Child Death Review Board

Queensland **Family & Child** Commission

Timeliness and Permanency

in transfer of parental responsibility

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.

> *Child Safety has a responsibility to protect a child, if the child does not have a parent able and willing to protect them from significant harm.*
>
> - Child Safety Practice Manual

Introduction

This summary report explores systemic challenges in achieving timely and permanent arrangements for children when parental responsibility is transferred from parents to the Chief Executive of the department responsible for Child Safety under the *Child Protection Act 1999* (Qld) (CP Act). These transfers occur when a child is in need of protection and has no parent both able and willing to protect them from significant harm, prompting the Childrens Court to allocate custody or guardianship to the State or another suitable guardian.

The analysis in this report focuses on delays in case planning, reliance on interim orders, and variability in permanency planning and decision making. It draws upon four case examples previously considered by the Child Death Review Board (the Board), where parental capacity was absent and litigation functions were carried out by the Office of the Director of Child Protection Litigation. Its data indicates a 15.5 per cent year-on-year increase in referred matters in 2024–25 (4,126 matters), signalling rising demand and sustained pressure on child protection and litigation systems.[1]

Complementing the Board's review *Overestimating parental willingness in light of ability*, this report examines the opposite end of the spectrum, where parents are assessed as not willing and able to care for the child or children. Across the four cases reviewed, parents were assessed as not able and willing to protect their children due to the impact of factors such as domestic and family violence, mental ill health, intellectual disability, and substance use. Each case illustrates how systemic factors, including workload pressures, cross-agency coordination, and external disruptions (including public health crises such as COVID-19) affect the progression from interim safety to permanent stability for vulnerable children.

Cultural planning and child participation are critical requirements under the CP Act; however, these were only applicable in a limited number of cases reviewed. While not the primary focus of this report, they are addressed where relevant. This report does not revisit early intervention strategies, instead, it considers what happens after those measures fail and the State assumes responsibility for a child's care, with a particular focus on systemic factors that influence timeliness and permanency outcomes.

1 The State of Queensland (Office of the Director of Child Protection Litigation) annual report 2024-2025, p 36.

Legal and policy context

Legislative framework

In instances where the State assumes parental responsibility for a child, it does so under a legislative and policy framework designed to protect children and uphold their rights. The CP Act establishes the principles, thresholds and decision-making processes governing state intervention, which are operationalised in practice through the Child Safety Practice Manual.

The CP Act is grounded in the paramount principle that the safety, wellbeing, and best interests of the child must guide all decisions.[2] This principle applies not only in the immediate sense of keeping a child safe from harm, but also in planning for their long-term stability, development and sense of belonging. While families are expected to provide care and protection, the State is required to intervene when no parent is both able and willing to protect the child from significant harm.[3] This threshold of "able and willing" is critical. It marks the point where the system moves from supporting families to assuming responsibility for a child's care.

Permanency principles and long-term planning

The CP Act embeds permanency principles to minimise uncertainty and promote stability, ensuring stable care arrangements for children.[4] Permanency is not limited to physical placement, it encompasses secure relationships, continuity of care, maintained connections, identity and belonging. The legislative framework requires decision-making to progress children toward timely long-term solutions, such as reunification, kinship care, guardianship or permanent care, rather than prolonged reliance on interim or short-term orders.

The Child Safety Practice Manual supports this framework by outlining expectations for permanency planning, concurrent planning and evidence preparation.[5] Together the CP Act and the Child Safety Practice Manual are intended to ensure that children do not remain in temporary arrangements longer than necessary and that permanency decisions are actively progressed once reunification is no longer viable within a timeframe suitable to the child's needs.

Orders and litigation architecture

Under section 61 of the CP Act, the Childrens Court may make a range of child protection orders including:

- Directive orders (requiring parents to take or refrain from specific actions)
- Supervision orders (allowing a child to remain at home under departmental oversight)
- Custody orders (to a family member or the Chief Executive)
- Short-term guardianship (to the Chief Executive)
- Transition orders (to support reunification)
- Long-term guardianship (to a suitable person or the Chief Executive)
- Permanent care orders (to a suitable person, not the Chief Executive).

Prior to the determination of a child protection order application, interim emergent orders (such as Temporary Assessment Orders, Court Assessment Orders and Temporary Custody Orders), may be made to secure a child's immediate safety while assessment or proceedings are underway.

These interim orders are sought and managed by Child Safety, with legal support and representation from the Office of the Child and Family Official Solicitor. They operate within an early protective and investigative phase of the system, designed to stabilise risk while longer-term decisions are considered.

2 Child Protection Act 1999 (Qld) s 5A
3 Child Protection Act 1999 (Qld) s 5B(d)
4 Child Protection Act 1999 (Qld) s 5BA
5 https://cspm.csyw.qld.gov.au/practice-kits/permanency-1/concurrent-case-planning/seeing-and-understanding/concurrent-planning

The Director of Child Protection Litigation (DCPL)[6] becomes involved where an application for a child protection order is required. Acting on referral from the Chief Executive of Child Safety, DCPL determines whether to apply for orders and conducts litigation in the Childrens Court. This independent litigation function is intended to provide an additional safeguard, ensuring that applications are evidence based and aligned with legislative principles.

Under section 67 of CP Act, the Childrens Court may make interim orders on adjournment, including granting temporary custody to the Chief Executive or a suitable family member, to ensure the child's ongoing safety during proceedings. Where an application for a child protection order is filed before an interim order expires, section 99 of the CP Act provides that an existing order continues until the application is decided, unless the court orders otherwise. These provisions are intended to maintain continuity of protection throughout litigation and minimise disruption for children while matters remain before the court.

Safeguards: Aboriginal and Torres Strait Islander Child Placement Principle and child participation

Under section 5C of the CP Act, additional principles apply for Aboriginal and Torres Strait Islander children. These include the right of Aboriginal and Torres Strait Islander peoples to self-determination, and consideration of the long-term effect of decisions on a child's identity and connection with family and community.[7] Central to these safeguards is the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP), which comprises five interrelated elements: prevention; partnership; placement; participation; and, connection.[8] The ATSICPP, embedded in legislation and operationalised through the Child Safety Practice Manual, requires early cultural consultation, active family involvement, and sustained efforts to maintain cultural identity and community ties. These processes ensure decisions are culturally safe and uphold the rights of Aboriginal and Torres Strait Islander children.

Child participation is a statutory requirement under section 5E of the CP Act. Children must be given meaningful, age appropriate and ongoing opportunities to express their views and have those views considered in planning and court processes that affect their lives. Participation is not discretionary or optional; it is a statutory requirement and a basis of best-practice decision-making within the child protection system.

> *"...children who experience one or two placements prior to permanency generally fare better than those subject to multiple placement changes which is associated with an increased behavioural risk."*
>
> - Australian Institute of Health and Welfare

6 An independent statutory office established under the Director of Child Protection Litigation Act 2016 (Qld).
7 An independent statutory office established under the Director of Child Protection Litigation Act 2016 (Qld).
8 Child Protection Act 1999 (Qld) s 5C(s)(a)-(e).

Evidence base and comparative context

Literature review

Australian and international research consistently demonstrates that timely permanency is critical for children's safety, wellbeing and long-term development once they enter out-of-home care. The Australian Institute of Health and Welfare (AIHW) data indicates that 76 per cent of children achieve permanency within two years of entering care, while 24 per cent remain beyond that timeframe. The AIHW indicates that extended stays in temporary or unstable arrangements are associated with poorer mental health outcomes, educational disruptions, and increased behavioural issues.[9]

National monitoring frameworks, including the AIHW Permanency Outcomes Performance Framework, track indicators such as *time to permanency determination and placement stability.* Placement stability is consistently identified as a key predictor of positive outcomes, with AIHW data indicating children who experience one or two placements prior to permanency generally fare better than those subject to multiple placement changes which is associated with an increased behavioural risk.[10]

The Australian Institute of Family Studies similarly reports that delays between substantiation and final permanency orders correlate with negative outcomes for children. These delays are often attributed to systemic factors, such as high caseloads, evidentiary complexity and the absence of concurrent planning.[11]

Attachment theory, which underpins Queensland's Child Safety Practice Manual and permanency planning framework, provides a developmental lens for understanding these findings and emphasises that early caregiving experiences shape a child's internal working model of relationships, including expectations of trust, safety and self-worth.[12] Secure attachment develops through consistent, responsive and nurturing caregiving, supporting resilience, emotional regulation and positive social and educational outcomes. In contrast, caregiving that is inconsistent can lead to insecure or disorganised attachment patterns, increasing the risk of emotional and behavioural difficulties. Children subject to statutory intervention, many of whom have experienced maltreatment, loss, and repeated disruption, are particularly vulnerable to attachment disturbances, reinforcing the importance of timely permanency and stable caregiving arrangements.

Emerging Australian research further emphasises the concept of relational permanency: Corrales et al. (2025) propose a model that prioritises enduring relationships and a sense of belonging, including in non-family-based care settings such as therapeutic residential care.[13] This approach aligns with the principles of ATSICPP, reinforcing that permanency extends beyond legal orders and is a development necessity that encompasses relational, cultural and identity continuity.

> *"Children subject to statutory intervention, many of whom have experienced maltreatment, loss, and repeated disruption, are particularly vulnerable to attachment disturbances, reinforcing the importance of timely permanency and stable caregiving arrangements."*

9 Australian Institute of Health and Welfare (AIHW). Permanency outcomes for children in out-of-home care: indicators.
10 Australian Institute of Health and Welfare (AIHW). Permanency outcomes for children in out-of-home care: indicators. Canberra: AIHW; 2023.
11 Australian Institute of Family Studies (AIFS). Timely decision making and outcomes for children in out-of-home care: A quick scoping review. Canberra: AIFS; 2019
12 https://cspm.csyw.qld.gov.au/practice-kits/permanency-1/working-with-children/seeing-and-understanding/what-is-attachment
13 Corrales, T., McNamara, P., Smith, B., Bath, H., Clark, E., Goodchild, K.-L., Grabda, S., Harrison, M., & McGrady, B. (2025). "They just want people in their lives that will be there forever": A conceptual model of permanency for children and young people in therapeutic residential care. Children and Youth Services Review, 172, 108211. https://doi.org/10.1016/j.childyouth.2025.108211

Jurisdictional comparison

Queensland's permanency framework, embedded in the CP Act, is grounded in permanency principles under section 5BA but relies primarily on principle-based guidance rather than mandatory timeframes. The Child Safety Practice Manual provides practice direction, including expectations around case planning and permanency decision-making, however does not prescribe binding timelines for progression from interim to final orders. By contrast, other jurisdictions adopt more prescriptive approaches for permanency planning.

New South Wales	Amendments to the *Children and Young Persons (Care and Protection) Act 1998* via the Permanency Planning amendments in 2001, introduced explicit permanency planning obligations requiring authorities to ensure that children are provided long-term safe, nurturing, stable and secure environments through permanent placement.[14] The legislative framework emphasises timely permanency decision making, with heightened urgency for younger children, and supports concurrent planning to reduce delay.
Victoria	Formalises permanency objectives through the *Children, Youth and Families Act 2005*, section 167. Case plans must specify a permanency goal, such as family reunification, adoption, permanent care or long-term out-of-home care and define clear timelines. Reunification is prioritised within 12 months, with alternative permanency options required to be actively considered if reunification is unlikely by 24 months. These requirements are reinforced through the Roadmap for Reform: Strong Families, Safe Children also emphasises early decision-making, concurrent planning, and transparent performance reporting.[15]

These comparative frameworks illustrate how mandated timeframes, structured concurrent planning and publicly reported performance indicators can reduce variability in permanency outcomes. In contrast, Queensland's principle-based approach, without statutory deadlines, may permit extended reliance on interim orders where progression to permanency is not actively driven.

Data and performance insights

Whilst Queensland reports child protection outcomes through national performance, publicly available data specific to permanency timeliness remain limited. AIHW data show that across Australia, the median time from entry into care to achieving a permanent arrangement (such as long-term guardianship or adoption) frequently exceeds two years, with significant variation between jurisdictions.[16]

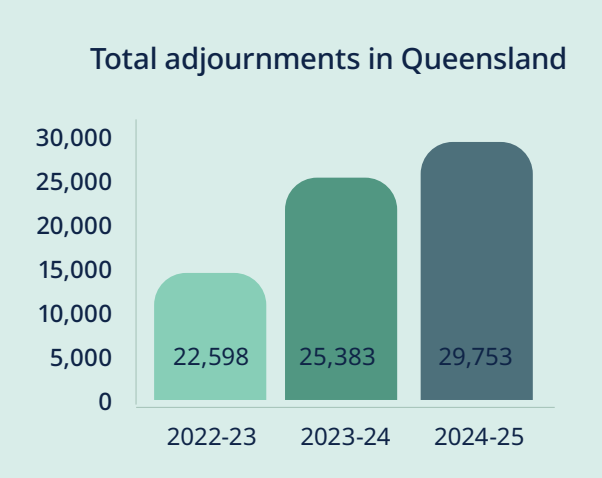
Recent data from the Office of the DCPL provides additional insight into system performance once matters progress to litigation. The most recent annual report indicates an increase in both elapsed time and procedural activity across child protection matters, with the average time from lodgement to determination in 2024–25 increasing to 357.1 days up from 312.9 days in the previous year.

Average increase of 44.2 days =

almost 1 year

Total adjournments for the year increased to 29,753 across the state from 25,383 in the previous year, with the reason for most attributed to Family Group Meetings (43.%) and service of documents (31.6%) and an average increase in the number of court events rising to 9.4 compared with 8.7 previously.[17]

The data highlighted the continued use of Court Assessment Orders involved in 30.5 per cent of matters, and Temporary Care Orders involved in 30.1 per cent of matters referred to DCPL in 2024–25.[18] While these interim orders are designed to ensure immediate safety, extended reliance on interim mechanisms may contribute to prolonged uncertainty for children where progression to permanency is not actively driven.



14 Children and Young Persons (Care and Protection) Act 1998. S 8 (a1)
15 https://www.dffh.vic.gov.au/publications/roadmap-reform-strong-families-safe-children
16 Australian Institute of Health and Welfare (AIHW). Permanency outcomes for children in out-of-home care: indicators. Canberra: AIHW; 2023.
17 The State of Queensland (Office of the Director of Child Protection Litigation) annual report 2024-2025 p 121, 126.
18 The State of Queensland (Office of the Director of Child Protection Litigation) annual report 2024-2025 p 19.

Case summaries

Case study one

Child1 was an infant, born several weeks premature with serious medical complications. Shortly before their death, Child1 was diagnosed with a life-limiting disorder. The child required intensive hospital care, nasogastric feeding, and an NDIS package for ongoing support throughout their life. Child1 was completely reliant on a caregiver for proactive daily care needs.

From birth, Child1 was subject to a Temporary Custody Order due to child protection concerns with both parents. Concerns included: chronic domestic and family violence perpetrated by Father, Mother's unmanaged mental health (and subject to an Involuntary Treatment Order), and both parents' polysubstance use. Child Safety assessments determined both parents to be neither able or willing to protect Child1 or meet their complex medical and daily care needs.

Child1 was placed in general foster care with carers who also cared for the child's older sibling, maintaining sibling connection. Kinship care was explored but was not viable due to the child's complex medical needs. A cultural support plan was later developed, and the carers engaged with family to maintain cultural connections. Both parents participated in a Family Group Meeting and a court-ordered conference during proceedings.

Key legal milestones:

Month 1:	Temporary Custody Order granted expiring 2 days later.
Month 1:	Matter referred to DCPL; allocated to Office of the DCPL lawyers.
Month 1:	Application filed for a Child Protection Order granting short-term custody to the Chief Executive for two years and Child1 was placed; initial affidavit lodged.
Month 1:	First mention; matter adjourned for appointment of separate representative, psychiatric assessment, social assessment report, and family group meeting.
Month 6:	Proceedings joined with sibling's matter under s115 CP Act; additional affidavits filed updating casework, placement, and medical needs.
Month 10:	Final order made for two-year short-term custody to the Chief Executive.

Possible considerations

The absence of transparent, routinely reported metrics for key permanency milestones, such as completion of case plans, readiness of cultural plans where applicable, and progression from interim to final orders, limits the system's capacity to monitor performance or identify systemic bottlenecks. Establishing clear indicators and reporting mechanisms would enable accountability and support continuous improvement.

Potential measures include:

- Average time from first interim order to final permanency order.
- Percentage of cases achieving permanency within 12 and 24 months.
- Timeliness of cultural planning and independent person processes (where applicable).

Embedding these metrics into routine reporting would provide the Board and other key stakeholders with a data-driven basis for assessing whether permanency principles are translating into timely and stable outcomes for children.

Case study two

Child2 was born with medical complications, requiring extended hospitalisation and support. The child was discharged into kinship care with Grandmother under a Temporary Custody Order.

Child2 was the youngest of several siblings who were already living in care arrangements with relatives under family agreements (later formalised through kinship approvals). The siblings had repeatedly been left with family prior to their removal without any provisions and without any indication of when parents would return.

Child2's parents presented significant child protection concerns, including domestic and family violence, methamphetamine and cannabis use, homelessness/ housing instability, lack of child supervision, and neglect. Child Safety determined Child2's parents were neither willing or able to protect or care for Child2, given the ongoing safety concerns identified. Although Child2 had not been in their parents' care since birth, exposure to domestic violence in utero was recorded as a concern.

Key legal milestones:

Month 1:	Temporary Assessment Order granted.
Month 2:	Court Assessment Order granted; custody to Child Safety continued under s 99 CP Act when the application was filed.
Month 2:	Application filed for a Child Protection Order granting short-term custody to the Chief Executive (two year duration sought).
Months 3 – 10:	Eight mentions / adjournments tied to Family Group Meeting scheduling, initial case plan development, and filing/service. Custody continued under s 99/s 67(1)(a)(ii) CP Act during adjournments.
Month 11:	Application withdrawn following Child2's death.

Kinship care with Grandmother provided day-to-day stability.

During the proceeding, Father appeared intermittently via audio visual link while incarcerated, then became uncontactable post release; Mother did not appear and remained transient.

Case study three

Child3 was a teenager experiencing cumulative effects of harm across childhood. Child3 was the subject child in 36 Child Concern Reports and nine Notifications. They experienced prolonged exposure to domestic and family violence and experienced periods of homelessness, parental substance use, and long-term educational disengagement. During primary school, Child3 was diagnosed with Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and Reactive Attachment Disorder, alongside mild intellectual impairment and communication difficulties.

Mother passed away at Child3's age 10. Father, who was his primary carer, passed away several years later. Child3 reportedly discovered each parent's body.

Following Father's death, Child Safety commenced an Investigation and Assessment and entered into an immediate safety plan with a family friend. Child Safety determined there was no parent willing or able to protect Child3, as both parents were deceased. Child3 was made subject to an Emergency Examination Authority due to suicidality; after discharge, the teenager stayed with various family members until a court order was made. Extended family and kin were assessed; none were willing or able to assume parental responsibility given Child3's complex needs. Child3 subsequently entered residential care.

Key legal milestones:

Month 1:	Court Assessment Order made; custody to the Chief Executive; medical examination/treatment permitted.
Month 2:	Office of the DCPL referral received; Form A and brief provided in accordance with DCPL Guidelines for emergent orders.
Month 2:	Application filed for long-term guardianship to the Chief Executive; DCPL advised the initial affidavit could be sworn/affirmed as drafted.
Month 2:	Child Safety advised the affidavit had been affirmed and uploaded; Office of the DCPL filed and matter listed.
Month 3:	First mention; adjourned for Family Group Meeting, case plan, and exploration of kinship options.
Month 5:	Updating affidavit filed (case plan exhibited; health/NDIS information; family/kin updates; views and wishes).
Month 5:	Final order made for long-term guardianship to the Chief Executive until age 18.

Child3's views were recorded throughout proceedings. The child stated repeatedly that they did not want care involvement and declined a referral to the Office of the Public Guardian, with this refusal documented in submissions.

Post-order, Child3's engagement with education and therapeutic services remained limited; declined referrals and engagement with Child and Youth Mental Health Service and Evolve. The child passed away at 14 years. Methylamphetamine intoxication was noted on autopsy.

Case study four

Child4 was born with a congenital heart condition requiring surgery and ongoing cardiac monitoring. The child was the youngest of two children. The parents presented considerable child protection concerns, including criminal offending, extensive domestic violence, chronic substance misuse, and unmanaged mental health. Mother was diagnosed with Attention Deficit Hyperactivity Disorder, depression, anxiety, Borderline Personality Disorder, and drug-induced psychosis; Father had reported concerns of drug-induced psychosis, anxiety, and depression.

Both parents had extensive histories of child protection involvement for several years. These concerns were in relation to their first child and remained unaddressed; Child4's older sibling was removed and placed into care.

Child4 was placed in kinship care with Aunt under a Temporary Custody Order shortly after birth due to an unacceptable risk of harm in the parents' care. Given the continued concerns, Child Safety determined neither parent was able nor willing to protect Child4 from harm. Kinship care provided stability and strong attachment, with Child4 meeting developmental milestones and maintaining frequent contact with the sibling and extended family, as well as supervised contact with the parents.

Key legal milestones:

Month 1:	Temporary Custody Order granted; Child4 placed with Aunt.
Month 1:	Office of the DCPL received referral.
Month 1:	Application filed for a Child Protection Order granting short-term custody to the Chief Executive. Filed prior to Temporary Custody Order expiry, enlivening s 99 CP Act allowing it to continue.
Month 2:	First mention adjourned until 9 July 2020 (COVID-19 protocols) interim orders granted pursuant to s 67(1)(a)(ii) CP Act for all adjournments.
Month 2:	Initial affidavit filed.
Month 5:	Adjourned.
Month 6:	Updating affidavit filed (case plan and parental engagement update).
Month 6:	Adjourned.
Month 6:	Adjourned.
Month 6:	Final order made for short-term custody to the Chief Executive for two years.

Both parents failed to attend the Family Group Meeting where the case plan was developed and did not meet any of the case plan goals. Contact was suspended due to repeated non-attendance. Concurrent planning identified permanency through long-term out-of-home care if reunification failed.

Systemic observations across cases

The four cases reviewed: Child2, Child1, Child3, and Child4, highlight recurring systemic issues affecting timeliness and quality of progression toward permanency once parental responsibility transfers to the State. Although the children's circumstances varied considerably, including profound medical vulnerability, cumulative trauma, and entrenched domestic and family violence, consistent patterns emerged across order pathways, highlighting impacts of timeliness, evidence preparation, resourcing, and externally driven constraints. Secondary systemic observations arose regarding the participation of children in one case and the application of ATSICPP principles in another.

Order pathways and alignment to permanency goals

Across all four cases, the pathway from interim orders to final outcomes generally aligned with statutory thresholds and case plan goals, consistent with section 61 order options and the permanency principles in section 5BA of the CP Act. The consistency with which permanency rationales were articulated, however, and the speed at which they were operationalised, varied significantly.

Child3's matter demonstrates an alignment between assessed risk, permanency principles, and order selection. The progression from Court Assessment Order to long-term guardianship to the Chief Executive (approximately two months) reflects a clear assessment that reunification was not achievable given Child3's parents predeceasing him, and that permanency required a stable legal authority (s.5BA; s.61). In contrast, Child2 and Child4 remained on short-term custody pathways for extended periods, despite longstanding and well-documented parental incapacity. In Child2's case, although neither parent was willing or able to care for the child and the child had never been in their care, proceedings extended over several months and eight adjournments, pending family group meeting convening and case plan readiness. Child4's proceedings were similarly prolonged by adjournments, with short-term custody ultimately granted after approximately four and a half months, notwithstanding entrenched parental risk and the prior removal of the sibling.

Child1's matter reflects an appropriate short-term custody pathway in circumstances where reunification efforts, parental engagement, and cultural connections were actively explored, and kinship was assessed but not viable due to extreme medical complexity. However, delays in finalising the case plan and convening the family group meeting meant permanency reasoning was not clearly documented or communicated during the early stages of proceedings.

Collectively, these matters suggest that while order pathways generally tracked case plan goals, variability in the articulation and evidencing of permanency reasoning, rather than order choice itself, influenced the pace toward stable outcomes.[19]

...although neither parent was willing or able to care for the child and the child had never been in their care, proceedings extended over several months and eight adjournments, pending family group meeting convening and case plan readiness.

19 https://www.families.qld.gov.au/_media/documents/foster-kinship-care/permanency-planning-594.pdf , Child Protection Act 1999 (Qld) s 5BA, 61.

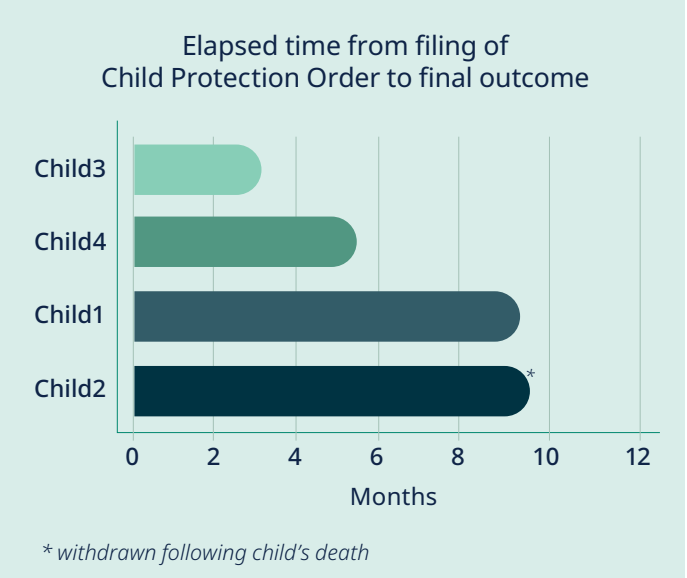
Timeliness: Interim drift versus decisive progression

Interim orders are designed to stabilise safety quickly; however, across the cases reviewed, interim drift occurred where adjournments accumulated and foundational documentation, such as case plans and cultural plans were not ready for court. This pattern reflects broader systemic pressures identified in the Office of the DCPL data, which shows increasing elapsed time and procedural activity across child protection matters.

Child2's case most clearly illustrates interim drift, with eight adjournments over several mentions while custody continued under interim provisions pending case plan development, cultural planning, Family Group Meeting outcomes, and filing and service requirements. Child4's matter similarly experienced multiple adjournments, compounded by COVID-19 protocols that delayed court listings, affidavit filing, and home visits, extending proceedings beyond what would ordinarily be expected for an infant with immediate safety concerns.

By contrast, Child3's matter demonstrates that interim drift is not inevitable. Despite the complexity of his history and the need for corroborating health and NDIS information, early evidence readiness and permanency analysis consistent with s.5BA principles enabled a final order after only two mentions.

These contrasts indicate that observed timeliness appears more strongly associated with evidence readiness and early permanency decision making than with the complexity of the cases themselves, reinforcing the importance of pre-listing requirements for case plan, cultural plan, and affidavit completion to avoid unnecessary adjournments.



Evidence quality and corroboration

Across the reviewed matters, the quality and readiness of affidavit evidence materially affected court progression and adjournment frequency. Office of DCPL data indicates that in 72.3 per cent of matters, further evidence or clarification was requested from Child Safety, reflecting systemic gaps in initial affidavit completeness that can prolong proceedings.

Child3's matter benefited from targeted affidavits and written submissions that clearly articulated cumulative harm, the absence of viable kinship options, and the necessity of long-term guardianship. Even in this matter however, corroboration with Queensland Health, NDIS, and the Registry of Births, Deaths and Marriages were delayed due to external dependencies, illustrating the vulnerability of proceedings to third-party constraints.

In Child1's matter, initial affidavits improved following DCPL feedback, with subsequent updated affidavits attaching psychiatric assessments, medical information, and case planning material. Early affidavits did not explicitly reference ATSICPP considerations which required later rectification through submissions. Child2's matter similarly reflects dependencies on family group meeting outcomes and case planning documentation, which were not available at early mentions, contributing to repeated adjournments.

These patterns underscore the need for standardised affidavit frameworks requiring explicit articulation of permanency rationale (linked to s.61 order options and s.5BA principles), cumulative harm analysis, and ATSICPP compliance, alongside disciplined use of updating affidavits to maintain court readiness.[20]

20 https://cspm.csyw.qld.gov.au/procedures/recommend-a-child-protection-order/prepare-an-affidavit, Child Protection Act 1999 (Qld) s 5BA, 61.

External factors and resource constraints

Each matter demonstrates the impact of external disruptions and resourcing pressures on court progression. Child4's case was directly affected by COVID-19 restrictions, resulting in reduced home visits, delayed affidavits, and administrative adjournments. Child2's matter reflects workload pressures through missed or late recorded home visits and delayed documentation, increasing oversight risks despite an otherwise stable kinship placement.

These observations reflect broader systemic pressures identified in Office of DCPL data earlier, including high adjournment rates linked to family group meetings and service of documents, and an increase in same-day matters. Under the Collaborative Family Decision Making program, family group meeting convenors operate largely as region-based roles, facilitating meetings across multiple service centres and preferably in community settings rather than departmental offices.[21] This approach enhances convenor independence from casework and supports culturally responsive and family-led processes; however, it can lead to an unfamiliarity between convenors and Child Safety Officers and increase the logistical load (travel, venue selection, multi-party preparation) and thereby affect the speed of convening family group meetings, especially for matters with court-ordered timeframes or heightened urgency (e.g., infants, complex medical needs). In the cases reviewed, adjournments linked to family group meetings featured prominently, and delays in convening or readiness (agenda, participants, cultural protocols, Independent Person processes) can compound interim drift where case plans are not available at first or second mention.

These pressures highlight the importance of contingency resourcing, transparent recording of mitigations (e.g. virtual contacts, joint carer visits), and escalation pathways to preserve momentum toward permanency during periods of disruption.

Secondary observations: Participation and ATSICPP

Participation and ATSICPP obligations were directly engaged in Child3's and Child1's matters, respectively, but remain systemically significant given that Aboriginal and Torres Strait Islander children comprised approximately 44.5 per cent of referred matters in 2024–25.[22]

Child3's case highlights participation challenges for adolescents with trauma and neurodevelopmental disability. Although his views opposing care were consistently recorded, formal advocacy through the Office of the Public Guardian was not activated due to his refusal of engagement with the agency, exposing a gap between statutory participation obligations and practical engagement mechanisms for highly vulnerable young people.[23]

Child1's matter demonstrates that while active efforts toward ATSICPP compliance occurred in practice, including cultural support planning and sibling connection, early documentation did not clearly evidence these efforts. The family group meeting occurred approximately six months after the first mention, indicating that ATSICPP fidelity depends as much on early documentation as on substantive practice, particularly in urgent medical contexts.[24]

21 https://www.families.qld.gov.au/_media/documents/protecting-children/fgm-convenor-handbook.pdf
22 The State of Queensland (Office of the Director of Child Protection Litigation) annual report 2024-2025. p 80.
23 https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/participation , Child Protection Act 1999 (Qld) s 5E.
24 https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/child-placement-principle. Child Protection Act 1999 (Qld) s 5C.

Summary

Consolidated, these cases illustrate that while legislative pathways to permanency are well established, variability in evidence readiness, timeliness of case and cultural planning, and resource constraints continue to affect how swiftly interim protection translates into stable legal arrangements. Strengthening pre-listing gates (case plan and, where applicable, cultural plan readiness), embedding permanency principles into both order selection and affidavit templates, and improving documentation fidelity emerge as key levers to reduce interim drift and support timely permanency outcomes.[25]

Possible considerations

The cases reviewed highlight systemic challenges in achieving timely and permanent arrangements once parental responsibility transfers to the State. While legislative principles emphasise permanency and stability, practice gaps persist due to delays, reliance on interim orders, and variability in planning and evidence preparation. The following will be considered by the Board to shape recommendations:

- Explore mechanisms to reduce reliance on interim orders and adjournments, including introducing internal pre-listing readiness requirements (case plan and, where applicable, cultural plan) before first/second mention, to promote timely progression to final orders.
- Recommend development of a statewide timeliness and permanency protocol, drawing on interstate practice (e.g. NSW permanency planning obligations and Victoria's time-bound case planning goals) to set clear expectations and reduce variability.
- Explore strategies to improve timeliness of cultural planning and independent person processes, such as setting internal timeframes and escalation triggers to ensure ATSICPP elements are evidenced early in proceedings.
- Recommend establishing core performance indicators and reporting requirements that track timeframes for key milestones, such as case plan completion, cultural plan development (where relevant), and progression from interim to final orders, to improve accountability and transparency.
- Strengthen compliance monitoring for affidavit content, consider quarterly auditing a sample of affidavits for permanency rationale, cumulative harm analysis, and ATSICPP documentation, and use findings to inform targeted training or practice refreshers.

Conclusion

This summary report highlights that while Queensland's child protection legislation provides clear pathways for transferring parental responsibility, practice variability in timeliness, permanency planning, and evidence preparation continues to affect outcomes for children. Interim drift, delayed case planning, and inconsistent documentation of permanency principles undermine the intent of section 5BA to provide children with stable, long-term arrangements. Strengthening pre-listing controls, embedding permanency principles and ATSICPP compliance in decision-making, and improving affidavit fidelity are practical steps toward reducing delays and achieving permanency more consistently. These improvements are not only procedural but also developmental, ensuring children experience safety, stability, and belonging within timeframes appropriate to their age and needs. By considering the possible recommendation areas outlined, the Board can influence systemic improvements that uphold children's rights and developmental wellbeing, including cultural identity and participation in decisions that shape their lives.

25 https://cspm.csyw.qld.gov.au/practice-kits/permanency-1/overview-of-permanency/what-is-permanency-planning, Child Protection Act 1999 (Qld) s 5BA.

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