use: includes alcohol, cannabis, methamphetamine, volatile substances and other illicit drugs
- self-harm and suicidal ideation: often linked to underlying mental health issues and trauma
- offending and arrests: involvement with the justice system due to criminal behaviour
- risky driving and motor vehicle accidents: includes driving under the influence, speeding and not wearing seatbelts
- unsafe sexual activity: early or unprotected sex, sometimes associated with low self-esteem or trauma
- association with antisocial peers or environments: this increases the risk of engaging in harmful or illegal activities.

While other factors, including school disengagement and exposure to domestic and family violence, are not high-risk behaviours themselves, they are significant risk factors that contribute to the development of high-risk behaviours. They reduce protective supports and increase vulnerability to harm.

High-risk behaviours often stem from deeply rooted vulnerabilities, including trauma, mental ill-health, neurodivergence and intergenerational trauma. These experiences can shape how individuals cope with distress, often leading to maladaptive behaviours that are misunderstood or stigmatised. Rather than receiving support and care, people exhibiting these behaviours frequently encounter punitive responses, especially when their risk-taking behaviour reaches a point where their actions may harm themselves or others. This cycle of vulnerability translates into criminalisation and incarceration. It reflects systemic failures to address the underlying causes and perpetuates harm instead of fostering healing and rehabilitation. For Aboriginal and Torres Strait Islander young people, intergenerational trauma stemming from colonisation, forced removals, and cultural disconnection has been linked to higher rates of mental ill-health, incarceration, and poor social and emotional wellbeing.[92]

90 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019* – Alcohol, 2019.

91 Champion KE, Mather M, Spring B, Kay-Lambkin F, Teesson M and Newton NC, *Clustering of multiple risk behaviors among a sample of 18-year-old Australians and associations with mental health outcomes: a latent class analysis*. University of Newcastle Open Research, 2025.

92 Australian Institute of Health and Welfare, Youth detention population in Australia 2022–23, 2023.

What is often unseen may reveal why some teenagers disengage, highlighting the need to explore deeper causes

"Studies of the pathways to antisocial behaviour have identified persistent conduct problems, oppositional behaviour and physical aggression in the preschool and early primary school years as among the strongest predictors of adolescent aggression, delinquent behaviour and a range of negative long-term outcomes... More broadly, impulsivity, low school achievement, poor parental child-rearing practices and poverty have all been identified as key predictors of involvement in juvenile crime."[93]

To truly understand the heightened risk-taking behaviours observed in these teenagers, we must look beyond the immediate consequences and explore the foundational experiences that shape their development. For many, the starting point was marked by exposure to neglect, instability and trauma during critical developmental windows long before adolescence. These young people did not simply lack a 'basic start in life', many were exposed to complex layers of disadvantage, trauma and instability from an early age.

Such conditions can erode the development of self-regulation and risk awareness, leaving teenagers more vulnerable to impulsive decisions and less likely to perceive danger in the same way their peers might. The absence of protective factors such as stable caregiving, emotional support and consistent boundaries, can lead to a diminished sense of self-worth and a greater willingness to engage in risky behaviours. By linking these behaviours to their origins, the Board can better understand the urgency of early intervention and the need for holistic support systems that address not just the symptoms but also the root causes of vulnerability.

This year the Board reviewed the cases of six teenagers between 13 and 17 at the time of their deaths who died either by suicide or in transport incidents. Two of them died due to suicide and four died in transport incidents.

- **In five of these cases the teenagers were neurodivergent or had learning, speech or cognitive issues.** Analysis by Queensland Advocacy for Inclusion indicates that in Queensland students with disabilities are twice as likely to be suspended as their peers and have a one in four chance of being suspended.[94] Further, Aboriginal or Torres Strait Islander students and students with a disability are disproportionately likely to be subject to a school disciplinary absence.[95]
- **In four of these cases the teenagers experienced some level of mental ill-health: one of them had a diagnosed mental health condition and all four experienced suicidal ideations.** Since the Board's inception, it has considered 31 deaths due to suicide. Twelve of these children were Aboriginal or Torres Strait Islander, including two of the six young people reviewed this year. In 2022, suicide was the second leading cause of death among Australian children aged 5 to 17, after land transport accidents.[96]

93 Batchelor S , Carr A, Elias G, Freiberg K, Hay I, Homel R, Lamb C, Leech M and Teague R, '*The Pathways to Prevention project: doing developmental prevention in a disadvantaged community*'. *Trends & issues in crime and criminal justice* no. 323. Canberra: Australian Institute of Criminology, 2006.

94 Queensland Advocacy for Inclusion, Economic cost of suspensions for Queensland students with disability, Queensland Advocacy for Inclusion, Brisbane, 2024.

95 Department of Education, unpublished data request 2025 (TF25/363)

96 Australian Bureau of Statistics, Intentional self-harm deaths (Suicide) in Australia, 2023.

Five of the six reviewed teenagers were subject to a Department of Education review and were disengaged from school at the time of their death.

The Board also considered 98 child death cases reviewed between July 2020 and December 2024 which involved school disengagement and high-risk behaviours.[97] In this broader group:

- nearly one-third of the compulsory school age children were disengaged from education
- two-thirds of the older compulsory participation phase children were disengaged from education
- children who were disengaged from education were more likely to have died from suicide or transport-related causes than children who were engaged.

These unseen factors such as neurodivergence, mental ill-health, and disability often remain invisible in the system until a crisis occurs, by which point opportunities for early support and intervention may have already been missed. Their invisibility contributes to disengagement, isolation, and escalating risk, making it harder for services to respond effectively. This underscores the urgent need for early, coordinated intervention that recognises and responds to these vulnerabilities before they compound into harm and further escalate to high-risk behaviours.

Case example 9: Link between early disengagement from school and start of high-risk behaviours

Two teenagers experienced multiple adverse childhood experiences. The reported concerns included severe domestic and family violence, physical abuse and neglect, parental substance misuse, inappropriate supervision, parental criminal behaviour and incarceration.

The first teenager was excluded from school at age eight. Their criminal offending and substance use, including volatile substance use (VSU), also emerged around this time. They began disengaging from education at age 10, and the last recorded attendance at a state school was at age 11. Records suggest that poor school attendance was a concern from a much younger age. Their only engagement with schooling in his high-school years was during periods of incarceration.

The second teenager had multiple primary school enrolments as a child. Recorded behavioural incidents related to being disruptive and non-compliant in class and truanting class. In a later interview with Youth Justice, the teenager recalled feeling anxious when called upon in class. At age 12, a 10-day suspension was administered for not participating in classes. The teenager did not return to school after this incident and was reported to have relocated to another area.

Their behaviour at school was likely, in part, a consequence of their formative years. The two teenagers' schools responded to their behaviour incidents with expulsion and suspension. Such punitive approaches may invertedly reinforce school absenteeism and further increase the likelihood of disengagement. Evidence suggests school expulsions often have the effect of intensifying surveillance and control and increase a child's social exclusion.[98]

97 Queensland Family and Child Commission, School engagement levels in cases to date, Information Paper for Child Death Review Board Meeting #25, Brisbane, 2025.

98 Homel R et al, 'Preventing the onset of youth offending: The impact of the Pathways to Prevention Project on child behaviour and wellbeing', *Trends & issues in crime and criminal justice*,2015, 481, p. 2.

Common circumstances in life of the six teenagers displaying high-risk behaviours

Among the six teenagers whose cases were examined[99], their family environments were notably lacking in protective factors that might have mitigated their exposure to risk. These deficits in support and stability contributed to circumstances where risk-taking behaviours could escalate unchecked.

The Board has explored the characteristics commonly associated with young people at elevated risk and identified several recurring factors across the lives of these individuals, including:

- **Five of the teenagers had a history of alcohol or illicit substance use and two young people also engaged in VSU**. Statistics show a 95 per cent decline in petrol sniffing across 17 Aboriginal communities from 2006 to 2018 – with fewer than one per cent of people aged 5 to 39 affected.[100] However, this year's cases demonstrate that VSU can still have a profound and devastating impact on children, families and communities. The Board has examined several cases where VSU impacted the lives of young people. The Board's 2021 review noted:

"Volatile substance use has a range of serious physical consequences for users.[101] It is also correlated with other adverse outcomes, including mental illness, involvement in crime, violent anti-social behaviour, disengagement from education and use of alcohol and other substances… They described these young people as the most disengaged and vulnerable of all clients accessing youth services."[102]

- **All six teenagers engaged in criminal behaviours and sought connection to antisocial peers.** All had a history of stealing motor vehicles and driving without a licence, often in a dangerous manner. There were multiple examples of the young people in the company of others, including older siblings and peers, who were known to the QPS and Youth Justice, when they were engaged in crime and substance use. A recent report by the Australian Human Rights Commission's noted:

"Many children and young people discussed the role of 'bad influences' and 'peer pressure' in their antisocial behaviour, including not attending school, drug use and criminal activity. They reported that problems at home lead them to 'branch out to different friend groups that may not be good'. Children and young people described a sense of belonging with peers that shared similar home lives, while 'with other young people you feel judged by them, can't connect with them'."[103]

In three reviewed cases, teenagers were missing or their whereabouts were unknown, with one showing signs of criminal exploitation by an adult. As noted in the Board's 2024 collective review report, *The System as a Corporate Parent*, a January 2022 QPS operation, Uniform Kalahari, investigated alleged grooming and exploitation of children and the alleged supply of drugs to them. The operation resulted in the charging of 12 people with 263 offences against 52 young people aged as young as 11.[104]

99 Department of Education only completes a review of cases where a departmental service has been provided to the child or young person in the 12 months before their death.

100 Australian Indigenous HealthInfoNet, *Alcohol and Other Drugs Knowledge Centre, Latest information and statistics on volatile substance use*, 24 July 2024.

101 Acute effects may include hallucinations, confusion, blurred vision, headaches, aggression, poor memory and vomiting. VSU can also lead to neurological injury; cognitive impairment; impairment of vision, hearing and movement; and damage

102 D'Abbs P and MacLean S, *Volatile Substance Misuse: A review of interventions, 2008*; Karam J, Sinclair G and Rackstraw L, *Dignity, Diversion, Home and Hope: A review of interventions for volatile substance misuse in regional Northern Queensland*, 2014.

103 Australian Human Rights Commission *'Help way earlier!': How Australia can transform child justice to improve safety and wellbeing*, 2024, p.12.

104 'Dozens of vulnerable children allegedly preyed upon in Cairns, upending Queensland's youth crime debate'. *The Guardian*, 25 September 2023, Accessed 9 January 2024.

Experiences of six teenagers who died by suicide or in motor vehicle incidents

All six teenagers:

- experienced abuse or neglect by a parent or parental figure
- experienced domestic and family violence in their homes and/or extended families
- were exposed to problematic parental alcohol or substance use during their lives
- engaged in criminal behaviours.

Five of the teenagers:

- had at least one parent involved in the criminal justice system (two parents were incarcerated during the review period)
- used volatile substances, illicit drugs or alcohol (all were affected by substances at the time of their deaths)
- were neurodivergent or had learning, speech or cognitive issues (one acquired through the impacts of a shooting where he was critically injured)
- were known to the youth justice system
- were not engaged in schooling or education at the time of their death.

Four of the teenagers:

- spent time in youth detention in the year before their death
- experienced some level of mental ill-health, with one young person having a diagnosed mental health condition and all four experiencing suicidal ideations and issues related to substance use
- had experienced parental separation
- had parents who were known to the child protection system as subject children.

Three of the teenagers:

- were exposed to suicidal behaviours or suicide deaths in their family.

Two of the teenagers:

- experienced the death of a parent.

Early intervention and healing can help to reduce long-term impact of harm from adverse childhood experiences

"The key to turning around the lives of disadvantaged children is getting in early, with the support and resources that the child, parents, school and the community needs.[105]"

The Department responsible for Child Safety practice guidelines remind staff that often high-risk behaviours are a way for the child or young person to communicate an unmet need and that the behaviour is often a mismatch between the person and the environment they are in.[106] The Adverse Childhood Experiences Study, conducted by the Centres for Disease Control and Prevention and Kaiser Permanente, provides seminal evidence linking childhood trauma and unmet needs to high-risk behaviours in adolescence and adulthood, highlighting how toxic stress and maladaptive coping mechanisms emerge from early adversity.[107] Recognising high-risk behaviour as a signal of deeper needs and calls for help reframes the missed opportunities for early intervention in the cases of the six teenagers whose cases are reviewed in this section of the report.

Investigations into the experiences of the six teenagers made apparent there were missed opportunities for the system to respond to their needs and their families' needs for support much earlier. Many of the teenager's school behaviours were likely influenced by developmental delays, disability and neurodivergence, which contributed to their disengagement from education. Despite clear indicators of trauma and disability, early screening and intervention were often lacking. Evidence suggests that timely support, such as speech and language therapy, can improve behavioural outcomes.[108]

Earlier, more intensive family intervention may have helped support some of the teenager's parents and extended family in managing the complex challenges they faced, potentially preventing further harm and reducing the long-term impact of adverse childhood experiences. This includes ensuring that there are adequate family support services available to respond to risks before they escalate. The Board notes that there have been positive investments in community intervention programs and targeted support for Aboriginal Community Controlled Organisations; however, overall funding for early intervention remains comparatively low.

Schools are well-placed to coordinate early intervention and prevention efforts because of their daily contact with children and their central role in communities. However, they cannot do it alone. Addressing the complex socio-economic and developmental needs of vulnerable children requires a coordinated, cross-sector approach involving families, communities and local support services. The absence of such collaboration makes later child protection efforts more difficult and less effective.

Young people can also be supported early through healing-focused approaches that recognise the impact of trauma and prioritise emotional recovery alongside safety. Culturally responsive therapeutic programs, particularly those embedded in schools, community hubs and Aboriginal Community Controlled Organisations, can help children process adversity, build resilience and strengthen their sense of identity and belonging. When healing is integrated into early intervention, it not only supports individual wellbeing but also helps break cycles of intergenerational trauma and disadvantage.

105 Griffith University, *Professor Ross Homel: Early intervention is the key to keeping kids out of the criminal justice system*, Griffith University, Brisbane, 2022, p. 3.

106 DCSSDS, Child Safety Practice Manual: Positive behaviour support and managing high risk behaviour, DCSSDS website, n.d. accessed 1 July 2024.

107 Felitti V. J, Anda R. F, Nordenberg D, Williamson D. F, Spitz A. M, Edwards V, Koss M. P, & Marks J. S, *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*. American Journal of Preventive Medicine, 1998, 14(4), pp. 245–258.

108 Ross Homel, *Submission No 70 to the Australian Human Rights Commission Youth Justice and Child Wellbeing Reform Project*, Griffith University, 2023, p. 5.

The Board's discussion of relational practice highlights the importance of human connection in care environments, especially for children. Drawing on the work of Jarrod Wheatley and the Centre for Relational Care, the Board supports a model of professional individualised care, which emphasises stable, empathetic relationships as central to healing. This approach aligns with trauma-informed care and advocates for systemic reform, recognising that children in crisis need consistent, **meaningful** relationships—not just services—to heal.

Reflecting this philosophy, the Board has previously commented that all children entering care should have provision of mental health and healing services automatically upon entry. Many children arrive with histories of trauma, neglect and instability. Embedding both therapeutic and relational support from the outset aims to ensure that healing begins immediately and is sustained through connection and care.

ECEC is a powerful tool to set children up for success in school and later life. Benefits of high-quality early education include improved self-regulation, language, literacy and cognitive skills and increased wellbeing, belonging and positive sense of identity.[109]

The Board acknowledges that improvements have been made to support children at a young age with new initiatives in progress to enhance education and support services for families:

1. SNAICC is currently leading Connected Beginnings, an Australian Government funded program that supports Aboriginal and Torres Strait Islander children to access early childhood, health, and family services.
2. Queensland's 'Free kindy' initiative provides 15 hours of free kindergarten for 40 weeks, with additional hours subsidised through the Australian Government.
3. The Australian Government is providing $9.5 million for an intensive ECEC model trial. The model is designed to support vulnerable and disadvantaged children to bridge the gap to school readiness, for children from birth up to 3 years. The model has a dual focus:
    a. to redress the impacts of trauma on children through trauma-informed and attachment-focused care
    b. to provide an enriched early learning and care environment achieved through a rigorously developed curriculum and intentional pedagogy.
4. Queensland's current child and family prevention and early support strategy, Putting Queensland Kids First, included $10.73 million to embed health practitioners in 20 priority primary schools.[110]

109 Dandolopartners on behalf of SNAICC, Evidence on optimal hours of ECEC for Aboriginal and Torres Strait Islander children, SNAICC, Collingwood, 2023, p. 6.

110 Department of the Premier and Cabinet (Queensland), *Putting Queensland Kids First: Giving our kids the opportunity of a lifetime*, Queensland Government, Brisbane, 2024, p. 11.

The protective factors of education engagement

The Board's earlier work on the life trajectories of children known to the Board highlighted the important safeguarding impact of early childhood for young people. School disengagement has been observed by the Board in a number of case reviews and this year it asked for a deeper analysis to occur. The Board approved the following definition of 'disengagement from education':

- children of compulsory school-age were:
  - not enrolled in any form of education, or
  - were enrolled in education but had not attended for more than 30 days in the review period
- young people in the compulsory participation phase were not engaged in education, training or employment.

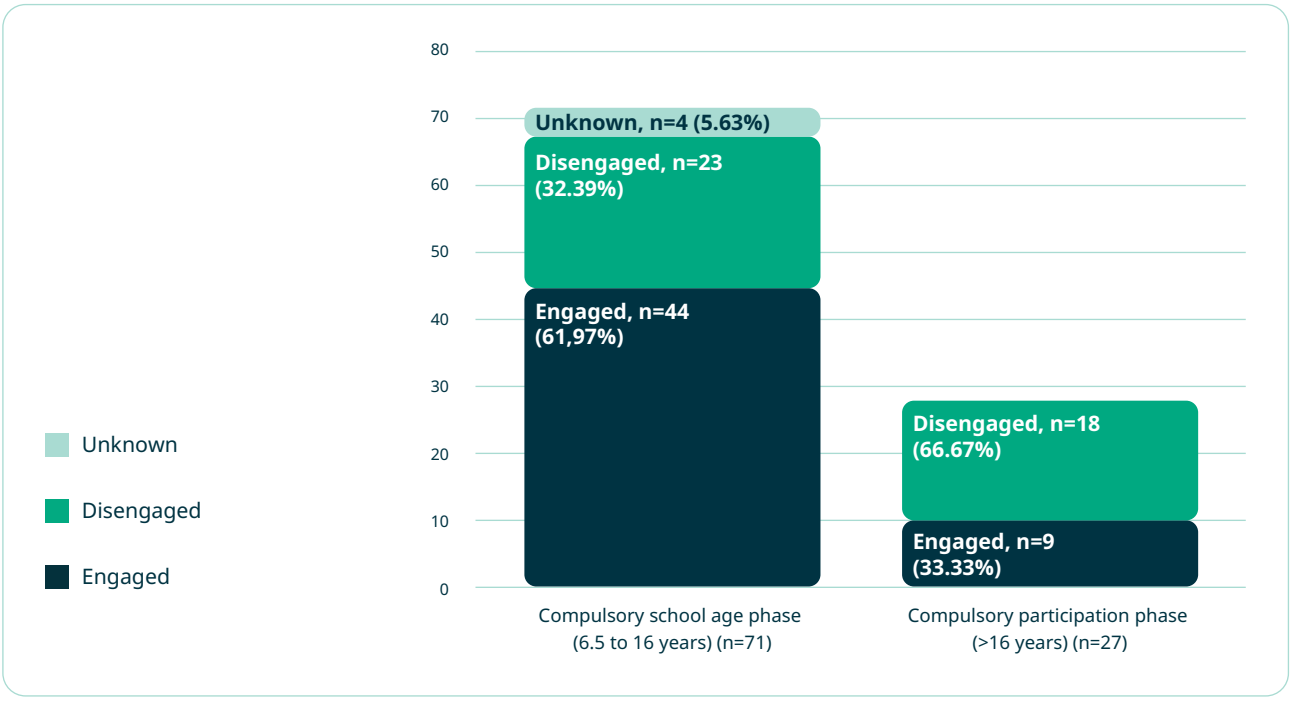
The analysis of school engagement across the children reviewed by the Board revealed that of the 98 cases of deaths of children who were above the minimum compulsory school age of six years and six months at the time of death:

- 71 children were in the compulsory school age of their education (younger than 16 and not completed year 10) at the time of their death
- 27 children were in the compulsory participation phase of their education (aged 16 and 17 or had completed year 10) at the time of their death.

Of the 71 children who were in the compulsory school age, 44 (62%) were engaged in education and 23 (32%) were disengaged at the time of their death. In four cases (6%) the engagement level could not be determined from the records, as Education did not conduct reviews of these cases and the other agency reviews did not provide enough information to determine whether the child was enrolled and/or engaged with education.

Of the 27 older children in the compulsory participation phase, nine (33%) were engaged and 18 (67%) were disengaged from education at the time of their death. Of the 18 who were disengaged from education, 13 had disengaged before age 16 when they were still in the compulsory school age. See Figure 12.

Figure 12: Education engagement levels in 98 child death cases reviewed between July 2020 and December 2024

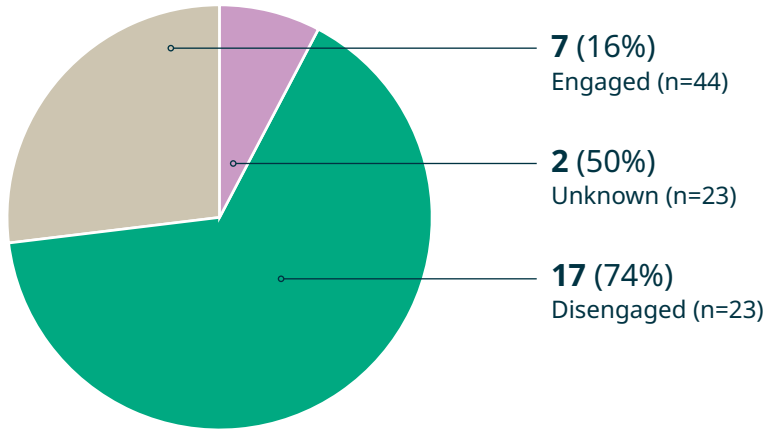


Correlation between disengagement from education and prevalence of high-risk behaviours

Analysis indicates a higher prevalence of high-risk behaviours among children and young people who were disengaged from education, compared to their engaged peers. Examples of high-risk behaviours observed in cases reviewed for this report included offending behaviours (particularly motor vehicle-related offences), substance use, significant mental health concerns including suicidality and non-suicidal self-injury, excessive property damage, and repeated homelessness in context of absconding from home or placement.

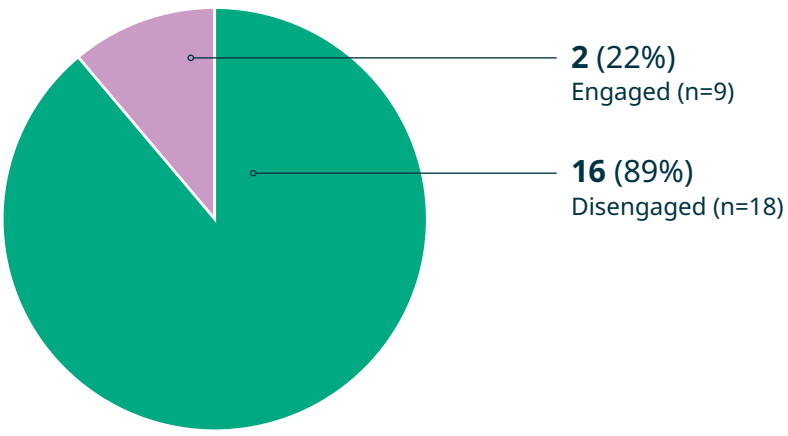
In the compulsory school age cohort, seven (16%) of the 44 children who were engaged in education were reported as displaying high-risk behaviours in the 12 months before their death. In comparison, 17 (74%) of the 23 children who were disengaged from education were reported as displaying high-risk behaviours. Of the four children whose engagement levels could not be determined, half were reported as displaying high-risk behaviours.

Figure 13: High-risk behaviours and engagement with education: 71 cases of children in the compulsory school age of their education reviewed by the Board between July 2020 and December 2024



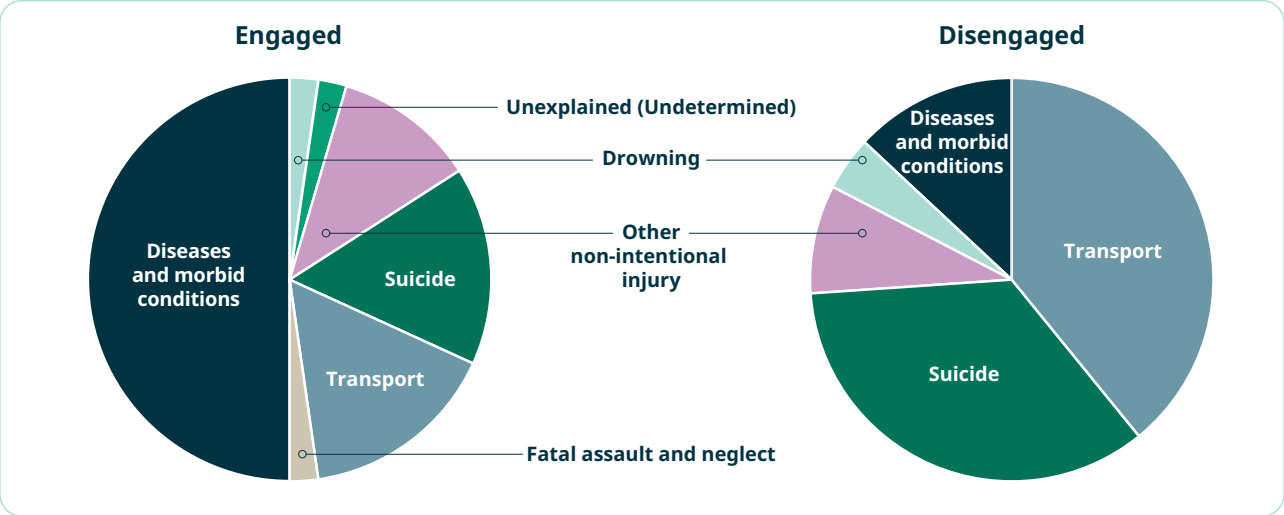
In the compulsory participation phase cohort, two (22%) of the nine young people who were engaged in education were reported as displaying high-risk behaviours in the 12 months before their death. In comparison, 16 (89%) of the 18 young people who were disengaged from education were reported as displaying high-risk behaviours.

Figure 14: High-risk behaviours and engagement with education: 27 cases of young people in the compulsory participation phase of their education reviewed by the Board between July 2020 and December 2024



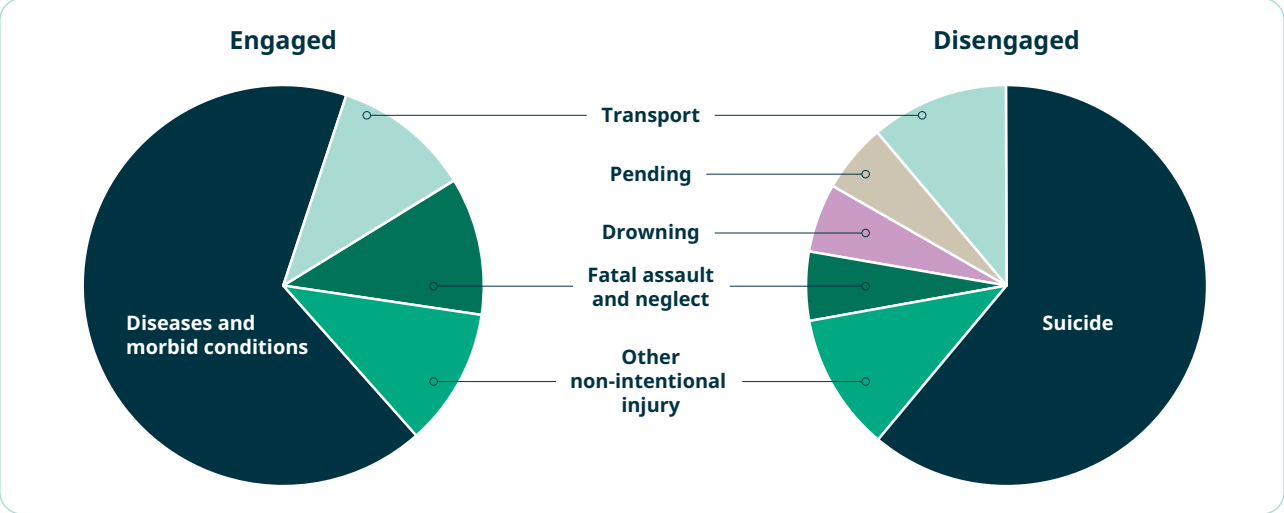
Turning to causes of death, among the reviewed cases in the compulsory school age suicide and transport incidents were a much more significant cause of death for the disengaged children (74% of all deaths of disengaged children) than for the engaged children (32% of all deaths of engaged children).

Figure 15: Category of death and engagement with education: 67 cases of children in the compulsory school age of their education reviewed by the Board between July 2020 and December 2024



Significantly, all the young people in the compulsory participation phase who died from suicide were disengaged from education.

Figure 16: Category of death and engagement with education: 27 cases of young people in the compulsory participation phase of their education reviewed by the Board between July 2020 and December 2024



A key finding from the analysis was that children who were disengaged from education tended to display high-risk behaviours more than their engaged peers. Suicide and transport-related categories of death were commonly observed in children who were disengaged.

Recent initiatives to promote engagement with education for at-risk young people

Based on the above the Board in this review considered recommending an audit of education re-engagement and engagement services. However, the Board notes that the Queensland Government has made investments in recent years to re-engage young people in education and prevent disengagement from leading to long-term disadvantage. A central part of this strategy has been the establishment of Regional Youth Engagement Services across the state. These services bring together schools, training providers, community organisations and partner agencies to identify and support disengaged young people. The aim is to provide tailored assistance that helps young people to return to education or to transition into training and employment pathways, ensuring they are not left without opportunities for growth.

The Board noted that in 2024 the Queensland Government announced a $288 million Youth Engagement Education Reform Package, representing one of the most substantial commitments in this area to date. This investment expands the Queensland Pathways State College model, which offers an alternative schooling environment for Year 10–12 students at risk of disengagement. It also funds the deployment of 78 Intensive Education Case Managers across Queensland, dedicated to providing individualised support for students who have been suspended or excluded, and helping them to re-enrol in education or find a new pathway.

Another important reform has been the introduction of FlexiSpaces within schools—specialised learning environments designed for students who do not thrive in traditional classrooms. These flexible, adaptive zones allow young people to learn in ways that better match their needs, building confidence and engagement. The Queensland Pathways State College model complements this by offering small, supportive settings that still lead to a Queensland Certificate of Education, ensuring students have meaningful qualifications on completion.

The 2025–26 Queensland Budget reinforced this commitment with a suite of new measures. A $50 million investment over five years will establish or expand Crime Prevention Schools in high-need areas such as the Gold Coast, Townsville, Rockhampton and Ipswich. These schools will provide targeted education, mentoring, and life-skills training for at-risk young people. More broadly, the budget allocated $814.8 million over four years for new primary and special schools, alongside a record $9.4 billion commitment to public education improvements. These investments will deliver more teachers, safer learning environments and better facilities for all students, including those at risk of disengagement.

Together, these initiatives signal a deliberate and coordinated effort to re-engage young Queenslanders in education, recognising that connection to learning is one of the strongest protective factors against future safety risks, disadvantage and preventable death. The Board is monitoring these reforms and expansions in hope that they will connect more Queensland children to brighter futures.

When young people remain unsupported, their risks often escalate

A harmful cycle emerges when young people's escalating risky behaviours are met with increasingly punitive and withdrawn system responses. Rather than addressing the root causes, these reactions often deepen trauma and lead to exclusion from school, unstable housing and disengagement from support services. As their needs intensify, they are labelled as difficult and receive less support, reinforcing a trajectory of isolation and reduced intervention. In one case that the Board reviewed this year, no individuals or agencies were willing or able to supervise or care for the teenager involved, leaving police as the only responders, tasked with detaining the teenager simply because no one else would take responsibility.

By the time of their first recorded offence, many of the teenagers in this report had already experienced a series of compounding vulnerabilities. The Board identified multiple and recurring touchpoints in their lives that preceded their involvement with the justice system. These included early signs of domestic and family violence, involvement of youth justice and/or child protection services, indicators of mental ill-health or neurodivergence, and harmful associations with peer groups engaging in antisocial behaviour. Disengagement from school often occurred alongside increasing contact with police, substance misuse and emerging offence histories. In several cases, these teenagers were also subject to exploitation by adults, exhibited self-harming behaviours or suicidality, and were involved in road incidents that ultimately led to their deaths.

Many of the teenagers whose cases were reviewed by the Board this year were using alcohol or illicit substances. Two were engaging in VSU involving petrol, glue and deodorant, which contributed to violent and dangerous behaviours. The Board observed that the service system struggled to manage these escalating risks, particularly when teenagers refused to engage with available drug and alcohol support. Although some had previously participated in youth justice programs, they later disengaged, leaving them without consistent support or intervention.

One teenager was believed to be exploited by an adult who encouraged motor vehicle offences and supplied illicit drugs to a group of transient and vulnerable young people. Another child cited boredom and possible overcrowding at home as reasons for absconding, breaking curfew and engaging in high-risk behaviours. Records also indicated that pressure from his older sibling, particularly following their release from detention, likely influenced the child's offending behaviour.

Despite the involvement of multiple government departments, no single agency assumed responsibility for coordinating assessments or responses for these teenagers. This lack of leadership and structured coordination meant that no mechanism was prioritised to ensure their needs were addressed holistically. As will be highlighted in Chapters 6 and 7, this gap in accountability and planning left high-risk young people without a clear pathway for support. This lack of coordination also contributed to delays in responding to cases of missing teenagers and addressing risks of criminal exploitation.

This underscores the urgent need for a dedicated, multiagency framework to guide collaborative intervention and case management. The Board has emphasised the need for stronger interagency collaboration and timely, unified responses, particularly for this cohort of young people at risk of harm to themselves and others.

Case example 10: Responding to offending behaviour, criminal exploitation and lack of supervision of a teenager who subsequently goes missing

Mother struggled to keep Child at home, noting Mother's children would leave late at night after everyone was asleep. Mother told the Department responsible for Child Safety she was concerned that a neighbour was supplying her Child and other children with methamphetamine and cannabis and encouraging offending behaviour, including motor vehicle offences.

The Child was reported missing after being recorded as absent at a Queensland Health appointment, with Mother informing authorities that QPS was aware. They were later found not at home during a bail check and was said to be staying with Father after running away. Though sighted twice, the Child was officially reported missing by Aunt and located the next day when arrested.

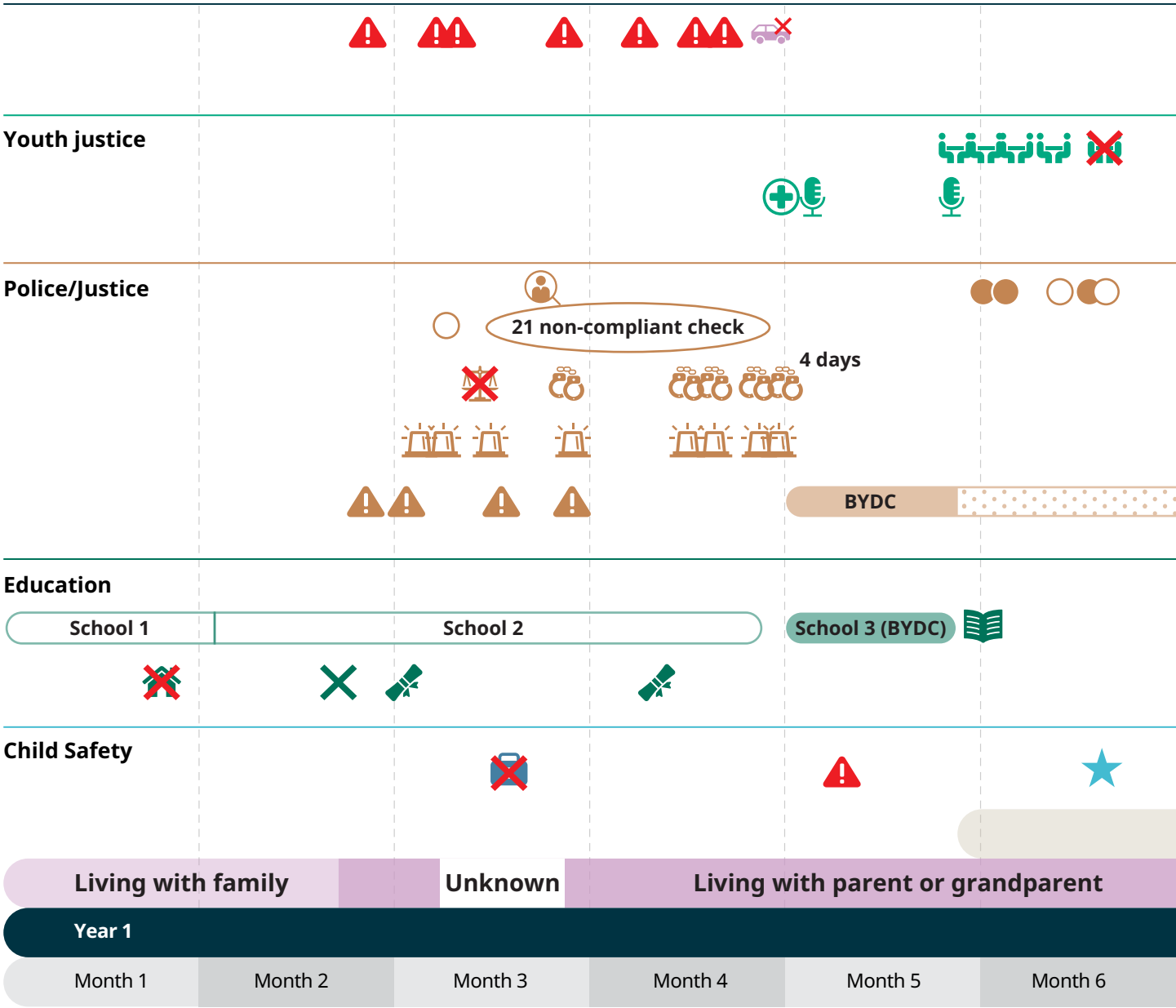
Sometime thereafter, QPS street-checked the Child at the Safe Night Precinct with an unrelated adult and moved them on. Because there were no Child Protection Orders in place, efforts to locate him only began if a parent or guardian reported him missing. No formal requirement exists for agencies to communicate when a child, who may have multiple police interactions or be subject to Youth Justice orders, goes missing.

In the Child's case, the QPS noted that a Child Harm Report could have been generated, given his age and duration of time missing, which was four days before a report was made. Directions in a 72-hour release plan from youth detention stated that if they absconded, a missing person protocol should begin immediately.

The Child had been involved in at least two motor vehicle crashes before the one that took their life. The coroner found that the Child died as a result of driving despite their young age, lack of training and persistent rejection of systemic supports for education. No evidence was found of any attempts to educate the Child about driving or safety, despite the known behaviour.

The timeline of interventions for the Child is shown in Figure 17.

Figure 17: Case example 10: Responding to offending behaviour, criminal exploitation and lack of supervision of an adolescent who subsequently goes missing – timeline of system touchpoints



Child Safety

- Intake enquiry (from YJ)
- CPN
- CCR
- Safety Assessment (safe)
- Contact with parent (I&A outcome)
- Unsuccessful contact with parent
- I&A (unsubstantiated)

Health

- Fail to attend medical appointment

Multi-agency

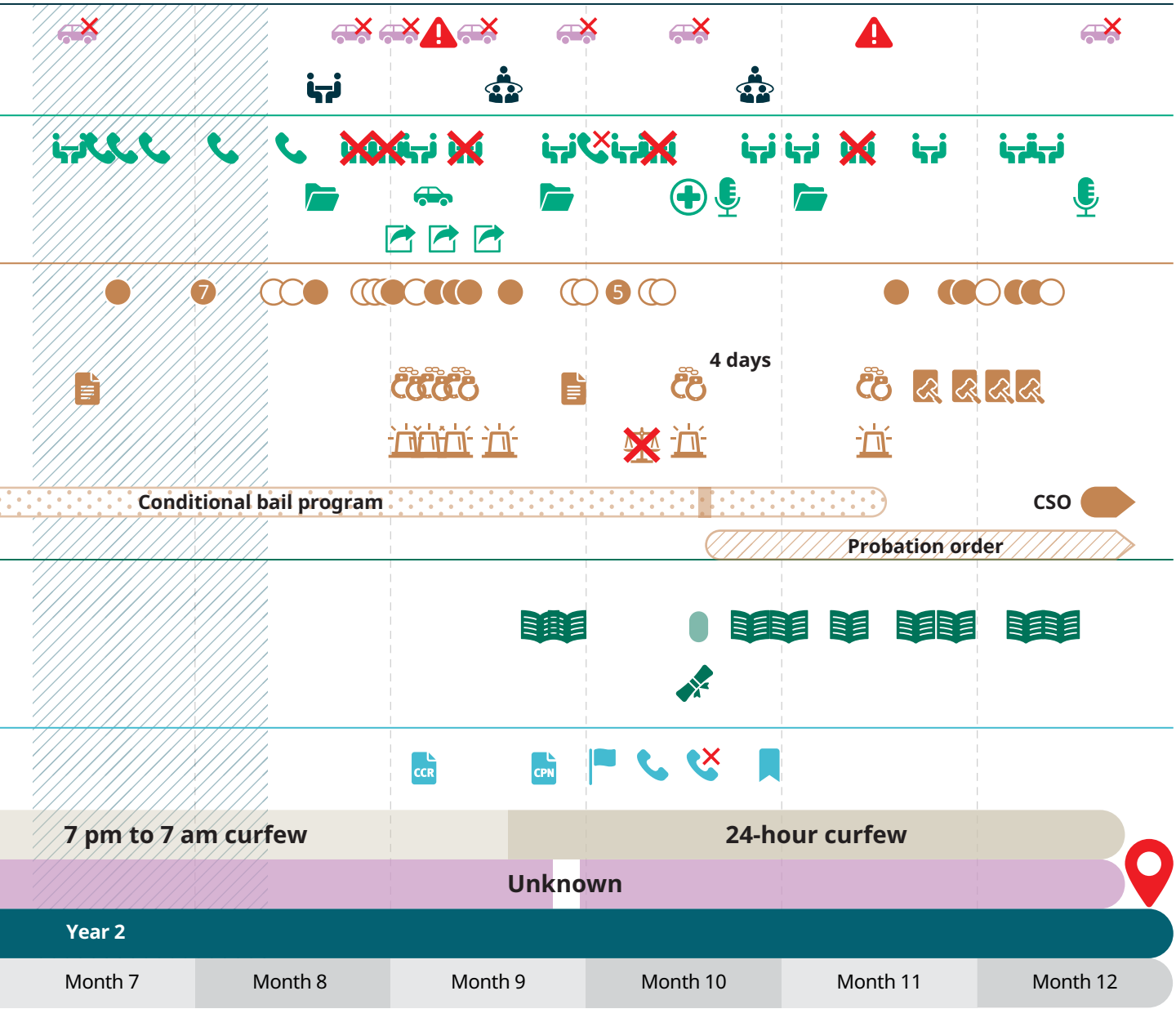
- Family-led decision-making meeting
- SROI meeting

Education

- State high school enrolment
- Enrolled – BYDC
- 10-day school suspension
- Referral to Regional Education Services
- Attempted school home visit (not present)
- Attends 2-hour alternative learning session

Police/Justice

- Compliant bail check
- Non-compliant bail check
- Arrest
- Notice to appear
- Fails to attend court
- Held in watchhouse



Reports as per Probation Order

Missing person report

Conditional bail program

Remand – BYDC

Probation Order

CSO

Youth Justice

Welfare check at watchhouse

Intake exam

Case review

In-person meeting with YJ caseworker

Failed to attend in-person meeting with YJ caseworker

Contact with YJ caseworker

Failed contact with YJ caseworker

Attends driving program (not completed)

Court diversion referral

Other key events

Suicide risk alert

COVID-19 limited Youth Justice service delivery

Vehicle/driving related offences

Non-vehicle/driving related offences

Reported period of methamphetamine use

Day of death

Case example 11: Inability of the system to respond effectively to teenagers who display significant substance abuse issues and high-risk behaviours

The Child was assessed as a child in need of protection (risk of emotional harm and neglect) with Father the person responsible. The Child was chroming heavily every day and had started using methamphetamines. They had been 'kicked out of home' and was living with peers in the community. They were well-known to Youth Justice by this time, though was not attending Youth Justice appointments.

A Child Concern Report was recorded following concerns that the Child appeared to be living in a vacant unit alone, was never supervised by an adult, and was always seen in the same clothing.

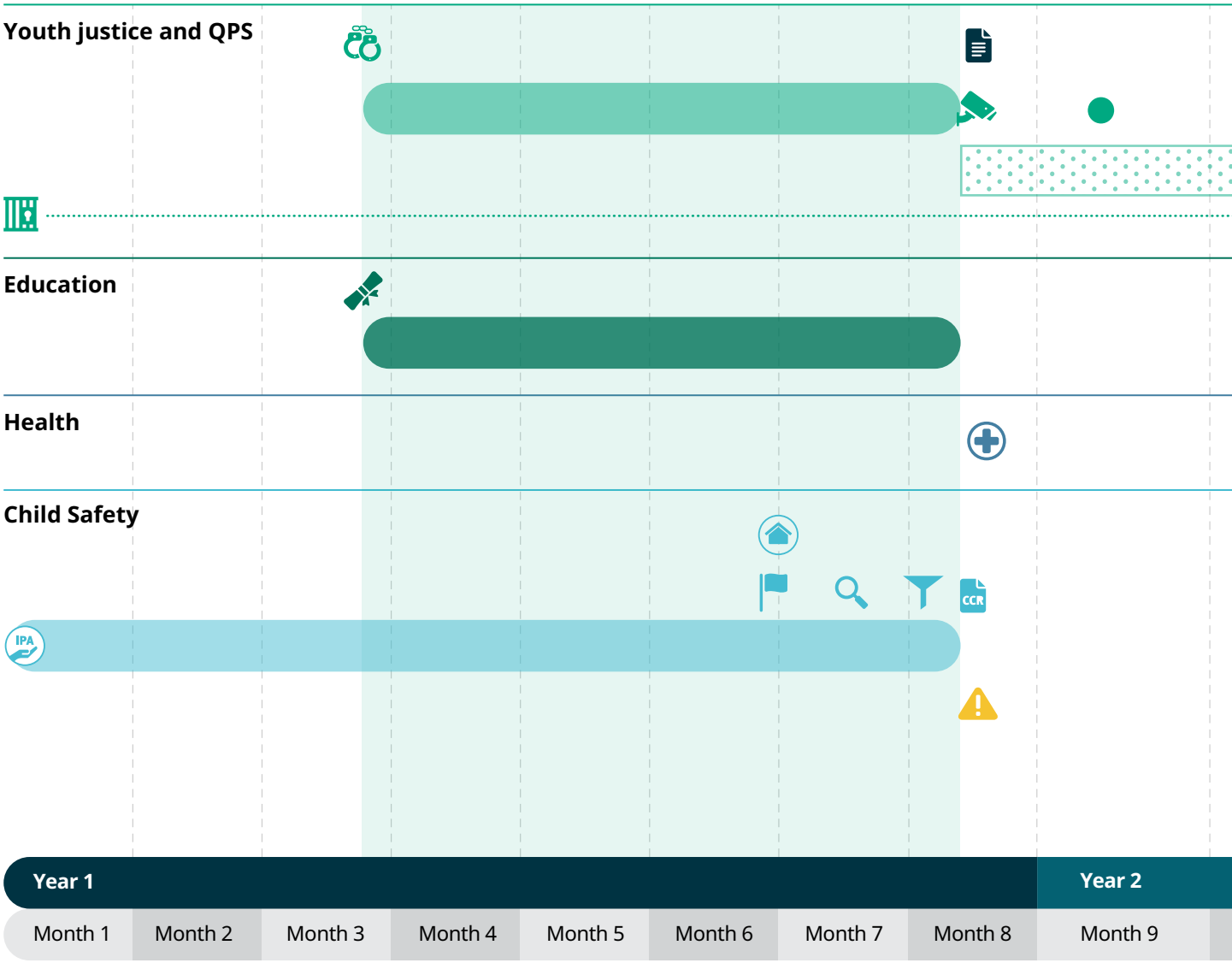
In the following months, the Child continued to engage in high-risk behaviours. They were taken to hospital under an Emergency Examination Authority when they fell from a 6–8 metre concrete wall while intoxicated.

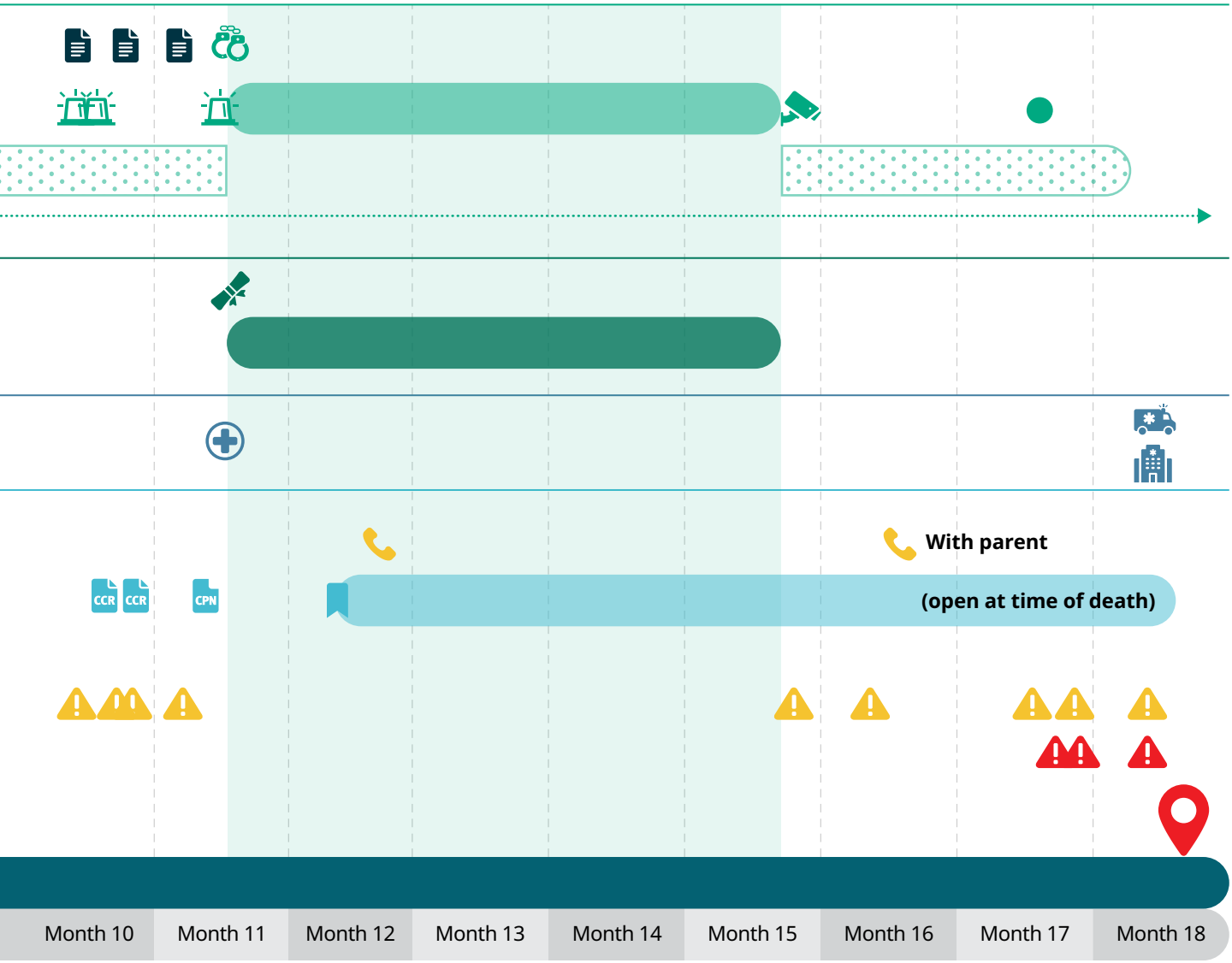
QPS responded to reports that the Child and peers were sniffing petrol and committing break and enters. Police spoke with the residential care service who was supposed to be caring for the Child and one peer. The service advised:

"there was nothing they could or would do because the children were high and they were not allowed to have them at the shelter whilst high… At this time, nil persons or other organisations/agencies are willing or able to help supervise/care or deal with the children and are placing responsibility on Police to deal with the incident by 'locking up' the kids as no one can control or is willing to control the children involved".

The timeline of interventions for this Child is shown in Figure 18.

Figure 18: Case example 11: Inability of the system to respond effectively to young people who display significant substance abuse issues and high-risk behaviours – timeline of system touchpoints





Child Safety

- IPA
- CCR
- CPN
- SSoDR check
- Family risk evaluation (medium)
- Safety Assessment (safe)
- I&A
- Phone contact
- Visit at BYDC

Other key events

- VSU
- Suicidal ideation / attempt
- Child harm report
- SCAN Meeting
- Day of death

High-risk behaviours test the capability, coordination and access arrangements of the current systems

The Board has consistently underscored the significant challenges faced by families, communities and service systems in supporting teenagers who engage in high-risk behaviours. Across the six cases reviewed this year that involved death by suicide or in transport incidents, records reveal a recurring sense of hopelessness among families and service providers who were striving to safeguard these teenagers.

Common themes emerged, including limited service availability, poor engagement and a lack of coordinated, wrap-around support. Youth Justice reviews of the six cases highlighted missed opportunities for early intervention, inadequate case management and insufficient planning and oversight. As the coroner noted in one case, systemic responses to high-risk offending, particularly motor vehicle-related offences, were often reactive and largely ineffective.

Many of these young people live with undiagnosed disabilities and mental health challenges, and experience system fatigue. Repeated unmet needs often lead to disengagement from services. The current system lacks the capacity, workforce and flexibility to respond effectively, especially outside standard business hours or in non-traditional settings.

Further barriers include siloed agency operations, limited outreach and service designs that are not accessible or youth friendly.

Addressing these systemic shortcomings requires a coordinated, multi-agency approach, enhanced workforce capability and the development of integrated service models that are proactive, flexible and tailored to the needs of at-risk young people.

Putting a case forward for economic investment

The current system's inability to effectively respond to young people with high-risk behaviours is not only a social and moral concern, it also carries significant economic consequences. These young people's behaviour creates high costs for the agencies who are tasked to manage or help them. They frequently cycle through crisis services, emergency departments, detention centres and unstable housing driving up costs across government portfolios.

1. Each hospital emergency department presentation alone can cost the health system between $500 and $1,200 depending on the level of urgency, and many young people present repeatedly.[111]
2. According to the Productivity Commission's *Report on Government Services 2025*, the average annual cost per young person in detention is approximately $700,000 to $800,000.[112]
3. While specific per-child cost figures for Queensland in 2025 are not publicly detailed, national estimates and state-level reports suggest that residential care placements, which are among the most intensive and costly forms of care, can cost more than $1,000 per child per day.[113]

The cost of inaction is profound measured not only in lives lost but in the escalating financial burden across government systems. Each missed opportunity for early support compounds trauma and increases the likelihood of long-term service dependency. Beyond the immediate costs, there are broader economic implications: reduced educational attainment, increased unemployment and intergenerational disadvantage. These young people's behaviour creates high costs for government, yet with early, targeted investment, their trajectories can be changed. A shared investment approach, supported by cross-agency governance and funding reform, is essential to break the cycle of crisis and deliver meaningful change.

111 Australian Institute of Health and Welfare, Emergency department care, 2024.
112 Productivity Commission, *Report on Government Services 2025: Youth Justice*, 2025.
113 Robinson Z, 2025, *Online Submission – NSW Office of the Advocate for Children and Young People*, Independent Pricing and Regulatory Tribunal (IPART).

Concluding comments

The cases reviewed highlight that young people's high-risk behaviours often arise from complex, unmet needs and systemic neglect. Their risky actions are not simply personal failings but reflect a broader misalignment between the individual and their environment. This disconnect underscores the need for more responsive and supportive systems that can effectively engage vulnerable young people, particularly those showing signs of escalating distress such as suicidality. Unfortunately, current responses remain largely reactive, failing to prevent crises before they occur.

This cohort faces severe consequences including criminal exploitation, incarceration and premature death if left unsupported. The economic and social costs of failing to address their needs are substantial, making actions for this group a critical priority. Systemic failures continue to drive escalating costs, prompting calls for new funding models and leadership from cross-agency and government bodies. Proactive strategies focused on prevention and early intervention are needed to identify and support these young people before they reach crisis points.

In its inaugural 2020–21 annual report, the Board's recommendations included:

- 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. This recommendation was revisited in Recommendation 3 of the 2023–24 annual report: specialised placement options and continuity of care for children with complex needs
- 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.

Four years on, there has been some improvement towards a coordinated system response to youth suicide. However, cases reviewed in 2024–25 continue to highlight opportunities to improve system responses to children and young people experiencing mental health issues, including suicidal ideation and self-harming behaviours.

In 2021–22 the Board reviewed several cases of young Queensland people who had lost their lives after significant complex and high-risk behaviours escalated. The Board noted that as the young people's behaviours escalated, they received less, not more, government service support. The Board recommended that the government should create a fit-for-purpose model offering a continuum of care for children with high-risk behaviours. The recommendation stressed that the model should acknowledge that multiple government departments interact with these young people and that there is no single entity responsible for the necessary assessment, response and holistic oversight.

The recommendation included that the model should:

> "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
> - integrates ongoing access for the child to family, culture and education."

The Board's 2023–24 annual report stated that the Board "does not consider that sufficient action has been taken" in relation to this recommendation.

In its 2023–24 annual report the Board further recommended:

> "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 [for] 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."

The Board has noted the Queensland Government's election commitment regarding a secure care service. The Board considers it appropriate to again emphasise the need for improved government responses to children in care exhibiting high-risk behaviours. Within this context, and noting that its past recommendations remain open, the Board has focused on recommendations that will prevent young people from escalating into this cohort including strengthened family support services, early childhood support, education reengagement and health support.

Recommendations made in this chapter consider the impact of mandatory departmental involvement based on risk assessment, particularly in circumstances where a child has a parent who is able and willing to act protectively. The recommendations consider the balance of assessing risk where it presents potential for harm to a child, and where additional secondary system supports may be engaged or enacted through notification to the statutory system.

Recommendations

The Board recommends that:

Recommendation 4

The Minister for Families should commission work that will enhance the operational capacity, accountability and cross-agency collaboration of SCAN teams (or another legislated, multi-agency committee) such that it delivers a legislated accountability mechanism that works across portfolios to ensure timely and coordinated responses to complex risk indicators in children and families. Specifically, an improved multiagency case management process should include:

a. a strategic mechanism for targeting pre-emptive support to families to ensure they are engaging the right cohorts—particularly unborn children, infants, and young people with cumulative risk factors as explored through the chapters in this report—and not duplicating or misdirecting resources

b. joint case management reviews for any child in care who has more than two placement moves in a 12-month period, or any child below the age of 12 who is in residential care

c. a structured framework that triggers mandatory involvement from the Department responsible for Child Safety or Youth Justice when a young person presents with a cluster of high-risk indicators such as intergenerational trauma, care experience, cognitive impairment, developmental delays, school disengagement and early contact with the justice system

d. expanded eligibility to include children with significant unmet needs who may not yet meet the Department responsible for Child Safety's threshold but may benefit from a coordinated system response, including those with chronic health conditions, high health service usage or complex medical discharge needs who require multi-agency coordination and planning.

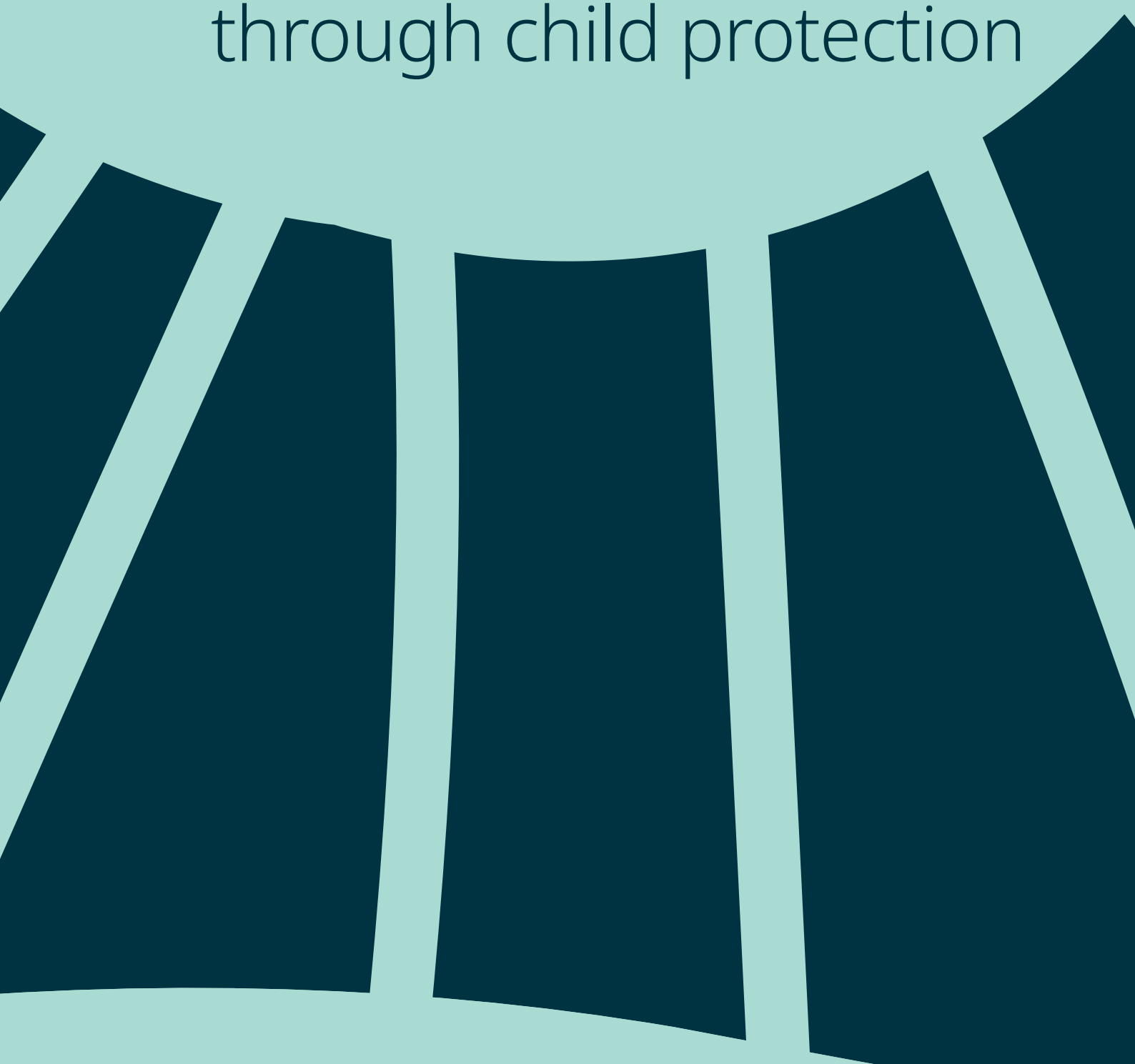
Recommendation 5

The Department of the Premier and Cabinet should lead a project alongside the Department of Education, Queensland Health and the Department responsible for Child Safety to develop a strategy to further integrate health and family services within ECEC settings and public schools. This strategy should include consideration of:

a. providing the necessary infrastructure, resourcing and workforce to deliver on the service needs of children and their families, across the spectrum of universal supports to timely, targeted and tailored interventions and support
b. reviewing accessibility and availability of services, both government and non-government, to build parenting capacity and improve how the system can better connect children and parents to these services
c. reviewing the Healthy Kindy Kids program to ensure the mechanism will be sufficiently robust to identify and coordinate diagnostic screening of children, not just for potential speech, hearing and visual impairments, but more broadly children with developmental delays, behavioural concerns and/or other undiagnosed disabilities that, when otherwise unaddressed, may increase a child's likelihood of later disengaging from education
d. creating integrated referral points to ensure children and their parents/caregivers identified with additional areas of need are connected to appropriate early childhood interventions, therapy or behavioural supports, including where applicable supporting families with access to the NDIS and ensuring they are supported while waiting for assessments and/or diagnoses
e. implementing a targeted rollout that prioritises specific communities/local government areas/ schools with the greatest need.

CHAPTER 5

Identifying domestic and family violence in risk assessments: connecting families through child protection



The Board reviewed cases this year that examined the quality of decision-making at key points, especially during intake and I&A. Several cases involved domestic and family violence where risks were missed or not properly addressed, highlighting the need for better early assessment and interagency coordination.

While the Department responsible for Child Safety teams can identify domestic and family violence risks, responses often default to legislative child protection mechanisms rather than proactive safety planning. This raises concerns about the effectiveness of current child protection assessment tools in evaluating domestic and family violence and guiding supportive interventions.

This chapter highlights the need to shift from a child protection response to a child safety pathway, focusing on early risk identification and coordinated action. Once risk is identified, collaboration across services such as housing, health, and coordination mechanisms like SCAN or High Risk Teams (HRTs) is essential.

Case studies and Child Concern Reports show that despite repeated opportunities, safety responses were often lacking, underscoring the need for systemic reform and stronger interagency coordination.

Domestic and family violence as a wider social concern

The 2023 Australian Child Maltreatment Study has reaffirmed that exposure to domestic and family violence is one of the most prevalent and harmful forms of child maltreatment in Australia. Among Australians aged 16 and over 39.6 per cent reported being exposed to domestic and family violence during childhood. This figure rises to 43.8 per cent among young people aged 16 to 24.[114] Exposure to domestic and family violence is one of five core maltreatment types identified in the study, alongside physical abuse, sexual abuse, emotional abuse and neglect. It is now widely recognised as a serious form of harm in its own right, that is, even if it is not accompanied by personal physical abuse. The study highlights that children who experience domestic and family violence have significantly increased risk of mental health disorders, harmful behaviours and long-term health impacts. This underscores the need for systemic, cross-sector responses to prevention and early intervention.

Domestic and family violence remains a significant and persistent issue across Queensland, with far-reaching impacts on children and families. About one in five women in Queensland have reported experiencing physical or sexual violence by a current or former partner.[115] In the 2024–25 year, the QPS attended over 200,000 domestic and family violence-related incidents, highlighting the scale of the issue.[116]

There was a high prevalence of domestic and family violence among the cases the Board examined for this report. Domestic and family violence was present in 49 (77%) of the 64 new cases reviewed this year. There were multiple safety risks in the families within the Board's remit.

Domestic and family violence and forms of child maltreatment extend beyond the scope of child protection and require a broader, whole-of-government response. The Queensland Government has committed to a comprehensive strategy to prevent violence, supported by the *Domestic and Family Violence Common Risk and Safety Framework (CRASF)*. The CRASF outlines responsibilities for identifying and responding to domestic and family violence.[117] Importantly, both the *Domestic and Family Violence Strategy 2016-2026* and the CRASF acknowledge that children exposed to domestic and family violence are victims in their own right. This reinforces the need for coordinated, multi-agency action.

Child protection systems, particularly current intake and assessment tools, often fail to identify key risks like domestic and family violence. While the Department responsible for Child Safety plays a critical role, it should not be the sole agency responsible or the default response to all forms of child maltreatment. These responsibilities are often placed solely on the Department responsible for Child Safety, rather than being recognised as a shared responsibility, despite research showing that risk assessment and management are more effective when multiple stakeholders collaborate in identifying and addressing concerns.[118] A broader, multi-agency approach is essential to better safeguard children's wellbeing and address the complexity of these issues.

114 Australian Child Maltreatment Study, *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study*, 2025.

115 Queensland Government Statistician's Office, *Domestic and Family Violence Survey Report, Queensland Social Survey 2024*. Queensland Treasury, 2024.

116 Queensland Courts, *Domestic and Family Violence statistics*, 2025.

117 Department of Families, Seniors and Disability Services (Queensland), *Domestic and Family Violence Common Risk and Safety Framework (CRASF)*, 2025.

118 McPherson, L., Macnamara, N., & Hemsworth, C. (1997). *A model for multi-disciplinary collaboration in child protection*. Children Australia, 22(1), 1117.

Assessing risk within a statutory child protection agency

The Department responsible for Child Safety, like other government and non-government agencies, holds a critical responsibility to identify and respond to domestic and family violence. As discussed, the 2023 Australian Child Maltreatment Study indicates exposure to domestic violence is the most common form of maltreatment. This underscores the need for the child protection system to be equipped to recognise and respond to domestic and family violence as a serious form of child maltreatment.

However, current child protection intake and I&A processes are primarily designed to inform the legislative threshold for statutory intervention. As a result, they often fall short in identifying or appropriately responding to risks such as domestic and family violence or patterns of neglect. Case reviews reveal that while risks such as domestic and family violence may be identified, the risk is not consistently acted upon and is frequently assessed as a parental issue rather than a direct threat to a child's safety and wellbeing.

Domestic and family violence is consistently evident in the cases reviewed by the Board. The Board has concluded that current risk assessment tools are inadequate highlighting a systemic gap in how risk is identified and addressed.

The Department responsible for Child Safety has two distinct channels for responding to domestic and family violence:

1. As a child protection matter, under its legislative mandate to ensure the safety of children
2. As part of a whole-of-government response, through frameworks like the CRASF.

In Queensland, child protection is governed by the *Child Protection Act 1999* (Qld), which places the safety, wellbeing and best interests of children as the highest priority. Under this Act, the Department of Families, Seniors, Disability Services and Child Safety is responsible for protecting children who are at risk of significant harm and whose parents are unable or unwilling to provide adequate protection. This Act outlines principles such as supporting families to care for their children, placing children with kin where possible, and ensuring children maintain connections to their identity and culture. When a child cannot be safely cared for by their family, the State assumes responsibility for their protection and care.

The CRASF provides a shared, system-wide approach to recognising, assessing and responding to domestic and family violence. It includes tools for screening, risk assessment, and safety planning, and it explicitly recognises children and young people as victim-survivors in their own right.[119] Agencies using the CRASF are expected to collaborate across sectors, apply culturally appropriate and trauma-informed practices, and respond to a broad spectrum of domestic and family violence-related risks including coercive control and technology-facilitated abuse.

Both child protection and CRASF pathways require the ability to accurately identify and assess risks that impact the safety of children within families. Strengthening these capabilities across systems is essential to ensure that children exposed to domestic and family violence receive the protection and support they need regardless of whether their situation meets the threshold for statutory intervention.

119 Department of Families, Seniors and Disability Services (Queensland), *Domestic and Family Violence Common Risk and Safety Framework (CRASF)*, 2025.

Clarification of safety responses and protection responses

The article *Safeguarding vs child protection* from the Australian Childhood Foundation[120] explains the distinction between two important concepts in child welfare:

1. **Child Safeguarding** refers to the proactive responsibility of organisations to ensure their environments, operations and representatives do not harm children. It involves creating a culture of safety, inclusion and awareness. It includes measures like:
    a. building child-safe environments
    b. empowering children to participate and have a voice
    c. training staff to identify and respond to risks
    d. establishing strong reporting and risk management systems.
2. **Child Protection**, on the other hand, is more reactive. It involves responding to specific incidents or risks of harm, such as abuse or neglect, often through legal or formal intervention.

Decisions to initiate a child protection response are made with great care and consideration. Removing children from their families is recognised as a serious and life-altering action, and as such the threshold for statutory intervention is deliberately set high. This ensures that child protection responses are reserved for situations where there is a clear and significant risk to a child's safety and wellbeing. Put simply, a process to investigate safety is not always the best mechanism to address risk. The dual roles are often in competition with each other.

Across Australia, child protection legislation, risk assessment tools and intake processes vary by jurisdiction.

Risk assessment framework/tools across Australian jurisdictions

- New South Wales uses the Structured Decision Making Framework and suite of tools to assess the safety of and risk to children. There are some specific circumstances where a professional judgement tool called the Alternate Assessment is used, such as when the child is in out-of-home care.
- Victoria uses the SAFER children framework guide. The SAFER children framework is centred on five practice activities of risk assessment:
    - Seek, share, sort and store information and evidence
    - Analyse information and evidence to determine the risk assessment (three elements: analysis, judgements, decisions)
    - Formulate a case plan
    - Enact the case plan
    - Review the risk assessment.

120 Australian Childhood Foundation, Safeguarding vs child protection, 2025.

However, there is a growing national emphasis on improving consistency and effectiveness in identifying and responding to child maltreatment. In Queensland, the Department responsible for Child Safety has introduced an Enhanced Intake and Assessment approach in 2025, aimed at strengthening how Notifications are received, assessed, and recorded. This model supports more accurate identification of risks, particularly those related to domestic and family violence. It aligns with broader reforms under the *Child Safe Organisations Act 2024* (Qld), which promotes national consistency in child safety standards.[121]

When discussing a safety response, it is important to distinguish between formal child protection interventions and broader multi-agency responses. The Department responsible for Child Safety has three possible pathways when assessing risk to a child:

1. Risk of significant harm, which meets the threshold for a statutory child protection response.
2. Observed risk which does not meet the threshold for child protection intervention but which may warrant a safety response, often involving coordination with other agencies.
3. Low-level or insufficient risk, which may not require immediate action but could benefit from monitoring or support.

This tiered approach reflects the complexity of child safety concerns and the need for flexible, proportionate responses. It also reinforces the importance of accurate risk identification whether through child protection legislation or frameworks like the CRASF to ensure children receive the right support at the right time.

Lack of recognition of domestic and family violence when screening child protection concerns

Despite increased awareness of domestic and family violence, its impact on children is still often underestimated, with risks frequently misinterpreted as isolated conflict rather than patterns of coercive control.[122] This can lead to inadequate responses, even though children exposed to domestic and family violence, whether directly or indirectly, are victims in their own right.[123] Growing recognition of this reality, as highlighted by the National Children's Commissioner, is essential for developing effective support systems and preventing lifelong harm.[124]

Current tools and processes often fail to detect the presence and severity of domestic and family violence. This issue is not isolated; data indicates that these gaps occur frequently at the intake and I&A stage. This not only compromises opportunities for the Department responsible for Child Safety to perform risk assessment, but also reflects broader gaps in training, screening tools and practice guidance when it comes to recognising thresholds for domestic and family violence.

Given the recurring presence of risks such as domestic and family violence and neglect in cases reviewed by the Board, the Board has focused on understanding how these risks are identified and addressed. Data from the Board's investigations reveal that decisions intended to protect children have, at times, been inadequate, particularly when multiple Child Concern Reports, which are recorded when reported concerns do not meet the threshold for a formal Notification, were overlooked. In these instances, a child protection response was not prioritised, raising concerns about missed opportunities to intervene and safeguard children at risk.

121 Queensland Family and Child Commission, *Guidelines for implementing the Universal Principle and Child Safe Standards in Queensland*, Queensland Government, 2025.

122 Australia's National Research Organisation for Women's Safety, *Domestic and family violence, housing insecurity and homelessness: Research synthesis*, 2019.

123 Healey L, Connolly M and Humphreys C, 'A Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: Bridging the Research and Practice Divide.' *Australian Social Work*. 71. 1–10, 2018.

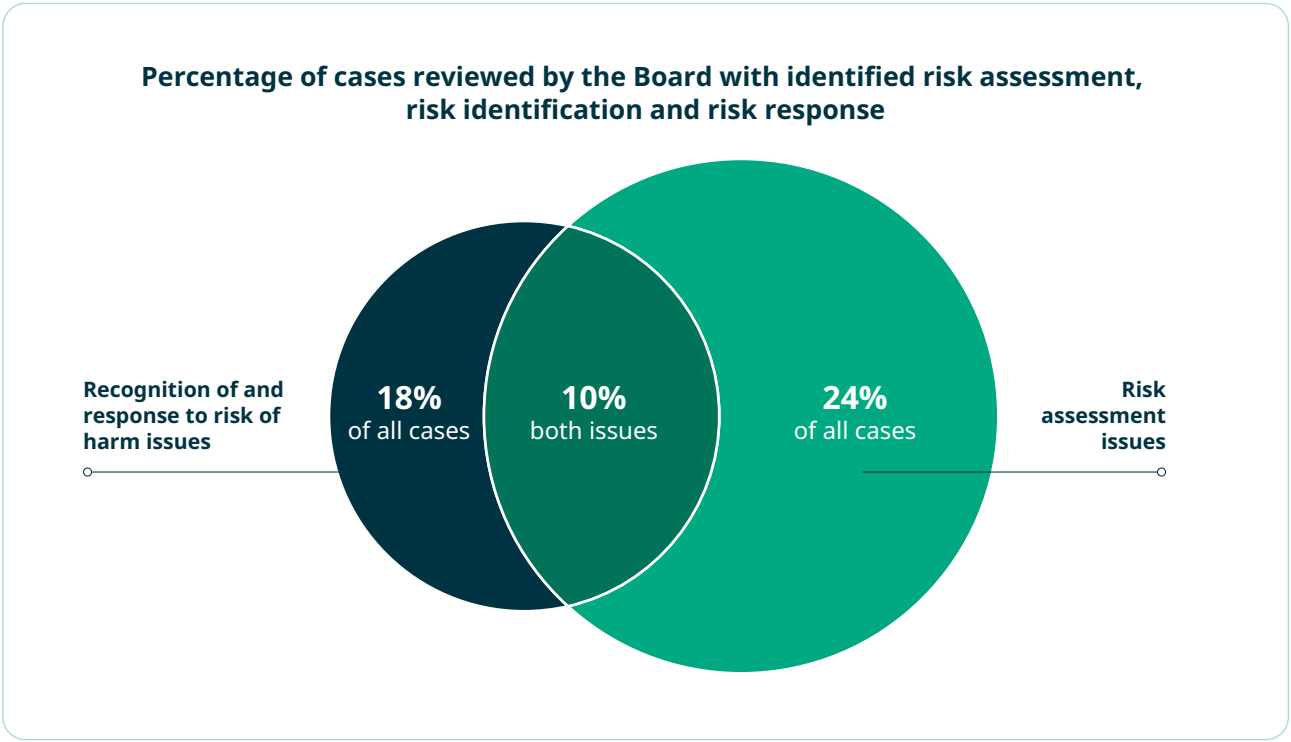
124 Australian Human Rights Commission, *National Children's Commissioner calls for children to be recognised as victims in their own right*, 2024.

What the data is telling us

Out of 157 total cases categorised by the Board since 1 January 2024, 55 cases (or 35%) showed gaps or weaknesses in risk assessment or response to the risk of harm. Of these 55 cases:

- 37 cases had gaps in risk assessment
- 28 cases had gaps in the recognition of and response to risk of harm
- 15 cases were identified as having both these issues

Figure 19: Gaps in risk assessment and response to the risk of harm in 157 reviewed cases



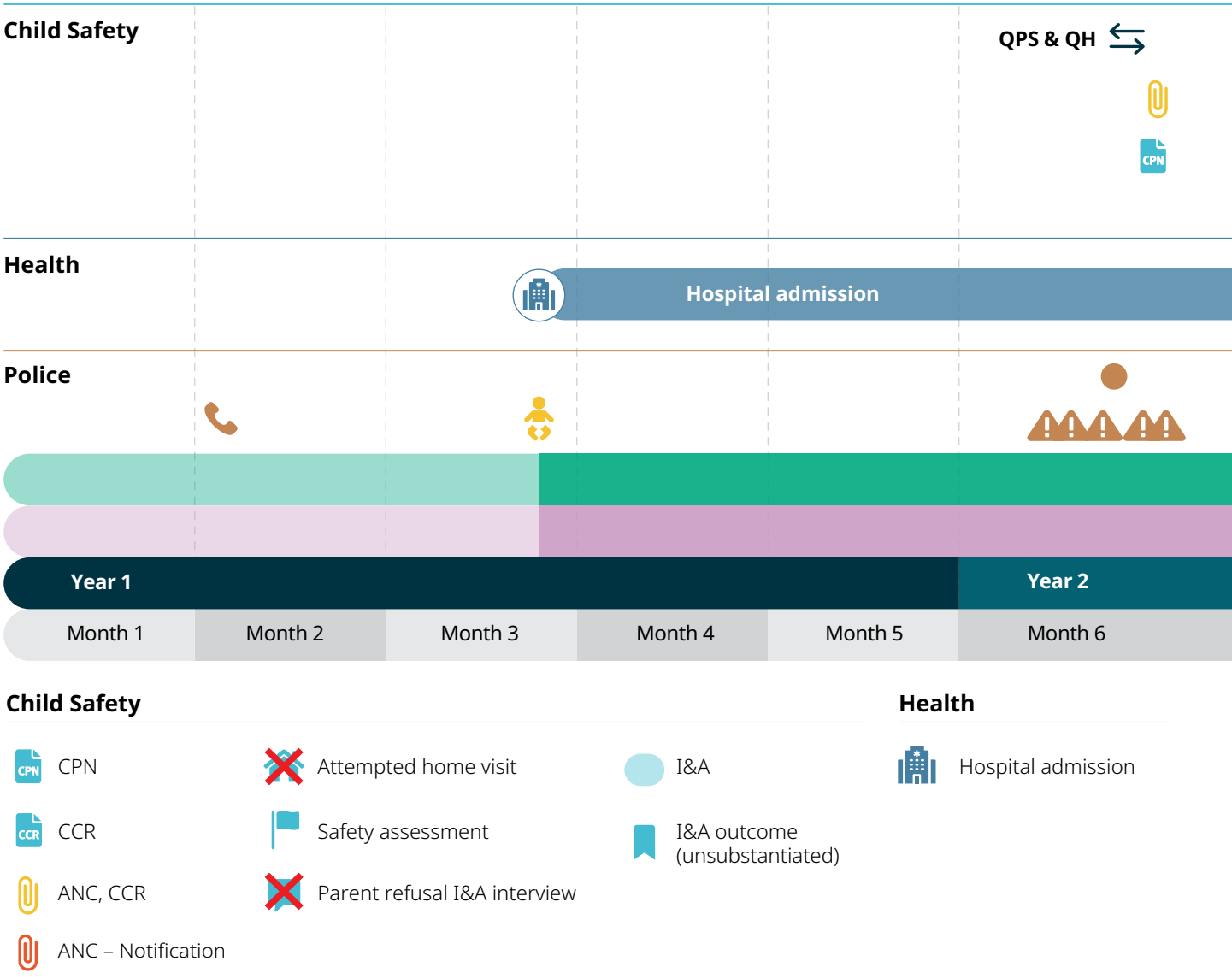
Case example 12: Lack of identification of the risk of domestic violence harm

A mother was transferred to hospital due to signs of early labour and gave birth to a premature infant, who required an extended stay in the neonatal intensive care unit. During this time, the infant underwent multiple medical treatments including oxygen support, infection management and surgeries for various health complications.

While the infant was in intensive care, child protection services received several Notifications raising concerns about domestic and family violence, physical injuries observed on a sibling and the mother, and the overall safety of the home environment. Reports included allegations of assault, emotional dependency on the sibling, unhygienic living conditions, and exposure to smoking around the medically vulnerable infant. Although one investigation concluded that the children did not need protection, subsequent concerns persisted regarding continued perpetration of domestic and family violence, health risks and the suitability of the family's living arrangements.

The timeline of interventions for this child is shown in Figure 20.

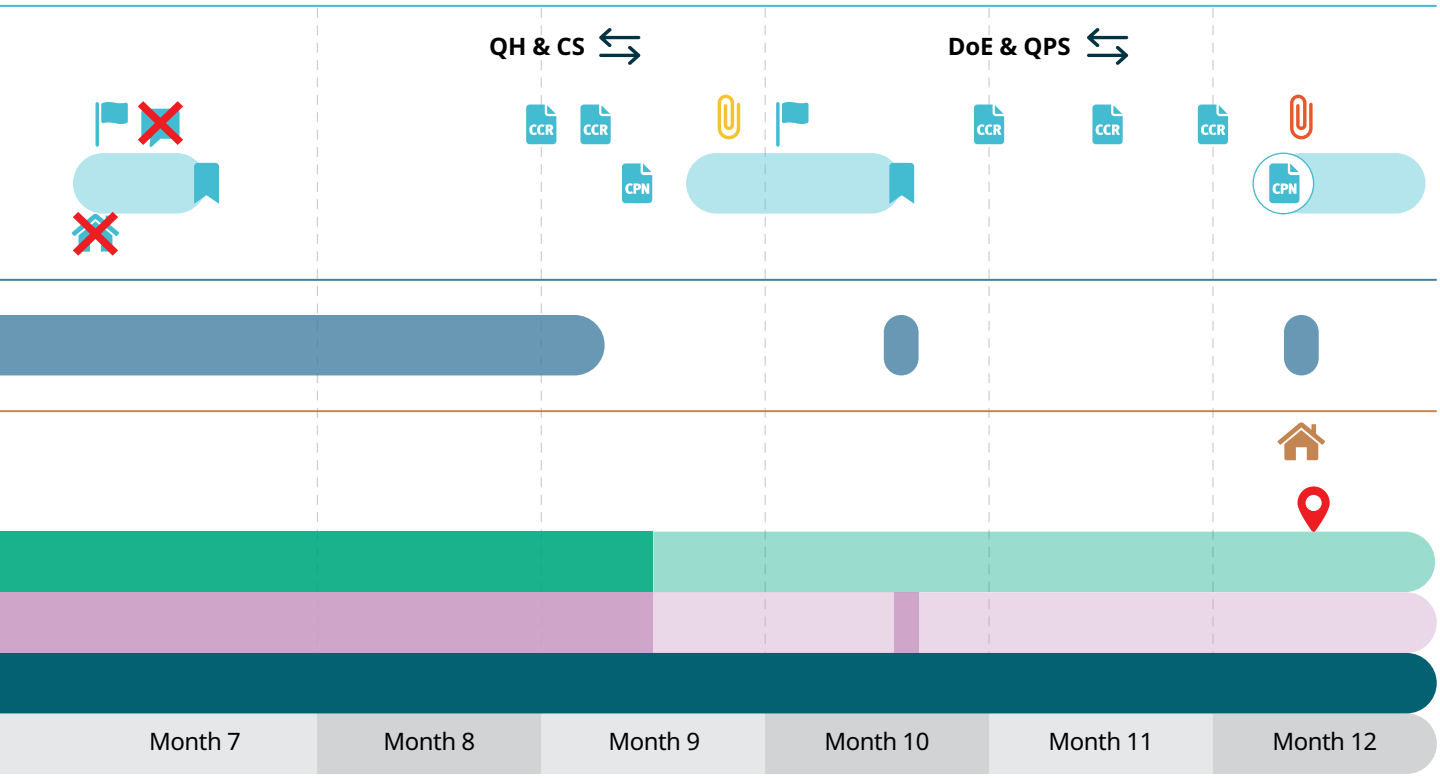
Figure 20: Case example 12: Lack of identification of the risk of domestic violence harm – timeline of system touchpoints



Overall, the reviewed cases show a lack of recognition of the impacts of domestic and family violence at intake; repeated Child Concern Reports within a short timeframe; and a need to listen to professional health notifiers when screening child protection concerns.

The presence of multiple Child Concern Reports within a short timeframe should serve as a critical indicator of escalating risk. However, in several of the reviewed cases there was inadequate recognition of the cumulative harm suggested by repeated reports. Each Child Concern Report was often assessed in isolation, with insufficient synthesis of historical concerns, leading to a fragmented understanding of risk. This narrow lens failed to trigger an appropriate escalation of response or deeper investigation, despite patterns suggesting chronic neglect, instability or exposure to domestic violence.

This practice reflects a systemic gap in risk assessment processes, where procedural thresholds are not always matched by critical reflection. Opportunities to intervene earlier and more effectively were missed, as repeat Notifications did not result in meaningful changes to the child protection response. Strengthening the system's capacity to identify and respond to cumulative risk of harm is essential to ensuring children are not left in situations of prolonged or compounding risk.



Police

- Drug and weapon concerns reported to police
- Police street check
- Sibling welfare conducted by Police
- Reported domestic and family violence incident

Other key events

- Residing in remote area
- Residing in urban area
- Sibling school attendance
- Sibling hospital school attendance
- Information shared
- Day of birth
- Day of death

The Board has closely examined how risks such as domestic and family violence and neglect were identified in the cases it reviewed. The Board concluded that these risks were not adequately recognised or addressed. While this does not amount to a direct criticism of the Department responsible for Child Safety, it does raise important questions about missed opportunities for earlier intervention. In some instances, the Board has questioned whether a High-Risk Team response could have been triggered—an approach that may have provided a more appropriate and coordinated response to the complexity of the risks present.

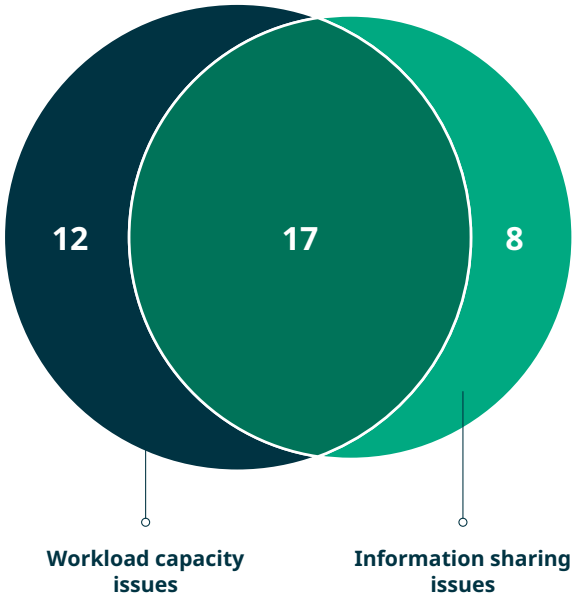
Limitations for identifying risks

Across many of the cases reviewed, systemic issues related to information sharing or the Department responsible for Child Safety's workforce capacity significantly impeded effective risk identification and timely child protection responses.

Of the 50 cases reviewed by the Board with identified risk assessment issues:

- 29 cases (58%) had workload capacity constraints only
- 25 cases (50%) had information sharing issues only
- 17 cases (34%) had both information sharing and workload capacity issues
- 13 cases had neither issue.

Figure 21: Causes of issues in risk assessment or response to risk of harm in 50 reviewed cases



Further, a thorough I&A should gather information about the child, parents, harm or abuse, and the broader family, cultural and environmental context to identify risks and protective factors. Information from parents should be verified through reliable sources such as government agencies, support services, schools and extended family. The Board has consistently found that inadequate information-gathering is a common issue in child death reviews, often leading to incomplete assessments and a limited understanding of the risks facing children.

The Enhanced Intake and Assessment approach provides a more effective framework for identifying and responding to domestic and family violence within the child protection system

Certain families, particularly those at risk of neglect or domestic and family violence, often receive a child protection response. To improve outcomes, there is a need to strengthen pathways within the child protection system that offer supportive and preventative responses, rather than defaulting to formal child protection interventions. This involves building a more nuanced approach that addresses risk while promoting safety and stability.

Risk assessment in Queensland child protection is now guided by the Enhanced Intake and Assessment approach.

The new Enhanced Intake and Assessment approach has changed the way in which Child Concern Reports and Notifications are responded to:

Enhanced Intake and Assessment approach

The new procedure for responding to a Child Concern Report or Notification is detailed in the Child Safety Practice Manual.

Response to a Child Concern Report

In summary, a Child Concern Report will now be responded to by one of the following:

- Protective advice: Practitioner provides information and advice aimed at helping the family increase safety for the child and reduce future Child Safety involvement.
- Referral to Family and Child Connect, Intensive Family Support or Family Wellbeing Service.
- Active Support Response pathway: Professional judgement will be applied for matters where this is the third or more intake for the family within a 12-month period. Child Safety contacts the parent or pregnant woman to discuss the concerns and seek their consent to make a targeted referral. If a family does not give consent for an Active Support Response or is unable to be contacted, the matter will be closed.

Response to a Notification

In summary, a Notification will now be responded to by one of the following:

- Safety and support response: A response to a Notification provided by an external agency to assess the support needs of a family and coordinate support to the child and family to reduce risk to the child.
- Standard response: A standard response is a response to a Notification that is undertaken by an authorised officer. It includes an assessment of the child's immediate safety and the family's support needs. Where possible an Assessment and Service Connect co-responder will work with Child Safety and the family to assess the family's needs and coordinate services to decrease the likelihood of the child becoming a child in need of protection.
- Priority response: A priority response is a response to a Notification and is an assessment undertaken by an authorised officer of a child's need for protection.

Note: A safety and support response can be returned to a standard response, and a standard response can be escalated to a priority response under certain circumstances.

The role of coordination mechanisms including SCAN and HRT more broadly

These cases of child death highlight the need to better use child protection assessment tools to evaluate domestic and family violence and guide supportive interventions. Once risk is identified, coordinated responses involving services like SCAN teams—multi-agency panels that coordinate responses to child harm and HRTs—specialist groups addressing complex domestic and family violence cases, are essential.

Case studies show that despite multiple critical case reviews, safety responses were often missing, highlighting the need for systemic improvement. The SCAN system is intended to support interagency coordination when child protection concerns arise, but its effectiveness is currently limited. There is a lack of clarity around how SCAN operates and whether cases that meet statutory thresholds are being appropriately progressed. Reviews have highlighted missed opportunities for collaboration, particularly where cases were not referred to SCAN despite clear indicators of risk.

This includes children with complex medical needs or developmental delays, or high-risk infants being discharged from hospital, in situations where parental neglect is a concern. The SCAN system's criteria are restrictive, often excluding children not yet known to the Department responsible for Child Safety, which prevents early multi-agency engagement. SCAN is further explored in Chapter 6.

A recurring issue is the ineffective use of existing coordination mechanisms. Decisions are often made in isolation without input from partner agencies. This lack of interagency collaboration undermines the ability to accurately assess risk and deliver coordinated, effective support. Agencies such as the Department responsible for Child Safety and Queensland Health need to be encouraged to work together more proactively, using SCAN and other multidisciplinary tools to share information, plan for safety and coordinate services. Strengthening these pathways is essential to ensure that children at risk receive timely and appropriate responses.

Case example 13: Opportunity to strengthen system responses to domestic and family violence behaviours

QPS responded to a domestic disturbance at a residence after receiving a report from a concerned relative who heard yelling and suspected an assault had occurred. Upon arrival, officers found that a father had damaged property and physically assaulted the stepmother in the home. A two-year-old child was present during the incident and was recorded as having been exposed to the domestic and family violence.

In response, QPS applied for a Domestic Violence Order, naming the father as the respondent, the stepmother as the aggrieved, and the child as a named person for protection. A Child Harm Report was submitted by the attending officers. However, the SCAN team representative determined that the information did not meet the threshold for referral to child protection services, and no further action was taken at that time.

Concluding comments

The lessons from the cases reviewed by the Board highlight the importance of shifting from a traditional child protection response to a child safety pathway response, especially in cases involving domestic and family violence.

The Department responsible for Child Safety has the opportunity to identify risks early, but concerns arise when those risks, particularly domestic and family violence, are addressed through legislative child protection mechanisms. This raises important questions: when should a child protection response be triggered, and how should assessment tools be used to evaluate risk effectively?

Once the Department responsible for Child Safety identifies a concern, the focus should shift to collaborative safety planning. This includes coordinated efforts across services such as police protection, housing support and health services to build a comprehensive safety response. The goal is to move beyond reactive interventions and toward proactive, multi-agency strategies that prioritise the child's wellbeing.

Recommendations

The Board recommends that:

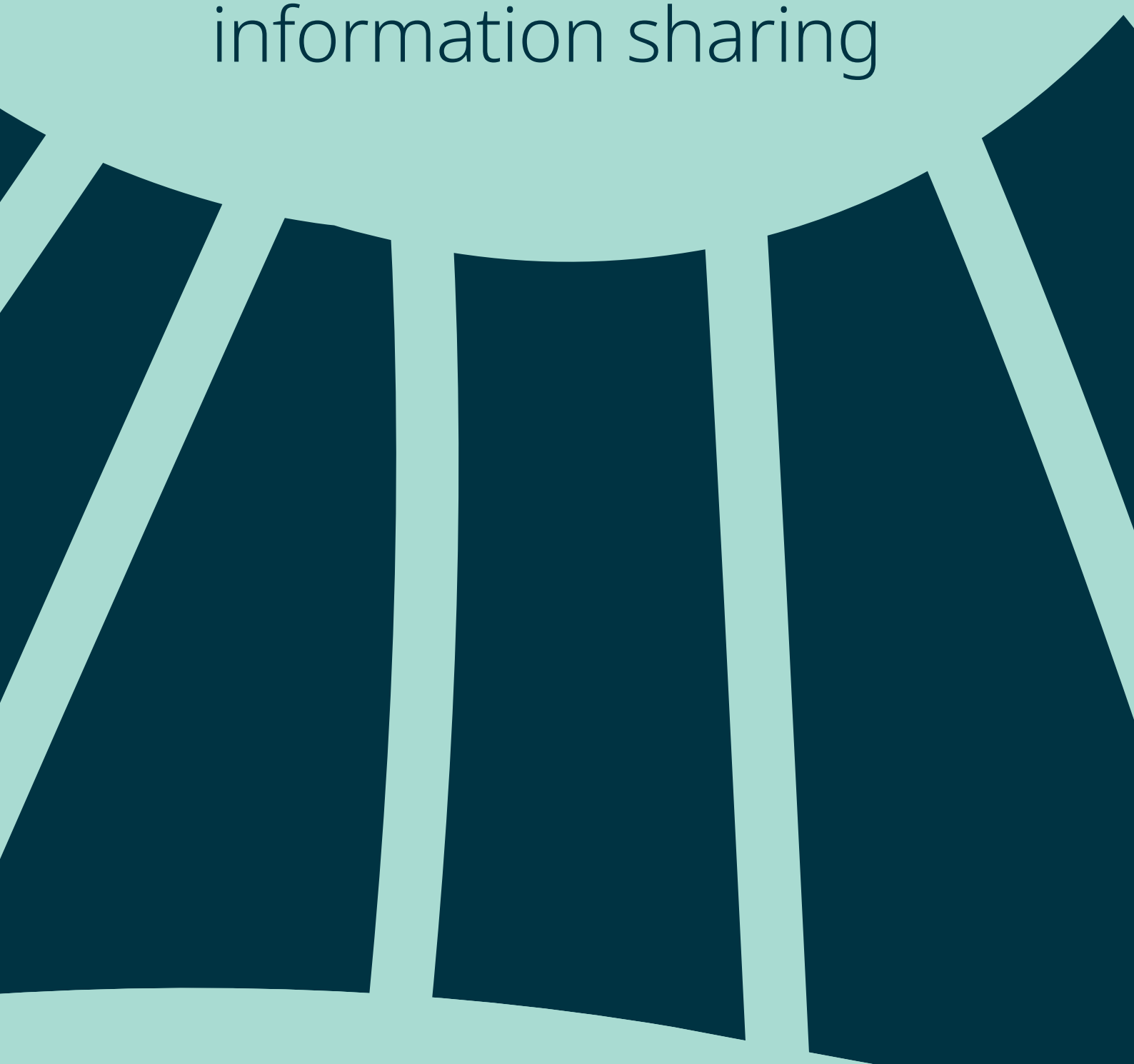
Recommendation 6

The Queensland Government should review emerging and existing applications of technology and artificial intelligence to enhance the effectiveness and efficiency of child protection functions. This review should prioritise opportunities to reduce administrative burden and streamline case management processes, with the goal of freeing up practitioner time for direct engagement with children and families. The review should also consider how technology can support timely, accountable and coordinated responses across agencies without displacing the critical role of human judgement in assessing and responding to risk. This review could include, but is not limited to, exploration of tools and systems that can:

- Facilitate seamless, secure information exchange and interoperability across government agencies to support coordinated and timely responses to risks to children, while addressing long-standing barriers to effective information sharing and clarifying lines of accountability.
- Incorporate predictive algorithms and machine learning to help practitioners in identifying and contextualising risks, needs and protective factors; support prioritisation of cases and resource deployment; and guide targeted, integrated referrals (for example, to the SCAN team). These tools should be positioned as productivity aids that enhance—not replace—professional judgement and responsibility.
- Automatically compile and synthesise child protection history and relevant case data to support robust risk assessments, inform decision-making and streamline court documentation. This includes surfacing the most recent and relevant information from across multiple plans across multiple organisations and multiple portfolios to reduce duplication and improve clarity, particularly by synthesising multiple perspectives to ensure there is not a one dimensional view.
- Reduce administrative burden by converting audio records of interviews or home visits into structured written documentation to support timely and accurate record-keeping.
- Enable real-time feedback loops between service providers and case managers, including automated updates on the status of outreach or scheduled services. This would support timely follow-up, clarify who is accountable for next steps and help identify and address barriers to service engagement (for example missed paediatric or mental health appointments).

CHAPTER 6

Better outcomes for children through interagency collaboration and information sharing



Child protection responses require the involvement of practitioners from different agencies and professional disciplines working in collaboration. However, there is a tendency for child protection responsibilities to be placed solely on the statutory child safety system, rather than being viewed as a shared obligation across government and community sectors.[121] This narrow focus overlooks the complex interplay of factors that contribute to a child's safety and wellbeing.

This year, the Board reviewed systemic inquiries, critical incident investigations, and child death reviews. These highlighted persistent issues with poor interagency coordination and information-sharing within the child protection system, despite widespread implementation efforts.

Working together: A system's approach to protecting vulnerable children

Systemic inquiries, critical incident investigations and child death reviews highlight poor interagency coordination mechanisms and poor interagency information sharing as key issues within the child protection system despite widespread implementation.[122,123]

The complexities of child protection cases often involve multiple risk factors such as domestic and family violence, trauma, mental health concerns, complex health needs, substance misuse, criminality and housing instability. This necessitates a multidisciplinary approach to prevention and response. No single agency can address these intersecting issues alone; rather, successful child protection outcomes rely on cooperation between government departments, non-government organisations, law enforcement, healthcare providers and educational institutions across prevention, early intervention and tertiary responses.[124]

Interagency collaboration within the Australian child protection system has evolved in response to the recognition that no single agency can effectively address the complex needs of vulnerable children and families. This has culminated in models such as multi-agency stakeholder meetings, continuity of coordinated care, integrated service delivery and cross-agency information sharing.

Jurisdictions have made considerable effort to develop policy and practice that embeds collaborative mechanisms. However, despite these efforts, barriers to effective interagency collaboration persist. There are notable gaps in understanding how to develop and sustain effective partnerships at the frontline level.[125,126] Issues such as competing agency priorities, ineffective information sharing and the absence of shared accountability mechanisms continue to hinder progress.

Strengthening interagency collaboration is critical, as failures in delivering effective coordinated care can lead to children falling through the cracks, exacerbating risks and delaying essential interventions. A comprehensive, efficient and ubiquitous coordinated interagency approach is widely recognised as essential for addressing these challenges.[127]

121 Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection*, June 2013, 2013, p. xi.

122 Community Development and Justice Standing Committee, *Inquiry into the prosecution of assaults and sexual offences*, Parliament of Western Australia, 2008, p. 171.

123 Child Protection Systems Royal Commission, *The life they deserve: Child Protection Systems Royal Commission report*, Government of South Australia, 2016, p. 20.

124 Stevens E and Gahan L, *Improving the safety and wellbeing of vulnerable children. Australian Institute of Family Studies*. 2024, p. 5.

125 Cooper M, Evans Y and Pybis J, Interagency collaboration in children and young people's mental health: A systematic review of outcomes, facilitating factors and inhibiting factors, Child: Care, Health and Development, 2016, p. 42.

126 Ball E, McManus M, McCoy E. et al. *Implementation of Multi-agency Safeguarding Arrangements Regarding Exploitation of Young People: Aligning Policy and Practice Using Normalisation Processing Theory*, Journal of Applied Youth Studies, 2024, p. 449–468.

127 Herbert J. and Bromfield L, *National comparison of cross-agency practice in investigating and responding to severe child abuse*, Australian Institute of Family Studies, 2017, p. 32.

Key barriers to effective interagency collaboration

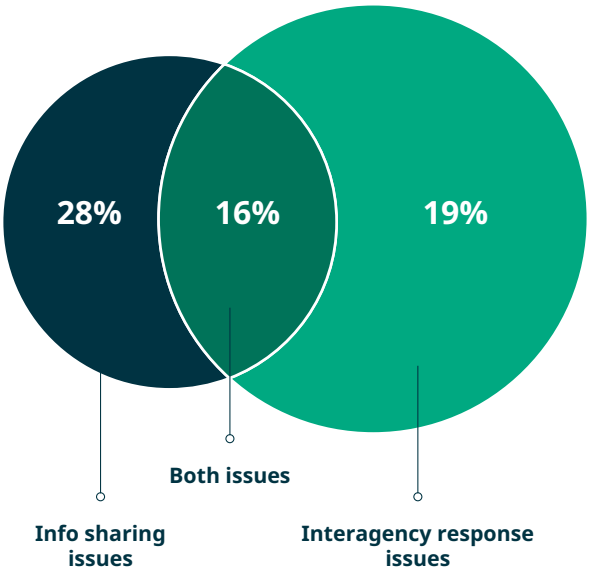
This chapter examines interagency coordination under two categories: practitioner-level coordination, integration and collaboration barriers and system-level information sharing barriers.[128]

Of the 64 cases reviewed in this period, 20 cases (31.25%) identified gaps or weaknesses in interagency collaboration.

Of these 20 cases:

- 18 cases (28%) had identified practitioner level information sharing issues
- 12 cases (19%) had identified system level interagency response issues
- 10 cases (16%) were identified as having both information sharing and system level issues.

Figure 22: Issues in information sharing and interagency collaboration in 64 reviewed cases.



While several integrated, multi-agency mechanisms exist[129] such as SCAN teams, Domestic Violence HRTs, and Youth Co-responder Teams (YCRTs) they are currently underutilised, narrowly focused or misaligned with the needs of vulnerable children. Despite the presence of clearly defined priority cohorts, including unborn children, young parents and high-risk adolescents (all of which are explored in the chapters of this report) there is no consistent, statewide mechanism to ensure that agencies work together in a structured and accountable way. The Department responsible for Child Safety alone cannot meet the complexity of these needs. Programs like Multiagency Collaborative Panels (MACPs) are targeting the wrong cohorts; HRTs are limited to domestic and family violence contexts; and SCAN is failing to respond to the full range of risks identified across Chapters 2 to 5. These gaps reflect a broader systemic failure to coordinate responses across agencies, leaving critical risks unaddressed and vulnerable children without the support they need.

This lack of coordination is particularly concerning for children under eight, who often fall through the cracks due to the absence of a dedicated, multi-agency case management model. There is no statewide structure that ensures consistent planning, oversight and shared accountability for this cohort especially when responsibility is devolved to regional levels without adequate commitment or resourcing. Expanding the Community Visitor Program and establishing a cross-agency oversight mechanism would help ensure that "eyes are on the child" and that all relevant agencies are actively engaged in monitoring and supporting children's wellbeing. These reforms are essential to shift from fragmented responses to a system that is proactive, integrated, and child-centred.

> Information sharing is an old concept from the age of paper, information access is the solution we need in the digital age.

128 Stevens E and Gahan L, *Improving the safety and wellbeing of vulnerable children*, Australian Institute of Family Studies and the Australian Human Rights Commission, 2014, pp. 19–20.

129 Queensland Family and Child Commission, *2023 – 2024 Annual Report on the Performance of the Queensland Child Protection System*, 2024, p. 63.

Effectiveness of interagency coordination meetings

- **SCAN team system.** Led by the Department responsible for Child Safety; enables a coordinated response to the protection needs of children. Core members of the SCAN team system are the Department responsible for Child Safety, the QPS, Queensland Health and Education.
- **Domestic Violence HRT.** "Currently 11 HRT teams, which are led by the Department of Families, Seniors, Disability Services and Child Safety. While HRTs do not provide ongoing case management, they enhance responses to domestic and family violence through time-critical information sharing, safety management for victims and increased line of sight of high-risk perpetrators.
- **MACPs.** MACPs enable government and non-government agencies to provide intensive case management and holistic support for young people identified as high risk or who require a multi-disciplinary approach. MACPs coordinate access for young people to services such as mental health, drug and alcohol programs, reconnecting with school and school engagement support, cultural connections, and connecting with doctors and allied health providers.
- **YCRTs.** YCRTs include dedicated teams of police and youth justice workers providing a rapid response to target young people at risk of offending and young people on bail, including checking their compliance with bail conditions and following up to ensure they are accessing the right services. In 2023–24, three out of every five engagements were with First Nations young people.

The Interagency Code of Practice in South Australia identifies that one of the most significant ways to develop effective inter-agency collaboration and collaborative competence is for practitioners to participate in joint training. South Australia works to give effect to this through using professional development mechanisms, such as performance reviews, to embed collaboration as a key component of child protection work across agencies.[130]

Multi-stakeholder meetings provide a critical opportunity for agencies working with a child and family to share information, break down service delivery silos and coordinate case management. However, without consistent utilisation, full agency participation, and clear follow-through, these meetings often fall short of delivering meaningful outcomes. A key barrier to effective cross-agency collaboration is the irregularity of meetings and inconsistent attendance, as well as a failure to consider which additional agencies, beyond the core representatives, should be involved based on the family's needs.

The Board reviewed cases (including the one below) that show committed attempts at multi-agency coordination. Yet even with regular meetings, outcomes are often limited when core drivers of risk, such as lack of antenatal engagement, housing instability, unaddressed domestic and family violence and the absence of family-led decision making, are not systematically addressed.

These meetings must be more than procedural; they should be vehicles for timely resolution of case plans, early identification of risk, and genuine engagement with families. Antenatal services play a vital role in early support and risk detection; housing stability is foundational to child safety and wellbeing; and domestic and family violence responses must be integrated across agencies. Supporting family-led decision-making ensures culturally safe and empowering approaches, particularly for Aboriginal and Torres Strait Islander families. Strengthening the function of these forums is essential to ensuring that children and families receive coordinated, holistic and responsive support.

130 Government of South Australia, *Interagency Code of Practice: Investigation of suspected harm to children and young people*, 2024, Version 5.3, p 43.

Case example 14: Missed opportunity for collaboration between agencies to make coordinated plans for a child whilst incarcerated

A Child was referred to SCAN. At the meeting, each agency shared its current service delivery to the Child, raised questions and suggested possible actions. The core members agreed to close the matter to SCAN as the Child was incarcerated, noting a review would need to occur in six weeks' time and the matter could be re-referred to SCAN if further expert advice or multi-agency action were required. Despite this, records indicate that service delivery to the Child did not become more collaborative or more effective after the SCAN discussion. There is no record of a 6-week review occurring and the Child's case was not re-referred to SCAN. This was a missed opportunity for agencies to use the period of the Child's incarceration to make coordinated plans about their return to the community and the services that would need to be in place.

Case example 15: Lack of identifiable actions or coordinated responses arising from the multi-agency collaborative mechanisms

The Board reviewed the case of a Child with a number of health challenges including Type 1 diabetes, vision impairments, developmental delays and communication difficulties. Child protection history for the family dated back many years. Concerns included lack of supervision, neglect of educational and medical needs, physical harm, children witnessing violence towards Mother by her partners and parental substance misuse.

In addition to her medical and disability needs, the Child had vulnerabilities including family conflict resulting in periods of sleeping rough, food insecurity, volatile substance use, mental health issues, suicidal ideation and early school disengagement. During the review period, she was regularly hospitalised due to hyperglycaemia because of unmanaged diabetes. Mother expressed scepticism about the validity of the Child's diagnosis and the Child was afraid of needles so was not self-administering medication.

The Child was referred to alcohol and drug counselling in response to the Child being hospitalised after losing consciousness following volatile substance use. They attended the program twice during the review period.

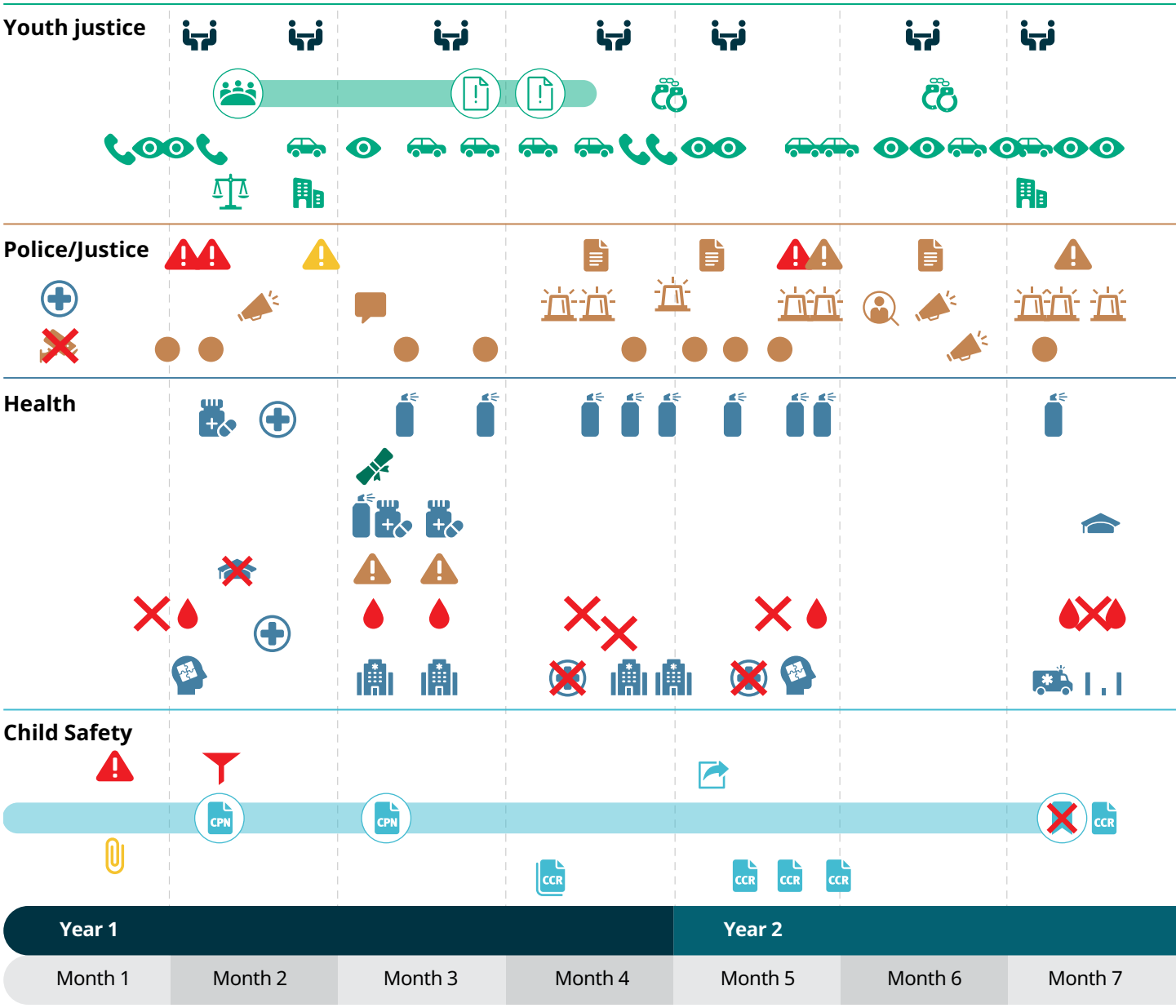
That same year, the Child was referred to Coordinated Care of Vulnerable Young People (CCYP), the same month the Department responsible for Child Safety recorded a 5-day Response Priority Timeframe Notification about her. The child protection concerns included the Child experiencing domestic and family violence perpetrated by Mother's partner against Mother and the Child, possible grooming behaviours by Mother's partner, the Child being assaulted by Mother, the Child leaving the home due to conflict, the Child engaging in chroming and poor management of the Child's diabetes.

Nine additional notified concerns (including two Notifications) were recorded in the following 18 months while the I&A had not yet commenced. The Department responsible for Child Safety finalised the I&A with a 'no I&A outcome' in accordance with an Extended Review and Completion Strategy.

The Child's diabetes and hospitalisations due to hyperglycaemia were acknowledged during several CCYP meetings. However, hospitalisation and acute events were not always shared at the CCYP meetings. The Child remained awaiting a finalised NDIS plan for the Child's disability needs at the start of the review period. Obtaining NDIS support was likely foundational to improve healthcare management. A disability support worker obtained through NDIS planning may have provided the support needed to help administer medication and monitor the diabetes.

The timeline of interventions for this Child is shown in Figure 20.

Figure 23: Case example 15: Lack of identifiable actions or coordinated responses arising from the multi-agency collaborative mechanisms – timeline of system touchpoints



Child Safety

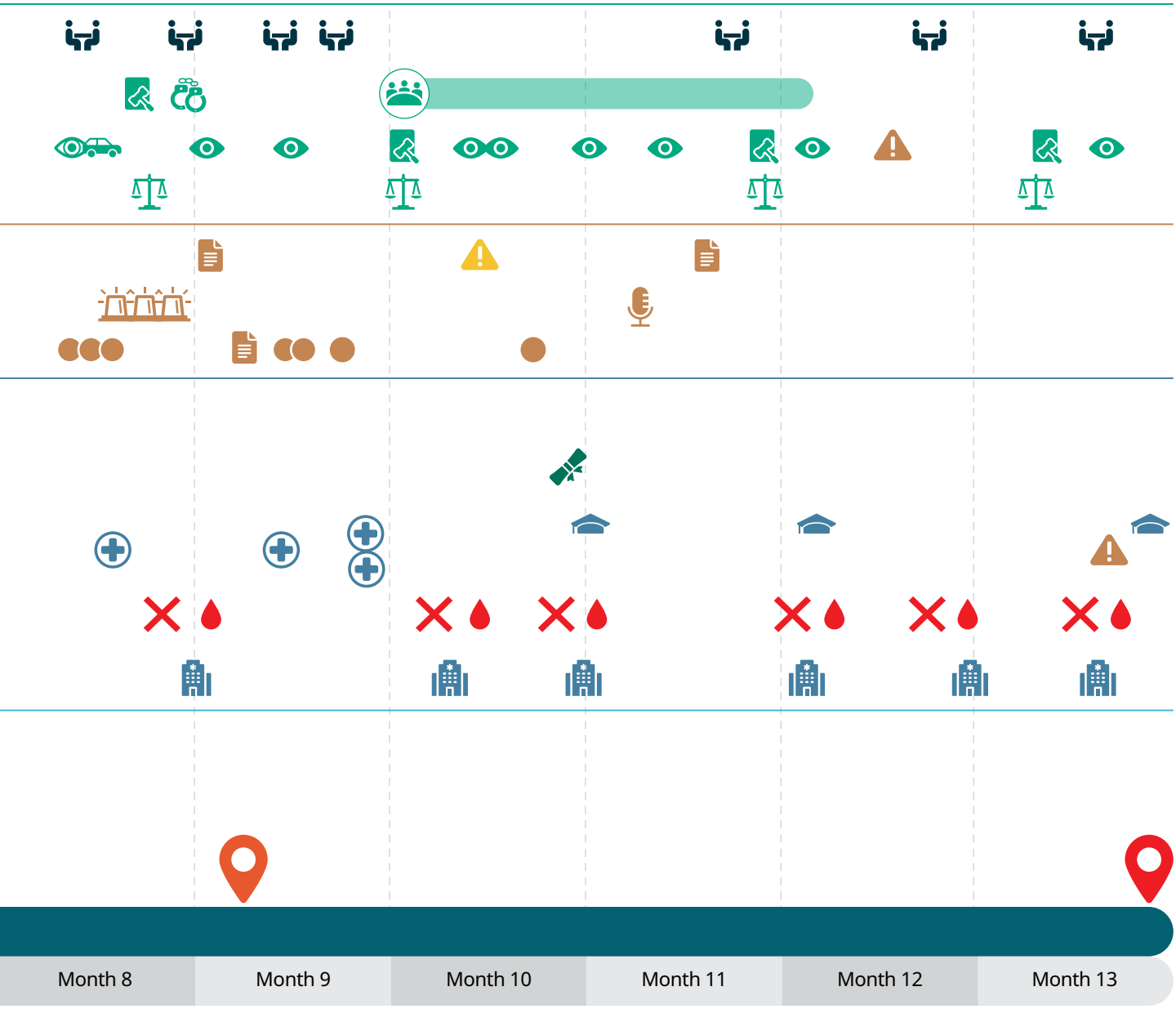
- CPN
- CCR
- CCR sibling
- Additional notified concerns (ANC) CCR / CPN
- I&A continued
- I&A transferred
- I&A closed (no outcome)

Health

- Emergency Department presentation under EEA
- Hospital admission
- Queensland Ambulance Service (QAS) response
- Diabetes education
- Did not engage with diabetes education
- Appointment non-attendance
- Serious medical event
- Non-compliance with medication advice
- Referral
- Volatile Substance Use (VSU)
- Substance use other than VSU
- Queensland Children's Hospital School enrolment

Police/Justice

- Domestic and family violence incident
- Probation Order ends
- QPS street check
- Offence committed
- Charged by Notice to Appear



Police formal caution

Police warning

Missing person report

Police interview

Youth justice

CDR

Court appearance

CDR warning letter

Watchhouse

YCRT transport

YCRT sight

Makes contact with YCRP

Good behaviour order

Youth support agency attendance

Other key events

Parent death

Day of death

Suspected sexual abuse

Coordinated care meeting

Suicidal behaviour

Suicidal risk alert

Sleeping rough

The Board also highlighted the ability of interagency mechanisms to hold systems to account. These themes were also shared in two other cases reviewed by the Board.

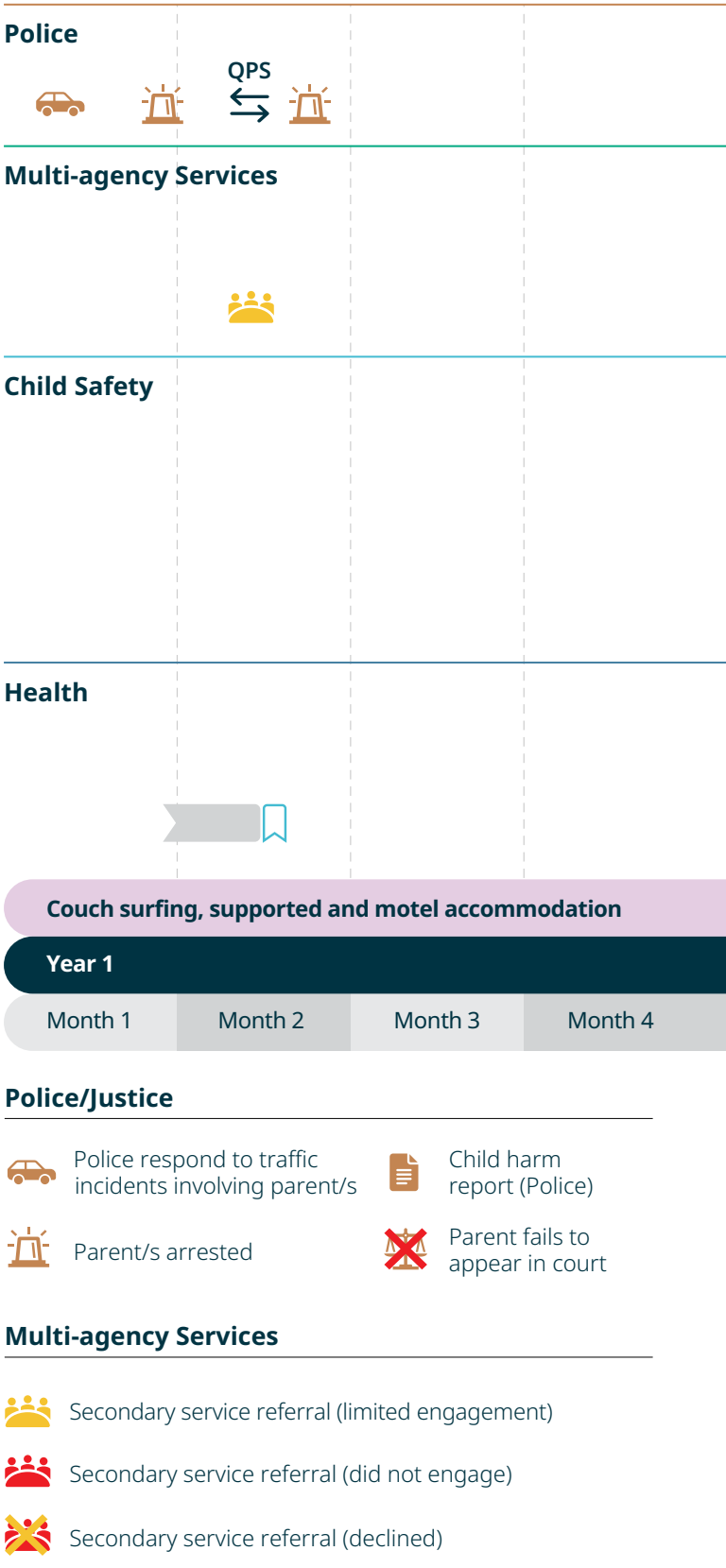
Interagency collaboration between Queensland Health and the Department responsible for Child Safety when responding to vulnerable children

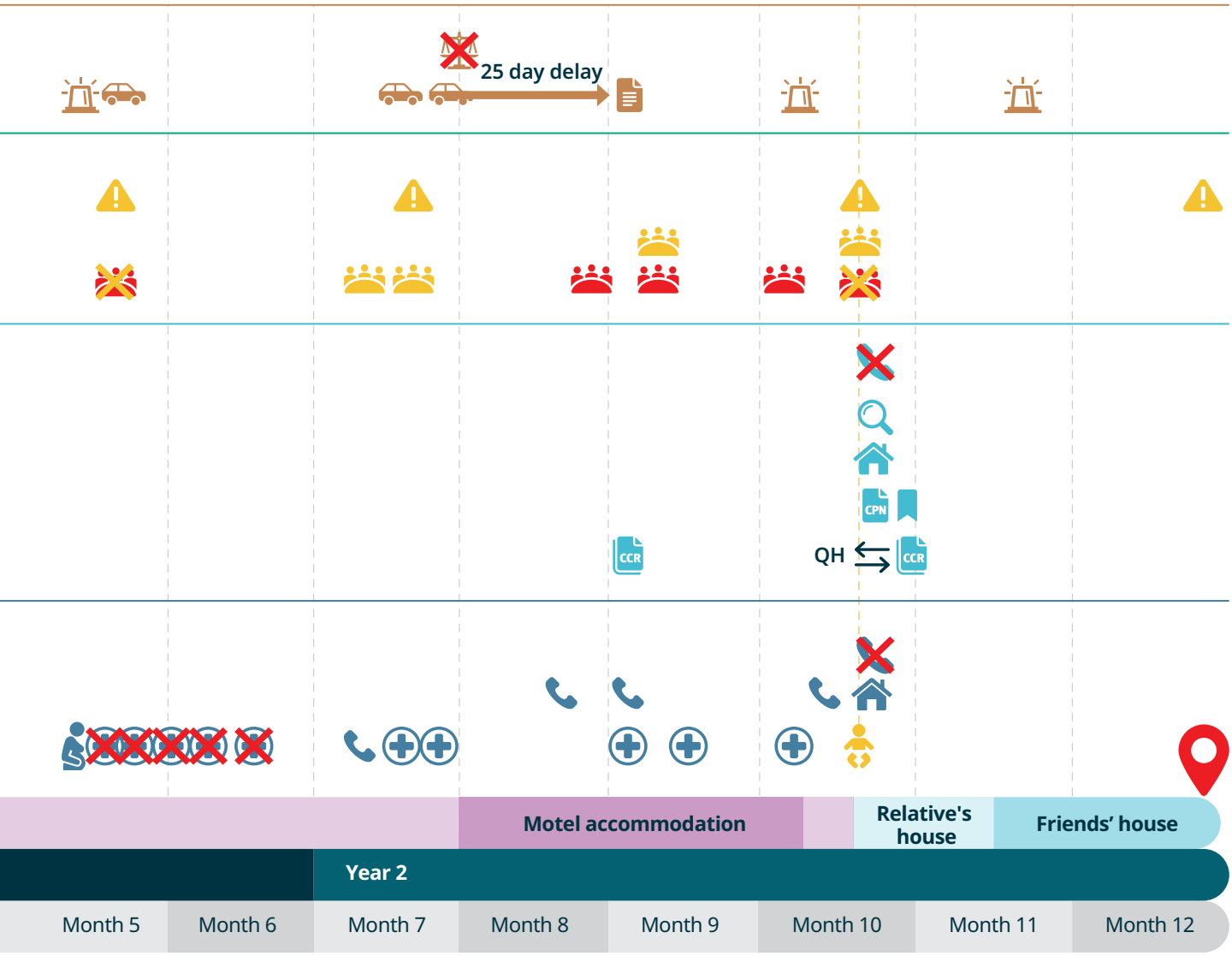
Health professionals, as mandatory reporters, play a vital role in child protection by identifying concerns about a child's safety and wellbeing. Health professionals may have greater visibility of children with chronic medical conditions and/or disabilities compared with other statutory child protection agencies, including the Department responsible for Child Safety and QPS.

Of the 39 cases considered in this thematic review, 11 cases (28%) were identified as having poor collaboration between the Department responsible for Child Safety and Queensland Health. Two of the cases were high-risk infants. Given their heightened vulnerabilities, these infants required additional monitoring to ensure their safety. There is an argument that both infants needed protection. More robust risk assessments, informed by greater information-sharing, would have improved service delivery in their respective cases.

The timeline of interventions for one of these children is shown in Figure 24.

Figure 24: Poor interagency collaboration – timeline of system touchpoints





Child Safety

- CPN (24-hr RPT)
- CCR
- Child Safety home visit
- Parent contact attempts x 3
- SSoDR check
- I&A closed (CNIOP)
- I&A closed for siblings (CNIOP)

Health

- Medical termination referral (did not proceed)
- Antenatal clinic appointment
- Contact from QHealth social worker
- Midwife visit (outside house)

Other key events

- Alleged DFV
- Information sharing
- Failed to attend or accept contact
- Day of birth
- Day of death

There were also missed opportunities for the Department responsible for Child Safety to have more flexibility in meeting another young person's mental health needs, either in collaboration with Queensland Health or through alternative mental health supports. While recognising these challenges, in the Board's view it is possible that the child protection system could have done more to support the young person to address and/or cope with her trauma. Trauma is pervasive in a child or young person's life, and a nuanced, multi-agency approach involving all agencies supporting the child is likely required for effective treatment.

Improving practitioner-level coordination

While multi-agency coordination has been readily implemented across Australia, there remains a lack of clarity around the structures and processes that promote effective practitioner-level coordination, as well as the best approaches for monitoring their impact on child safety outcomes.

A persistent challenge in multi-agency collaboration is the absence of a clearly defined leadership model. Each agency tends to deflect responsibility, often pointing to the Department responsible for Child Safety as the default lead, particularly when case prioritisation is required. This dynamic creates ambiguity and delays in decision-making, especially when critical services are needed but no agency feels empowered to convene or compel participation. These gaps highlight the need to clarify who leads collaborative efforts, establish a leadership model that supports sustained engagement, and define how agencies coordinate to respond to evolving needs. While time-limited problems may be solved through ad hoc coordination, enduring and complex cases require a structured approach to leadership, prioritisation and information sharing to ensure children and young people receive timely and appropriate support.

Without clear frameworks for accountability and evaluation, practitioner-led collaboration initiatives risk becoming procedural exercises rather than robust mechanisms that drive meaningful change. There is also a need to tactically implement practitioner-led collaboration to avoid excessive bureaucracy which impedes system responsiveness in an already overworked child protection system.

Improving information sharing

Effective interagency information-sharing is crucial for the safety and well-being of children within Australia's child protection system. Information-sharing mechanisms have been readily adopted, but they face several persistent challenges. Privacy legislation and confidentiality concerns can create uncertainty among practitioners about what information can be shared and with whom, leading to hesitation in disclosure. Privacy legislation is often used as an excuse to withhold information when this is not actually necessary, as the legalities of information-sharing are not as prohibitive as many practitioners believe.

Additionally, inconsistent data systems and incompatible IT platforms across agencies hinder seamless information exchange, resulting in delays and gaps in case coordination.

Variability in professional judgment and risk assessment thresholds further complicate information-sharing, as differing interpretations of what constitutes significant risk of harm can lead to inconsistent responses.

Out of the 39 children in this review, 67 per cent (26 children) were identified as suffering from gaps in information sharing, underscoring the prevalence of this systemic issue. Children were identified as having issues relating to information-sharing across one or more areas:

- lack of proactive information sharing was identified in 41 per cent of cases (16 children)
- missed opportunities for the Queensland Police Service to share information using child harm reporting were identified in 35.9 per cent of cases (14 children)
- lack of information-seeking was identified in 15 per cent of cases (6 children)
- inaccurate information-sharing was identified in 10 per cent of cases (4 children)
- delays in information-sharing were identified in eight per cent of cases (3 children)
- information-sharing restrictions were identified in five per cent of cases (2 children).

Lack of proactive information-sharing and seeking

"No child should ever suffer preventable abuse because one area of government didn't have information that another area of government did."
– Luke Twyford, Principal Commissioner, Queensland Family and Child Commission

The Board acknowledges the urgent need for stronger proactive information-sharing, particularly where there are indicators of mental health concerns, a history of domestic violence, or ongoing investigations into safety threats. Lack of proactive information-sharing and lack of information-seeking is a significant systemic issue. Since the Board's inception in 2020, 31 per cent of cases reviewed have had issues of either not seeking relevant information or not proactively sharing relevant information.

The Board identified critical issues related to delays and restrictions in information-sharing between agencies, which have had severe consequences for vulnerable children. In several reviewed cases, the lack of proactive information-sharing resulted in missed opportunities to provide necessary support and intervention. A notable example highlighted a child with a trauma history and multiple hospitalisations due to emotional dysregulation, where the lack of a mental health diagnosis and inadequate information-sharing among agencies may have contributed to an unfavourable outcome. Other cases demonstrated that inconsistent knowledge about a child's whereabouts and insufficient communication of health details significantly hampered timely risk assessments and interventions.

Without robust, proactive information-sharing mechanisms, vulnerable individuals like these may continue to fall through the gaps. This highlights the need for systemic reforms to ensure that critical information reaches the right agencies in a timely manner.

Several cases within the child protection system show the critical need for timely and proactive information-sharing between health services and child protection agencies to protect vulnerable children. These cases examined by the Board underscore a systemic issue within child protection, where failure to seek and share information can significantly impact child protection outcomes. Robust mechanisms for information-sharing and collaboration are essential to safeguarding vulnerable children.

Case example 16: Lack of information-sharing and safety response

The Board reviewed the case of a Child who was subject to a Child Protection Order when she had a trauma history including physical, sexual and emotional abuse and domestic violence that continued while living independently.

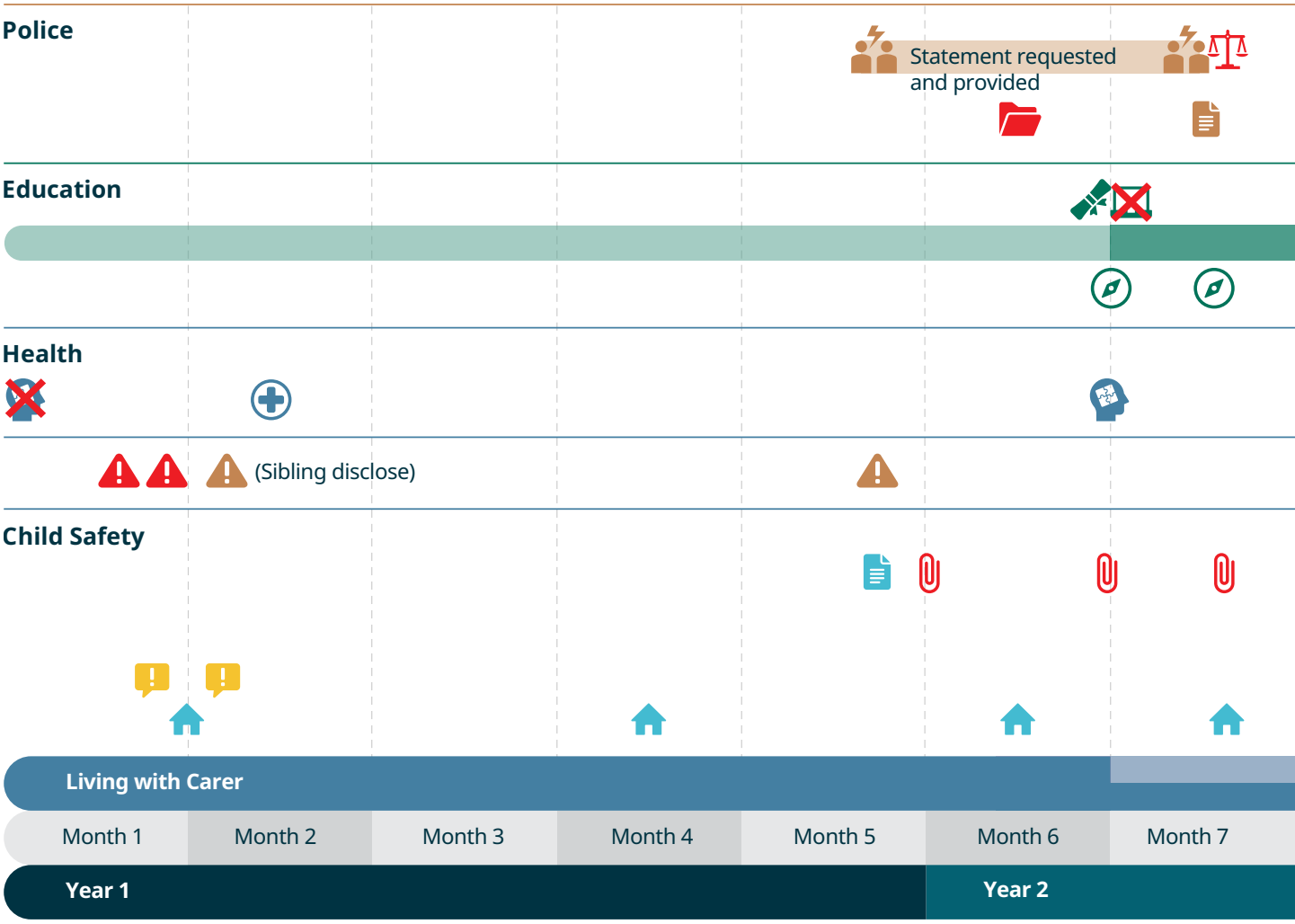
The Child had more than ten hospital presentations under emergency examination authorities for extreme emotional dysregulation with threats of harm to themselves and other family members. However, the Child was not diagnosed with a mental illness. Rather, the repeated emotional dysregulation caused by her chronic, complex trauma was labelled 'behavioural'.

She experienced seizure-type episodes and reported unknown offenders attempting to break into her home. Multiple agencies including the QPS and the Queensland Ambulance Service could not corroborate evidence to support this claim. Her safety plan ahead of discharge from a subsequent hospital stay was an agreement that she would stay in her previous carer's home until QPS concluded investigation on the alleged home invasion. The next day the Child was found deceased hanging in her home by her carer.

There were missed opportunities for the Department responsible for Child Safety to have more flexibility in meeting the Child's mental health needs, either in collaboration with Queensland Health or through alternative mental health supports.

The timeline of interventions for this Child is shown in Figure 25.

Figure 25: Case example 16: Supporting effective interagency collaboration– timeline of system touchpoints



Child Safety

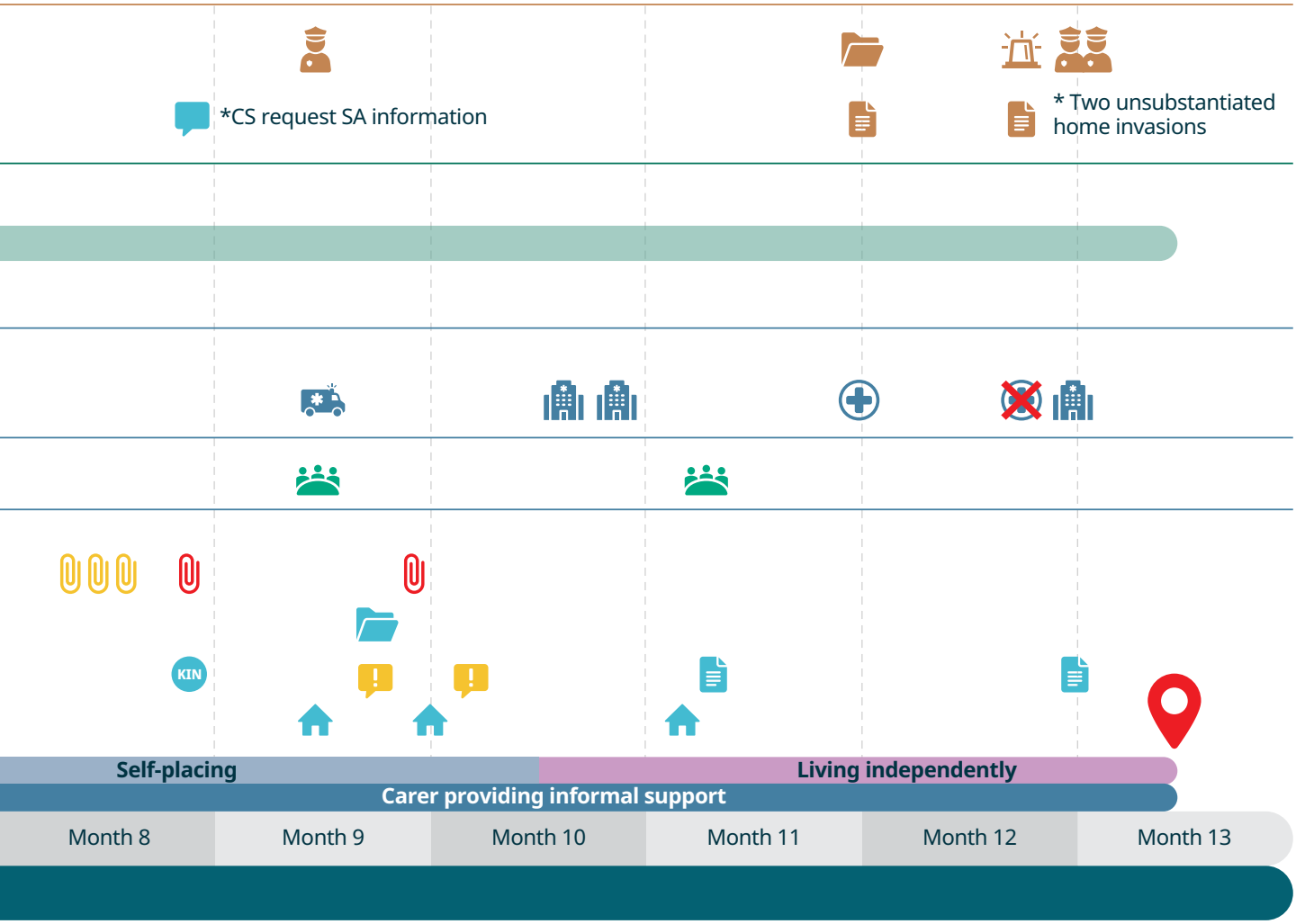
- Home visit
- CPN
- Case plan approved
- Kinship carer assessment endorsed (sibling)
- Concerns recorded as case note
- ANC Notification
- ANC CCR
- Carer reports care challenges

Health

- Mental health support ceased
- Mental health support recommenced (life coach)
- Outpatient appointment
- Failure to attend outpatient appointment
- Emergency Department presentation
- QAS response (self harm threats)

Education

- School disengagement
- Enrolled in distance education
- No internet access
- Guidance officer involvement



Police/Justice

- QPS response
- Sexual assault statement
- Parent granted order against second parent
- Parent charged with sexual assault
- Child Harm Report
- Temporary DVO: Boyfriend
- Boyfriend charged for DVO breach
- Disclosure of sexual assault
- DFV
- Sibling leaves
- Day of death

Support Services

- Secondary service referral

Delays in information-sharing and inaccurate information

When critical health details are not promptly communicated, the Department responsible for Child Safety may make decisions based on incomplete or outdated information, potentially delaying necessary protections or support services. Delays in sharing health information with the Department responsible for Child Safety can significantly impact timely intervention and risk assessment for vulnerable children.

Inaccurate information-sharing compromises child protection responses by leading to misinformed decision-making, delays in intervention and missed opportunities to safeguard at-risk children. When critical details are omitted, miscommunicated, or sent through incorrect channels, the Department responsible for Child Safety may underestimate risk or act based on incomplete assessments. Accurate and timely information-sharing is essential for effective child protection and intervention.

The purchase and implementation of the Unify case management system has been a significant undertaking for the Department responsible for Child Safety. As an integrated digital information-sharing platform, Unify represents a major shift in how child protection information is captured, stored and exchanged across the system. By consolidating records and enabling more seamless access to case information, it has the potential to reduce duplication, improve the timeliness of decision-making and provide a clearer picture of a child's circumstances and history. These improvements create opportunities for better collaboration between practitioners and partner agencies and ultimately for more effective safeguarding of children.

However, while Unify marks a critical step forward, its implementation must be viewed as part of a broader, ongoing commitment to modernising technology in child protection. The introduction of new systems can bring transitional challenges, including the need for training and adaptation, and the need to ensure that technology does not inadvertently increase administrative burdens. For this reason, it will be essential to continue monitoring the impact of Unify – particularly to monitor whether it frees practitioners to spend more time directly engaging with children and families, rather than being absorbed in system processes.

Importantly, the Department responsible for Child Safety cannot afford to rest on the progress made with Unify. Technology continues to evolve rapidly, and the child protection system must keep pace to remain effective. Delivering modern digital tools that are responsive, user-friendly and capable of supporting frontline decision-making is a continuous process, not a one-off achievement. Ongoing investment, refinement and feedback from practitioners will be critical to ensure that systems like Unify genuinely enhance practice and contribute to safer outcomes for children.

Concluding comments

The lessons from the cases reviewed by the Board highlight persistent challenges in collaboration and information-sharing. Despite established frameworks, interagency coordination and information-sharing remain inconsistent, often resulting in fragmented responses to child protection needs.

While multi-agency meetings and mechanisms like SCAN are intended to improve collaboration, their effectiveness is undermined by irregular scheduling, inconsistent attendance and limited follow-through on actions.

Case examples highlight how delays, omissions and failures to proactively share critical information can lead to missed opportunities for intervention and inadequate support for vulnerable children. The deaths reviewed this year highlight this – particularly the intersection of delays in information-sharing and inadequate risk assessment processes.

Misunderstandings about privacy laws, incompatible IT systems and differing professional judgments continue to hinder effective and timely information-sharing across agencies. The Board hopes that the upcoming Unify platform can help address some of these challenges.

Recommendations

The Board recommends that:

Recommendation 7

The Queensland Government should produce a Statement of Intent outlining how it will enable and empower cross-portfolio accountability and information-sharing to keep children who are known to the Department responsible for Child Safety safe. This statement should embed a whole-of-system approach that recognises the shared responsibility of all agencies – not just the Department responsible for Child Safety – for identifying and responding to early risk in infants and young children. It should articulate how modern information-sharing systems and clear governance mechanisms will ensure accountability for the safety of children. This Statement of Intent should be produced by March 2026 to enable consideration by the Commission of Inquiry in its final report.

CHAPTER 7

Addressing two persistent gaps in supporting vulnerable families

In the course of the Board's work this year a recurring theme emerged – families who remain outside the reach of services and monitoring. This chapter explores the persistent reality that some families remain unsupported despite being known to the child protection system. It considers two persistent gaps in supporting vulnerable families: barriers to service access in remote communities and highly mobile families and challenges working with families going through Sorry Business. This is not a new observation; across multiple annual reports the Board has consistently identified systemic barriers that prevent vulnerable families from receiving timely and coordinated support. The repetition of this theme underscores the need for sustained, cross-sector reform to ensure that no child is left unseen or underserved.

In the 2020–21 Annual Report, the Board highlighted entrenched issues such as workforce constraints and culturally unsafe practices that impacted service delivery. In 2021–22, it called for comprehensive workforce reform to address shortages, promote place-based approaches and strengthen support for carers. The 2022–23 and 2023–24 annual reports continued to monitor these recommendations, noting that while some progress had been made many of the same challenges persisted – particularly in regional and remote communities and among families navigating complex cultural and social circumstances.

This chapter builds on those findings, reaffirming that targeted, flexible and culturally responsive service models are needed to ensure that the child protection system reaches the families who need it most.

Barriers to service access in remote communities and highly mobile families

Despite sustained investment and effort, the Board continues to observe cases where services fail to reach families living in remote or highly mobile circumstances. Families in geographically isolated areas often face limited access to essential health and community services. The absence of local infrastructure means that people must travel considerable distances to receive care, an undertaking that is time-consuming and costly and contributes at least in part to families not engaging with referrals or services. This isolation amplifies the challenges already present in households that are affected by domestic and family violence, mental health concerns and substance misuse.

These barriers make it particularly difficult for parents and caregivers to provide the best possible care for their children. When access to support is delayed or denied, families are left to navigate complex and often high-risk situations without the guidance or resources they need. The limited availability of specialist services, such as paediatric and mental health care, further compounds these difficulties. The lack of local expertise and the logistical complexity of coordinating outreach services contribute to persistent service gaps.

Inadequate support can have both immediate and lasting impacts on a child's wellbeing. Early recognition and intervention in response to childhood adversity play a critical role in preventing health and developmental issues from persisting into later life. These systemic constraints highlight the urgent need for innovative, flexible and culturally responsive approaches to service delivery. Improving access to support for isolated communities must remain a priority if we are to ensure equitable support for all families, regardless of location.

Case example 17: Challenges accessing health and community services in isolated communities

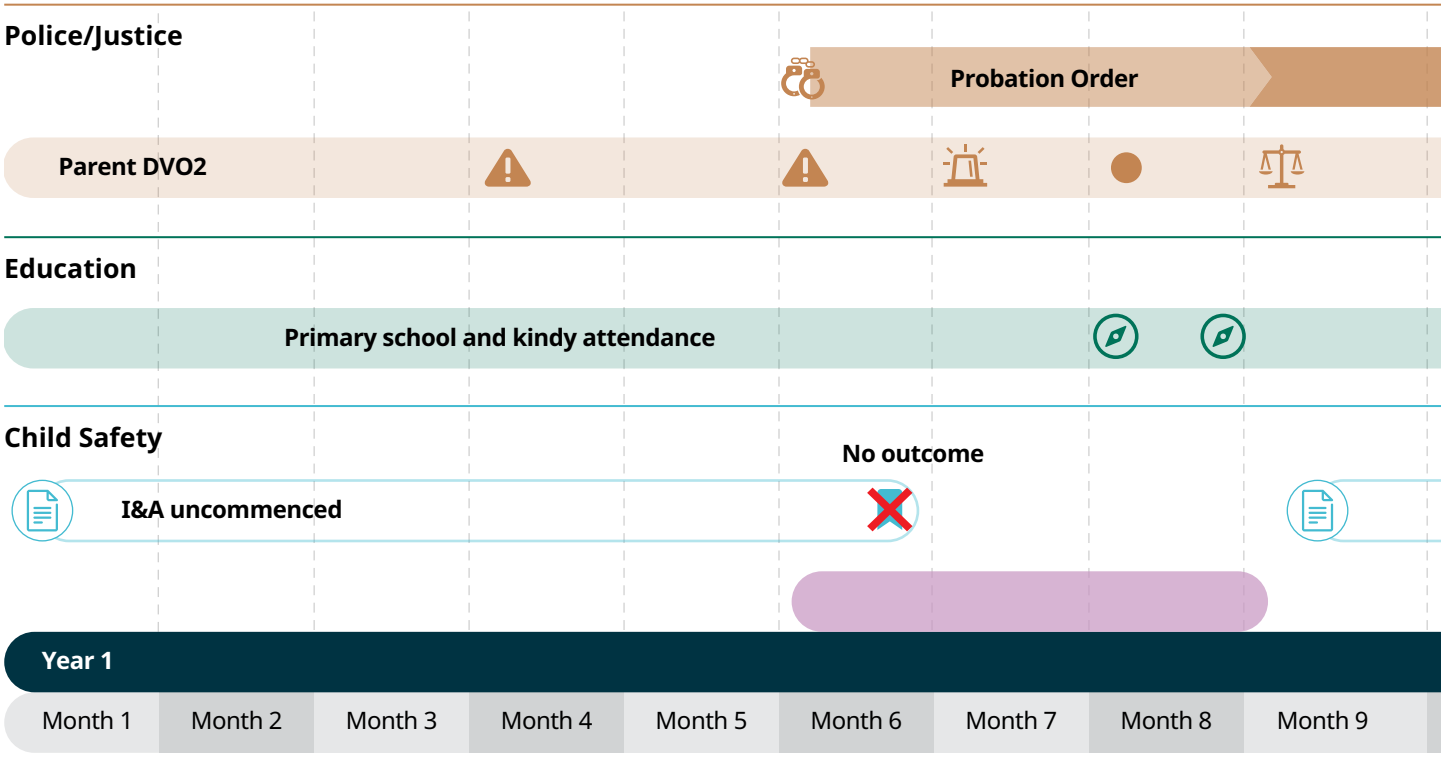
The Board reviewed the case of a family living in a remote community. The family had a history of domestic and family violence, with multiple Domestic Violence Orders in place against Father. Despite these orders, Father continued to perpetrate violence against Mother, and mother struggled extensively without Father and continued to reengage his support despite the Domestic Violence Orders. The geographical isolation of their community and the lack of local support services exacerbated the challenges faced by the family.

The children had significant health and wellbeing needs that were not adequately met due to the remote nature of their community. Two children required substantial adjustments for their social/emotional and cognitive disabilities, but the limited availability of specialist services meant they did not receive the necessary support. Similarly, the other two siblings faced cognitive delays and speech issues, but the Department of Education's speech language pathologist was only available at school two days per fortnight, which did not coincide with the children's attendance. The non-school-aged child had limited visibility in the community and missed opportunities to receive health care. The logistical barriers to accessing paediatric and mental health care further compounded the difficulties faced by the family.

The family's geographical and social isolation heightened the risks associated with domestic and family violence, and the lack of accessible health and community services contributed to their vulnerability. The absence of local support services and the logistical challenges of accessing services prevented the family from receiving timely and effective assistance. This case study highlights the critical need for innovative solutions to improve service accessibility and support for remote and isolated communities.

The timeline of interventions for this family is shown in Figure 26.

Figure 26: Case example 17: Challenges accessing health and community services in isolated communities – timeline of system touchpoints



Police/Justice

- Parent detained in watchhouse overnight – released on bail
- Parent charged for breach of bail
- Parent attend court
- Probation order
- DVO breach
- Police call out or Police station attendance in relation to DFV

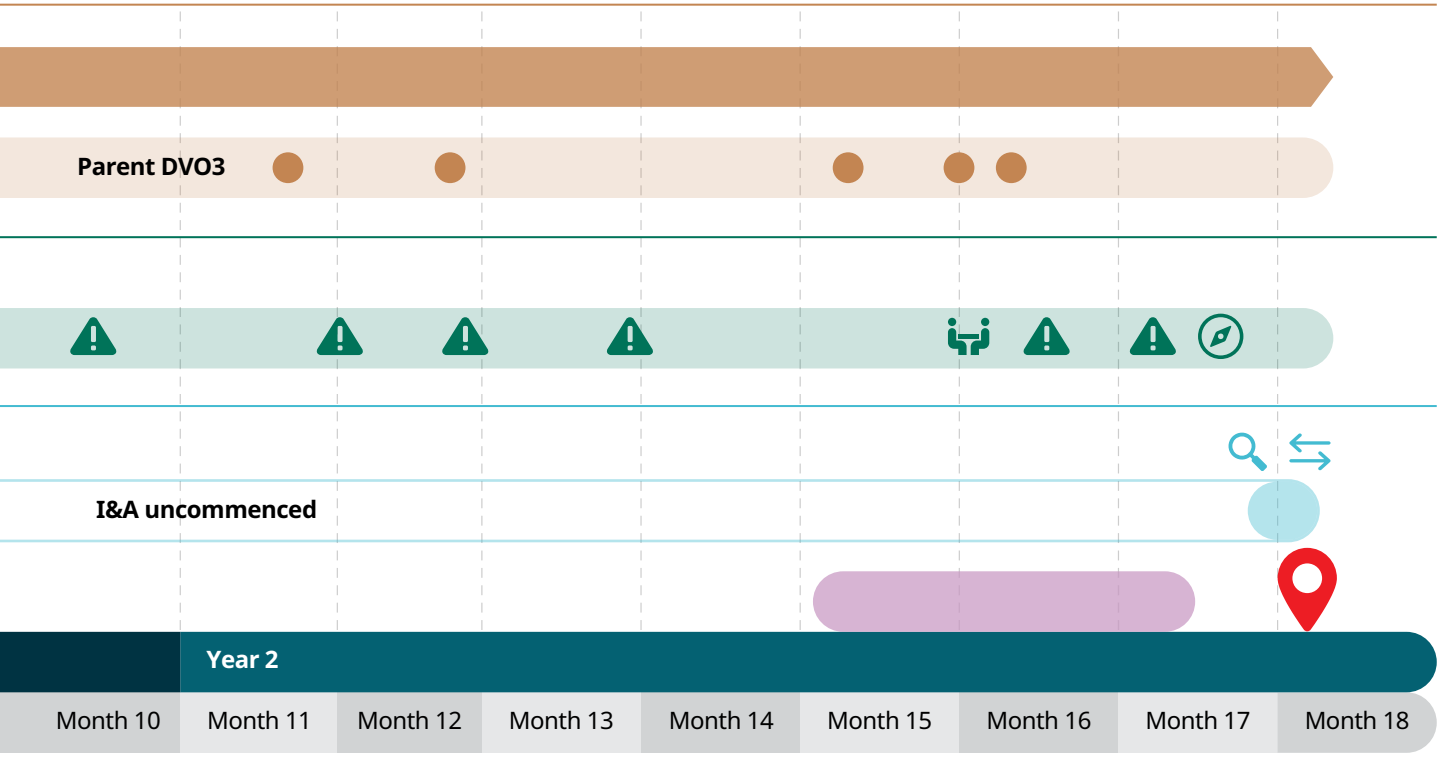
Education

- Student Needs Action Committee
- Behavioural, physical or emotional incident
- Contact with Guidance Officer

This case highlights the persistent challenge of reaching families who remain outside the scope of service delivery and monitoring. Despite sustained investment and well-established frameworks, structural limitations such as geographic isolation and highly-mobile living arrangements, continue to hinder timely and effective support for vulnerable children. The Board noted that families in remote areas face compounded challenges due to limited access to health and community services, specialist care and outreach support. These barriers make it difficult for parents and caregivers to provide the best possible care and often leave families navigating high-risk situations without adequate guidance or resources.

In the 2021–22 annual report the Board recommended workforce reform to ensure service accessibility and delivery. It 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



Child Safety

- Notification (10-day RPT)
- I&A closed (no outcome)
- I&A uncommenced
- I&A commenced but children not yet sighted
- SSoDR check of parents' criminal and DFV histories
- QPS and DoE provide information under s195 of CP Act

Other key events

- Parents reported to have separated
- Day of death

- 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.

This recommendation remains "Open – In Progress".

The case highlighted above illustrates the significant challenges of delivering consistent and reliable government services in remote and hard-to-reach locations. Limited staffing, competing priorities and logistical barriers all contributed to gaps in support and services for the family. These challenges are not confined to a single department but are systemic, affecting health, education, child protection, domestic and family violence and family support services alike. It is unreasonable to expect that all departments can be everywhere remote locations need a different integrated government service model. Without a coordinated approach to address service inequities, children and families in these regions will continue to face a higher risk of poor outcomes.

Working with families who are going through Sorry Business

The Board has previously identified that government service systems often lack the flexibility and cultural responsiveness required to maintain effective service delivery. This year this issue specifically arose in cases during periods of Sorry Business.

The Board reviewed cases where, during these significant cultural and grieving periods, services were reduced, delayed, or disengaged, resulting in poorer outcomes for children. Rather than recognising and adapting to the cultural significance of Sorry Business, systems too often failed to maintain support or intervene appropriately. This reflects a service delivery gap, not a failure of families. It highlights the need for culturally informed approaches that uphold the rights, dignity and safety of Aboriginal and Torres Strait Islander children and families during times of mourning.

Specifically, the Board reviewed the case of a family that faced significant challenges in accessing essential services due to the cultural practice of Sorry Business. The death of the father in late 2023 under tragic circumstances initiated a period of Sorry Business that profoundly affected the family's ability to engage with service providers. During this time, the Department responsible for Child Safety and Queensland Health staff had difficulties in contacting the family, visiting their home and providing necessary health services to the child and their siblings. The impact of Sorry Business on service delivery was evident when the Department responsible for Child Safety staff were advised not to visit certain families for a week. Accepting this limitation without other alternatives created barriers to timely interventions, especially when urgent health and safety needs were at stake. For instance, multiple home visits by a Queensland Health nurse navigator were cancelled or rescheduled due to Sorry Business, limiting the opportunities to monitor the infant's health and provide essential care.

Case example 18: Working with families who are going through Sorry Business

Baby was born several weeks after the passing of Father, during a period in which the family was engaged in Sorry Business. Mother had recently returned to her home community following weather-related disruptions that had isolated the region.

In the weeks following the birth, a number of child health home visits scheduled for Baby were cancelled, some due to staffing shortages and others at the request of family members who asked for re-booking in light of ongoing cultural obligations. A health professional visited the home during this period, where she met the grandmother, who advised that Mother had recently given birth. The health professional continued to attempt home visits and made contact with extended family, providing supplements and emphasising the need for Baby's sibling to be weighed and monitored. However, she was told by family members that services should stop intruding during the period of mourning and that services did not understand Sorry Business. This occurred on the day prior to Father's funeral.

Child protection staff became aware of Baby's birth through a home visit, during which Baby was not sighted but siblings were. A later case note recorded that further home visits could not proceed for cultural reasons, to allow the family to continue grieving.

Throughout the next two months health services continued to attempt contact in person and by phone, reiterating the need for supplements and monitoring of Baby's sibling. A family member reported during this time that the child was gaining weight and that services should not interfere with cultural practices.

Later in the month, child protection officers attended the home. Mother spoke with them at the gate, explaining that Baby was asleep and that it was too hot to bring Baby outside. The officers indicated they would return that afternoon, but the follow-up visit did not occur due to other urgent work priorities.

Service delivery in diverse communities must integrate cultural practices into planning and implementation. This approach ensures that key services remain available and equitable, while being delivered in ways that respect and accommodate cultural contexts. The *Child Protection Act 1999* (Qld) affirms that the safety, wellbeing and best interests of the child must always remain the paramount consideration. While it is essential to respect cultural practices, there are circumstances where sighting a child and progressing child protection work must continue, even during periods of Sorry Business.

Cultural practices influence the timing and manner in which families interact with services. Recognising this, government systems must adapt their delivery approaches so that vital health, education and family supports can be provided without compromising cultural obligations.

The Department responsible for Child Safety's practice guidelines notes that home visits and meetings should be cancelled for two to three weeks in response to Sorry Business. If rescheduling, practitioners should ask the family the time and place that suits them as well as find out if there is a family member who is best placed to be the spokesperson for the family:

- When a family is experiencing Sorry Business, it is important and respectful for practitioners to provide space and time for the family's grieving process.
- Any protocols and processes that are not respected can hinder relationships between the community and Child Safety staff, including Aboriginal and Torres Strait Islander staff.[131]

The Department responsible for Child Safety's guidelines also acknowledge that there may be times when urgent business needs to be conducted to meet statutory requirements. The guidelines advise to consult with Aboriginal and Torres Strait Islander practice leaders, identify community organisations who have a close relationship with the family, identify key family members to liaise with and determine whether the child could be sighted by another person or service.[132]

In the case discussed above, the health service review report noted that there are online guidelines on the QHEPS First Nations Health Office for Queensland Health staff and there was area specific orientation for outreach hospitals or health services. The review report acknowledged that it is appropriate for staff to consult with the relevant health worker and/or Aboriginal and Torres Strait Islander Liaison Officer to discuss cultural aspects relevant to the family. Staff are aware of this through orientation. The North West Hospital and Health Services panel advised the need for this to be reinforced as an outcome of the review.

Strengthening coordination and communication between agencies, such as the Department responsible for Child Safety and Queensland Health, can help reduce disruptions and ensure culturally sensitive yet timely support. For example, there are opportunities for intra-agency case conferences and SCAN referrals to facilitate a more coordinated response, ensuring that the immediate health and safety needs of children are met while respecting cultural practices.[133]

The Board was significantly concerned that there did not appear to be attempts to legitimately engage cultural or community-based organisations that knew the family and could provide safety monitoring and support during this time.

Sorry Business presents a complex intersection of cultural respect and child protection imperatives. While it is a deeply important practice, the Board observed that the department's policy approach can delay critical interventions when agencies are unable to form trusted relationships with community members or organisations. The paramount principle under the *Child Protection Act 1999* (Qld) remains the safety and wellbeing of the child. Strengthening coordination between agencies can help ensure cultural practices are respected without compromising the safety of children.

131 Queensland Government, *Respect for cultural protocols and practices.* Child Safety Practice Manual.
132 Queensland Government, *Respect for cultural protocols and practices.* Child Safety Practice Manual.
133 Queensland Government, *Respect for cultural protocols and practices.* Child Safety Practice Manual.

These issues reinforce the need for child protection agencies to have staff who can navigate local cultural constraints. In its 2021–22 annual report the Board recommended workforce reform to ensure service accessibility and delivery. It recommended that:

> "The Queensland Government implements a 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 delivery holistic family support and early intervention."

This recommendation remains "Open – In Progress". The Board urges a whole-of-government response rather than isolated agency actions. A sustainable and culturally competent workforce is needed to ensure that the child protection system reaches the families who need it most.

Recommendations

The Board recommends that:

Recommendation 8

The Department of Families, Seniors, Disability Services and Child Safety should work with cultural authorities to provide greater consistency and understanding of how to monitor and respond to a child's safety during Sorry Business, including through greater partnership with local community-controlled organisations, community leaders and families to ensure place-based approaches are sustainable.

Recommendation 9

The Department of the Premier and Cabinet conduct a review of remote service delivery models, focusing on equity across health, education, domestic and family violence and family support services.

CHAPTER 8

Monitoring the Board's earlier recommendations

The Board has specific functions as set out in the *Family and Child Commission Act 2014* (Qld).

These functions include making recommendations about:

- improvements to systems, policies and practices for implementation by government and non-government entities that provide services to, or otherwise interact with children and their families; and
- legislative change.

The Board is required to monitor the implementation of its recommendations.

2023–24 Recommendation 1

Improved cross-government commitment to all children in care

Department of Premier and Cabinet, and Department of Families, Seniors, Disability Services and Child Safety

The Board recommends that the Department of the Premier and Cabinet 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.

Government Response

The Queensland Government recognises that supporting the needs of children and young people who are in care, or have experience of living in care, is a shared responsibility across all government agencies. The government acknowledges that this responsibility extends beyond the core business of the child protection system and encompasses health, education, housing, training, employment, justice, and community services.

The Queensland Government provided support for the intent of this recommendation, which seeks to strengthen whole-of-government accountability and collective responsibility for children and young people in care through public commitments by portfolio Ministers and Directors-General. The government acknowledges that all portfolios have a critical role in promoting the safety, wellbeing, and life outcomes of children and young people with care experience.

In May 2025, the government advised that this recommendation aligns with its broader reform agenda under the Safer Children, Safer Communities policies and associated comprehensive reform program. The Safer Children, Safer Communities agenda is designed to identify and implement practical measures that will make a tangible difference in the lives of children and young people in care.

On 18 May 2025, the Queensland Government announced the establishment of a Commission of Inquiry into the Child Safety System, which commenced on 1 July 2025 and will report by 30 November 2026. During the Inquiry, the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS) will continue to progress the *Safer Children, Safer Communities* election commitments and undertake exploratory work to inform future reform.

Under the *Safer Children, Safer Communities* program, the Queensland Government has committed to several key initiatives to strengthen the child protection and care system, including:

- delivering a dual-carer model for therapeutic residential care by 2030
- increasing Child Safety staffing by 20 per cent by 2028
- investing $50 million to establish a Secure Care facility by 2028 for young people with mental health needs
- piloting a $28.8 million professional foster care program for children with disabilities and complex needs in residential care
- providing a $1,500 annual education and extracurricular allowance for each child in out-of-home care, commencing 1 July 2025.

The Queensland Government has proposed that the status of this recommendation be updated from *Not started* to *Open – In progress,* reflecting the commencement of significant cross-agency work under the *Safer Children, Safer Communities* agenda. The government advises that these reforms will build the foundations for improved collaboration, coordination and accountability across government agencies in meeting the needs of children and young people in care and will inform how future whole-of-government commitments are articulated and delivered.

Board Observations

The Queensland Government's response demonstrates a clear commitment to improving support and opportunities for children and young people in state care. The establishment of the Commission of Inquiry into the Child Safety System marks a significant step towards examining systemic issues and identifying reforms to strengthen care and protection arrangements. The Inquiry's focus on uncovering systemic failures and recommending evidence-based reform reflects a proactive approach to addressing long-standing challenges.

In alignment with this, the government's Safer Children, Safer Communities agenda sets out several key reforms, including:

- the introduction of a dual-carer model for therapeutic residential care by 2030
- a 20 per cent increase in Child Safety staffing by 2028
- a Secure Care facility for young people with mental health needs by 2028
- a professional foster care pilot for children with disabilities and complex needs
- a $1,500 annual education and extracurricular allowance for each child in out-of-home care.

These measures represent a strategic effort to strengthen the child protection system and improve the quality of care available to children and young people. However, while these initiatives are promising, they do not fulfill the intent of the recommendation, which sought explicit, public commitments from all portfolio Ministers and Directors-General to collectively prioritise the needs of children and young people in care.

The Board recommended a whole-of-system recalibration–one that makes every Minister and Director-General accountable for improving outcomes for children in care, regardless of portfolio. The intent was to secure clear, public commitments that extend beyond core service delivery functions to include access to employment, training, housing, health, and community opportunities. In the same way that the Early Childhood Education and Care sector operates under a shared commitment to keep children safe from harm, this recommendation sought a shared government-wide commitment to improving life outcomes for children in care.

While the Safer Children, Safer Communities plan and associated initiatives under the Making Queensland Safer strategy (such as Regional Reset, Staying on Track, Kickstarter Grants, Transition 2 Success, Youth Development Partnership Fund, School-Based Policing, and Police Citizens Youth Clubs) reflect a broad public commitment to enhancing social and community engagement for at-risk young people, these efforts are primarily targeted toward youth justice and prevention contexts. They do not specifically articulate commitments to children and young people living in family-based or out-of-home care.

The Board acknowledges the government's recognition that supporting children and young people in care is a shared responsibility across portfolios. However, this principle has not yet translated into a formal, public statement of commitment from each Minister or Director-General, nor into a mechanism for tracking and reporting each portfolio's contribution to improving outcomes for children in care.

To realise the intent of this recommendation, the Board considers it necessary for government to adopt an explicit, coordinated framework of shared accountabilities–one that names the contribution of each agency and commits every portfolio to advancing the safety, wellbeing, and life outcomes of Queensland's children and young people in care.

2023–24 RECOMMENDATION 1: OPEN – IN PROGRESS

2023–24 Recommendation 2

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

Department of Families, Seniors, Disability Services and Child Safety, and Queensland Health

> The Board recommends that the Department of Families, Seniors, Disability Services and Child Safety (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.

Government Response

The Queensland Government continues to progress actions to strengthen sexual and reproductive health education and support for children and young people in care. DFSDSCS and QH are collaborating to ensure that children and young people in care have access to accurate, age-appropriate, and sensitive information about sexual health, wellbeing, relationships, and consent.

QH remains the lead agency responsible for sexual and reproductive health education and advice for all Queenslanders. QH has advised that in 2023, approximately 2,056 hours of training were delivered to foster and kinship carers, government and non-government personnel, and key partner agency staff. Topics included trauma and disrupted attachment, harmful sexual behaviours, and trauma-informed care. QH has also developed a suite of capacity-building resources, including fact sheets and educational materials on harmful sexual behaviours.

The Queensland Sexual Health Framework continues to guide this work, with an objective to support culturally responsive, early education and preventive health measures for priority populations, including young people. Between 2019 and 2024, QH funded True Relationships and Reproductive Health, in collaboration with the DoE, to deliver the Relationships and Sexuality Education Support Program *(Relationship Ready).* This program provides training and resources for educators, parents, carers, youth sector workers and vulnerable young people, covering topics such as sexual health, consent, contraception, and healthy relationships. In 2023–24, the program's focus included young people not engaged in formal schooling, supported through co-designed resources such as *Real Talk: About Sex n' Stuff.*

QH has confirmed that it will continue to collaborate with DFSDSCS through 2025–26 to promote awareness of these existing training and resource materials, and to review their suitability for child protection practitioners, carers, and residential care providers. Where updates or additional materials are required, QH and DFSDSCS will consider appropriate funding and delivery options.

QH has also released a *Domestic and Family Violence Capability Framework* in April 2025, together with updated resources to strengthen the health workforce's ability to respond to suspicions and disclosures of domestic and family violence. In partnership with the University of Southern Queensland, QH has developed new training and clinical resources addressing non-fatal strangulation (sexual choking) within intimate partner relationships among young people. These materials, responding to research identifying the increasing prevalence and associated health risks, will be released in late 2025, with training delivered through the QH domestic and family violence Specialist Health Workforce Program.

DFSDSCS reports regular engagement with QH to improve access to health services and health education for children in care. DFSDSCS advises that these conversations are most effective when delivered by trusted adults known to the child and are embedded within existing casework and placement support.

DFSDSCS has also partnered with PeakCare Queensland to develop a *Child Sexual Exploitation Awareness Masterclass* for residential care staff, building on the core *Hope and Healing* training program. The 70-minute online course educates residential care staff on recognising, responding to, and managing disclosures of child sexual exploitation.

Additionally, DFSDSCS has partnered with The Healing Foundation to deliver training on respectful relationships, consent, and healthy relationship dynamics to young people in care. The program aims to reduce vulnerability to domestic and family violence and improve relationship literacy. Training commenced in July 2024 across Brisbane, Cairns, Mount Isa, the Gold Coast and online, and will continue until June 2026. An evaluation report will be delivered in July 2026. The training remains available online and is designed for use across residential care, youth support,

and homelessness services, with particular focus on engagement with Aboriginal and Torres Strait Islander young people.

DoE continues to support this cross-agency effort, working with DFSDSCS and QH to promote sexual health and wellbeing education for children and young people in care enrolled in state schools and state school boarding facilities.

Board Observations

The Board acknowledges the work of QH and the DFSDSCS to progress the intent of this recommendation. The actions undertaken to date demonstrate clear progress and an ongoing commitment to improving sexual and reproductive health education, guidance, and support for children and young people in care. The Board recognises the collaborative approach between QH and DFSDSCS, and the inclusion of the DoE and non-government partners, in developing and delivering training and resources on sexual health, healthy relationships, consent, and harmful sexual behaviours.

Initiatives such as the *Relationship Ready program, Real Talk: About Sex n' Stuff* resources, and the respectful relationships training delivered in partnership with the Healing Foundation provide practical, evidence-informed tools for practitioners, carers, and young people, including those in vulnerable or out-of-school settings. *The Child Sexual Exploitation Awareness Masterclass* developed with PeakCare for residential care staff further strengthens the capacity of the workforce to recognise, respond to, and manage concerns and disclosures of sexual harm. The Board also notes QH's continued leadership through the Evolve Therapeutic Services Program, and the release of the *Domestic and Family Violence Capability Framework* and new resources to equip clinicians to respond safely to disclosures of violence, including the emerging issue of non-fatal strangulation (sexual choking) among young people.

These initiatives collectively represent a strong and maturing cross-agency effort, underpinned by the Queensland Sexual Health Framework, which prioritises culturally responsive education and preventive health measures for young people. There is clear evidence of co-design with young people, attention to vulnerable populations, and alignment with trauma-informed principles.

In consideration of these positive developments, the Board notes that a consolidated practice guidance document tailored specifically for child protection practitioners, foster carers, and residential care providers has not yet been finalised. While training and resources are available, there is no single, mandated framework to ensure consistent, regular, and sensitive conversations with children in care about their sexual health, wellbeing, and relationships across Queensland. The current approach relies on voluntary uptake and individual program delivery, rather than system-wide practice integration.

The Board acknowledges the progress achieved to date and commends the agencies' efforts to embed sexual and reproductive health education within broader workforce capability initiatives. However, the sustainability of this progress will depend on the continued investment, coordinated implementation, and formal adoption of clear, statewide guidance to ensure consistent practice across all regions and care settings.

The Board will await further updates from the responsible agencies through the 2025–26 reporting period to better understand the effectiveness and reach of current initiatives, including the sustainability of training, resources, and practice guidance developed to date.

2023–24 RECOMMENDATION 2:
OPEN – IN PROGRESS

2023–24 Recommendation 3

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

Department of Families, Seniors, Disability Services and Child Safety; Queensland Health, Department of Education, Department of Youth Justice and Victim Support

> 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.

Government Response

The Queensland Government provided in-principle support to the recommendation to prioritise continuity of care for children and young people with complex needs. The Government recognises the importance of developing flexible, specialised and coordinated models of care that provide consistent support for children who present with complex behaviours, disability, mental health challenges, or significant substance use concerns.

Through the *Safer Children, Safer Communities* reform program, the Queensland Government has committed to a suite of initiatives designed to strengthen service responses and improve outcomes for children in out-of-home care and those with high and complex needs. These include the delivery of a new dual-carer model in therapeutic residential care, a professional foster care pilot for children with disabilities and complex needs, and the establishment of a Secure Care facility to provide safe, therapeutic accommodation for young people who are a danger to themselves or others.

The DFSDSCS is trialling new residential care models to build an evidence base for best-practice approaches to meet the needs of Queensland children and families. These models include short-stay residential care with assertive outreach, specialist therapeutic residential care for young people with complex mental health and disability needs, and models delivered by Aboriginal and Torres Strait Islander Community Controlled Organisations. DFSDSCS is also strengthening supports for families through expanded Family Wellbeing Services and continued funding for Intensive Family Support to assist families experiencing complex challenges.

In partnership with QH, DFSDSCS is developing a joint agency protocol to respond to children and young people in distress or at risk of suicide, ensuring timely and coordinated support for those requiring acute hospital admission. Queensland Health and DFSDSCS are also reviewing and updating the Evolve Therapeutic Services Memorandum of Understanding to strengthen clinical pathways, service delivery and reporting.

Across the youth justice system, the Department of Youth Justice and Victim Support (DYJVS) continues to implement reforms that improve care continuity for young people with complex needs. The Government has committed $175 million over four years to deliver the Staying on Track program, providing intensive through-care for young people exiting detention. The Regional Reset Program ($50 million) will commence in 2026 to deliver early intervention and short-stay residential programs for at-risk young people requiring wraparound support. The government is also investing $40 million to establish two Youth Justice Schools, designed to deliver tailored education, mentoring and family support for young people subject to youth justice orders.

QH continues to provide targeted supports for children and young people with complex health and disability needs, including those in the child protection and youth justice systems. Health and disability teams within youth detention centres, alongside ongoing collaboration through the Evolve Therapeutic Services Program, ensure continuity of clinical and mental health support. The DoE works in partnership with DFSDSCS, DYJVS and QH to maintain education engagement and wellbeing supports for children and young people with complex needs across care and justice settings.

Through these coordinated actions, the Queensland Government is building a more integrated and sustainable service system that strengthens continuity of care for children and young people with complex needs. The government remains committed to cross-agency collaboration and will continue to monitor progress as part of the broader Safer Children, Safer Communities reform agenda and the Commission of Inquiry into the Child Safety System (commenced 1 July 2025).

Board Observations

The Queensland Government's response demonstrates continued progress toward improving continuity of care for children and young people with complex and high-risk needs. The Board acknowledges the government's in-principle support and the range of actions being advanced across portfolios under the Safer Children, Safer Communities reform agenda. The announcement of the Commission of Inquiry into the Child Safety System and the government's stated commitment to systemic reform reflect a clear recognition of the scale and seriousness of the issues affecting these children and young people.

The Board notes that actions underway across the child protection, youth justice, health and education systems collectively signal progress toward a more integrated and responsive service system. This includes the trialling of new residential care models, expansion of Family Wellbeing Services and Intensive Family Support, and investments in professional foster care, dual-carer therapeutic models, and the planned Secure Care facility for young people with mental health or behavioural support needs. The government's investment in Staying on Track ($175 million), Regional Reset ($50 million), and the establishment of Youth Justice Schools ($40 million) also represents meaningful steps toward a continuum of care for young people transitioning between detention, care, and community. The development of a joint agency protocol between DFSDSCS and Queensland Health to respond to distress and suicide risk further demonstrates operational collaboration and an understanding of the complex intersection between mental health and child protection.

The Board finds that the government's response remains insufficient to meet the full intent of the recommendation. The actions to date, while numerous, remain programmatic and portfolio-based rather than constituting a cohesive, cross-system model of care. There is still no clear governance structure or nominated lead agency accountable for ensuring continuity of care across universal, secondary and tertiary systems. The recommendation also required the nomination of a lead role to produce quarterly public reporting on progress; this has not yet been established.

Early intervention pathways particularly those accessible through schools, community services, or early health responses are not yet consistently defined, coordinated or resourced at the scale necessary to prevent escalation to crisis. While the Secure Care initiative is a positive development, it remains in the planning phase, with no clear legislative or oversight framework in place to ensure its safe and therapeutic operation. Reforms such as the extension of the Evolve Therapeutic Services partnership and co-location of multidisciplinary health and disability teams in detention centres represent enabling activities that support the broader agenda, but do not yet amount to a system-wide continuum of care.

The Board acknowledges that government is building critical foundational pieces for reform and recognises the scale of investment and policy effort underway. To date, these efforts remain transactional and fragmented, with agencies progressing separate initiatives rather than a single, coordinated response that addresses structural barriers and establishes shared accountability. Sustainable reform will require a unified governance mechanism, cross-agency data sharing, and a long-term policy framework that links prevention, intervention, and specialised care under a single system of accountability.

2023–24 RECOMMENDATION 3:
OPEN – IN PROGRESS

2023–24 Recommendation 4

Guaranteed access to mental health supports for children in care

Queensland Health

The Board recommends that Queensland Health:

4.1 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)
- a multi-agency strategy to support engagement has been developed and enacted.

4.2 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, 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.

4.3 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.

Government Response

QH recognises the importance of maintaining support for children in care who disengage from mental health services. While services are voluntary unless criteria under the *Mental Health Act 2016* (Qld) are met, QH works with DFSDSCS and other stakeholders to develop multi-agency plans to address the child's needs, including through the Evolve Therapeutic Service model. Carers and support networks are engaged even if the young person is not.

QH continues to promote resources to guide decision-making, including Gillick competence and less restrictive treatment pathways, and acknowledges the need for improved awareness of these principles. Mental health representatives attend SCAN meetings when children with identified mental health needs are discussed, however is not a core function of the SCAN membership.

QH is reviewing current service models to strengthen responsiveness, including approaches to re-engage children who have previously disengaged from services.

Board Observations

Government actions show progress towards the intent of the recommendation. QH engages carers and stakeholders even when young people disengage, supports multi-agency planning through Evolve Therapeutic Services, and provides resources to guide decision-making and promote awareness of Gillick competence. Discharge planning processes also aim to ensure relapse prevention and re-entry pathways.

There remain opportunities for additional improvements to more completely implement the intention of this recommendation. Current processes rely on voluntary engagement unless thresholds under the *Mental Health Act 2016* are met, meaning referrals may not always remain open until a coordinated strategy is enacted. The approach lacks clear procedural or policy changes, such as updated referral closure criteria, requirements for SCAN discussions (including more consistent involvement of mental health representatives), or documented strategies to re-engage disengaged clients. Improvements to service access for Gillick-competent young people also remain vague, with limited indication that guidance has been revised or staff awareness initiatives rolled out.

A more formalised, system-wide mechanism to prevent premature referral closure and ensure sustained accountability is needed to fully align with the recommendation.

2023–24 RECOMMENDATION 4:
OPEN – IN PROGRESS

2023–24 Recommendation 5

Improving risk assessments of children with disability and chronic medical conditions

Queensland Health; Department of Families, Seniors, Disability Services and Child Safety

The Board recommends that Queensland Health take action to provide clear guidance that will support Child Safety to beter 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.

Government Response

The Queensland Government provided support for this recommendation, recognising the importance of ensuring that children living with disabilities and/or chronic medical conditions are appropriately supported, and that assessments of their safety clearly distinguish between intentional neglect or maltreatment and circumstances arising from parental capacity, health literacy, or systemic barriers in access to care and supports.

QH, through the *Statewide Child Protection Clinical Partnership* and System Policy Branch, is leading work in collaboration with the DFSDSCS to develop joint practice guidance for assessing the safety and wellbeing of children with disabilities and chronic medical conditions. This guidance will support consistent, evidence-informed decision-making across health and child protection practitioners, ensuring coordinated responses between health, disability and child safety systems.

QH has existing clinical education programs and guidelines that already contribute to this work, supporting clinician training, professional development, and interagency collaboration. The new practice guidance being developed in partnership with DFSDSCS will build on these foundations, providing clear frameworks to identify when risks to a child's safety stem from intentional neglect or from deficits in parental health literacy or competency that may be addressed through appropriate health or disability interventions.

DFSDSCS is introducing new decision-making guidance for Child Safety officers, providing a structured framework to improve understanding of neglect in the context of children with disabilities or chronic health conditions. This guidance will assist practitioners in assessing parental capacity, identifying appropriate referral pathways, and ensuring consistent consideration of health and disability factors in child protection decisions. In addition, DFSDSCS is reviewing its *Disability Practice Kit* to ensure content remains contemporary, evidence-based and aligned with current disability and child safety practice expectations.

Both departments are also working with the Commonwealth Government and other jurisdictions on the development of new NDIS rules, which are expected to influence the planning and funding of supports for participants, including children with complex disability needs.

DoE will continue to collaborate with QH and DFSDSCS under existing information-sharing provisions of the Child Protection Act 1999 (Qld) to support holistic assessments and coordinated intervention planning for children with disability and chronic medical conditions.

Through these combined efforts, the Queensland Government is strengthening interagency collaboration, improving practitioner capability, and ensuring that children with disability or chronic illness receive consistent, equitable, and well-informed protection and care responses across Queensland.

Board Observations

The Board acknowledges the progress made by the Queensland Government toward implementing this recommendation, particularly the collaborative work between QH and the DFSDSCS to strengthen assessment and decision-making for children living with disabilities and/ or chronic medical conditions. The government's commitment to developing new joint practice guidance represents a significant step toward closing a longstanding gap in child protection practice; the capacity to distinguish intentional neglect or maltreatment from issues arising from low parental health literacy, competence, or access to supports.

The Board notes that Child Safety's *Disability Practice Kit,* already embedded in the *Child Safety Practice Manual*, provides existing guidance for assessing safety, planning, and risk in cases involving disability or chronic health conditions. The planned updates to this resource, along with new decision-making frameworks and cross-agency information sharing protocols, are positive developments that align with the recommendation's intent. The collaboration between QH and DFSDSCS, supported by clinician training and existing education initiatives, provides a foundation for more consistent, evidence-informed assessments across systems.

While the direction of reform is clear, the Board observes that much of the work remains in development and has not yet been fully operationalised or embedded into practice. The forthcoming joint guidance and updated practice kit will require system-wide implementation, supported by sustained training, clear policy mandates, and consistent supervision to ensure practitioners across both agencies can reliably differentiate neglect from issues related to capacity or literacy. The Board also notes that the broader impacts of NDIS reforms and the integration of disability-related supports into frontline decision-making remain uncertain and should be monitored for their potential influence on the safety and wellbeing of children with complex needs.

The actions taken to date demonstrate meaningful collaboration and adherence to the intent of the recommendation, but the reforms are not yet complete. Success will depend on the translation of this guidance into everyday practice, consistent uptake across regions, and the long-term sustainability of the interagency framework..

2023–24 RECOMMENDATION 5: OPEN – IN PROGRESS

2023–24 Recommendation 6

Coordinated health delivery service for sibling groups

Queensland Health

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.

Government Response

The Queensland Government noted this recommendation for further consideration. Government recognises the importance of adopting a family-centred approach to health care that considers the wellbeing of siblings and promotes holistic service delivery. Queensland Health acknowledges that implementing this recommendation requires balancing clinical priorities with family-centred and trauma-informed practice.

In 2025–26, QH will consider this recommendation within the implementation of the Child Safe Organisations regulatory framework, reviewing existing policies and clinical guidance to identify opportunities to strengthen referral pathways and support consistent, family-focused care across Hospital and Health Services.

The government remains committed to ensuring QH services contribute to the safety and wellbeing of all children, including siblings, through improved coordination and family-centred practice.

Board Observations:

The government's response acknowledges the importance of family-centred and trauma-informed approaches in clinical practice but remains at an early stage of consideration. While QH's commitment to review this recommendation within the context of the Child Safe Organisations regulatory framework demonstrates alignment with broader systemic reform, there is no clear evidence yet of tangible progress, draft guidance, or consultation to embed family-centred practice across Hospital and Health Services.

The Board notes that recognising the interconnection between a child's wellbeing and that of their siblings is essential to identifying cumulative harm and unmet health needs. However, the current response does not provide sufficient detail about how clinicians will be supported to operationalise these principles or how referral processes for siblings will be formalised.

The Board acknowledges the government's intention to integrate this work with the implementation of the Child Safe Organisations framework in 2025–26. While this presents an appropriate opportunity to progress the recommendation, further clarification will be required on timeframes, governance, and expected outputs to demonstrate progress toward embedding family-centred health practice.

2023–24 RECOMMENDATION 6: NOT STARTED

2023–24 Recommendation 7

Maintaining action on reducing family and domestic violence

Department of Families, Seniors, Disability Services and Child Safety, Queensland Police Service

The Board recommends that 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.

Government Response

The Queensland Government provided in-principle support for this recommendation, affirming its commitment to reducing the impact of domestic, family and sexual violence on Queensland children and families. The Government recognises that children are affected by domestic, family and sexual violence both as direct victims and as witnesses to violence, and that coordinated, cross-agency responses are essential to ensuring their safety, wellbeing and recovery.

The Queensland Government continues to implement a wide range of reforms arising from the Women's Safety and Justice Taskforce reports *Hear Her Voice – Report One and Report Two, the Independent Commission of Inquiry into Queensland Police Service Responses to Domestic and Family Violence (A Call for Change),* and the earlier *Not Now, Not Ever* report. Across these reform agendas, the Government is investing heavily in the safety of women, children, and families and strengthening institutional accountability.

A total of $588 million has been allocated to support delivery of the Taskforce recommendations, with 102 of 277 recommendations delivered as at 30 September 2024. QPS is continuing implementation of the 78 recommendations from *A Call for Change,* with 65 recommendations completed as at 5 July 2025. Of the remaining recommendations, six are being led by the Department of Justice and seven have been incorporated into QPS business-as-usual operations. The Government has also provided $100 million in funding to support capability-building and internal reform within QPS and related agencies.

In addition to progressing recommendations from the Taskforce and the Commission of Inquiry, the Government has introduced further measures to strengthen Queensland's domestic, family and sexual violence response system. Key reforms include:

- three new Beyond DV Hope Hubs, providing safe, discreet spaces for victim-survivors to access wraparound support in community settings.
- doubling the capacity of DVConnect Women's Line and Men's Line, supported by a new Townsville-based hub to increase regional crisis response and referral capacity.
- piloting GPS tracking for up to 500 high-risk domestic, family and sexual violence offenders, enabling 24-hour real-time monitoring by a specialised team.
- delivering domestic and family violence Safe Phones to ensure victim-survivors have safe and reliable access to communication and support.
- increasing penalties for breaches of Domestic Violence Orders and improving timeliness of responses for victim-survivors.

The Government's broader reforms are supported by the *Domestic and Family Violence Reform: A Pathway Forward for Change – First Annual Report* and ongoing public reporting through the Women's Safety and Justice Reform Annual Report. Cross-agency mapping has been undertaken to align overlapping recommendations from multiple reviews and inquiries, supporting a coordinated and efficient delivery program across government.

Within the QPS, the *Domestic Violence Protective Assessment Framework* (DV-PAF) continues to guide frontline officers in identifying the person most in need of protection and assessing risk factors including child abuse and cultural safety. Targeted domestic and family violence training has also been strengthened following the commencement of the *Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Act 2024,* embedding trauma-informed, victim-centric practices.

The Department of Youth Justice and Victim Support (DYJVS) continues to participate in local HRTs through dedicated domestic violence liaison officers who provide local intelligence and ensure Youth Justice case management aligns with collective safety planning. Caseworkers adjust case plans based on

HRT outcomes, supervision requirements, and referral pathways to specialist domestic and family violence services.

DFSDSCS remains responsible for whole-of-government monitoring and reporting on the implementation of the *Not Now, Not Ever and Hear Her Voice* recommendations, ensuring continued focus on child safety within the domestic, family and sexual violence reform agenda.

Together, these actions represent a coordinated, system-wide effort to strengthen Queensland's response to domestic, family and sexual violence, enhance cross-agency collaboration, and ensure that children affected by violence are visible, supported, and safe.

The Common Risk and Safety Framework (CRASF) is the whole of system approach to integrated service responses. The CRASF recognises that children are victims within their own right and includes a risk assessment screening tool for use with children. New domestic and family violence risk assessments tools are being developed specifically for working with young people, and will support practitioners to better identify and respond to risk and ensure improved outcomes for young people impacted by DFV.

Board Observations

The Queensland Government has requested that this recommendation be classified as Open – In progress, noting that work has begun to address the impacts of domestic and family violence on children and young people and to continue implementation of past Board and review recommendations.

The government's response to Recommendation 7 demonstrates a strong and ongoing commitment to systemic domestic and family violence reform. Building upon major reform agendas, including *Not Now, Not Ever, Hear Her Voice* (Reports One and Two), and *A Call for Change,* the Queensland Government has adopted a whole-of-system approach intended to deliver integrated, trauma-informed responses across the justice, child protection, and human services systems. Significant funding allocations, large-scale training programs, and legislative reform reflect a strategic effort to improve safety, accountability, and institutional culture.

The Board acknowledges that these reforms represent one of the most substantial social reform efforts undertaken in Queensland's recent history and that transformational change of this scale will require sustained time and investment. Recent updates from the QPS indicate that 65 of 78 recommendations from *A Call for Change* have been completed, while the DFSDSCS reports substantial progress against the *Hear Her Voice* recommendations. Nonetheless, the Board remains concerned that the Government's reporting continues to focus on the number of recommendations closed, rather than on evidence of impact, implementation quality, or improved outcomes for children and families.

The closure of the Office of the Independent Implementation Supervisor in late 2024 leaves a significant oversight gap. Without an independent mechanism to assess the adequacy and sustainability of reforms, there is reduced assurance that the depth of cultural and structural change envisioned by the inquiries and taskforces will be realised. The Board emphasises that the purpose of this recommendation is to ensure that the wellbeing of children and young people remains central to domestic and family violence system reform, and that the cumulative harm experienced by children in violent homes is explicitly recognised and addressed in all responses.

While there is evidence of cross-government integration with domestic and family violence priorities embedded in ministerial charter letters, whole-of-government monitoring frameworks, and coordinated reporting implementation remains uneven. It is not yet clear how agencies are aligning information-sharing practices, resource allocation, and community-led service design to ensure consistent frontline

responses for children. In particular, the Board notes the continuing need for improvements in:

- assessing and responding to cumulative harm experienced by children
- ensuring police engagement with victim-survivors and children reflects a trauma-informed and culturally capable approach
- sustaining deeper cultural reform within QPS and other agencies to address issues of sexism, racism, and inclusion identified through multiple reviews.

The government's ongoing actions, such as the review of the QPS Child Harm guidelines, expansion of crisis services, and implementation of the *Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Act 2024,* are commendable. Many reforms remain in progress however and their translation into consistent frontline practice is yet to be demonstrated. Ensuring that systemic reform produces measurable change for children affected by domestic and family violence will depend on strengthened accountability, workforce capability, and embedding reforms into business-as-usual operations.

The Board commends the government's sustained investment and momentum across the domestic and family violence reform agenda and acknowledges the growing recognition of children as both direct victims and those exposed to harm in domestic and family violence contexts. The Board will continue to monitor the government's progress throughout the 2025–26 reporting year, with particular focus on how reforms are operationalised, sustained, and measured for their impact on the safety and wellbeing of Queensland children..

2023–24 RECOMMENDATION 7:
OPEN – IN PROGRESS

2023–24 Recommendation 8

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

Department of Families, Seniors, Disability Services and Child Safety, Queensland Police Service, Queensland Health, Department of Education

The Board recommends that:

8.1 The Queensland Government invest in a public campaign to assist parents to understand childhood behaviour development, positive parenting techniques and the consequences of corporal punishment.

8.2 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 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, workers, support workers, and nominate an independent medical professional.

Government Response

The Queensland Government supports this recommendation in principle. The Government recognises the importance of helping parents to understand child development, positive parenting techniques, and the consequences of corporal punishment, while also strengthening professional capability across all agencies to identify and respond to the vulnerabilities of young and non-verbal children.

Regarding part 8.1, the Queensland Law Reform Commission (QLRC) is currently conducting a review of particular criminal defences, including the domestic discipline (corporal punishment) defence. The review is due for completion on 1 December 2025. The findings of this review will inform any future public education or awareness campaign to ensure that community messaging on positive parenting and child behaviour development is clear, evidence-based, and consistent with Queensland's legal and policy framework.

Following completion of the QLRC review, the Queensland Government will consider the need for, and design of, a public campaign to support parents and carers in understanding non-violent, developmentally appropriate approaches to child behaviour and discipline. Agencies will work collaboratively with the DFSDSCS to plan for implementation once the QLRC report has been delivered and government consideration finalised.

Regarding part 8.2, the Queensland Government is progressing a range of initiatives across agencies to strengthen awareness, capability, and consistency in responding to young and non-verbal children who may be at risk of harm.

In 2025, QH will embed new material in its mandatory *Child Aware* Training for all staff, focusing on the specific vulnerabilities of children under five years and non-verbal children. This training will enhance clinician understanding of developmental indicators, non-verbal disclosure, and physical signs of abuse or neglect. QH continues to promote evidence-informed frameworks for identifying non-accidental injuries and to work with partners across government to ensure the consistent application of health-based assessments and early intervention approaches.

The QPS acknowledges the additional vulnerabilities of young and non-verbal children and continues to deliver trauma-informed, child-focused responses through its specialist Child Protection and Investigation Units (CPIUs). CPIU officers receive specialist training through the *Child Protection and Youth Justice and Interviewing Children and Recording Evidence* (ICARE) program, which is based on the internationally recognised PEACE model (*Preparation and Planning, Engage and Explain, Account, Closure and Evaluation).* The training equips investigators to build rapport, encourage disclosure, and obtain admissible evidence while minimising trauma to the child. The QPS also partners with the Queensland Intermediary Scheme, which supports investigators in Brisbane and Cairns to interview vulnerable victims and witnesses aged under 16, or those with communication difficulties. The Scheme links speech pathologists, psychologists, occupational therapists, and social workers to facilitate communication during interviews.

Where there is evidence of physical injury, police investigators request medical reports and statements to support evidentiary requirements and ensure independent medical assessment. QPS decision-making is guided by the Operational Procedures Manual and Director of Public Prosecutions Guidelines, which require corroborating evidence and the use of qualified experts in child-related matters.

The DoE continues to deliver mandatory Student Protection Training for all school staff, reviewed annually, with additional resources focused on identifying possible abuse and neglect, managing disclosures, and recognising vulnerabilities in children under five, non-verbal children, and children with disabilities. Two advanced online training modules have been developed to provide detailed information on recognising harm, responding appropriately, and supporting children after disclosures. While DoE staff do not have investigative powers, they contribute to multi-agency responses through early identification and reporting under the *Child Protection Act 1999 (Qld).*

As of March 2025, High Risk Infants training is mandatory for designated child safety positions. Updated DFSDSCS procedures and practice guidance for intake and notification responses reinforce the requirement to seek medical assessments and corroborating information from a range of sources. These updates will be supported by the rollout of the new UNIFY information system, which will strengthen information capture and case management.

Across agencies, the government is embedding improvements through the Child Safe Organisations Framework, which reinforces shared responsibility for identifying, assessing, and responding to the needs of vulnerable children

Board Observations

Regarding part 8.1, the government has advised that the Queensland Law Reform Commission (QLRC) is reviewing the defence of domestic discipline as part of its broader review of criminal defences, with findings due by 1 December 2025. This review will inform any future public campaign on corporal punishment and positive parenting. While awaiting QLRC's findings may ensure consistency and legal clarity, it also results in a substantial delay before government actively engages with this issue.

The Board notes the extensive body of research demonstrating that corporal punishment is associated with adverse outcomes for children and that non-violent parenting strategies are more effective in achieving compliance and long-term behavioural outcomes. In this context, postponing public education until after the QLRC review represents a missed opportunity for earlier, evidence-based awareness raising on positive parenting approaches.

For part 8.2, QH intends to include additional material in its mandatory Child Aware training to highlight the vulnerabilities of children under five and non-verbal children. The QPS advised that its existing frameworks, such as the ICARE program and the Queensland Intermediary Scheme, already provide trauma-informed, child-centred processes for interviewing and supporting vulnerable children. The DoE continues to embed training and resources addressing bias, identification of harm, and appropriate response strategies.

The Board acknowledges that these actions reflect recognition across agencies of the heightened vulnerability of very young and non-verbal children. Training enhancements, the presence of specialist investigative units, and the continued use of trauma-informed practice models are important elements of system capability. The development of advanced training modules and resources on unconscious bias are encouraging signs of professional growth and consistent with the intent of this recommendation.

The Board notes that many of the reported activities reflect existing practice rather than new or expanded measures introduced in direct response to this recommendation. The government's updates have not clarified whether a clinical bruising decision rule, such as the *Ten-4-Faces-P* model, has been formally adopted, whether investigations now routinely seek broader collateral information for non-verbal children, or whether processes for obtaining independent medical reviews have been strengthened. These are key components of the recommendation's intent that remain unaddressed.

The Board recognises meaningful steps towards capability improvement and cross-agency awareness of child vulnerability, but progress remains limited and fragmented. The absence of clear evidence regarding adoption of clinical decision tools or enhanced investigative procedures suggests that the response remains at an early, procedural stage.

2023–24 RECOMMENDATION 8:
OPEN – IN PROGRESS

2023–24 Recommendation 9

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

Department of Families, Seniors, Disability Services and Child Safety, Queensland Health

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.

Government Response

The Government acknowledges that parental substance use remains a critical factor contributing to child harm and that continued investment in practitioner capability, interagency collaboration, and service integration is essential to achieving improved safety and wellbeing outcomes for children.

In June 2024, the Office of the Chief Practitioner within the DFSDSCS established a dedicated Practice Leader (Alcohol and Other Drugs) role to provide statewide leadership and expertise in alcohol and other drug (AOD) treatment, harm reduction, and best practice in child protection contexts. This role supports the development and implementation of a departmental Alcohol and Other Drugs Practice Strategy, designed to enhance the capability of Child Safety practitioners to identify, assess, and respond to risks arising from parental substance use.

The strategy focuses on three key objectives:

- review of the *Child Safety Drug and Alcohol Practice Kit* and guidance – ensuring content remains contemporary, evidence-based, and reflective of emerging substance use patterns.
- workforce capability and training strategy – building practitioner confidence and skill through targeted learning and development opportunities.
- referral pathways and access to services – improving coordination and integration with health and specialist AOD services to support holistic responses for families.
- To support implementation, the Office of the Chief Practitioner has delivered statewide professional development opportunities, including a webinar in December 2024 *on Assessing and Responding to Alcohol and Substance Risk in Child Safety Practice,* and a follow-up webinar in February 2025 on Substance *Use Intervention, Pathways and the Service Landscape in Queensland.* These sessions were delivered to all Child Safety staff and provided practical guidance on recognising and responding to parental substance use and related risks to children.

DFSDSCS continues to collaborate with QH, particularly through the Mental Health, Alcohol and Other Drugs Strategy and Planning Branch and the Clinical Planning and Service Strategy Division, to ensure alignment of child protection practice with the broader specialist treatment and harm reduction system. Queensland Health provides expert clinical advice and workforce development support through the Insight Centre for Alcohol and Other Drug Training and Workforce Development, ensuring that Child Safety practitioners have access to current best practice information, clinical resources, and training.

The AOD Practice Kit and associated training modules are currently under review to ensure the guidance reflects updated service pathways, contemporary understanding of methamphetamine use, and improved alignment between Child Safety and health services. This work will be supported by the Practice Leader (AOD) and informed by feedback from practitioners, health partners, and families.

DFSDSCS has proposed that this recommendation be considered complete, noting that the required practice guidance has been developed and is now being embedded into day-to-day practice, supported by ongoing collaboration with QH and specialist AOD services. However, the government remains committed to continuous improvement and to further embedding AOD practice principles across the child protection workforce.

Board Observations

The government's actions align well with the recommendation's intent and have established a sustainable foundation for improvement. Evidence of practical application, consistent uptake, and measurable impact is still required to consider the recommendation complete.

The appointment of a Practice Leader (Alcohol and Other Drugs) within the Office of the Chief Practitioner demonstrates strategic leadership to embed improvements in practice across the child protection system. The establishment of this dedicated role, supported by the delivery of statewide webinars and collaboration with QH, reflects a structured and evidence-informed approach to strengthening child safety practice in cases involving parental substance misuse.

The Practice Leader provides statewide consultation, mentoring, and training to departmental staff and partners, underpinned by clear objectives to review and update the Alcohol and Other Drugs Practice Kit, build workforce capability, and enhance referral pathways to specialist services. The partnership with QH's Insight Centre for Alcohol and Other Drug Training and Workforce Development provides access to specialist expertise and supports alignment between child protection practice and the broader alcohol and drug service system. These activities represent tangible progress toward the intent of this recommendation and reflect a growing emphasis on integration between frontline practice and specialist clinical supports.

The response demonstrates good quality, combining updated practice tools with workforce development and interagency collaboration. This approach creates a practical and sustainable framework to support frontline practitioners in assessing and responding to substance use risk within families. Sustainability is further supported through the ongoing leadership role within the Office of the Chief Practitioner and continuing cross-agency partnerships with QH.

While policy and training initiatives have commenced, further information is required to confirm that changes are consistently reflected in day-to-day decision-making and service delivery across Child Safety and QH. Evidence such as staff surveys, training completion rates, practice audits, or policy reviews could strengthen understanding of the extent to which the updated guidance has influenced practice and outcomes for children.

The Board acknowledges that progress has been steady and well-directed but agrees with its prior position that closure of this recommendation should be contingent on demonstrated embedding and measurable impact.

2023–24 RECOMMENDATION 9:
OPEN – IN PROGRESS

2022–23 Recommendation 1

Assessing the safety of children who are registered for home education

Department of Education, Queensland Police Service, Department responsible for Child Safety, Seniors and Disability Services

1.1 Initiate a regular process of data sharing with the Queensland Police Service and the Department responsible for 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

The Queensland Government continues to progress actions in response to Recommendation 1, with work underway to strengthen oversight and improve data sharing arrangements for children registered for home education in Queensland.

DFSDSCS has partnered with the Commission, the DoE and the QPS through the Queensland Home Education Review. The recommendations from the review are being considered by government.

The DoE reports a continued commitment to partnership with DFSDSCS and QPS to identify options for ongoing data sharing, in line with Recommendation 1.1. The department will continue to respond to data requests initiated by the Commission as part of its oversight function. The department notes, however, that any ongoing, systematised data sharing arrangements between agencies would require substantial collaboration and legislative amendment, along with modifications to information technology systems and development of operational protocols.

The QPS Child Abuse and Sexual Crime Group's Policy and Programs Unit has completed a full review of Chapter 7 (Child Harm) of the Operational Procedures Manual. Feedback was sought from operational areas involved in responding to child protection matters, and the review included consideration of current guidelines concerning child harm referral and reporting. The information within the Operational Procedures Manual has been restructured in several areas to increase readability and accessibility. The updated content is currently progressing through the QPS approval process and will be incorporated into the current version of the manual once approved.

With respect to Recommendation 1.2, the Home Education Unit Review was finalised in September 2024, and the Queensland Government's response was published in July 2025. The government response confirmed its support for all eight recommendations of the review and commits to further consideration and consultation on out-of-scope matters identified by the reviewer, including:

- oversight of students' movement in and out of state/non-state schooling and home education,
- opportunities for partial school enrolment, and
- regulation and oversight of unregistered families who home educate their children.

The review's recommendations aim to reposition and enhance the governance structures around home education in Queensland, improve communication and collaboration, and strengthen regulation and accountability. They also reflect opportunities to leverage technology to improve existing processes and to establish a home education support mechanism that will provide advice and resources to families.

The Department of Education will take a multi-staged approach to implementing the eight recommendations from the review. The government has also recently introduced and passed legislation to extend the age eligibility for home education registration to 31 December in the year the student turns 18, allowing students to complete their final year of senior schooling while remaining registered. The recommendations also reflect opportunities to leverage technology to improve existing processes and establish home education support mechanisms to provide enhanced resources and advice to families.

The Queensland Government advises that legislative reform arising from the review, and the broader consideration of oversight mechanisms, will continue through future reviews of the Education (General Provisions) Act 2006.

Board Observations

The government's actions demonstrate continued engagement with the Board's recommendations, though implementation remains in the early stages and the core intent of regular data sharing and strengthened oversight has not yet been achieved.

In relation to part 1.1, the Department of Education has reaffirmed its commitment to identifying options for ongoing data sharing with the QPS and the DFSDSCS, but notes that regular, systematised sharing of data will require legislative amendment, ICT system modifications, and the development of operational protocols. The department continues to respond to data-sharing requests initiated by the Commission, but no enduring mechanism or framework for proactive sharing has yet been established.

The QPS has completed a full review of Chapter 7 (Child Harm) of its Operational Procedures Manual, which includes restructuring and updating child harm referral and reporting guidance. The updated Operational Procedures Manual content is currently progressing through the QPS approval process. The Board welcomes this progress but notes that further advice is required on how the amendments will enhance cross-agency collaboration and improve visibility of vulnerable children, including those registered for home education.

The Board also notes that since September 2024, no additional requests or operational actions have been made by agencies to progress regularised data sharing for home-educated children. The government acknowledges that authorising legislation will be required to support ongoing data sharing between agencies.

Overall, while the government has identified the legislative and operational barriers to regular data exchange, there remains no concrete mechanism or interim process in place to ensure proactive, ongoing information sharing. The intent of this recommendation—to increase the visibility and safety of children registered for home education through systematic data sharing—has not yet been realised.

Regarding part 1.2, the Board acknowledges that the Queensland Home Education Unit Review was finalised in September 2024 and that the Queensland Government formally accepted all eight recommendations in July 2025. The review's findings aim to enhance governance, communication, collaboration and regulatory oversight of home education in Queensland, and include commitments to explore technology solutions and establish a home education support mechanism.

The government has also passed legislation extending the age eligibility for home education registration to 31 December in the year a student turns 18, supporting continuity of education for senior students. The Board recognises this as a positive, student-focused reform.

However, the review explicitly identified that legislative frameworks and enforcement powers were out of scope, and the government's response notes that further consideration and consultation are required to address key matters such as oversight of students moving between education settings, partial enrolment, registration processes for unregistered families, and data on children with learning or mental health needs.

These issues partially address the Board's concerns but fall short of the comprehensive legislative and regulatory oversight required to ensure that home-educated children's educational, social, health and wellbeing needs are safeguarded. Strengthened mechanisms for assessment, home visits, and cross-agency information sharing remain necessary to give effect to the recommendation's intent.

While the government has taken measurable steps following the review, including its acceptance of the eight recommendations and commitment to further consultation, the substantive elements of Recommendation 1, particularly regularised data sharing and legislative reform for strengthened oversight, remain under development. Legislative changes and operational protocols required to achieve full alignment with the recommendation's intent are yet to be progressed.

While Education, Child Safety and QPS continue to collaborate under the Commission-led review process, and the review outcomes represent a significant step forward, the recommendation's core objectives – regular data sharing and strengthened regulatory oversight – have not yet been realised. Further legislative reform and implementation of interagency protocols are required before this recommendation can be considered complete. The Board recognises the need to establish relationships with the sector prior to legislative reforms that strengthen oversight of children (recommendations 1.1 and 1.2). This would be consistent with previous advice from the Queensland Family and Child Commission (QFCC), provided in its submission to the Education (General Provisions) and Other Legislation Amendment Bill 2024, that further regulating home education before fully understanding and responding to the reasons why so many parents are turning to home education may further risk the education of already vulnerable children.

The Board acknowledges the government's reform posture but emphasises that proactive and ongoing information sharing between agencies must be prioritised to ensure visibility of all vulnerable children, regardless of education setting. Continued monitoring will be required to ensure the commitments made translate into legislative, regulatory, and operational change.

2022–23 RECOMMENDATION 1: OPEN – IN PROGRESS

2022–23 Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice

Department of Youth Justice

2.1 The Department of Youth Justice takes immediate action to articulate Queensland's Detention Operating Model, and Government commits to publishing this model.

2.2 The Department of Youth Justice 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

For 2.1: Significant work has advanced in relation to the publication of Youth Detention Centre (YDC) operational policies on the department's website. The inaugural YDC operating model document is in the final stages of drafting and has been provided to QFCC for review and feedback. This model is expected to be published on the department's website in November 2025. Supporting resources to articulate the YDC operating model such as the YDC services and daily routine have also been developed (both available online).

For 2.2: The department's Strategic Workforce Plan has been published on the department's intranet page, including updates to the industrial framework such as wage and allowance increases, retention incentives, and reclassification of youth detention centre officer roles. An identified position within the youth detention central recruitment team has contributed to a substantial increase in First Nations applicants for Detention Youth Worker roles. This has been achieved through strengthened relationships with key community stakeholders and First Nations organisations, targeted information sessions, and enhancements to the applicant assessment process to improve cultural safety. The recruitment process now places strong emphasis on cultural capability, support, and sensitivity throughout the end-to-end experience. Positive feedback has been received formally and informally from First Nations applicants.

The Department of Youth Justice has completed implementation of Recommendations 2.1 and 2.2. A Strategic Workforce Plan for youth detention centres has been finalised, including updates to the industrial framework such as wage and allowance increases, retention incentives, and reclassification of officer roles.

- the completion of the Employee Value Proposition, and
- updates to the industrial framework with the completed implementation of:
  - wage increases of four per cent and related allowances, with back pay to 1 August 2023 and further increase of four per cent from 1 August 2024
  - Cost-of-Living Allowance payment of three per cent of base wages
  - YDC Operational Employee Allowance, which increased from a maximum of $50 per fortnight, to a maximum of $353.80 per fortnight
  - Youth Detention and Youth Justice Skilled Worker Retention Allowances, which both equate to an uplift of $45 per fortnight payable to staff after two years of continuous service
  - Student Supervision Allowance increase backdated to 1 August 2023, and
  - Review of AO2 role profile and upgrade of officers undertaking the work to AO3 completed.

The Employee Value Proposition has also been delivered.

In addition, the Youth Detention Operating Model has been articulated and published on the department's website, providing transparency about how Queensland's detention centres operate.

Board Observations

The Department of Youth Justice has published the Youth Detention Operating Model and finalised a Strategic Workforce Plan, addressing the Board's recommendation for an articulated operating framework and workforce strategy. These actions meet the formal requirements of the recommendation and represent clear progress. The workforce plan includes industrial reforms, financial incentives, and role upgrades designed to strengthen attraction and retention, while the publication of the operating model provides transparency about how detention centres operate.

In the 2023–24 Annual Report, the Board noted the need for industrial reform which bolsters the workforce's cultural capability. These concerns remain, as the published operating model may not yet provide the full operational detail, access to key policies (such as separation), or a clear articulation of the legislated "purpose of detention" that the Board highlighted.

Similarly, while the workforce strategy delivers industrial reforms and retention measures, it does not yet reflect the cultural capability focus or input from the youth justice peak body that the Board identified as critical for long-term workforce sustainability. The workforce strategy is heavily weighted toward financial incentives, with less evidence of long-term planning for recruitment pipelines, staff wellbeing, career progression, or cultural change – all critical for sustainability.

It is unclear how the model and workforce strategy will adapt to challenges specific to new centres, particularly in regional areas where staffing pressures are greatest.

Overall, while the government has delivered the required outputs, ongoing monitoring, refinement, and investment in workforce capability and organisational culture will be essential to ensure the model and strategy deliver the sustainable, systemic improvement the Board intended.

**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)

Department of Youth Justice

3.1 The Queensland Government 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 The Queensland Government commission the Board to utilise its review process to review the 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

The Queensland Government accepted this recommendation and is progressing key initiatives to strengthen workforce presence and culturally safe service delivery in First Nations communities. Local Decision Making Bodies (LDMBs) continue to meet and identify service gaps, with a review underway to inform future design and implementation. An Aboriginal and Torres Strait Islander Economic Strategy is being developed to drive long-term economic development, employment, and business growth. Responsibility for Best Practice Industry Conditions for Social Services Procurement has transferred to the Department of Families, Seniors, Disability Services and Child Safety following machinery-of-government changes in November 2024. The government remains committed to workforce reform to support culturally safe, coordinated, and integrated services.

DFSDSCS notes the closure of this recommendation, noting the range of workforce development activity underway.

Board Observations

In the 2023-24 Annual Report, the Board indicated that it would close this recommendation subject to the above work progressing throughout 2024–25. The 2025 update does not clearly indicate whether the government remains committed to continuing the initiatives outlined in the 2024 update. The only references provided relate to Local Decision Making Bodies (LDMBs) and the development of a First Nations Economic Strategy. Notably, the language used to describe LDMBs has shifted significantly, from 'bodies that empower communities to influence and co-design how services are delivered' in 2024, to 'meetings in many communities, along with interagency meetings in remote and discrete communities, to identify service gaps and local solutions' in 2025. This change in language suggests a marked shift in both direction and commitment.

Further, the update does not clarify the status of several initiatives previously introduced, including Paving the Way – First Nations Training Strategy, the Indigenous Workforce and Skills Development Grants, Our Way, and the Grow Your Own Regional Workforce Program. There is also no further information on the previously stated intention to develop a 10-year plan to transition investment into the Aboriginal and Torres Strait Islander Community Controlled Organisations sector, or the proposed workforce strategy to be developed in partnership with QATSICPP.

Government has not provided any further updates on Child Safety's actions outlined in the 2024 update, specifically those originally committed to by the former government under the Department of Social Services' Safe and Supported Action Plans (2023–26). Additionally, there is no further mention of the community engagement model being developed to support the involvement of local communities in service design to better meet the needs of Aboriginal and Torres Strait Islander children and families.

There is a stark contrast in the level of detail provided by the government between the 2024 and 2025 updates, leading to uncertainty about the continuation of the significant progress that was being made in advancing Recommendation 2.

2022–23 RECOMMENDATION 3:
OPEN – IN PROGRESS

2021–22 Recommendation 1

Workforce reform to ensure service accessibility and delivery

Department of Youth Justice, Employment, Small Business and Training, Department responsible for Child Safety, Seniors and Disability Services; Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts, Queensland Health, Department of Education, Department of Justice and Attorney-General

The Board recommends: 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; and
- include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers.

Government Response

In 2025, the Queensland Government provided an update to this recommendation and proposed its closure, noting that the intent had been met through whole-of-government approaches to skills and workforce development, including compliance with the Queensland Government's Specific Purpose Planning Requirements.

The government response highlights a commitment to strong collaboration between government, industry, employers and training sector stakeholders. The Department of Trade, Employment and Training leads this work as Queensland's State Training Authority, engaging with peak industry associations, employer groups and industry skills advisory bodies to ensure a strong industry voice in workforce development. This includes collaboration through Industry Skills and Jobs Advisors, Industry Workforce Advisors, the Gateway to Industry Schools Program, Regional Jobs Committees and Jobs and Skills Councils.

Across the human services system, the government reports ongoing action to strengthen workforce capability, retention and wellbeing. Agencies have implemented strategic workforce plans that align with new operating models, respond to labour market pressures, and prioritise leadership, capability, culture and safety. These initiatives aim to address workforce challenges, support employee wellbeing and improve recruitment and retention outcomes across the human services system.

The Department of Youth Justice and Victim Support (DYJVS) advises that priority roles have been reviewed, and dedicated teams are progressing workforce planning and analytics. Work is underway to recognise staff contributing cultural knowledge and those working in regional and remote areas, including research into remuneration and allowances. DYJVS remains committed to progressing these initiatives and will continue to provide updates as this work advances.

DFSDSCS advises it continues to implement its Strategic Workforce Plan 2023–26, which targets leadership and talent engagement, capability and future workforce planning, and safety, wellbeing and culture. Regional Workforce Plans have been developed by regional leadership teams with support from People and Culture, embedding place-based strategies reviewed annually to ensure they remain current and effective. Under this framework, a Retention Strategy for Child and Family has been implemented to attract and retain staff aligned to the department's service needs and values. Specifically, DFSDSCS is:

- commissioning PeakCare Queensland Inc. to develop a workforce strategy to meet current and future needs of the residential care sector (scheduled for completion in October 2025)
- contemporising Hope and Healing training modules to lift the skills and experience of residential care workers and foster and kinship carers
- 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 government's portfolio-based approach demonstrates progress on workforce planning, particularly within youth justice and service delivery contexts, and addresses elements of staff attraction, retention, and cultural capability. However, the response does not yet meet the broader intent of the Board's recommendation for a whole-of-government human services workforce reform agenda. The approach remains siloed, focusing on departmental initiatives rather than coordinated, cross-agency action to address competition for scarce specialist resources, particularly in regional and remote areas.

The Board's concern - that fragmented workforce planning negatively impacts children and families when systems compete rather than collaborate - remains unaddressed. The absence of a coordinated, system-wide workforce strategy (including joint commissioning, pay parity across portfolios, and targeted growth of foster and kinship carers) represents a significant gap. Without a cohesive whole-of-government response, sustainability and long-term systemic reform will remain limited.

The government has implemented meaningful departmental workforce initiatives but has not addressed the recommendation's intent for coordinated cross-portfolio human services workforce reform. The Board considers the intent not met and the government's response as effectively a rejection of systemic reform.

2021–22 RECOMMENDATION 1: CLOSED - NOT COMPLETE

2021–22 Recommendation 2

Workforce reform to ensure service accessibility and delivery

Department of Youth Justice, Employment, Small Business and Training, Department responsible for Child Safety, Seniors and Disability Services, Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts; Queensland Health, Department of Education, Department of Justice and Attorney-General

The Board recommends: 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; and
- 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.

Government Response

The Queensland Government accepted this recommendation and is progressing key initiatives to strengthen workforce presence and culturally safe service delivery in First Nations communities. Local Decision Making Bodies (LDMBs) continue to meet and identify service gaps, with a review underway to inform future design and implementation. An Aboriginal and Torres Strait Islander Economic Strategy is being developed to drive long-term economic development, employment, and business growth. Responsibility for Best Practice Industry Conditions for Social Services Procurement has transferred to the Department of Families, Seniors, Disability Services and Child Safety following machinery-of-government changes in November 2024. The government remains committed to workforce reform to support culturally safe, coordinated, and integrated services.

DFSDSCS notes the closure of this recommendation, noting the range of workforce development activity underway.

Board Observations

In the 2023–24 Annual Report, the Board indicated that it would close this recommendation subject to the above work progressing throughout 2024–25. The 2025 update does not clearly indicate whether the government remains committed to continuing the initiatives outlined in the 2024 update. The only references provided relate to Local Decision Making Bodies (LDMBs) and the development of a First Nations Economic Strategy. Notably, the language used to describe LDMBs has shifted significantly, from 'bodies that empower communities to influence and co-design how services are delivered' in 2024, to 'meetings in many communities, along with interagency meetings in remote and discrete communities, to identify service gaps and local solutions' in 2025. This change in language suggests a marked shift in both direction and commitment.

Further, the update does not clarify the status of several initiatives previously introduced, including *Paving the Way – First Nations Training Strategy, the Indigenous Workforce and Skills Development Grants, Our Way, and the Grow Your Own Regional Workforce Program*. There is also no further information on the previously stated intention to develop a 10-year plan to transition investment into the Aboriginal and Torres Strait Islander Community Controlled Organisations sector, or the proposed workforce strategy to be developed in partnership with QATSICPP.

Government has not provided any further updates on Child Safety's actions outlined in the 2024 update, specifically those originally committed to by the former government under the Department of Social Services' *Safe and Supported Action Plans* (2023–26). Additionally, there is no further mention of the community engagement model being developed to support the involvement of local communities in service design to better meet the needs of Aboriginal and Torres Strait Islander children and families.

There is a stark contrast in the level of detail provided by the government between the 2024 and 2025 updates, leading to uncertainty about the continuation of the significant progress that was being made in advancing Recommendation 2.

**2021–22 RECOMMENDATION 1:
OPEN - IN PROGRESS**

2021–22 Recommendation 3

Continuity of care for children with complex needs

Department responsible for Child Safety, Seniors and Disability Services; Queensland Health, Department of Education, Department of Youth Justice, Employment, Small Business and Training

The Board recommends: that the Queensland Government develops a fit-for-purpose model that provides a continuum of care for children with highrisk 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:

3.1 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; and
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model.

3.2 Include an early intervention stream that provides a pathway for hildren 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.

3.3 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
- integrates ongoing access for the child to family, culture and education.

Government Response

The Department of Youth Justice and Victim Support notes its continuing work on programs aligned to this recommendation, including the *Staying on Track* program, the *Regional Reset* program, and the establishment of four Youth Justice Schools. The department also cites quality improvement processes that review cases involving the death or serious injury of young people known to the system, and ongoing operational performance reviews that incorporate child death review findings. Access to accommodation for high-risk young people with complex needs can be escalated through the MACP. The department advises that *Staying on Track* providers will deliver tailored mentoring, education and employment supports, and accommodation pathways as required. On this basis, the department suggests its contribution to this recommendation be closed.

Board Observations

The government's actions demonstrate incremental progress in building service responses for young people with high-risk behaviours, particularly through *Staying on Track, Regional Reset*, and Youth Justice Schools. Case review processes and the escalation of accommodation issues to MACPs also indicate some system responsiveness.

However, the Board's concerns remain unaddressed. These initiatives do not yet amount to a fit-for-purpose continuum of care with a clear systemic owner, as originally recommended. The model remains fragmented across multiple programs and panels, with no unified framework spanning prevention, early intervention, and specialised tertiary care. The Board also notes that current responses do not adequately meet the needs of children requiring specialised accommodation and support and has reinforced this gap through new recommendations in its 2023–24 Annual Report.

Overall, while individual programs contribute to the intent of the recommendation, the absence of an integrated, system-wide model means that the recommendation remains in progress. Sustained cross-agency reform and the establishment of a dedicated, accountable mechanism will be necessary to fully realise the Board's intent.

2021–22 RECOMMENDATION 3:
OPEN – IN PROGRESS

Schedule of closed Board recommendations

2022–23

Recommendation 4: closed – complete

The Queensland Government strengthens its policies to ensure that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

Recommendation 5: closed – complete

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.

Recommendation 6: closed – complete

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).

2021–22

Recommendation 4: closed – complete

The Board recognises there is significant reform occurring in the area of domestic and family violence. The Board recommends: 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; and
- the role of fathers and fathering, as promising points for behaviour change intervention.

Recommendation 5: closed – complete

The Board recommends: 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; and
  - implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.

Recommendation 6: closed – not complete

The Board recommends: that the Queensland Government engages with the Commonwealth Government to improve access for vulnerable children and families to the National Disability Insurance Scheme (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; and
- 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

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 Child Concern Report 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 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.

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 of the Board

Referral of exceptional matter: Review of system responses to child sexual abuse

Section 29I of the *Family and Child Commission Act 2014* to ask the Board to carry out a review. This section allows the Attorney-General, in exceptional circumstances, to ask the Board to carry out a stated review to identify opportunities for continuous improvement in systems, legislation, policies and practices and to identify preventative mechanisms to help protect children and prevent deaths that may be avoidable.[134]

In this case, the Attorney-General requested that the Board consider the offending of Ashley Paul Griffith (the offender) as a case study to identify any weaknesses in the laws, policies, procedures and practices that occurred across the early childhood education and care, police and blue card systems.

Terms of Reference for the Review were approved by the Board on 20 December 2024 and were released publicly in January 2025.[135] Under the Terms of Reference the Board was required to:

1. establish a timeline of conduct by the offender
2. examine the legislative framework, policies and procedures that operated during the time of offending
3. identify the context of child sexual offending in Queensland
4. identify best practice for protecting children from sexual abuse
5. seek and consider the views and experiences of people directly impacted by the offender's behaviour
6. analyse the legislative and policy framework in place to protect children from child sexual abuse
7. examine the responses of the early childhood education and care, police and blue card systems.

To support this significant and complex task, a dedicated team of seven staff was established within the QFCC, including secondees from the Queensland Police Service and the Department of Education.

To respond comprehensively to the Terms of Reference, the Board exercised its statutory powers under section 29P of the *Family and Child Commission Act 2014* to request relevant information from government and non-government agencies. In 2024–25 these efforts resulted in the collection of more than 20,000 pages of documentary material, which continues to inform the Board's analysis.

The Board made it a priority to centre the voices and experiences of those most directly affected. Victim-survivors, their families and former colleagues of the offender were invited to share their experiences through a formal call for submissions, launched with the assistance of the Australian Federal Police on 28 March 2025 and hosted on the Board's website from 31 March 2025. This process helped the Board to identify gaps in system responses and define areas requiring urgent improvement. Psychological and emotional support services were made available to ensure the process was conducted in a trauma-informed and safe manner.

In parallel, the Board undertook a legislative mapping exercise to establish the frameworks in place during the period of the offender's conduct. This revealed a crowded and complex legislative environment, with 26 principal Acts and over 100 amending Acts relevant to the early childhood education and care, police and blue card systems.

134 *Family and Child Commission Act 2014*, s. 29I.

135 https://www.qfcc.qld.gov.au/sites/default/files/2025-01/System%20Responses%20to%20Child%20Sexual%20Abuse%20Terms%20of%20Reference.pdf

To supplement this work with high-quality, independent research, the Board engaged Griffith University, the University of New South Wales, the University of the Sunshine Coast and the Australian Institute of Family Studies to explore issues of prevention, detection and response to child sexual abuse. The Queensland University of Technology also contributed findings from the Australian Child Maltreatment Study. The Board sought further insights through direct engagement with national and international child safeguarding experts, including commissioners, ombudsmen and policy leaders across several Australian jurisdictions.

On 30 April 2025, the Board convened the first of a series of policy roundtables to test emerging insights and challenge system assumptions. Experts from government and non-government sectors, as well as academic researchers, joined Board members to examine the offender's known contacts with systems, the legislative environment, and factors associated with men who sexually offend against children. The roundtable produced valuable analysis and contributed to the Board's emerging views about the complexity and fragmentation of system safeguards.

To broaden its evidence base, the also Board contacted 51 non-government stakeholders in February 2025, inviting them to prepare submissions on the systemic and policy issues under review. Public updates have been provided via the Board's website, offering transparency and tracking progress. Two public discussion papers have also been released to inform submissions from both impacted parties and the wider public.

The final report of the Review is scheduled for release in late 2025. It will include detailed findings and recommendations aimed at preventing future harm and strengthening the safety and wellbeing of children across Queensland.

Board Meetings in 2024–25

The Board held five scheduled and two extraordinary meetings in 2024–25. Principal Commissioner Luke Twyford presided as Chair at all meetings. A quorum[136] was present at all meetings. Meetings were:

Meeting 23 — 26 September 2024. At this meeting, the Board reviewed 11 cases and received a presentation from Cathy Taylor, Independent Implementation Supervisor (IIS), Office of the IIS. Ms Taylor provided an update on the implementation of the Queensland Government Response to recommendations from the two Women's Safety and Justice Taskforce *Hear her voice* reports and recommendations from the independent Commission of Inquiry *A Call for Change: Commission of Inquiry into Queensland Police Service* responses to domestic and family violence.

Meeting 24 — 20 November 2024. At this meeting, the Board reviewed 10 cases and received a presentation from Ms Angela Masson, Deputy Director-General, Housing and Homelessness Services representing Mr Mark Cridland, Director-General, Queensland Department of Housing, Local Government, Planning and Public Works. Ms Masson provided a consolidated summary of Housing and Homelessness Programs, including an overview of social housing, youth housing and transitional programs, youth foyers and other youth-specific supports, specialist homelessness services, crisis response and integrated services.

Extraordinary Meeting 1 — 16 December 2024. This meeting was convened to enable the Board to discuss the proposed approach to the review into the Ashley Paul Griffith case, later referred to as the System Response to Child Sexual Assault Review. Matters discussed included the correspondence from the Attorney-General asking the Child Death Review Board to carry out the review, the draft terms of reference and the draft timeline for the review.

Extraordinary Meeting 2 — 20 December 2024. This meeting continued the discussion from Extraordinary Meeting 1, with a particular focus on finalising the terms of reference for the review.

Meeting 25 — 19 February 2025. At this meeting, the Board reviewed 6 cases. Ms Beck O'Connor, Commissioner, Office of the Victims' Commissioner (OVC) attended the meeting as an observer. Commissioner O'Connor provided an overview of the work the OVC will be undertaking including establishing the Sexual Violence Review Board, a statutory independent Board, the first of its kind in Australia to review system barriers and responses, investigate and prosecute sexual offences.

Meeting 26 — 16 April 2025. At this meeting, the Board reviewed 21 cases. No guest speakers attended the meeting.

Meeting 27 — 18 June 2025. At this meeting, the Board reviewed 17 cases. Tere Vaka from Vaka Psychology was invited to provide a debrief opportunity for Board members to speak about the impacts of vicarious trauma.

136 See *Family and Child Commission Act 2014*, s. 29ZF.

Child Death Review 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.[137]

Board members are appointed for a term of three years. The current three-year appointment terms commenced on 1 July 2023 and will conclude on 30 June 2026.

Chair: Mr Luke Twyford

Mr 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: Ms Simone Jackson

Simone Jackson is a proud Kamilaroi woman from Southwest Queensland and an accomplished Government Executive with over 25 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 & 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 Ipswich and West Moreton, over three clinical sites, Ipswich, Booval and Laidley. Kambu Health is a cradle to grave service with early years through to palliative care operating programs funded through numerous state and commonwealth departments. Simone has been a member of the Queensland Parole Board since 2017 and on the Board of Thriving Queensland Kids Partnerships since 2023. Ms Jackson's term expired on 16 March 2025.

Deputy Chair: Ms Sharon Cavanagh-Luskin

Ms Cavanagh-Luskin was appointed on 23 May 2025.

Sharon Cavanagh-Luskin, a Kuuku Ya'u, Irukandji, and Wonnarua First Nations woman, she is Illuminate-FNQ First Nations Chief Scientist. Sharon plays a pivotal role in advancing health, science, and education to enhance outcomes for Aboriginal and Torres Strait Islander peoples, as well as other underserved and vulnerable communities across Northern Australia. With a strong background in public health, she was awarded the inaugural Queensland State Award Fulbright Scholarship and completed a postgraduate fellowship at Harvard University's T.H. Chan School of Public Health, focusing on the Quality Use of Medicines. Her contributions include the establishment of a pharmacy outlet in the Yarrabah Aboriginal community—improving access to essential medications and health literacy—and the design of a Model of Care for stroke patients across three major Queensland health services. These initiatives reflect her commitment to integrating evidence-based healthcare with culturally responsive practice.

As the founder of a not-for-profit organisation dedicated to strengthening science, technology, engineering and mathematics (STEM) engagement across Northern Australia. The organisation integrates science, environmental sustainability, space medicine innovations and cultural education through programs such as the annual Science and Environment Festival, creating platforms for innovation and inclusive dialogue. Her work centres on embedding First Nations perspectives within national STEM narratives and expanding access to educational and career pathways in science for rural and remote communities across Northern Australia. She is especially passionate about co-developing STEM and space industry prototypes that address local ecological, cultural, and technological challenges. Through technical tours, STEM forums, and interactive learning models, she showcases the scientific merit of First Nations knowledge systems while advancing inclusive, place-based science education. Her partnerships with government, academia, industry, and community reflect a commitment to equity, cultural integrity, and First Nations-led innovation in the STEM sector.

137 *Family and Child Commission Act 2014*, s. 29W-29Y.

Mr Murray Benton

Murray Benton is a proud Aboriginal Barkindji Koori man from Central West New South Wales and serves as Deputy Chief Executive Officer of Youth Justice at Queensland's Youth Justice and Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP). Murray brings extensive leadership and frontline experience across housing, homelessness, and child, youth, and family services with deep expertise in systemic issues affecting young people in the youth justice and child protection systems. He has led specialist service delivery in regional communities working across crisis response, intensive case management, domestic family and sexual violence, primary health and antenatal care, sexual and reproductive health, disaster recovery, and multicultural support. He also played a key role in developing Queensland's first local housing action plan. In 2018, Murray gained national recognition for The Good Fight Australia, a youth mental health and suicide prevention campaign informed by personal family experience. He led the initiative for two years, advocating for stronger Government responses to bullying and self-harm in schools, with wide-ranging support nationally and internationally.

With close ties to the Stolen Generations Murray brings a critical lens to the impacts of severed cultural identity and kinship.

He is a dedicated advocate for preventing and ending violence against women and children, shaped by his own childhood experience as a victim alongside his mother. He champions the need for greater male awareness, accountability, and targeted prevention and intervention. In 2024, Murray was appointed to the Board of Directors of DVConnect, Queensland's leading statewide crisis support service for people affected by domestic, family, and sexual violence.

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 an early childhood adversity researcher based at the University of Queensland and the Queensland Centre for Mental Health Research. Her work aims to ensure all children have access to the safe, loving, violence-free childhoods they need to thrive in childhood and across life. 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.

She serves on the World Health Organisation's Technical Advisory Group for Violence Against Children Estimations and has served as an expert 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. As an academic she has published extensively in leading international journals and received funding of >$10 million.

Associate Professor Haslam has a strong belief in the importance of prevention and early intervention and is committed to conducting and using gold standard scientific research to improve the lives of children and families. She 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.

Ms Carly Jacobitz

Carly is the current Deputy Chief Executive-(Child, Youth and Family) at Life Without Barriers (LWB). 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, LWB. 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.

Ms 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 the Department responsible for Child Safety is the Chief Practitioner. Dr Meegan Crawford is the Chief Practitioner in the Department responsible for Child Safety, Queensland. After graduating as a social worker, Meegan commenced her career over 30 years ago as a Child Safety Officer. 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.

Commenced April 2025, Victoria Van Houdt is the Acting Chief Practitioner. Victoria has a 25-year career in child protection and adoptions including roles in direct practice, strategic policy and executive experience. As the Acting Chief Practitioner, Victoria leads the teams delivering Delegated Authority, Domestic and Family Violence Integrated Service Response Program, Child Safety complaints, training, and child death and serious injury reviews teams; specialist services supporting child protection practice and for children with a disability; and the teams responsible for operational policy, procedures, partnerships and programs. The role of the Chief Practitioner is a member of the Child Death Review Board and Domestic and Family Violence Death Review and Advisory Board.

Youth Justice

The Board position within the Department of Youth Justice and Victim Support is the Senior Executive Director, Strategic Performance, Reporting and Insights. Mr Darren Hegarty occupies this position. Darren has led a number of positive and significant reforms for children and youth in both the youth justice and child protection systems. Notably within the Youth Justice portfolio, Darren oversaw the implementation within Youth Justice of the first Bail Support Services, Youth Co-Responder, and Taskforce Guardian, which were partnerships with the Queensland Police Service and the first of their kind in Australia. Other significant reforms include multiple Youth Justice Strategy and Action Plans, Commissioning of the West Moreton Youth Detention Centre, Out of Home Care Reinvestment program, including Queensland's first Mental Health Recovery Residential and Queensland's First Adolescent Outreach Residential Service, improved service delivery frameworks within the Department responsible for 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 refocused investment in Intensive Family for children and youth. Nationally, Darren co-authored the Australasian Youth Justice Association's first Youth Justice Service Standards. Within Darren's portfolio and directly correlating to the work of the Child Death Review Board is the Quality and Improvement directorate which leads the Department's System and Practice Review function.

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

Ms Hayley Stevenson, Assistant Director-General, Student Support Branch, has been attending Child Death Review Board meetings as the DoE proxy representative since January 2025. The Department of Education's representation on the Board is 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 (CASCG). Detective Acting Superintendent occupies this position. Detective Acting Superintendent Stephen Blanchfield has over 35 years of policing experience, with more than 25 in investigative roles across Queensland. He is a recognised leader in child protection, sexual violence, and serious crime investigations, having led high-profile cases including the Daniel Morcombe murder. As Operations Manager of the Child Trauma and Sexual Crime Unit, he spearheaded the QPS Sexual Violence Response Strategy and helped establish key initiatives like the Sexual Violence Liaison Officer network. A subject matter expert in investigative interviewing, Stephen works with national and international partners to improve policing practices. His commitment to reform, victim support, and officer wellbeing earned him the Exemplary Conduct Medal (Investigations), reflecting his enduring impact on policing and justice for Queensland's most vulnerable.

Attendance

Table 5: Attendance at Board meetings in 2024–25.

		Meeting number and date						
Member (person or position)	**Agency**	**23** **26 Sep 2024**	**24** **20 Nov 2024**	**EO 1** **16 Dec 2024**	**EO 2** **20 Dec 2024**	**25** **19 Feb 2025**	**26** **16 Apr 2025**	**27** **18 Jun 2025**
Luke Twyford	QFCC (Chair)	Present	Present	Present	Present	Present	Present	Present
Simone Jackson	Non-government (Deputy Chair)	Present	Present	Present	Present	Present	N/A – Term expired 16 March 2025	
Sharon Cavanagh-Luskin	Non-government (Deputy Chair)	N/A – Position appointed 23 May 2025						Present Via teams
Murray Benton	Non-government	Present	Present	Present	Present	Present	Present	Present via Teams
Divna Haslam	Non-government	Present	Present	Present	Present	Present	Present	Present
Carly Jacobitz	Non-government	Present	Present	Present	Present	Present via Teams	Present	Present
Beth McNamara	Non-government	Present	Present	Present	Present	Present	Present	Present
Marlene Longbottom	Non-government	Present via Teams	Apology	Apology	Apology	Present via Teams	Present via Teams	Present via Teams
Chief Practitioner	Child Safety	Present Meegan Crawford	Present Meegan Crawford	Present Meegan Crawford	Present Meegan Crawford	Present Meegan Crawford	Present Meegan Crawford	Present Victoria Van Houdt
Assistant DG, Disability, Inclusion and Student Services	Education	Present Robyn Albury	Apology	Apology	Apology Proxy (Hayley Stevenson)	Apology Proxy (Hayley Stevenson)	Apology Proxy (Shelley Bampton)	Apology Proxy (Hayley Stevenson)
Stephen Stathis	Queensland Health	Present	Present	Apology	Present	Apology Proxy	Present	Present
Senior Executive Director, Youth Justice Workforce and Practice	Youth Justice	Apology	Present	Apology	Apology	Present	Present	Present via Teams
Detective Superintendent CASCG	Police	Present Stephen Blanchfield	Present Denzil Clark	Present Denzil Clark	Present Denzil Clark	Present Denzil Clark	Present Stephen Blanchfield	Present Denzil Clark

Conflicts of interest

Two Board members, as required by legislation[138], disclosed a potential conflict of interest relating to the Board taking on responsibility of the System Response to the Child Sexual Assault Review at the Extraordinary Board Meeting number two held on 20 December 2024. Both individually discussed the conflicts of interest with the Chair. The Chair assessed that there are no perceived or potential conflicts of interest that limited their ability to perform their functions as Board members.

Stakeholder engagement and partnerships

The Board continued to maintain professional relationships with a range of stakeholders throughout 2024–25. Stakeholders supported the Board by:

1. undertaking internal agency reviews and providing insights into relevant legislation, policies, procedures and practices
2. providing insights into the experiences of individuals, families or communities or contributed expertise on matters that affect them
3. contributing data, research or expertise to inform the Board's work
4. carrying out similar review functions in other Australian jurisdictions
5. implementing, or assisting in the implementation of, system changes recommended by the Board
6. 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 2024–25 to discuss death review processes and identify opportunities for improvements.

The Board is also a member of the Australian and New Zealand Child Death Review & Prevention Group. Through this group, the Board is able to engage and share learnings with similar interstate entities.

Promoting our work

The Board maintains a website at https://www.qfcc.qld.gov.au/board, which provides information about its structure, functions and work.

Between 1 July 2024 and 30 June 2025, the Board and its work featured in 575 media items, an increase from 493 over the previous reporting period, with an estimated audience reach of 28.6 million across Australia. Media items comprised:

- 369 online items (estimated audience reach 24.6 million)
- 161 radio items (estimated audience reach 958,000)
- 35 television items (estimated audience reach 633,000)
- 10 print items (estimated audience reach 2.4 million).

Media items focused on:

- The launch of Queensland's review of System Responses to Child Sexual Abuse
- Queensland's plan to implement a SecureCare facility and the related recommendations made by the Board
- Individual child death cases referred to the Board or subject to coronial inquests
- Case studies from the Board's annual reports, relating to the deaths of two children who spent time in detention and the death of a child who had experienced homelessness
- Visibility of children who are homeschooled and associated child safety risks, following outcomes of a review of home education regulation completed by the Queensland Family and Child Commission on the Board's request.

During the same period, the Board and its work featured in 18 posts on social media, which reached a combined audience of 330,531. The social media posts included:

- Annual Report (208,247 views)
- Review into System Responses to Child Sexual Abuse (52,539 views)
- Reappointment of Luke Twyford as Chairperson of the Child Death Review Board and Principal Commissioner of the Queensland Family and Child Commission (41,063 views)
- Regulation of Home Education Insights Papers (25,600 views)
- Queensland Government's response to the Board's recommendations (3082 reviews).

138 *Family and Child Commission Act 2014*, s. 29ZJ.

Information requests

Pursuant to section 29P 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, to inform its usual review work on three occasions in 2024–25 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.

To inform the work of the System Response to Child Sexual Assault Review, the Chair used the s 29P information request powers 16 times to request information from government and non-government agencies as it relates to the review. Information was provided in response to all of these requests. Further information requests to both government and non-government entities are likely to be issued with respect to clarifying information and policy landscape to inform the review.

Coronial information requests

Some child deaths reviewed by the Board are reportable to the Queensland Coroner[139]. 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*, to obtain a copy of the Board's review and findings.

During the 2024–25 reporting period, the Board complied with six 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[140].

Risk management

The Secretariat, on behalf of the Board, 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 strategic risk register captures and monitors strategic and operational risks for the Board. For purposes of accountability, it is presented six-monthly to the Commission's Audit and Risk Management Committee.

139 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

140 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
AAIMH	Australian Association for Infant Mental Health
ARACY	Australian Research Alliance for Children and Youth
BiOC	Birthing in Our Community: an Aboriginal and Torres Strait Islander-led service for mums, bubs and families in southeast Queensland
Board, the	Child Death Review Board
CYMHS	Child and Youth Mental Health Services
Department responsible for Child Safety/DFSDSCS/Child Safety	Department of Families, Seniors, Disability Services and Child Safety Previously the Department responsible for Child Safety, Seniors and Disability Services.
DPC	Department of the Premier and Cabinet
Education/DoE	Department of Education
QATSICPP	Queensland Aboriginal and Torres Strait Islander Child Protection Peak
OVC	Office of the Victims' Commissioner
QFCC	Queensland Family and Child Commission
QH/Health	Queensland Health (includes hospitals and health services)
QLRC	Queensland Law Reform Commission
QMHC	Queensland Mental Health Commission
NDIS	National Disability Insurance Scheme
QPS/Police	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 Families, Seniors, Disability Services and Child Safety (Child Safety), the Department of Youth Justice and Victim Support (Youth Justice), Queensland Health (Hospital and Health Services (HHS)) 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).

Term or acronym	Meaning
Youth Justice	The Department of Youth Justice and Victim Support. Previously the Department of Youth Justice, Employment, Small Business and Training.
Child protection terms[141]	
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).
Child Protection Notification (CPN)	A child protection notification is a subset of notifications that meet the statutory threshold for suspected significant harm or risk of significant harm, where parents may be unable or unwilling to protect the child.
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.
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.
CRASF	Common Risk and Safety Framework
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.
ETS	Evolve Therapeutic Services
Family and Child Connect (FaCC) service	Family and Child Connect are funded non-government community-based intake and referral services that help 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.

141 See Glossary | Child Safety Practice Manual (csyw.qld.gov.au)

Term or acronym	Meaning
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).
HRT	High Risk Team
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.
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).
Multi-Agency Collaborative Panels (MAC-Ps)	The Multi-Agency Collaborative Panels involve relevant government and non-government organisations who work together to coordinate service deliver 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.
Child Protection Notification (CPN)	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.

Term or acronym	Meaning
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	The Suspected Child Abuse and Neglect team refers to team made up of core member agencies and other stakeholders involved in providing a multi-agency response to children in contact with Child Safety, as part of the Suspected Child Abuse and Neglect team system. See Suspected Child Abuse and Neglect team core member agencies. The Suspected Child Abuse and Neglect team is comprised of: • a Suspected Child Abuse and Neglect team coordinator (Child Safety) • a Suspected Child Abuse and Neglect team administration officer (Child Safety) • core member agency representatives • relevant stakeholders from core member agencies, other prescribed entities or service providers who can provide expertise and resources to inform discussion and deliberations by core member representatives.
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 two years, severity of offences, time spent in custody, and the offender's age.
YCRT	Youth Co-responder Team. Youth co-responder teams are a joint Youth Justice and Queensland Police Service initiative. Specialised teams consist of youth justice workers and police officers in police vehicles that engage with youths in local communities to reduce the risk of offending and keep the community safe. Riding in designated youth co-responder police vehicles, YCRTs visit locations frequented by youth—including parks, local shopping centres and residential areas—and engage directly with youths and refer them to relevant services and supports to stop them from offending.

Term or acronym	Meaning
Other	
AOD - Alcohol and other drugs	
CASCG	Child Abuse and Sexual Crime Group
Domestic and family violence (DFV)	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.
DVO	Domestic Violence Order
ECEC	Early childhood education and care
SIDS	Sudden Infant Death Syndrome
STEM	science, technology, engineering and mathematics
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.
VSU	volatile substance use

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 seven occasions in 2024–25. A total of 64 child deaths were reviewed in this period.
Financial reporting	The Board is audited as part of the Queensland Family and Child Commission. 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	7	$0	N/A	$0
Deputy Chair (nongovernment)	Simone Jackson	5	$3375	N/A	$3375
Deputy Chair (nongovernment)	Sharon Cavanagh-Luskin	1	$1125	N/A	$1125
Member (nongovernment)	Murray Benton	7	$4500	N/A	$4500
Member (nongovernment)	Divna Haslam	7	$4500	N/A	$4500
Member (nongovernment)	Carly Jacobitz	7	$4500	N/A	$4500
Member (nongovernment)	Beth McNamara	7	$4500	N/A	$4500
Member (nongovernment)	Marlene Longbottom	4	$4500	N/A	$4500
Member (government)	Victoria Van Houdt	7	$0	N/A	$0
Member (government)	Robyn Albury/ Hayley Stevenson	5	$0	N/A	$0
Member (government)	Stephen Stathis	5	$0	N/A	$0
Member (government)	Darren Hegarty	4	$0	N/A	$0
Member (government)	Denzil Clark/ Stephen Blanchfield	7	$0	N/A	$0

Number of scheduled meetings/sessions	**5**
Number of extra-ordinary meetings/sessions	**2**
Total superannuation paid (non-government)	**$2458.21**
Total out-of-pocket expenses	**(parking and accommodation): $1420.70**

Child Death Review Board

Queensland **Family & Child** Commission

Queensland Government