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

Fatal medical conditions

secondary to neglect

Summary Report 2026

Queensland
Government

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Acknowledgements

The Queensland Child Death Review Board (the Board) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities, and 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 (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.

> *It has become clear that new ways of thinking about professional working with children and families is necessary as old ways of working do not necessarily provide better outcomes for children.*[1]

Introduction

This report considers a small cohort of children known to the child protection system who died from medical conditions, with a particular focus on systemic factors affecting access to timely and appropriate healthcare. It identifies common system-level issues across these cases that may have compounded risk and contributed to the progression and severity of individual health issues. The Child Death Review Board (the Board) recognises that early intervention can be lifesaving; however, delays can be detrimental to survival outcomes, which highlights the critical role of early intervention and the detrimental impact of delays in care on survival outcomes.

Each case has been considered by the Board in previous thematic reviews. Across all cases, a common theme was a persistent failure: to uphold the best interests of the child as a paramount principle and to centre decision-making on the child.

This summary report will examine systemic issues arising in cases where children known to the child protection system died from medical conditions, with a particular focus on failures in timely recognition, assessment, and response to medical neglect and unmet health needs. The report will explore how delayed or fragmented interagency responses, particularly between Child Safety and health services, may have contributed to missed opportunities for early intervention and escalating risk.

The report will consider circumstances where medical conditions were treatable or manageable with timely access to appropriate healthcare, but where breakdowns in care, oversight, or coordination compounded harm. The report will centre on system-level factors influencing decision-making, information sharing, and accountability for children at heightened medical vulnerability. The review will focus on tertiary child protection and interagency system performance for children already known to services, rather than broader population-level health prevention strategies.

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[1] Leadbetter, J., Daniels, H., Edwards, A., Martin, D., Middleton, D., Popova, A., … Brown, S. (2007). Professional learning within multi-agency children's services: researching into practice. Educational Research, 49(1), p 84.

Natural cause deaths and potentially avoidable deaths

Data from the Queensland Child Death Register

Between 2020 and 2025, natural cause deaths accounted for 71 per cent of all child deaths in Queensland. Aboriginal and Torres Strait Islander children experience a higher overall child death rate compared with non-Indigenous children during this period.

Data from the Queensland Child Death Register, as provided by the Queensland Family and Child Commission's Child Death Prevention team in 2025, identified that of the 1,535 deaths attributed to disease and morbid conditions, 126 children (or 8%) were known to the child protection system in the 12 months prior to their death. Aboriginal and Torres Strait Islander children were overrepresented within this group, with a rate of 41 deaths per 100,000 children, compared with 18 per 100,000 for non-Indigenous children.

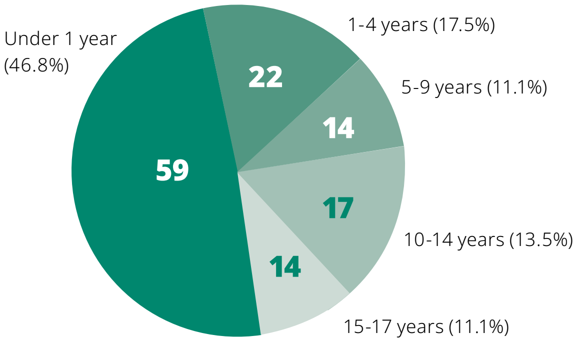
Mortality from natural causes among children is largely driven by deaths occurring in the neonatal period (0–27 days). Infants who die within the first four weeks of life are most commonly born prematurely and/or with congenital abnormalities. These conditions occur across the population and are not, in themselves, indicative of child abuse or neglect. This pattern largely explains the underrepresentation of children known to Child Safety in deaths from natural causes, in contrast to their overrepresentation in mortality from all other causes. As shown in Table 1, mortality rates from natural causes for children known to Child Safety are lower than those of the general population for children under one year of age, Aboriginal and Torres Strait Islander children, and non-Indigenous children.

For the purposes of this report and in line with cause of death data utilised in Queensland, natural causes include perinatal conditions, congenital anomalies, neoplasms, infections, other diseases and medical conditions.

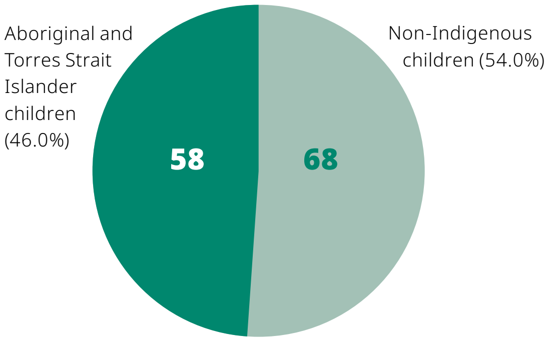
Table: Natural Cause Deaths by child protection status and Indigenous status 2020-21 to 2024-25 (sourced from the Queensland Child Death Register, September 2025).

Population group	Children known to Child Safety (per 100,000)	All children (per 100,000)	Comparative note – children known to Child Safety versus all children in population group
Non-Indigenous children	18.3	23.0	Lower than general population as mortality is driven by perinatal/congenital conditions <28 days and not indicative of abuse or neglect. Elevated relative to the general population.
Aboriginal and Torres Strait Islander children	40.9	50.3	Lower than general population, but elevated relative to non-Indigenous children.
Under 1 year	247.4	379.7	Lower than general population as mortality is driven by perinatal/congenital conditions <28 days and not indicative of abuse or neglect
1-4 years	22.7	10.0	Overrepresented
5-9 years	9.5	5.4	Overrepresented
10-14 years	10.6	4.9	Overrepresented
15-17 years	16.3	8.4	Overrepresented

Natural cause deaths to children known to Child Safety by age



Natural cause deaths to children known to Child Safety by Indigenous status



Contributors to death for children with medical conditions

The Queensland Family and Child Commission's Child Death Prevention team has proposed that a child death attributed to natural causes may be considered potentially avoidable where both of the following conditions are met:

- the medical condition was treatable using existing healthcare resources; and
- there was a breakdown in care.

These criteria were met for all children considered in this report except one. In that case, neglect contributed to the child's underlying health condition; however, earlier access to healthcare may have reduced the likelihood of the child's death.

Delays in accessing healthcare can arise for various reasons, including operational constraints within health services and circumstances in which parents or caregivers do not seek care on behalf of a child. These findings underscore the importance of coordinated, proactive responses across health services and other relevant agencies to ensure the children with medical conditions receive timely, appropriate and effective care.

Diabetes and epilepsy – both chronic and complex medical conditions – were central features in two cases involving young people. Effective management of these conditions requires close monitoring and consistent engagement with healthcare services, particularly where self-management or parental oversight is limited. In a submission to the Australian Senate Inquiry into Excess Mortality in May 2024, Diabetes Australia noted that diabetes is underreported as a cause or contributor to deaths and highlighted the impacted of delays in both routine and emergency healthcare on excess mortality.[2] Similarly, timely routine and emergency healthcare for people with epilepsy is crucial, as effective seizure management is associated with reduced risk of Sudden Unexpected Death in Epilepsy (SUDEP).[3]

The remaining two cases examined in this report involved infants under one year of age who were particularly vulnerable due to their developmental stage and inability to self-protect. One child died because of sepsis, while the other child died following a fatal assault and neglect.

> *“Delays in accessing healthcare can arise for various reasons, including operational constraints within health services and circumstances in which parents or caregivers do not seek care on behalf of a child.”*

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[2] Diabetes Australia, Submission to the Australian Senate Standing Committees on Community Affairs: Excess mortality of Australians with diabetes Sub 10 - Diabetes Australia.pdf, 14 May 2024.

[3] Epilepsy Action Australia, https://www.epilepsy.org.au/leading-experts-call-for-greater-awareness-of-sudden-unexpected-death-in-epilepsy-to-help-save-lives/, 2023.

Themes across child death reviews

The cases examined in this report are consistent with patterns observed in other child death reviews, reflecting reoccurring themes and risk factors commonly associated with child deaths. Across all cases, parental and child-specific risk factors were present, including domestic and family violence, mental health concerns, and problematic substance use, occurring either independently or in combination.

All children had current, recent, and/or long-term involvement with the child protection system. In most cases, multiple concerns had been reported to Child Safety over time, either by a single agency or by multiple agencies. In circumstances of limited engagement with services, the potential for cumulative harm and neglect warranted explicit consideration but was not consistently recognised or addressed.

Across the cases, insufficient attention was given to identifying and assessing co-occurring risks to other children in the household, indicating a limited consideration of the family as a whole. Multiple system failures were identified in every case, including missed opportunities where effective communication and coordinated responses – particularly by Child Safety and Health – would have supported or enabled a more integrated approach to care.

Extended periods of limited or no agency contact with families were evident across all cases. As a result, comprehensive – and in some cases, basic – child safety and health assessments were not undertaken. This contributed to the absence of coordinated and sustained case management and to prolonged periods during which necessary treatment or intervention did not occur.

In each case, this was influenced by assumptions that responsibility for the child's safety or health needs rested with another agency. There were instances where action was delayed or not taken due to a perceived inability to intervene during periods of cultural significance, or due to a failure to appropriately understand and respond to the cultural beliefs, practices, and behaviours until risks had escalated to critical levels.

Neglect was a significant contributing factor in all cases, particularly where agencies failed to recognise, assess, and respond to the urgency and severity of the child's condition. This occurred despite most children or young people having had contact with an agency in the days preceding their death.

Across all cases, decision-making did not place the child at the centre. This was exacerbated by limited visibility of the child – either in a physical sense, or through inadequate understanding of the child's developmental, cognitive, or medical needs. The heightened vulnerability of children who were non-verbal, non-mobile, or cognitively impaired was not consistently at the forefront of assessments and decision-making. For the young people in this cohort, assumptions about age and perceived capacity to manage their own health contributed to insufficient assessment and, at times, a reluctance to explore concerns further.

A lack of effective information sharing was also evident. Agencies often held relevant concerns but worked in parallel rather than collaboratively. Where interagency meetings occurred, coordination was undermined by the absence of key decision-makers, incomplete information, or a focus on issues peripheral to the specific risks facing the child.

What is not apparent in the agency case reviews are the human and cognitive factors that influence decision-making by parents, caregivers, and professionals. Individual agency reviews tended to document policy processes and timelines but provided limited insight into the critical moments where different decisions may have altered the child's trajectory.

> “*For the young people in this cohort, assumptions about age and perceived capacity to manage their own health contributed to insufficient assessment and, at times, a reluctance to explore concerns further.*”

Integrated system responses

Interagency coordination

The *Child Protection Act 1999* (Qld) (the Act) sets out principles for coordinating service delivery and the information sharing between prescribed entities. In particular:

- s159B(d) - entities should contribute, within each entity's own sphere of responsibility, to assessing and meeting the protection and care needs of children and supporting their families[4]
- s159B(f) - entities should work collaboratively and in a way that respects the functions and expertise of each of the entities.[5]

In all cases examined in this report, both Child Safety and Queensland Health (Health) held concerns at various points; however, joint coordination of actions to address the concerns was insufficient or not evident. In retrospect, there was significant potential for more effective collaboration between Child Safety and Health through proactive, coordinated action. Joint planning and home visiting may have altered outcomes for some children; in the absence of clear leadership, shared accountability, and agreed mechanisms for collaboration, such approaches were difficult to implement and sustain.

More commonly, agencies undertook the individual actions required of them under legislation to assess and respond to needs of children they encountered, but did not routinely work together in a formalised, consistent or standardised way. This limited the effectiveness of system responses in situations involving complex and escalating health and safety risks.

Risk assessment

The Child Safety Practice Manual (CSPM) provides that, when responding to a child protection notification (CPN), Child Safety and Queensland Police (police) may undertake a joint response where the matter is a priority and there is an allegation of a criminal offence against a child.[6] There is no equivalent requirement in the CPSM or legislation that formalises joint responses between Child Safety and Queensland Health where health concerns are identified.

This represents a significant gap, particularly in circumstances where individual agencies have been unable to assess a very young child or infant. A formalised joint approach between Child Safety and Health would support coordinated planning to ensure children are seen by medical practitioners with appropriate urgency. It would also strengthen information sharing, enable more comprehensive joint risk assessments, and support relationship-building and shared learning between agencies.

Timeliness of agency responses

Delays in the commencement of investigation and assessment (IA) by Child Safety were identified in all cases reviewed:

- Case 1 - 5 months
- Case 2 - 6 months
- Case 3 - 'no IA outcome' after 18 months
- Case 4 - 2 months

Such delays can inhibit other agencies from actively engaging with the child and family during critical periods, reducing opportunities to assess, intervene and mitigate risk.

High caseloads further contributed to delays, including in planning for unborn children which in some instances did not occur until close to, or after, birth – when an investigation could formally commence. Timely case allocation, commencement and completion are critical to reducing the risk of harm and enabling effective interagency engagement.

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[4] Child Protection Act 1999 (Qld), s159B (d), https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010#sec.159B

[5] Child Protection Act 1999 (Qld), s159B (f), https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010#sec.159B

[6] Queensland Government, https://cspm.csyw.qld.gov.au/procedures/investigate-and-assess/undertake-a-priority-response#Consult_with_the_Queensland_Police_Service_to_decide_if_there_will_be_a_joint_response, 8 Jan 2026.

Case summaries

Case study one

In the case of Baby, 4 months old, there were several parental risk factors observed including domestic and family violence, mental health concerns, problematic substance use, transience, and a household living environment that was overcrowded and unhygienic.

Both had their own child protection histories as subject children. The siblings of Baby were subject children in an Intervention with Parental Agreement (IPA) with neglect as the primary issue. The IPA had been in place for several months. One of the siblings had a diagnosed medical condition secondary to neglect that warranted a visit by the Nurse Navigator every two to three weeks due to the severity and nature of the condition.

While Mother was pregnant, Health provided a report to Child Safety highlighting risks linked to the ongoing neglect of the other siblings. Despite the notification requiring a 10-day response, there was a prolonged delay in commencing the IA. It was observed at the time that average caseloads were very high, alongside ongoing challenges relating to staff turnover and workforce experience.

Both Child Safety and Health made repeated attempts to engage with Mother during pregnancy, however, she received minimal to no antenatal care. No Unborn Child High Risk Alert (UCHRA) was initiated, and no safety planning occurred during this period.

As an unborn child, Baby was not brought forward at Suspected Child Abuse and Neglect (SCAN) meetings, which remained primarily focused on the siblings. Home visiting under the existing IPA was also limited. Although Child Safety was aware of the expected timing of the birth, awareness of the birth of Baby did not occur until more than a month after delivery.

After Baby was born, Mother took the child to a routine hearing test at approximately two weeks of age. Although offered at the appointment, Mother declined to have the child weighed. During the same month two scheduled child health home visits were cancelled due to staffing constraints, and a third visit was cancelled by Grandmother. On one occasion, a Nurse Navigator attended the family home and sighted and weighed the sibling of Baby. During this visit, the Nurse Navigator was advised that Mother had recently given birth. The Nurse Navigator made attempts to conduct further home visits, speaking with other family members and providing supplements but was unable to see the sibling.

Child Safety staff became aware of the birth of Baby the following month, during a home visit under the IPA. It was during this time the family were undertaking a period of Sorry Business following the death of Father. A case note recorded that home visits could not take place that day for cultural reasons.

Throughout the following two months, both Child Safety staff and the Nurse Navigator attempted further home visits. It is unclear from available records whether either agency was aware of the other's engagement attempts, noting that visits were undertaken in relation to different children within the family. There was no evidence of referrals by either agency for cultural advisory support to assist with engagement during this time.

On one occasion, during a visit to the home of an extended family member to see the children, the Nurse Navigator was asked to stop attending the home. The Nurse Navigator continued attempts to engage both in person and by phone. During a telephone conversation, she was advised that Baby was gaining weight and that further involvement was not required during the period of Sorry Business.

Over a two month period (when Baby was approximately 3 and 4 months old), Child Safety attempted six home visits - two in relation to the IPA and four to commence an IA. Mother then moved with her children to another district to live with Grandmother of Baby. Child Safety Service Centre 1 (CSSC1) transferred a casework request to the local Child Safety Service Centre 2 (CSSC2).

Baby was first sighted three days prior to death by a Child Safety Officer (CSO) from CSSC2. Baby was covered with a blanket, appeared lethargic, and was observed to have a significant rash on the wrist. Multiple people were noted to be residing in the two-bedroom residence.

The following day, two CSOs attended the family home and spoke with Mother at the gate. Due to an unchained dog in the yard, the CSOs were unable to enter the property and requested that the mother bring Baby outside. Mother declined, stating that it was too hot and that the child was sleeping. The CSOs advised they would return later that afternoon; however, this did not occur due to competing work priorities.

The day prior to Baby's passing, the attending CSO emailed the Senior Team Leader, advising that Child1 required prompt medical attention, expressing concern that Mother did not have the insight or capacity to seek appropriate care.

Sepsis in children is the biggest single cause of preventable death in childhood in Queensland. The Queensland paediatric sepsis mortality study observed that nearly thirty per cent of sepsis-related deaths occurred in the community, predominately unexpectedly, among infants and younger children without underlying medical conditions known to increase sepsis risk. Most of these deaths were likely preventable with timely sepsis recognition and treatment.[7] A search of the publicly available Child Safety Practice Manual does not identify specific practice guidance on the recognition or management of signs of sepsis or infection.[8]

Cultural practices

Sorry Business

The safety of a child must always be paramount.[9] This case highlights the tension between respecting cultural practices, particularly during periods of grief such as Sorry Business, and ensuring that assessments of a child's safety and wellbeing are undertaken. In the four months between the baby's birth and death, they were assessed only once by a medical professional. While both Child Safety and Health made further attempts to engage these were unsuccessful, in part due to limited involvement of culturally appropriate partners who could have supported practice aligned with the family's cultural needs.

The case of Baby demonstrates that ensuring a child's safety requires not only attempts to visit a family, but engagement that is culturally informed and responsive is also critical. It also underscores the importance of cultural support advisors being available to both Child Safety and Health to assist with family engagement and provide meaningful input into decision-making throughout case management.

Earlier involvement of cultural practice advisors may have supported Child Safety and other agencies to navigate cultural protocols sensitively during Sorry Business. Coordinated cultural support across agencies – through guidance, supporting relationship building, and assisting with assessments – may have strengthened engagement with the family and contributed to a different outcome.

A similar issue was identified in the *2024-25 Child Death Review Board Annual Report*, which recommended that Child Safety strengthen partnerships with local community-controlled organisations, community leaders, and families to improve consistency and understanding of how to monitor and respond to a child's safety during Sorry Business.[10]

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[7] Queensland Family and Child Commission/Queensland Paediatric Sepsis Program, Queensland paediatric sepsis mortality study, https://www.qfcc.qld.gov.au/sites/default/files/2024-03/Paediatric%20Sepsis%20Mortality%20Study.pdf, Feb 2024.

[8] Queensland Government, https://cspm.csyw.qld.gov.au/, 11 Dec 2025.

[9] Child Protection Act 1999 (Qld), Ch 5A https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010#ch.5A

[10] Child Death Review Board, Annual Report 2024-25 (Rec 9), https://www.qfcc.qld.gov.au/sites/default/files/2025-12/report-cdrb-child-death-review-board-annual-report-2024-25.pdf, p 12.

Possible considerations

In light of the findings outlined in this case review, consideration may be given to whether further examination or refinement of previous recommendations relating to interagency coordination and joint risk assessment would be appropriate.

Particular consideration may be given to reflecting on existing recommendations made in recent Annual Reports, including:

- Annual Report 2024–25, 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 intervention towards a stronger, health-led outreach and support approach…*[11]
- Annual Report 2023–24, Recommendation 5: *Queensland Health take action to provide clear guidance that will support Child Safety to better assess the safety of children living with disabilities and/or chronic medical conditions with a specific focus on distinguishing between intentional parental neglect or maltreatment compared to deficits in the health literacy or competency of the parent that should be addressed through health and/or disability support services.*[12] [13]

The cases examined in this report raise questions about whether existing policy and practice settings sufficiently support coordinated, proactive risk assessment for children at critical stages of development, particularly:

- unborn children and infants under one year of age, and
- young people with chronic or complex medical conditions.

Consideration may be given to whether there is scope for more formalised cross-agency approaches to joint risk assessment and safety planning in the perinatal period and early infancy. Matters may include:

- whether earlier joint relationship-building with families during pregnancy could better support assessment, early intervention, and safety planning prior to birth
- whether clearer expectations or mechanisms are needed to support joint safety planning between Child Safety and Health before a child's birth
- how agencies should respond where both Child Safety and Health are unable to establish contact with a family in the days or weeks following a child's birth, including whether timely multiagency discussions should be more explicitly embedded in practice.

Consideration may also be given to the extend to which coordinated joint home visiting and co-located service models could strengthen interagency collaboration and support shared understanding of risk and urgency, particularly in cases involving neglect and unmet health needs. While examples of effective joint practice exist in some locations, these appear to be dependent on local initiative rather than supported through consistent, system-wide policy or procedure.

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[11] Child Death Review Board, Annual Report 2024-25 (Rec 1), https://www.qfcc.qld.gov.au/sites/default/files/2025-12/report-cdrb-child-death-review-board-annual-report-2024-25.pdf, p 9.

[12] Child Death Review Board, Annual Report 2023-24 (Rec 5) https://www.qfcc.qld.gov.au/sites/default/files/2025-02/Child%20Death%20Review%20Board%20Annual%20Report%202023-24.pdf, p 10.

[13] This recommendation remains in progress, with Child Safety and Health collaborating to develop joint practice guidance for assessing the safety and wellbeing of children with disabilities and chronic medical conditions. The Board observed that 'success will depend on the translation of this guidance into everyday practice, consistent uptake…and long-term sustainability….'

Case study two

In the case of Child, 16 years old, although born in Australia, the parents were born in another country and spoke limited English. Child was largely non-verbal.

Known family risk factors included Father's significant alcohol misuse and domestic and family violence perpetrated against Mother. A child protection history in the parents' country of origin was unknown.

The parents were separated. Child lived with Father and siblings; Mother and remaining siblings lived separately and had no contact with Child or Father. Child had medical diagnoses that impacted cognitive functioning and ability. Child also suffered from epilepsy.

Father provided full-time care for Child at home, without access to formal respite. Child displayed aggressive behaviours and had not attended school for an extended period. Although enrolled in a home education program, concerns were raised that it was not effectively accessed.

In the year prior to the Child's death, Child Safety received 16 reports of concern from multiple sources alleging neglect, emotional abuse, and physical abuse while in the Father's care. Concerns that Father was harming Child by restricting food, using physical punishment, social isolation measures, and culturally based remedies that were physically painful for Child were reported. Medical professionals repeatedly advised Child Safety that Child's seizures were not being appropriately treated, and that mismanagement of medication posed a risk of death.

During an approximate six-month period, the concerns continued to raise concerns, resulting in 11 sets of Additional Notified Concerns (four Notifications and seven Child Concern Reports). While a Notification was recorded by Child Safety, commencement of an IA did not occur until approximately six months later and was triggered by Father indicating an intention to relinquish care.

Despite repeated medical advice regarding the risks associated with seizure mismanagement, health risks appeared to be minimised or insufficiently prioritised. Inadequate NDIS supports were noted as the primary concern, rather than Father's behaviours and the impact on the health and safety of Child.

In contrast, NDIS disability support staff considered that Child was subject to medical neglect and potentially emotionally and physically abusive practices used to manage behaviour. They reported that Father disagreed with medical advice, did not recognise the importance of medical appointments or emergency treatment, and continued to double-dose or add medications despite being informed of the associated risks. Support staff indicated that these issues had been repeatedly discussed with Father using interpreters, and expressed concern that managing Father's behaviour and decision-making exceeded the intended scope of the NDIS role.

Child was subsequently placed in a NDIS-supported unlicensed care arrangement. As the placement was unlicensed, it was not subject to the same level of monitoring and oversight as licenced placements.

The IA was finalised approximately two and a half months before the Child died, with an outcome of Substantiated – Child in need of protection. Child Safety commenced an Intervention with Parental Agreement (IPA) and Child remained in the custody of the department under a Child Protection Care Agreement until the time of death. An application for a Child Protection Order granting Long-Term Guardianship to the Chief Executive was being prepared in the days prior to the death of Child. While placed in the NDIS-supported arrangement, Child was subject to only one prescribed Child Safety visit. During the final year of life, Child had not been able to access appropriate medical intervention.

Information on epilepsy is included within the CSPM with other forms of disability (intellectual disability, autism spectrum disorder, foetal alcohol spectrum disorder and attention deficit hyperactivity disorder).[14] [15] The guidance provides information on diagnosis, treatment, medication management and first aid, and the importance of an Epilepsy Management Plan. The advice notes the need for the correct dose at the same time each day to keep symptoms controlled and the importance of regular medication reviews.

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[14] Queensland Government, https://cspm.csyw.qld.gov.au/practice-kits/disability/overview-of-disability/types-of-disabilities, 21 March 2022.

[15] Queensland Government, https://cspm.csyw.qld.gov.au/practice-kits/disability/overview-of-disability/identifying-and-understanding-common-disabilities, 19 Dec 2025.

Cultural practices

Traditional medicine

In the case of Child, a significant tension emerged in how child protection concerns were understood and responded to, particularly in relation to the respective roles of Child Safety and the supports provided through the NDIS. A central issue was whether the identified risks arose primarily from limitations in Father's access to appropriate support, or from Father's beliefs, behaviours, and decisions in relation to the care of the child.

Father held specific beliefs regarding the treatment of the child's epilepsy, including the use of traditional practices alongside prescribed pharmaceutical treatment which the father either altered or did not adhere to correctly. According to reports from the NDIS provider, Father was unwilling to reconsider or modify this approach, despite ongoing concerns raised by medical and disability professionals.

In this context, it is important to consider the cumulative harm and distress Child was likely to have experienced, particularly given the inadequate medical management of Child's epilepsy and exposure to other emotionally and physically abusive behaviours. The interaction between these factors heightened Child's vulnerability and compounded existing health risks.

Culturally informed support may have assisted agencies to better understand and respond to Father's cultural beliefs while prioritising the health and safety needs of Child. However, access to appropriate cultural support for this specific cultural group was limited, with a scarcity of interpreters available to facilitate meaningful engagement with the family.

Possible considerations

Cross-portfolio accountability and lead agency responsibility

Consideration may be given to whether further reflection or refinement of previous recommendations relating to cross-portfolio accountability and information-sharing would be appropriate. In particular, it may be considered necessary to revisit Recommendation 7, Annual Report 2024-25:

- 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.[16]

The cases examined in this report raise questions about whether current arrangements sufficiently clarify responsibility for oversight and coordination when multiple agencies are involved in a child's life – particularly where Child Safety is not the agency with the most frequent contact or the most relevant expertise.

In this context, consideration may be given to whether:

- clearer mechanisms are required to formally designate a lead agency responsible for oversight and coordination of a child's care and protection needs, based on the child's risks and the agency best placed to respond;
- existing leadership, governance and accountability arrangements across agencies adequately support timely, coordinated and effective interagency responses; and
- there is scope to further explore delegated authority or shared-leadership models, in addition to existing arrangements, to ensure responsibility for responding to child protection concerns is actively held across the system rather than assumed to rest solely with Child Safety.

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[16] Child Death Review Board, Annual Report 2024-25 (Rec 7), https://www.qfcc.qld.gov.au/sites/default/files/2025-12/report-cdrb-child-death-review-board-annual-report-2024-25.pdf, p 11.

Case study three

In the case of Child, aged 17 years, the family had an extensive child protection history, including concerns relating to neglect, physical harm, domestic and family violence and problematic substance use. The parents had separated, and Mother had re-partnered. Father lived nearby but died just prior to the death of Child. English was not the primary language spoken in the home.

Child had a complex medical history with multiple disabilities affecting speech, language, sensory and cognitive functioning. Child was frequently hospitalised following presentations to the Emergency Department due to unmanaged diabetes compounded by a needle phobia that resulted in not self-administering insulin. Both biological parents had histories of neglect in relation to their own diabetes management, and Mother had expressed scepticism regarding the validity of Child's diagnosis. There were multiple missed diabetic outpatient appointments.

Due to feeling unsafe in the family home with Mother and Stepfather, Child experienced periods of homelessness and sleeping rough. Child was often found out of home late at night and had repeated contact with police and community youth justice services, oftentimes related to volatile substance use (VSU). Child had not been engaged in school for over five years.

There was a history of multiple hospital presentations due to mental health concerns. Child was engaged with alcohol and drug counselling following a presentation to hospital unconscious, and remained engaged with the service for approximately two years until the time of death.

Multiple agencies were aware of these concerns and the case was discussed monthly through a multiagency collaborative forum. A child protection notification with a five-day response timeframe was recorded during this time, followed by nine additional notified concerns over the subsequent 18 months. Despite this, an IA was not commenced and was later finalised approximately six months prior to the child's death with a 'no IA outcome' under the Child Safety Extended Review and Completion Strategy. The rationale recorded was that the original concerns were historical and no new or significant information had been reported.

Health raised concerns with Child Safety on multiple occasions, with medical neglect (relating to diabetes), unmanaged VSU, homelessness, and safety and supervision all noted as concerns. As a result, Child Safety had a clearly articulated record of the potentially fatal consequences of poorly managed diabetes including death, coma, and serious lifelong health complications.

In the 12 months prior to death, on at least seven occasions, Child was transported by either police or ambulance to the Emergency Department under involuntary arrangements. Two harm reports were submitted to Child Safety, with additional hospital presentations identified following requests for information. There was minimal evidence that Child independently sought medical assistance for diabetes, and no indication that either parent sought care on the child's behalf.

Although multiple agencies attempted to engage Child, interagency coordination was inconsistent. Several agencies were unaware of each other's concurrent involvement, resulting in fragmented responses. There were multiple missed opportunities—particularly by police and youth justice—to report concerns to Child Safety or refer Child to additional supports.

There was a period of several months preceding Child's death where coordinated care team meetings were either cancelled, or where the child's key support personnel were not in attendance. There were also meetings where relevant agency information was unavailable, or where core agencies were unrepresented. This further limited opportunities for coordinated planning.

After not checking blood glucose levels or taking insulin for several months and collapsing, Child was admitted to hospital for three days. A harm report was submitted to Child Safety with the concerns finalised as a Child Concern Report (CCR). Child presented, or was admitted to hospital on a further five occasions prior to death. None of these presentations resulted in reports to Child Safety.

Child's NDIS package was confirmed at the multiagency collaborative meeting approximately 10 days prior to death. Plans were in place for follow-up regarding diabetes management involving the local Aboriginal Community Controlled Health Organisation; however, several meetings had been missed.

The CPSM does not identify specific practice guidance on the management of chronic health conditions such as diabetes.[17]

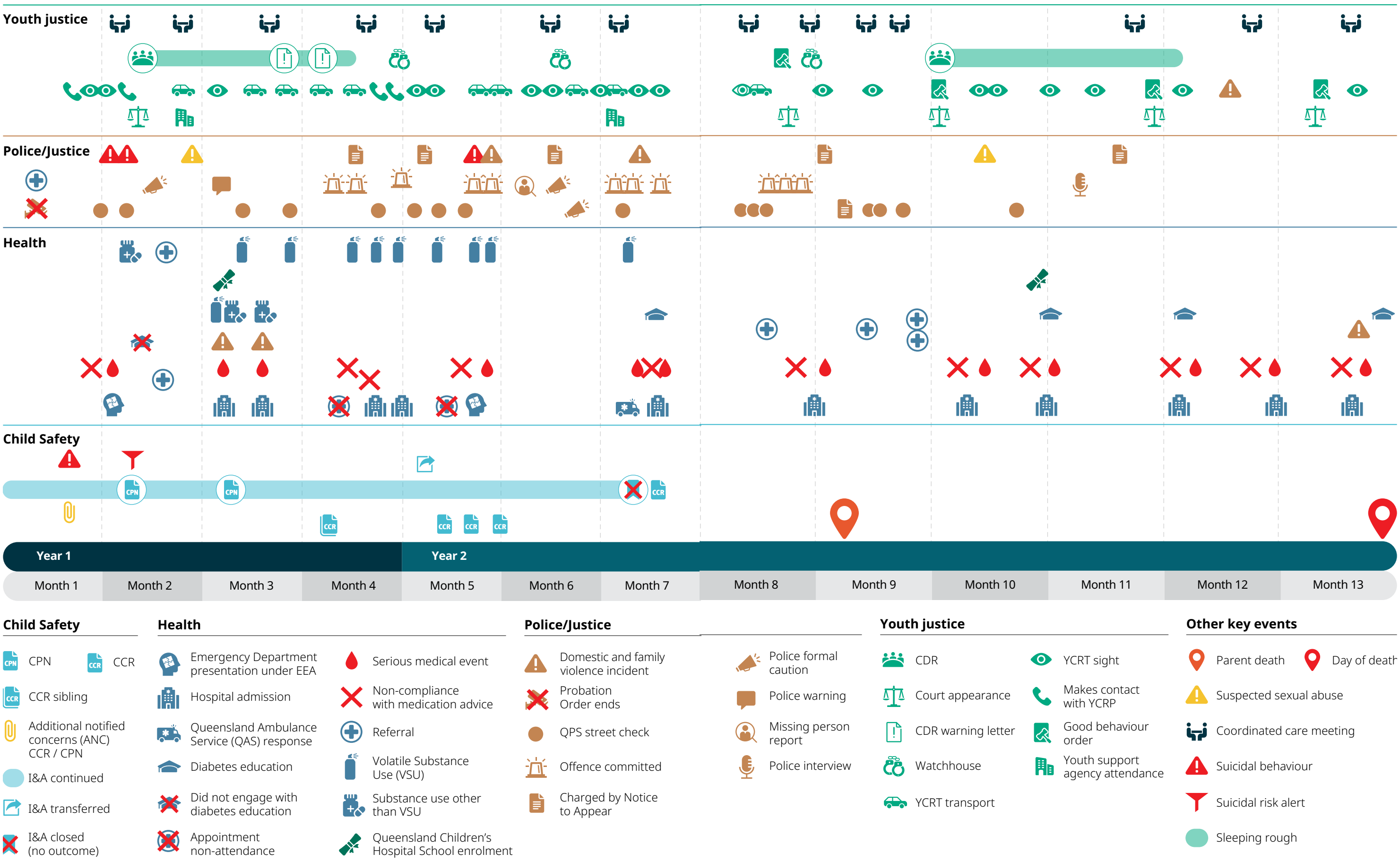
Other health beliefs

The case of Child highlights the importance of relevant agencies working together, at the right time, to identify and respond to medical risk. More proactive, coordinated engagement may have provided deeper insight into how the child's diabetes diagnosis was understood within the family, including whether this understanding influenced the child's needle phobia and other avoidant behaviours.

Both parents were known to have poorly controlled diabetes, and exploring their beliefs about managing the condition may have assisted in understanding their responses to their child's diagnosis. This was particularly relevant given the mother's expressed scepticism about the validity of her child's diagnosis.

While acknowledging the multiple compounding factors that contributed to the vulnerability of Child – including intellectual disability, problematic substance use, and experiences of neglect and physical abuse – engaging the parents to discuss their viewpoints may have supported a clearer understanding of the parents' own experiences and beliefs about diabetes, and if further intervention was required to convey the seriousness of the child's condition.

Figure: Case timeline of system touchpoints



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[17] Queensland Government, https://cspm.csyw.qld.gov.au/, 11 Dec 2025.

Case study four

Unlike other cases examined in this report, Child, 8 months, did not have an underlying diagnosed medical condition; both the child and twin sibling were however born prematurely at 35 weeks.

Father was incarcerated at the time of the birth and death of Child. Mother experienced multiple and complex challenges, including methamphetamine use, untreated mental health issues, poverty, and limited family and social supports. She had an extensive history of polysubstance use.

Siblings of Child had previously experienced harm secondary to neglect due to the Mother's substance use. One sibling had been hospitalised as an infant due to inadequate feeding, and there were further incidents recorded of significant neglect which resulted in Child Safety commencing an IPA. This was later closed after Mother withdrew her consent.

Prior to the birth of the twins, Health raised concerns with Child Safety regarding Mother's lack of antenatal care, problematic substance use, untreated mental health issues, and history of suicide attempts. These concerns were recorded as a Child Concern Report (CCR), and Mother was referred to Family and Child Connect (FaCC); however, she did not consent to support.

Following the birth of the twins, while they remained in the hospital special care unit, multiple concerns were reported to Child Safety. In addition to concerns regarding Mother's mental health, her attachment to the twins and her ability to meet their basic care needs, behaviours suggestive of drug use were also observed by staff. Three sets of concerns were recorded as CCRs, and Mother was referred to an Intensive Family Support (IFS) service. Mother subsequently engaged in approximately 20 face-to-face visits with IFS over the following months. There is no evidence that the twins received support from any health services in the immediate period after they were discharged from hospital.

When the twins were approximately two months old, IFS supported their enrolment in daycare and assisted Mother with transport to immunisation appointments. Both daycare and IFS later reported concerns regarding the Mother's ability to provide the children's basic care needs, including inadequate feeding, hygiene and clothing, with the twins observed to have severe nappy rash with bleeding. Concerns were also raised about ongoing maternal drug use, with IFS unable to engage Mother in alcohol and other drug services. These concerns were recorded by Child Safety as a Notification with a five-day response timeframe.

Shortly thereafter, the Mother disengaged from IFS and the twins stopped attending daycare. This resulted in the reduced visibility of the children to external services. There was a two-month delay before the IA commenced, during which time the family received no coordinated support to address their complex needs. During the IA, the child was sighted by Child Safety on one occasion.

Approximately eleven weeks prior to the death of Child, IFS met with Child Safety and advised that it would be closing its involvement due to the Mother's non-engagement. IFS reported continued concerns regarding the safety of both children, noting the Mother's regular drug use and its impact on her mental health, finances, and capacity to meet the children's care needs. A medical follow-up for both infants was recommended.

In the two weeks prior to the death of Child, while under an IPA, Child Safety attempted two home visits. Child was not sighted on either occasion.

Four days before the death of Child, Child Safety Officers, at Mother's request, attended the home of Mother's neighbour to sight the twins. During this visit, Mother consented to drug screening. Child Safety observed Child to be distressed, with significant nappy rash affecting the genital and buttock area. The twin was observed to have nappy rash that was even more severe.

Mother later found Child deceased. The twin was transported to hospital, and was observed to have features consistent with significant neglect, with bruising and abrasions also observed. It was later determined that Child died from severe acute dehydration and acute malnutrition after receiving little or no fluid or oral intake during a three-day period in which the mother engaged in substance use with a new partner.

Parental drug use

The case of Child highlights the critical importance of practitioners being acutely aware of alcohol and other drug use as a significant contributor to parental neglect of infants. The Board has previously made recommendations on two occasions calling for Child Safety to strengthen its response to parental substance use, including methamphetamine use, through improved practice guidance to support frontline risk assessment where substance use is a concern.[18] [19]

In response, Child Safety appointed a Practice Leader within the Office of the Chief Practitioner to provide statewide consultation, mentoring, and training, and to lead the development and implementation of the Alcohol and Other Drugs Practice Strategy. The Strategy is intended to strengthen practitioner capability to identify, assess, and respond to risks arising from parental substance use. Child Safety has also continued to work with Health to better align child protection practice with specialist health responses.

In the *2024–25 Child Death Review Board Annual Report*, the Board acknowledged tangible progress towards the intent of this recommendation, while noting that evidence of practical application, consistent uptake, and measurable impact is still required before the recommendation can be considered complete.[20]

Decision-making under system pressure

Individual agency reviews focus on the chronology of events leading up to a child's death and on agency processes, actions, or inaction. What is often absent is meaningful analysis of the key decision-making moments at which a different course of action may have altered the trajectory for the child and/or family.

The impact of workload pressures is not a new theme in child death reviews. The Board has previously addressed workforce shortages, including through recommendations in the *2021–22 Child Death Review Board Annual Report*.[21] Less visible, however, are the unconscious cognitive and behavioural processes that can arise from sustained workload pressure and other system stressors, and the way these processes influence professional judgement and decision-making.

This is not a new concept. Observations that social work professionals may feel overwhelmed in the period preceding a child's death were identified as early as the 2003 Victoria Climbié Inquiry led by Lord Laming. When professionals experience prolonged stress or feel overwhelmed, thinking and behavioural patterns may be affected, increasing the likelihood that critical information is overlooked as a coping response to feelings of helplessness.[22] Other impacts may include difficulty forming and maintaining effective relationships with children and families, anxiety affecting professional confidence, and the cumulative effects of organisational change and instability.

These dynamics appear relevant across the cases examined in this report:

- In the first case, questions arise as to what factors may have inhibited more urgent or decisive action after health concerns were identified and doubts expressed about the mother's capacity to respond.
- In the third case, despite escalating emergency department presentations in the period leading up to death, reports to Child Safety ceased. This raises questions about whether repeated reporting without observable outcomes may have influenced subsequent decision-making.
- Similarly, in the second and fourth cases, multiple concerns were reported by health and other services, yet risk escalation remained limited.

Recognising and examining these 'human factors' – including unconscious responses to system pressure – is essential to understanding how and why decisions are made in complex environments. Honest consideration of these factors is critical if child death reviews are to move beyond procedural analysis and support meaningful system learning and improvement.

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[18] Child Death Review Board, Annual Report 2022-23 (Rec 5) https://www.qfcc.qld.gov.au/sites/default/files/2024-08/Child%20Death%20Review%20Board%20Annual%20Report%202022-2023.pdf, p 13.

[19] Child Death Review Board, Annual Report 2023-24 (Rec 9) https://www.qfcc.qld.gov.au/sites/default/files/2025-02/Child%20Death%20Review%20Board%20Annual%20Report%202023-24.pdf, p 11.

[20] Child Death Review Board, Annual Report 2024-25, https://www.qfcc.qld.gov.au/sites/default/files/2025-12/report-cdrb-child-death-review-board-annual-report-2024-25.pdf, pp 143-144

[21] Child Death Review Board, Annual Report 2021-22 (Recs 1,2), https://www.qfcc.qld.gov.au/sites/default/files/2024-08/Child%20Death%20Review%20Board%20Annual%20Report%202021-2022.pdf, p 25

[22] Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A., and Sorensen, P. (2016). Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 - 2014. Final. University of East Anglia and University of Warwick: Department of Education, p 243- 245.

Possible considerations

Depth and quality of individual agency reviews

Consideration may be given to how existing mechanisms, including the Cross-Agency Review Group, are being used to provide feedback to agencies regarding the depth and quality of individual agency case reviews submitted for child death reviews.

In this context, consideration may wish to be given to whether feedback provided through the Cross-Agency Review Group sufficiently supports agencies to move beyond procedural or chronological reporting, toward more meaningful analysis of service delivery and decision-making. While current reviews often outline timelines and compliance with processes, they frequently provide limited insight into the contextual and human factors influencing actions or inaction at critical points.

Consideration may be given to whether clearer expectations could be articulated – through existing feedback mechanisms – about the inclusion of qualitative information in agency reviews, such as:

- professional judgement and reasoning at key decision points;
- the quality of relationships with children, families, and partner agencies; and
- organisational or operational influences, including workforce pressures, policy or practice changes, and structural reorganisation.

Strengthening the use of existing feedback mechanisms in this way may provide deeper insight into system conditions affecting practice and to identify opportunities for meaningful system improvement, without introducing additional reporting requirements.

Conclusion

The key themes identified within this review were based on system issues that fit more within the scope of tertiary child protection than early intervention. Exploring the broader social influences like poverty which align with an ecological systems theory framework and other micro, meso, exo and macro system[23] influences described above may provide a more comprehensive understanding of factors that, in the long term, may have contributed or led to the outcomes for the children noted in this report.

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[23] Bronfenbrenner, U. "2. (1979). Basic Concepts". The Ecology of Human Development: Experiments by Nature and Design, Cambridge, MA and London, England: Harvard University Press, pp. 16-42. https://doi-org.libraryproxy.griffith.edu.au/10.4159/9780674028845-004

The Board is preparing to highlight these issues in its next annual report.

If you have thoughts to contribute, please contact cdrb@qfcc.qld.gov.au