

## **Proposal for Child Safety Legislative Reform: Transparency, Accountability & Fairness**

**To:** Commission of Inquiry &

The Honourable Meaghan Scanlon MP  
Minister for Child Safety, Seniors and Disability Services  
Parliament of Queensland

**Subject:** Proposal for Child Safety Reform – Transparency, Accountability, Body-Worn Cameras & Contact Restoration Policy

### 0.0 Introduction

Dear Commission of Inquiry

I am writing with deep respect and a genuine commitment to improving the fairness, transparency, and integrity of Child Safety operations in Queensland. My intention is to raise concerns based on lived experience and to propose practical, reasonable reforms that would strengthen public trust, protect families, and support workers by ensuring accuracy in decision-making. This document includes pages 1-17 with exhibits attached at the bottom.

## 1.EXECUTIVE SUMMARY

This proposal seeks the implementation of a clear policy and legislative reform framework addressing systemic failures within Child Safety, including:

- Mandatory body-worn cameras or audio recordings for Child Safety Officers (CSOs).
- Accountability measures and consequences when CSOs provide false, inaccurate, or misleading documentation.
- Compensation pathways for families proven to be adversely affected by incorrect departmental actions.
- A new administrative framework called the **Contact Restoration Provision**, ensuring fairness when Child Safety repeatedly cancels family contact sessions.

Currently, the framework penalises parents for missing contact but provides **no equivalent consequences** when the Department fails to attend or facilitate scheduled sessions. This imbalance undermines natural justice, prolongs separation, and erodes trust.

This proposal aims to restore fairness, increase transparency, and ensure that parents continue to progress towards reunification even when departmental administrative failures occur.

## 1.1 CURRENT SITUATION & RATIONALE FOR CHANGE

Parents routinely receive correspondence advising that missed contact sessions may result in a review of their family time and progression. For example in my experience

*“If you cancel the visits with Child Safety, we will need to review the current family time arrangements as it’s important for Child Safety to see how you’re interacting with the children and meeting their needs. These observations inform decision making for future family time decisions such as moving visits to your home, moving to unsupervised time and increasing family time.”*

However, when CSOs fail to attend, cancel late, or repeatedly interrupt scheduled contact, parents lose valuable opportunities to demonstrate progress even when they were present, willing and able to participate.

a. For Parents -This creates

- A significant power imbalance
- Barriers to reunification
- Emotional, and psychological harm

-Financial Impacts for those with occupations

- Unfair administrative advantage in favour of Child Safety
- A lack of accountability for departmental failures

b. For Children – This creates

- Barriers to reunification
- Emotional and psychological harm distress
- Trust issues with the department and parents

Additionally, Child Safety decisions heavily rely on CSO case notes, which often include subjective interpretation. When case notes contain inaccuracies, or key details are omitted, parents have **no evidence** to challenge these statements. Without audio or video recordings, truth becomes dependent on memory, bias, or assumption.

This undermines procedural fairness and can contribute to unnecessary or prolonged placement in care.

## 1.2 PROPOSED LEGISLATIVE & POLICY REFORM

- a. Mandatory Body-Worn Cameras or Audio Recording; Child Safety Officers should be required to record their interactions with families, just as Queensland Police and Paramedics do. These recordings should cover:
- Home visits during IPAs
  - Safety assessments
  - Interviews with children or parents
  - Supervised family contact
  - Delivery of case planning decisions

- Family group meetings/Family contact reviews.
  - The department of child safety should get clear verbal or written consent from parents over 18years old to audio record or video record interactions with them or their children.
- b. Benefits include:
- Accurate and reliable evidence.
  - Protection for both families, children and staff involved.
  - Reduction in false allegations
  - Greater transparency for courts and tribunals
  - Increased accountability in high-stakes decisions

Families should also be given the **right to request recordings** for their own legal protection from the first home visitation or interaction with The Department of Child Safety.

### **1.3 Accountability for False or Misleading Documentation**

Currently, when CSO documentation is later shown to be false, incomplete, or inaccurate, no consequences exist. This allows errors to influence court decisions with no corrective mechanism.

I propose:

- Mandatory review of any case where inaccuracies are identified
- Written correction or withdrawal of inaccurate statements
- Disciplinary action for repeated breaches from the department.
- Independent oversight of high-risk matters

Accurate record-keeping is foundational to child welfare and justice.

### **1.4 Compensation for Families Impacted by Departmental Errors**

When errors by Child Safety result in harm, families should have access to compensation.

Impacts often include:

- Loss of employment or work hours
- Disruption to Centrelink payments
- Emotional and psychological harm
- Forced counselling obligations when proven not needed.
- Legal costs
- Delays in reunification

Parents currently shoulder the burden of departmental mistakes, with **no pathway for remedy**. Compensation should apply when removals or restrictions were influenced by incorrect or unreasonable assessments/documentation or procedural failure.

## 2. CONTACT RESTORATION PROVISION

### *A New Administrative Remedy for Missed Departmental Visits*

**2.1 Policy Trigger:** This provision should activate when: **It is evident** Child Safety cancels or fails to attend three (3) or more scheduled contact sessions within five (5) consecutive weeks, **and the parent was ready, willing, and able to attend.**

Administrative Remedies -When this threshold is reached, one of the following remedies should apply: Impacts of these should be carefully and sensitively considered in decision making at family contact reviews. Examples of options are listed below.

#### Option A - Temporary Supervision Waiver

One semi-supervised contact in a safe community location once a week.

One unsupervised contact in a safe community location once a week.

#### Option B - In-Home Contact Adjustment

One contact at the parent's residence, monitored via phone check-ins rather than CSO physical supervision a week.

Option C - Increased or Extended Visits. Frequency or duration of visits increased until missed time is restored within that period.

Option D – Other that complies with fair and just reasoning in the best interest of the child.

## 2.2 Benefits

- Restores fairness and natural justice
- Prevents parental progress from being stalled due to departmental errors
- Encourages greater CSO accountability
- Supports children's right to consistent and meaningful contact with parents

## 2.3. WHY REFORM IS URGENT (LIVED EXPERIENCE)

In my own experience, numerous case notes contained inaccuracies, subjective interpretations, or omitted key details. Some statements presented as facts were untrue. These errors directly influenced decisions that separated me from my children. As a result, I experienced:

- Loss of work during the first week
- Delayed or suspended Centrelink payments
- Emotional distress
- Forced counselling impacting work and study
- Delays in contact with my children
- No accountability for and from the staff involved

These impacts were severe, yet the system provides **no pathway** for acknowledging or remedying departmental mistakes.

#### 2.4. REQUEST FOR ACTION

I respectfully request that the Minister and Departments who have duty of care in this matter to:

- Review the proposals in this submission
- Consider piloting body-worn cameras within Child Safety
- Direct policy teams to formally assess the Contact Restoration Provision
- Strengthen accountability around documentation accuracy
- Establish a compensation framework for families and children harmed by departmental errors

### 3. **Finical Delegation**

The department of child Safety should have an external department that oversees how funds are been used. At current they are their own law none direct funding or oversee how money is used. Currently, the Department operates with **broad discretionary power over financial decisions**, including education and care funding.

a. These decisions are:

- not independently reviewable
- not transparent
- not subject to meaningful external accountability

b. This creates a significant systemic gap, including:

- inconsistent decision-making across cases
- lack of transparency in how funds are allocated
- inability for parents to challenge or review financial decisions
- decisions being made without written justification
- financial outcomes that do not align with the child's best interests

This level of unchecked discretion is inappropriate in a system that directly impacts children's lives, education, and long-term outcomes.

### 3.1

**Proposed Legislative Reform: Where a child has been enrolled in private schooling for two years or more prior to Department involvement, and is actively attending that school at the time of intervention:**

a. The Chief Executive must prioritise and, where reasonably practicable, fund the continuation of that child's private education while the child is in care. This must be assessed in accordance with the **best interests of the child**, including:

- stability
- continuity of education
- emotional wellbeing
- established support systems
- Other reasons in the best interest of the child.

**b. Failure to Maintain Educational Continuity – Case Example**

In my experience, the Department made **multiple verbal assurances** that my son's private schooling would continue to be funded by them. These assurances were made by:

- Centre Manager [REDACTED] - [REDACTED] Department of Child Safety
- Centre Manager [REDACTED] - [REDACTED] Department of Child Safety
- Regional Executive of the [REDACTED] leader/Advisor [REDACTED]

I was specifically advised that **Term 1 school fees had been approved and paid**. However, days before the school term commenced [REDACTED]

- I was informed by phone (CSO [REDACTED]) that the Department would **not fund the school fees**.
- The department refused to give me a written explanation no formal decision or reasoning was documented.

**c. As a direct result:**

- [REDACTED] was unenrolled from his historical school that had a spot for him till year 12.
- [REDACTED] remained at home for the entire term while the department looks for a public school that caters for his cultural and religious beliefs.
- I am still advocating for the department to keep their promise of funding for another private school that caters for his cultural and religious beliefs. This would be a school he wouldn't need to transition when reunification happens.

**d. Impact on the Child-This decision caused significant and ongoing harm, including:**

- disruption to education
- loss of routine and structure
- emotional and developmental impact
- disconnection from a school community he had been part of for three years
- Trauma

The decision was not made in alignment with the child's best interests and the department does not hold anything to account.

**e. Parental Efforts to Resolve-Despite significant personal pressures, including:**

- family contact requirements
- counselling obligations
- impact on employment and income

I made every effort to maintain my son's educational stability. I proposed multiple reasonable solutions:

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**3.2 System Failure- The expectation that a parent should financially contribute to education while:**

- the child is under the custody of the Chief Executive
- the parent has restricted access and decision-making power
- the Department controls all placement and care arrangements

This is unreasonable and lacks fairness on the maxim level.

**a. Excessive Instability and Transitions- The Department's decision has created unnecessary instability.**

is now exposed to multiple transitions: In Care

1. removal from parental care
2. removal from a school he attended historically
3. transition to a carer-based school catchment area

Reunifications

4. potential transition back to parental catchment area
5. future transition to a long-term school that caters for his needs.

This level of disruption is excessive and avoidable. The impact of removing him from his established school environment is greater than any identified risk used to justify the decision.

**b. Department Position and Statements-Statements made by Department representatives highlight systemic issues:**

- “We put all children in the same category” [REDACTED] Central Child Safety Manager
- “The Department only funds government services (public schools)” Team Leader [REDACTED]
- “We make all the Financial decisions and its non-reviewable, not even by QCAT” Team Leader [REDACTED]

This reflects a **policy-driven approach**, rather than an **individualised assessment of the child’s needs**. Children must not be treated as uniform cases. Educational decisions must be made based on **individual circumstances and best interests**, not internal funding preferences.

### **3.3 Proposed Outcome -It is proposed that:**

- private schooling continuity be recognised as part of **child stability and best interests**.
- financial decisions impacting children be **reviewable by an independent body**
- written reasons be required for all funding decisions

**Compensation**-The department should provide private tutoring twice a week to support the child being behind school. Engagement of the child’s participation into tutoring can be given to the mother and the department.

### **4. Family Group Meetings and Case Planning**

**Problem;** My Family Group Meeting (FGM) was delayed by approximately **4 months** after my children entered care, despite early requests.

a. During this time:

- I was actively working toward expectations for reunification
- there was **no formal case plan in place**
- progress made prior to the FGM was **not formally recognised or structured**

b. When the FGM did occur:

- it did not properly account for the **progress already made before the case plan was created**
- no clear timeframes or review dates were set

I was advised by Team Leader [REDACTED] that: There is no legislation requiring a timeframe for Family Group Meetings or family contact reviews. This creates a system where delays by the Department result in **lost time and unrecognised progress for parents**.

### **4.1 System Change Required- It is proposed that:**

- Family Group Meetings must consider and formally recognise **all progress made by parents prior to the case plan being created**, including actions taken from the time children enter care
- Case plans must be aligned with:
  - expectations outlined in affidavits
  - existing reunification requirements already known to the Department
- Where there are Department delays (e.g. FGM held months after removal), → the **first review must occur within 2–3 months of the FGM**, not 6 months
- Review timeframes must be calculated from the **date children entered care**, not delayed administrative dates
- Parents must not be disadvantaged by delays outside of their control

## **5. Privacy and Information Sharing**

**Problem- Sensitive personal information relating to parents is being shared with external parties without adequate safeguards. In my experience:**

- Documents provided to external parties (e.g. schools) contained **court-related information and judicial directives**, which should not be disclosed without necessity
- This information was only redacted **after I requested it**, indicating that it would have otherwise been shared in full
- Disclosure of such information risks:
  - damaging professional relationships (e.g. with teachers)
  - creating bias or judgement toward the parent
  - breaching personal dignity and privacy

Further, the **Letter of Introduction** provided to services contained:

- detailed, copied extracts from affidavit material
- personal disclosures disputed and contested matters before the courts.

This goes beyond what is necessary for service engagement.

### **5.1 System Change Required -It is proposed that:**

- All information shared with external parties must be **limited to what is strictly necessary and relevant**
- **Court documents, judicial comments, and contested affidavit material must not be shared** with external providers like schools and counsellors unless:
  - the parent has provided **informed consent**.
- Parents must be given the opportunity to:
  - **review and approve information** before it is shared externally
  - request redactions where they are uncomfortable.

**Letters of Introduction** must be standardised to include only:

- a **summary of concerns**



- areas requiring support

For example:

- Anxiety
- Domestic and family violence s
- Mental health
- Healthy communication within relationships

-They must not include detailed personal history or copied affidavit content unless they have given informed consent and the parent or young person is no longer disputing or contesting the matter before the courts.

## 6. CONCLUSION

These reforms would protect children, families, and staff. They strengthen transparency, improve public trust, and ensure decisions affecting children’s lives are based on accurate, reliable information. This proposal is made in good faith, with the vision of creating a more just, balanced, and accountable Child Safety System for all Queensland families.

Thank you for your consideration.

**Kind regards,**

