RAISING VOICES, REFORMING THE SYSTEM:

Together Submission to Commission of Inquiry into Child Safety System

Together
BRANCH OF THE ASU

Together is the the lagrest representaive voice of the workers within the Department of Families, Seniors, Disability Services and Child Safety and the broader Public Sector

This submission was made possible by union members.

This submission was made possible by the collective effort of frontline child protection workers who chose to speak up, at scale, about the system they work in every day.

Together thanks the 1,000-plus members who participated in the *Raising Voices, Reforming the System* survey. Their honesty and willingness to put their professional experience on record is the foundation of everything that follows in this submission.

Together also thanks the 32 members of the member-led steering committee, who built the survey, shaped the questions, and spent tireless hours ensuring this submission reflects the reality of frontline practice — not just the view from a desk. Their expertise and commitment to this work is evident on every page.

In particular, Together acknowledges Lucy, Alex and Raz for their leadership in bringing this work together. Their dedication to your colleagues, and to the children and families this system exists to serve, has made this submission what it is

Contents

Foreword Dee Spink | Assistant Secretary, Together Union 4

Introduction 5

Table of Recommendations 10

Chapter One: Reforming the Residential Care System ....

Chapter Two: Fixing a broken system ....

Chapter Three: Law and Power — The Child Protection Litigation Model ....

Chapter Four: Workforce Capacity and System Integrity ....

Conclusion 76

Foreword

Dee Spink | Assistant Secretary, Together Union

This submission is made on behalf of the thousands of child protection workers that Together, a branch of the Australian Services Union, represents across Queensland. **It reflects the lived experience, professional judgment and collective concern of a workforce that is deeply committed to the safety and wellbeing of children**, yet increasingly constrained by a system that is not designed to support them to meet that obligation.

For many years, our members have raised consistent and credible warnings about the direction of Queensland's child protection and family support system. They have spoken about unmanageable workloads, chronic under-resourcing, the erosion of professional judgment, and the growing reliance on downstream, high-cost interventions that do not deliver safety or stability for children. Too often, these warnings have been acknowledged but not acted upon.

The Commission of Inquiry represents a critical opportunity to change that trajectory.

However, Together notes that the shortening of the Inquiry's timeframe will place significant pressure on the Commission's capacity to fully examine the structural failures at the heart of the system.

This submission is grounded in extensive evidence provided directly by frontline workers. It draws on a statewide survey of child protection staff, detailed qualitative accounts from practitioners across roles and regions, and the union's long-standing engagement with child protection reform processes. The consistency of the evidence is striking. **Workers are not describing isolated failures or poor practice by individuals. They are describing a system that is structurally incapable of delivering what the law requires, despite the skill, professionalism and commitment of the people working within it.**

Across the chapters that follow, a clear picture emerges. Decision making has become fragmented and increasingly disconnected from practice. Workload benchmarks and funding models are based on assumptions that do not reflect reality. The system manages its own inadequacy through crisis triage, unpaid labour, and the normalisation of risk. Residential care has expanded not because it is effective, but because earlier, preventative parts of the system have been allowed to fail. Children, families and workers bear the consequences.

This submission starts from a position of respect for the professionalism and commitment of Department staff.

It demonstrates how the system has come to rely on workers compensating for structural failure — working well beyond their paid hours, absorbing risk, and making impossible choices between competing needs. That is not sustainable, and it is not safe.

Together makes this submission with a clear purpose: to assist the Commission to identify reforms that address root causes rather than symptoms. The law already sets out what children are owed in our state. The question before the Commission is whether the system is designed and resourced to make those obligations achievable in practice.

Our members believe that better outcomes are possible.

They know what works. They know what does not. This submission is an invitation to listen to that expertise and to design a system that supports children by supporting the workforce entrusted with their care.

Together welcomes the opportunity to contribute to the Commission's work and urges that the voices contained in this submission be treated not as commentary from the margins, but as essential evidence from those who hold the system together every day.

Introduction

The Queensland Government has established the Child Safety Commission of Inquiry to take a deep look at how the system is structured, how it is operating, and how it must change to better support children, families and workers. The Commission's Terms of Reference require it to examine the rapid growth of the residential care sector, the effectiveness of foster and kinship care, systemic and policy failures, the Department's performance as a corporate parent, workforce resourcing and cultural safety, and whether current legislation – including the *Child Protection Act 1999* and *Adoption Act 2009* – is fit for purpose.

This submission is made by Together, the union representing thousands of workers across Queensland's child protection system. Our campaign – *Raising Voices, Reforming the System* – was specifically designed so that this Commission hears the realities of frontline Child Safety work, not just the voices of executives. Our core message is simple: **fix the system – don't blame the people who hold it together.**

To inform this submission, Together undertook a statewide worker survey aligned with the Commission's Terms of Reference, including questions about residential care, family-based care, cultural safety, workforce conditions and decision-making.

The survey received **1,102 responses from the frontline Child and Family workforce**, representing a substantial proportion of the practitioners who directly deliver statutory child protection in Queensland. This high level of engagement demonstrates the urgency workers feel about the state of the system and the importance they place on having their voices included in the Commission's work.

Crucially, the survey also asked workers open-ended questions such as *"What's working well and what's not working well?"* and *"If you could tell the public or the Commission one thing about the reality of child protection work, what would it be?"* These responses, combined with member stories and workplace conversations gathered through the union's *Raising Voices, Reforming the System* campaign, form the backbone of this submission.

What is working: commitment, values, and peer support

Across roles, regions and tenures, workers consistently report that the strongest part of Queensland's child protection system is **not the structure, but the people**. Respondents highlight the dedication, compassion and perseverance of frontline staff who continue showing up for vulnerable children "with a real passion and interest in working with families" and who take pride in the "small wins" achieved despite overwhelming pressures._

Many workers point to the strength they draw from **supportive local teams and peers**, often describing colleagues – not systems – as the reason they stay. In a context where caseloads and risk are escalating, these networks of mutual support and solidarity are frequently the only buffer preventing turnover and burnout. For many, purpose and values remain the core motivators for remaining in the department against significant odds.

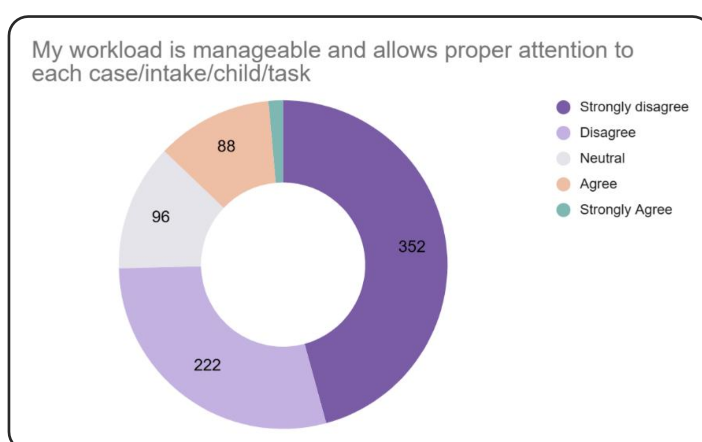
Survey data reinforces this: despite deep dissatisfaction with systems and resourcing, most respondents still agree that trauma-informed interventions are essential and that early, family-based support is the right direction for child protection – indicating that professional judgement and values are aligned with best practice, even when the system does not enable it.

What is not working: a system that is overwhelmed, under-resourced, and unsafe

The picture that emerges from workers' responses is of a system **stretched far beyond safe capacity**. Across the state, workers describe unmanageable caseloads, chronic vacancies, and an organisational culture in which frontline staff are expected to absorb ever increasing complexity with diminishing support._

Key survey findings include:

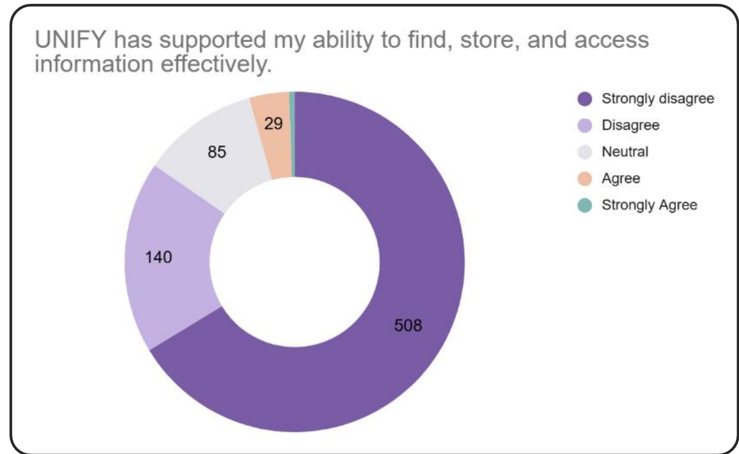
- **Workload and resourcing:** Responses to system-wide questions show very high levels of disagreement that workloads are manageable, that staffing levels are sufficient, or that the Department is adequately resourced to meet its legislative obligations._

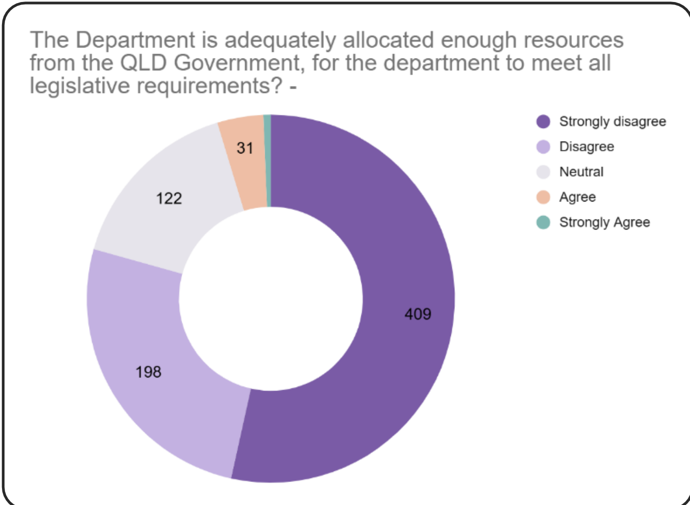


- **Safety at work: 77.45% of departmental employees report experiencing risks to their safety or wellbeing at work**, underscoring the physical and psychological danger attached to doing this job.

- **Technology and UNIFY: 88.86% of respondents say UNIFY and departmental technology have impacted their ability to do their work.**

  Many describe UNIFY as “dangerous”, “not fit for purpose”, and “the single most dangerous and impactful change” they have seen in decades of practice, because it is slow, confusing, and makes it harder to find the information needed to keep children safe.





- **Funding and early intervention: 88.90% do not believe the Queensland Government is funding enough preventive and early intervention services** to keep children safely at home, and **65.82% identify a funding gap for medical, disability and other assessments at the IA stage** that would help prevent chronic neglect and repeated re-entries to the system.

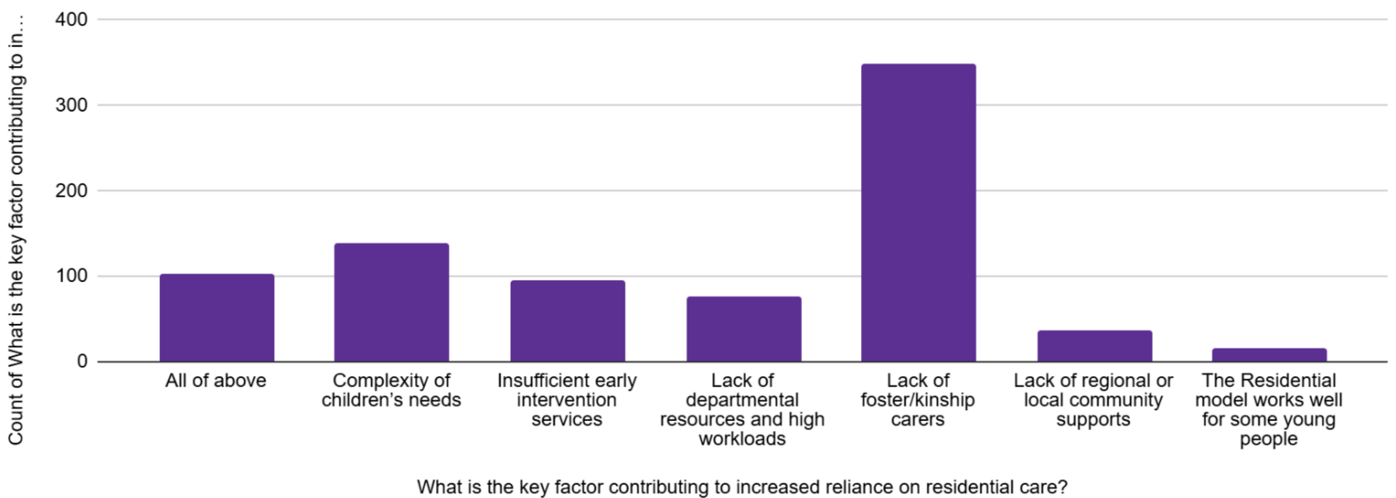
Workers also describe the emotional toll of relentless trauma exposure, high-risk situations and operating within a system that is constantly in crisis-management mode. Many respondents speak about burnout, vicarious trauma and fear for their own safety, all while struggling within an organisational structure unable to provide adequate supervision, training, or time for quality case work. Staff emphasise that the workforce is stretched beyond capacity, leaving children without the continuity, stability and depth of engagement they deserve.

Residential care, family-based care, and the use of public money

The Commission’s Terms of Reference explicitly ask whether Queensland is over-relying on a billion-dollar residential care sector, and what models of care are needed instead. Frontline workers are clear: **the current balance is wrong.**

Survey results show:

- **41.74% of respondents identify lack of foster/kinship carers as the key factor in increased reliance on residential care**, with further significant proportions pointing to complexity of children’s needs and lack of early intervention services.



- **84.16% believe that if the same level of funding invested in residential care were redirected into keeping children safely with their families, kinship or family-based care, the need for residential care would decrease.**

Workers' qualitative comments describe a system where children – including very young children – are placed in residential settings simply because no family-based options are available, and where residential care is often experienced as unsafe, unstable and nontherapeutic. At the same time, many emphasise that properly funded, professional family-based care, with strong therapeutic support, would better meet children's needs and deliver better value for public money.

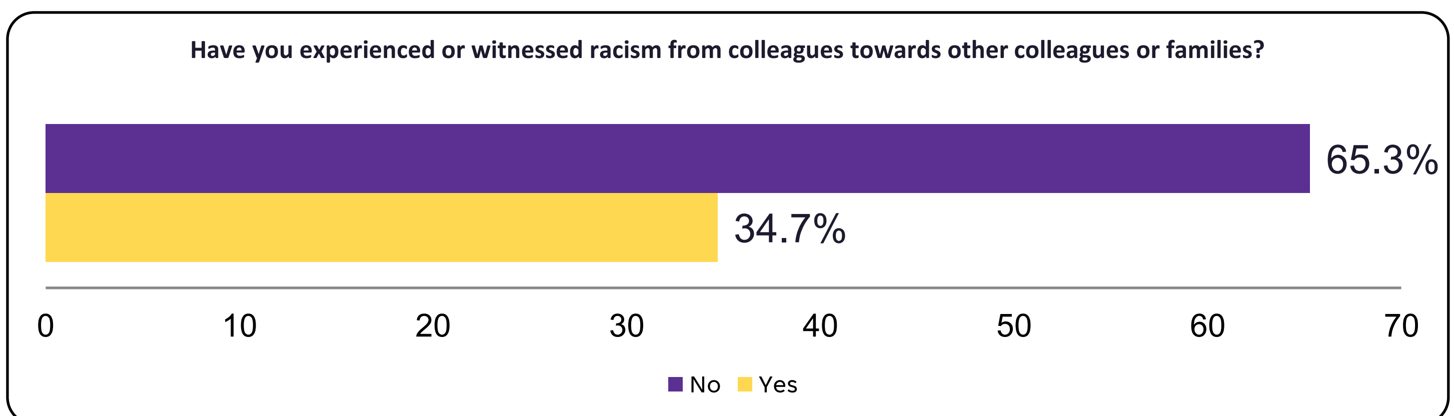
The strong support among respondents for **professional foster carers**, adequately paid and trained to meet complex needs, directly answers the Commission's questions about alternative models of care.

Cultural safety, racism and the corporate parent

The Commission has been tasked with examining cultural safety and outcomes for Aboriginal and Torres Strait Islander children, who are disproportionately in contact with the system.

The survey data confirms serious concerns:

- **34.74% of respondents report experiencing or witnessing racism from colleagues towards other colleagues or families.**



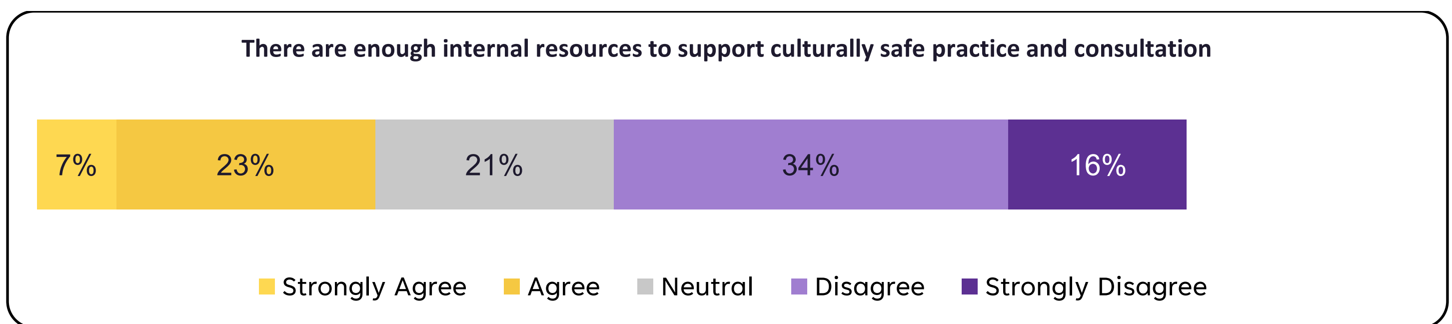
- Large proportions of workers **disagree** that the system currently provides enough culturally safe resources, that foster carers for Aboriginal and Torres Strait Islander children are

culturally competent, or that cultural knowledge and perspectives are consistently respected in decision-making.

Workers' narratives highlight the gap between policy language and practice: they describe cultural advisors being sidelined, Blue Card processes and carer assessments that do not adequately account for cultural context, and a lack of time and resourcing to build relationships in community. In this context, the Department's performance as a "corporate parent" must be judged not just by its intentions, but by the lived experience of children, families and workers – particularly First Nations families.

What workers want the Commission and the public to understand

When asked what they would tell the public or the Commission about the reality of child protection work, respondents use words like "extremely difficult", "relentless", and "emotionally and physically draining". They describe being "expected to do more and more with less and less" while facing constant criticism and little recognition for the complexity of their role.



Many say the public would be shocked to know the level of risk workers personally experience – threats, assaults, severe vicarious trauma – without adequate training, support or protective measures. One worker summarises the situation bluntly:

"If the public knew the truth, they would be outraged."

Most critically, workers are united in their message that **systemic failings – not frontline staff – are causing harm**. They describe a department constrained by underinvestment, inadequate early intervention services, unsafe workloads, and leadership and legal structures that are too often detached from practice realities.

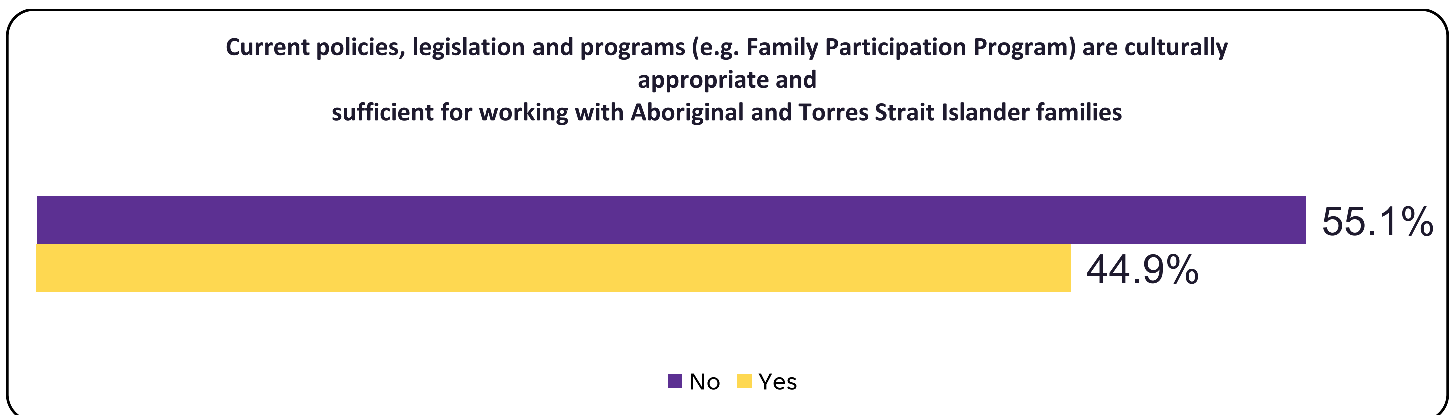


Table of Recommendations

The following table consolidates all recommendations made in this submission, organised by the chapter from which they arise. Each recommendation is a structural principle, not a detailed implementation plan, and is intended to guide systemic reform consistent with the Commission's Terms of Reference.

Chapter 1: Reforming the Residential Care System		
#	**Section**	**Recommendation**
Redesigning the model		
1	Reforming the Residential Care System	Reduce reliance on residential care by redirecting funding toward early intervention, family support, kinship care and professional foster care. Require any residential care procured by the State to operate under a mandated, evidence-based, trauma-transformative model of care, with clinical supervision and demonstrable therapeutic capacity. Tie funding to child outcomes.
2	Reforming the Residential Care System	Establish professional, specialist foster care and strengthen kinship support. Develop a professional foster care model that recognises the complexity of caring for traumatised children, including adequate remuneration, training, respite and therapeutic support. Move beyond pilot programs and commit to full implementation at scale. Invest in sustained, intensive in-home and outreach support for families and kinship carers.
Voice of the child and placement advocacy		
3	Reforming the Residential Care System	Where there are no risk or safety concerns and a young person is stable and objects to a placement move, an automatic 48-hour stay should be triggered for independent review of their wishes before any transfer proceeds.
4	Reforming the Residential Care System	Implement mobile outreach advocates for self-placed young people, a multi-agency response framework, and formal practice guidance for Child Safety Officers managing these cases — particularly where there are concerns about sexual or criminal exploitation. Community Visitor oversight must extend to self-placed young people.

Post-18 support		
5	Reforming the Residential Care System	Fund Supported Independent Living arrangements post-18 for young people in residential care, equalising the transitional support available to those in foster care. Placement type should not determine whether a young person leaves care with support or without it.
Worker safety and placement sustainability		
6	Reforming the Residential Care System	High-risk placements involving children with complex trauma, significant attachment disruption, or escalating behaviours should receive structured therapeutic review, bringing together the carer or youth worker, a clinician, and practice leadership to assess relational dynamics and develop a proactive plan for placement sustainability. Therapeutic review should be established as a preventive practice mechanism — activated early and regularly, not after breakdown has occurred.
7	Reforming the Residential Care System	Workforce safety measures in residential care and foster care settings should be developed in consultation with the relevant unions, including The Services Union, and should address both immediate safety responses and the clinical and supervisory infrastructure required to reduce the conditions that generate risk.

Chapter 2: Fixing a Broken System — EIAA, Early Intervention, Unify		
#	**Section**	**Recommendation**
8	Fixing a Broken System (Early Intervention)	Fund and resource early intervention and prevention services to match the scale of demand, particularly in regional and remote communities. Ensure services are assertive, accessible and sustained — not dependent on short-term pilot funding or passive engagement models that close cases after failed contact attempts.
9	Fixing a Broken System (EIAA/Unify)	Redesign or replace the UNIFY IT system to support — rather than obstruct — frontline practice. Ensure any replacement system is developed with sustained frontline worker input, is tested against actual workflow requirements, and does not add administrative burden that reduces time with children and families.

Chapter 3: Law and Power — The Child Protection Litigation Model		
#	**Section**	**Recommendation**
10	Law and Power: The Child Protection Litigation Model	Combine the State's child protection legal workforce into a single legal body with responsibility for the full lifecycle of child protection matters, from early advice through to final hearing. Locate that legal service within the Department of Child Safety, while preserving genuine legal independence to refuse to advance proceedings that are not legally justified.
11	Law and Power: The Child Protection Litigation Model	Embed legal officers physically within Child Safety Service Centres as a structural requirement, recognising that proximity is essential to informed, timely and coherent decision-making. Remote legal support should continue for regional and remote areas where on-site legal officers cannot be sustained, but the default should be physical co-location.
12	Law and Power: The Child Protection Litigation Model	Direct each form of expertise to the decisions it is equipped to answer. The combined legal service should operate on the Department's instruction for urgent protective decisions and predictive pathway decisions at filing, while retaining and strengthening the authority to refuse to advance a position that is not legally justified. Ultimate authority on disagreements should sit with the Department's regional leadership for crisis and predictive pathway decisions, and with the legal service for questions of legal justifiability.
13	Law and Power: The Child Protection Litigation Model	Reform the Children's Court Rules to introduce graduated evidentiary requirements proportionate to the nature of proceedings. Replace universal narrative affidavits at filing with standardised assessment material. Implement a portal-based disclosure model for immediate parental access to material. Expand the paralegal and case support worker model to the trial ratio of one paralegal and one case support worker per two teams across all frontline workplaces.

Chapter 4: Workforce Capacity and System Integrity		
#	**Section**	**Recommendation**
14	Workforce Capacity and System Integrity	Commission an independent, evidence-based reassessment of workload capacity to determine what caseload levels allow the State to meet its obligations under the Child Protection Act 1999 and the Human Rights Act 2019, accounting for case complexity, court involvement, placement instability, cultural obligations and geographic factors. Abandon static benchmarks not validated against child outcomes.

15	Workforce Capacity and System Integrity	Recalibrate workforce funding from a validated baseline. Reset funding based on the findings of an evidence-based workload assessment, rather than continuing to grow positions from an inadequate baseline. Ensure growth funding includes locked ratios for supporting roles — senior team leaders, managers, administrative officers, senior practitioners — and at defined scale thresholds, new offices with full infrastructure.
16	Workforce Capacity and System Integrity	Capture workload and capacity data directly from operational systems digitally, including actual hours worked, caseload allocation, visit compliance and case plan currency, to remove reliance on self-reporting through managerial escalation. Ensure workload governance reflects reality rather than masking systemic overwork through reporting practices that normalise risk.
Cross-Cutting		
#	**Section**	**Recommendation**
17	Cross-Cutting: Corporate Parenting	Re-centre the system on the State's role as corporate parent. Evaluate performance not only through compliance metrics but through children's lived experience, stability of relationships, cultural connection and wellbeing. Ensure system design enables workers to spend time parenting — building relationships, understanding children's needs — rather than being consumed by procedural and administrative burden.

Note: These recommendations are numbered for reference. They do not represent a priority ranking. The Commission may wish to consider them as an integrated reform package, recognising that workforce capacity reform (Recommendations 14–16) is a precondition for the effective implementation of all other recommendations.

Chapter One: Reforming the Residential Care System

Introduction

Children and young people enter out-of-home care because they are assessed as being at unacceptable risk of significant harm and do not have a parent able and willing to meet their care and protection needs. Many have experienced multiple Adverse Childhood Experiences (ACEs), including exposure to violence, neglect, substance misuse, and parental mental illness. Even children removed at birth often carry the developmental impacts of adversity during pregnancy, including Foetal Alcohol Spectrum Disorder, global developmental delay, and attachment disruption.

The cumulative effect of multiple ACEs is well-established: poorer physical and mental health outcomes, disrupted education, involvement with the justice system, and reduced life expectancy. These risks do not disappear when a child is removed from their family; they shape how children experience every subsequent placement and relationship.

Aboriginal and Torres Strait Islander children are significantly overrepresented in out-of-home care and are disproportionately affected by the legacy of colonisation, forced removals, and intergenerational trauma. Disruption of family, community and culture undermines the transmission of parenting knowledge and support systems that sustain safety. For many First Nations children, removal compounds rather than alleviates trauma, creating ongoing dislocation and a profound sense of not belonging.

Together also notes the submission of The Services Union (TSU), a fellow branch of the Australian Services Union, into the Commission of Inquiry. As the union for workers in the residential care sector, their insights into the current challenges of the system are crucial. Much like this submission as it relates to Departmental employees, Together recognises that residential care workers are constrained by a system that is not working.

Why children end up in residential care

Residential care has become a default placement not because it is clinically appropriate, but because **family-based care has been allowed to fail**.

Queensland's foster and kinship care model remains largely unchanged despite dramatic shifts in workforce participation, housing costs, and family structure. The system continues to rely on unpaid or underpaid carers to provide complex, trauma-responsive care without adequate training, income replacement, or ongoing therapeutic support. Recruitment and retention of carers has declined accordingly.

As a result, residential care — intended as a last resort, time-limited intervention — is now routinely used because no family-based placement is available. Children under 12, despite policy stating otherwise, are increasingly placed in residential settings. Providers report needing to recruit youth workers with early childhood experience, a tacit acknowledgment that the system is placing young children into environments never designed for them.

Children often enter residential care following placement breakdown, particularly where foster carers are unsupported to manage disability, trauma-related behaviours, or escalating needs. Once a child enters residential care, pathways back to family-based placements become harder rather than easier.

What children experience in residential care

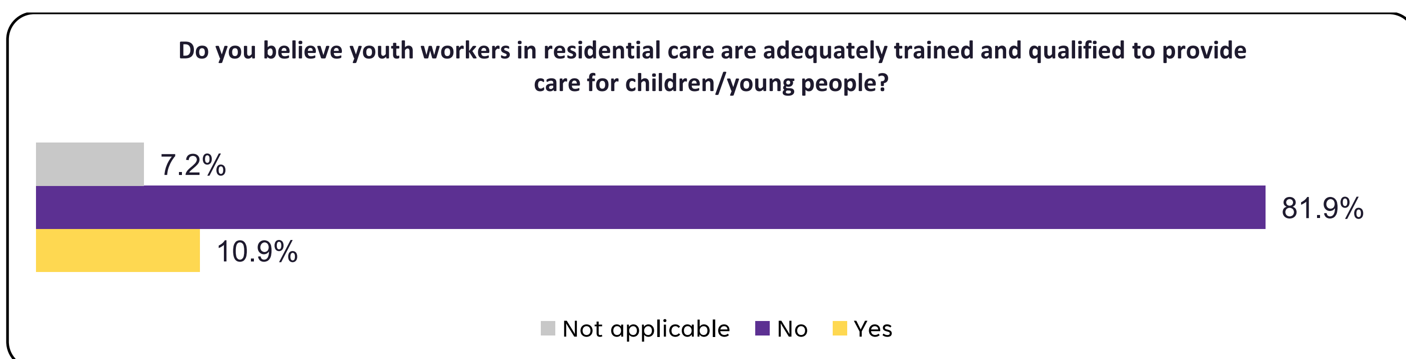
Entry into residential care is typically abrupt and crisis-driven. Children are often placed the same day they are removed from family or following sudden closure of a previous placement. There is rarely time for preparation, transition, or relational continuity.

Residential care is not a family environment. Children are mostly cared for by rotating staff working shifts, preventing the formation of secure attachment relationships. Instead of safety and predictability, children experience constant relational rupture. This reinforces trauma-based attachment strategies designed to keep adults emotionally distant as a means of self-protection.

Children are frequently placed far from their community, resulting in school disruption, loss of friendships, and disengagement from cultural and extracurricular connections. Permanency of place, relationships, and routine is rare.

Together notes that workers within residential care often face high workloads, insufficient staffing ratios, and task-driven operating models that significantly limit opportunities for relational, unstructured engagement with children, including everyday activities that create warmth and routine. As a result, houses frequently function as managed sites rather than homes. The Services Union's submission speaks to these challenges in-depth.

However, best practice does exist within the current system. One provider model our members observed in practice uses a relational model of care in which two youth workers rotate on a one-week on, one-week off basis. This arrangement can transform a placement into a home: workers both work and live in the house, presenting as consistent surrogate carers rather than shift workers. In one such model, two young people with significant disabilities and trauma histories—who had experienced breakdown across multiple foster and kinship placements—were able to thrive in residential care. One young person became school captain, graduated with pride, and successfully transitioned to NDIS Supported Independent Living in adulthood. The stability of the staffing model enabled sustained engagement in prosocial activities and strengthened cultural and family connection through genuine understanding, which in turn contributed to improved outcomes for both young people. The Commission should consider high-functioning, stable residential models of this kind as a potential blueprint for rebuilding the sector for some young people with complex needs who would otherwise struggle in more traditional care environments.



Rather than supporting healing, residential care frequently reproduces relational trauma. Many young people demonstrate this through "self-placement" — staying with family, friends, couch surfing, or sleeping rough. Young people consistently report feeling safer outside residential placements than within them.

When a child does not return overnight, the system often responds by closing the placement, framing absence as the child's failure rather than evidence of relational breakdown. Outreach, persistence, and trauma-informed engagement are rarely resourced or expected. Children are left effectively homeless.

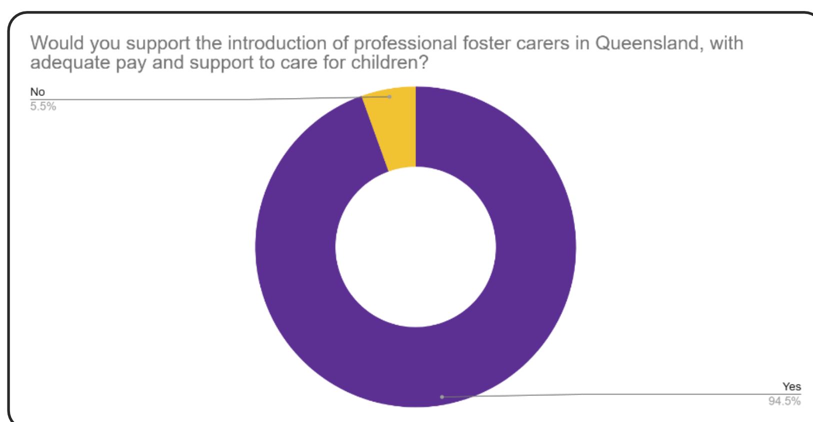
Residential environments also lack consistent boundaries and expectations. For children with trauma histories, this absence of structure increases anxiety, emotional dysregulation, and behavioural escalation. Without predictable adult responses within secure relationships, behaviour becomes the only means of control available to the child.

Challenging behaviour — including self-harm and suicidal ideation — is routinely treated as a crisis rather than as communication of unmet need. Emergency services are frequently called. Children are transported to hospital under Emergency Examination Authorities, assessed as "behavioural," and discharged back to the same environment without additional supports. This cycle creates friction across government systems and further entrenches harm.

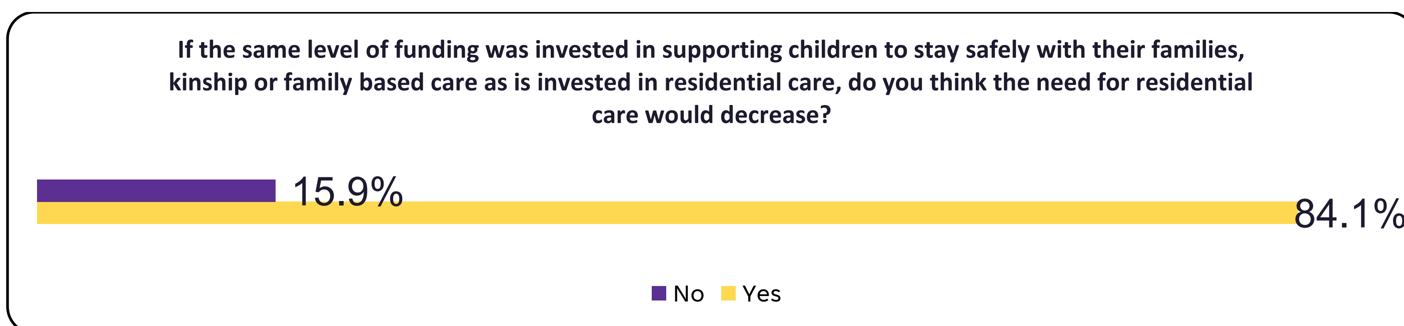
Frontline workers consistently report that children's trajectories worsen following entry into residential care.

What Workers Are Experiencing

Workers express deep frustration at how public money is allocated. Residential placements cost, conservatively, approximately $400,000 per child per year, with some exceeding $1 million. By contrast, foster and kinship carers receive allowances that do not compensate for lost income, time off work, or the emotional labour of providing therapeutic care.



Survey data shows that **84% of respondents believe that investing equivalent funding into supporting families, kinship carers, or foster placements would reduce reliance on residential care**. Workers overwhelmingly view current expenditure as misdirected — funding containment rather than care.



Carers are expected to manage children with complex trauma, disability, and behavioural needs while remaining in paid employment, attending frequent appointments, and navigating school disengagement — without income replacement, guaranteed respite, or consistent professional support. Burnout and placement breakdown are predictable outcomes of this design.

What the system purchases instead

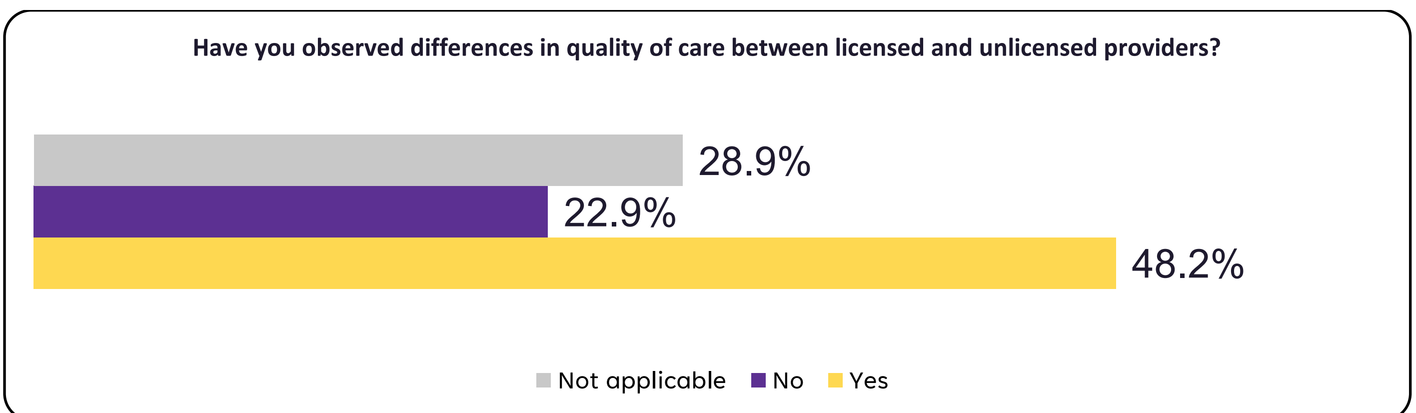
Residential care is delivered through a mix of licensed and unlicensed providers under Ongoing Service Delivery (OSD) and Individual Placement Support (IPS) contracts. Workers report wide variation in quality, with no consistent, enforced model of care.

Key themes include:

- **Absence of a mandated therapeutic framework**, particularly for Aboriginal and Torres Strait Islander children
- **High staff turnover and inconsistent training**
- **Limited organisational supervision and clinical support for youth workers**
- **Funding models that prioritise compliance over relational care**
- **Physical environments that are unstable, institutional, and poorly suited to traumatised children**

Providers are funded for outputs — hours, beds, transport — not outcomes. Youth workers are constrained by rigid funding rules that limit responsiveness to children's needs. Some are required to use personal vehicles, undermining professionalism and safety.

Workers describe both licensed and unlicensed providers delivering poor care; conversely, some unlicensed providers deliver excellent care despite systemic constraints. Quality is determined not by licence status but by **model of care, workforce stability, and organisational culture**.



Outsourcing care for profit

A significant proportion of respondents describe the residential care sector as exploitative. Providers profit from failure. There is no financial incentive to stabilise children, support reunification, or transition young people into family-based care. Children who "self-place" are often funded under risk management arrangements rather than supported to safely remain with family.

Workers describe residential care as a system that began as a necessary intervention and evolved into a market that benefits from poor outcomes.

Children leave residential care anyway

Despite the cost, many children in residential care regularly stay with family or return home at 18 without support. Workers consistently ask why equivalent outreach, in-home support, and safety planning could not have been provided without first removing the child.

Residential care often functions as a holding pattern — expensive, destabilising, and ultimately temporary — rather than as a pathway to healing or permanency.

Why this keeps happening

The over-reliance on residential care is not the result of individual failure. It is a predictable outcome of policy design, funding structures, and cultural assumptions.

Key systemic drivers include:

- An outdated foster care model that assumes carers can provide intensive care altruistically
- Chronic underinvestment in early intervention, therapeutic services, and in-home support
- Lack of a state-mandated, evidence-based model of care for residential placements
- Market concentration that leaves the Department with few alternatives and limited leverage
- Reactive placement decision-making driven by crisis rather than planning
- Workforce shortages and inconsistent training across both carers and residential staff

The Department does not require providers to demonstrate trauma-transformative practice in operation — only to assert it in documentation. Oversight focuses on compliance, not child experience. Residential care has become a structural response to workforce and resourcing failure elsewhere in the system.

Voice of the child and placement advocacy

Young people in stable residential placements are sometimes moved to accommodate system pressures — such as co-tenanting — without meaningful consultation with the young person or their care team.

In one case, a young person with significant mental health needs who had stabilised in a single-tenanted placement was earmarked for a move to cotenant to reduce costs. She strongly resisted, and her self-harm escalated considerably. In another, a young person with disability and significant health needs was similarly settled, but a funding panel decided to move him. It took sustained advocacy from the care team and a referral to an OPG advocate to prevent the move. Not all workers or young people have that capacity.

In other cases, workers who were less able to challenge regional departmental leadership were left to explain placement transfer decisions to young people who had no say in them — resulting in aggression, placement damage, and breakdown.

Young people who self-place are in a further black hole of oversight. Community Visitors do not see them. Workers managing these cases — particularly where there are concerns about sexual or criminal exploitation — have no formal practice guidance and limited multi-agency support. There is no standardised approach to children and young people who are subject to Custody or Guardianship child protection orders to the Chief Executive but are not provided a placement. This cohort is arguably some of the most vulnerable children and young people, but workers often comment that if they as a parent were to fail to provide the basic needs for their children of food, shelter and clothing, in the way the Department does, their children would be immediately removed.

Ending placement discrimination: post-18 support

Together members report a clear and unjustifiable disparity in the current system. Young people in foster care can remain in placement until the age of 21. Young people in residential care are exited at 18, frequently into a housing crisis, without equivalent transitional support.

This is not a minor inconsistency. It is a structural discrimination between placement types that determines whether a young person leaves care with a safety net or without one. The placement type a child was assigned — often not by choice and not based on their needs — should not determine the support they receive as they transition to adulthood.

Worker safety and placement sustainability

Youth workers in residential care and foster and kinship carers are disproportionately exposed to aggression and violence from the children in their care. This is not incidental. It is a predictable consequence of placing children with severe trauma histories, attachment disruption, and unmet therapeutic needs into environments that are not designed or resourced to address those needs clinically.

Current safety responses typically remove the worker or end the placement. The instinct to protect the worker is understandable, but the mechanism causes harm. Every placement breakdown reinforces what children with complex trauma already believe: that adults will not stay, that relationships are temporary, and that connection leads to abandonment. Safety responses that destabilise the child are not, in any meaningful sense, safe.

The Services Union's submission documents in detail the conditions under which residential care workers are currently expected to operate — sole-staffed shifts, minimal induction, limited access to clinical guidance, and inadequate support following critical incidents. Together endorses those findings. Where workers are placed in high-intensity relational environments without structured therapeutic oversight, adequate staffing, or a clinical framework for understanding and responding to children's behaviour, the conditions for placement instability are built into the model itself. This is not a reflection of individual worker capability. It is the predictable consequence of a system that asks workers to provide therapeutic care without the infrastructure or resources that therapeutic care requires.

What this looks like in practice

An eleven-year-old with a significant trauma history, problematic attachment, and escalating aggression was cycling through multiple placements. Each breakdown confirmed what her history had already taught her: that adults would always leave. The placements were not failing because the workers did not care. They were failing because no-one was holding the relational work clinically. It was only when a consistent team held the placement through the worst of it — supported by clinical oversight and a shared framework for understanding her behaviour — that her presentation began to stabilise. The difference was not a new placement. It was sustained, supported relationship.

This pattern is not unusual. Workers throughout the survey described children whose trajectories worsened with each successive breakdown, and placements that ended not because care had failed but because the system had no mechanism to hold them through difficulty.

Together supports The Services Unions recommendations for mandatory two-worker models in high-risk placements, structured post-incident support, and access to independent clinical advice — and

submits that these workforce safety measures and the therapeutic review mechanism recommended below are complementary, not competing, reforms.

Together Queensland's recommendations: Reforming residential care

Workers describe residential care as carrying responsibilities that would be better addressed earlier in the system. Together considers that residential care should not be marginally improved or expanded in its current form, but fundamentally redesigned, alongside greater investment in early intervention to reduce reliance on residential care over time. Together Queensland recommends that the Commission consider the following:

Redesign the model

- **Professional, specialist foster care:** Reduce the reliance on residential care by redirecting funding toward early intervention, family support, kinship care, and professional foster care.
- Queensland must establish a professional foster care workforce — trained, accredited, therapeutically supported, and adequately paid. While the Crisafulli Government has acknowledged the need for professional foster care through its commitment to pilot a professional foster care program, **pilot-level responses are no longer adequate**. The scale and complexity of need in Queensland's child safety system requires the Government to move beyond pilots and commit to full implementation, with sustained investment at scale. Professional foster care must be established as a core component of the system, not trialled as a limited initiative.
- **Trauma-transformative residential care:** Where residential care is used, it must be time-limited, genuinely therapeutic, and designed to transition children into family-based care. Providers must demonstrate evidence-based models such as Developmental Dyadic Psychotherapy and employ qualified clinical staff to support both children and youth workers.
- **Investment in kinship and family support:** Funding should prioritise safety-focused, intensive in-home support, outreach, and therapeutic intervention to prevent removal where possible and support reunification where it is safe.
- **Accountability for outcomes, not occupancy:** Contracts should be tied to relational stability, child wellbeing, and successful transitions — not beds filled or hours delivered. Providers must be accountable for care quality, workforce capability, and child experience.

Voice of the child and placement advocacy

- **Placement moratorium:** Where there are no risk or safety concerns and a young person is stable and objects to a placement move, an automatic 48-hour stay should be triggered for independent review of their wishes before any transfer proceeds.
- **Oversight of self-placed young people:** The Commission should consider the use of mobile outreach advocates for self-placed young people, a multi-agency response framework, and formal practice guidance for Child Safety Officers managing these cases — particularly where there are concerns about sexual or criminal exploitation.

Post-18 support

- **End placement discrimination:** The Government should fund Supported Independent Living arrangements post-18 for young people in residential care, equalising the transitional support available to those in foster care. Placement type should not determine whether a young person leaves care with support or without it.

Worker safety and placement sustainability

- **Therapeutic review:** High-risk placements involving children with complex trauma, significant attachment disruption, or escalating behaviours should receive structured therapeutic review, bringing together the carer or youth worker, a clinician, and practice leadership to assess relational dynamics and develop a proactive plan for placement sustainability.
- **Prevention, not crisis response:** Therapeutic intervention should be established as a preventive practice mechanism — activated early and regularly, not after breakdown has occurred.
- **Workforce safety in consultation with unions:** Workforce safety measures in residential care and foster care settings should be developed in consultation with the relevant unions, and should address both immediate safety responses and the clinical and supervisory infrastructure required to reduce the conditions that generate risk.

Chapter Two: Fixing a broken system

Generations of reform attempts

The Queensland child protection system is not unique in having a 'broken system' - this is a national problem. Child abuse, and the prevention of child abuse, are not easy conversations. It involves accepting that some harm caused by abuse can be tolerated, while other 'significant' harm is not. For many people in the community, that is a difficult threshold to hold - but this is the professional assessment that the skilled child protection workforce brings.

For decades, the Department, in all its shapes and forms, has attempted to interrupt the crisis or prevent the system from breaking. Together's *Raising Voices, Reforming The System* survey responses show that the workforce identify a failing cycle. In its simplest interpretation, despite all attempts, the system still does not resolve problems - it kicks the can down the road. Problems are not resolved, and they return, larger than originally presented.

Constant changes to policy, procedures, practice

In reviewing the reform agenda of the Department in the last three to five years, there have been competing reform priorities, in the context of workforce shortage. Workers report a constantly changing landscape and an expansion of their role without corresponding support or the eventuation of promised improvements. It is very clear throughout responses that workers want reforms that will enable deeper and meaningful engagement with the families, children and young people that they case manage. Conversely, most new initiatives or programs increase red tape and operate primarily as compliance activity. This cycle of ongoing change rarely allows any previous reforms to be embedded in practice, leading to uncertainty and lack of confidence in undertaking day-to-day tasks. Workers have highlighted some examples of this in their *Raising Voices, Reforming The System* survey responses, outlined below.

Enhanced Intake & Assessment Approach (EIAA)

The intent of the EIAA model was to improve consistency and quality of intake decisions, strengthen early intervention pathways (IFS, Family and Child Connect, community supports) and embed culturally safe practice including active efforts. New response pathways were created for notifications - Safety & Support Response, Standard Response, Priority Response. Significantly, a standard response shifts focus to a family needs assessment, not just assessing risk of harm.

Together participated in some consultation for EIAA in September 2023. Feedback from union members at that time documents that workers were expressing fatigue with the constant changes in frameworks and guidelines. Stage 1 of EIAA commenced in September 2024, with a full roll out occurring in April 2025 with the delivery of Unify. In theory, the EIAA model attempts to reform early intervention, however the implementation of this has received commentary throughout the survey about its operationalisation:

> *"The introduction of EIAA has meant that standard responses are probably not being considered in a child protection perspective when they should be and 72 hour priority responses are not getting touched - the resourcing is not right and neither is the practice."*

> *"The premise for EIAA was to offer front end support with the goal to divert families away from the CP system if their needs could be met communities organisations. There was no funding commitment or increase in funded agencies to properly support EIAA."*

"Processes for supports such as Safety and Service Response are not active and utilised as there are no providers working in that space. It was rolled out ahead of this capacity being filled. Together is not provided with statistics about the effectiveness of EIAA, and there is no publicly available data; however, survey responses identify that workers are experiencing a direct conflict between closure rate performance indicators, and undertaking quality assessments. It appears, from a worker perspective, that EIAA rewards speed over depth.

"EIAA - the procedures in the CSPM are the same for both responses. So there is no actual difference between standard and priority when you consider the information you need, tasks you do to get this. All families regardless of concerns should experience engagement rather than interviews. You cannot assess safety, risk, need and protection in isolation. It's hard to understand that a needs assessment by the department is the 'other action' part of the legislation. It's not working - if there is reasonable suspicion a child is in need of protection then shouldn't assess whether that is the case. They keep saying 70% are unsubstantiated - what about accuracy? Ones I have read have harm or risk and a safety plan that requires monitoring and intervention to address those risks- not closing. With strategies to just get rid of matters like review and complete and now a permanent review and close that makes me feel uncomfortable working here. Those strategies create a culture to push things to the side so that they will become eligible, so you can try and get to the other work."

On paper, EIAA appears to be a reform that could drive significant change. Anecdotally, from workers, the practical implementation is not shifting the dial on improving the right intervention at the right time for children and families. Workers report holding significant concern that the model is actually creating more risk and contributing to systemic cumulative harm. The Child Safety Practice Manual (CPSM) guides staff that Standard Response assessments may be reviewed and closed where a number of criteria are present, including when the assessment has been open and unallocated for 60 days. Workers are reporting through the survey that they are unable to commence Priority response assessments, let alone commence Standard response assessments. It's difficult to see that this Review and Close option as anything more than a workload management strategy and not addressing the cause. For EIAA to deliver on the outcomes it has set out to do, the Government must invest in appropriate secondary services so that diversion is an actual possibility.

Unify

The Unify system was delivered to frontline staff in two stages. The first stage was delivered in 2021, and had key functions such as Care Arrangement referrals, SCAN, and Person Profile. At this time, workers were required to use both Unify and ICMS (the case management system being replaced) in what was known as co-existence. In April 2025, Unify products for Intake, Assessment, Ongoing Intervention, Care Arrangements, Child Protection Court and Regulation of Care were delivered, in various states of readiness, across the Child Safety continuum and this has caused significant distress to the workforce. Together's *Raising Voices, Reforming The System* survey responses outline that Unify is a system that has made work harder, not easier:

"FIX UNIFY. People are delaying doing things like case plans, placement agreements etc. because they're convoluted and actively stressful, streamline online work."

"Unify increases my workload and the time it takes me to complete tasks. I have considered quitting as a result of how time consuming it is to complete tasks on unify while making time for contact times with families (multiple a day from anywhere between 1 to 3 hours long that need to be fully supervised), home visits and working on reunification and court related affidavits and gathering information for the court."

"Unify is a daily obstacle to be overcome. It has resulted in me being behind with case plans, lost time due to spending many hours in total looking for things eg placements, court orders. Unify is a disgrace and has caused huge additional stresses to workers."

"Child Safety = Titanic
Unify = Iceberg"

Union members reported directly to Together after the roll out of Unify that workers in Regional Intake Services were directed to **not carry out their legislative responsibilities** due to the issues in the system. A Child Concern Report (CCR) completion strategy was implemented which directed staff as follows:

1. Notified concerns contained in written notifications (for example health professionals, education and Queensland Police Service) can be entered verbatim into CCR reports, without editing/de-identifying. (S186 of the CPA requires a notifier to be anonymous). Instead, staff were directed to record

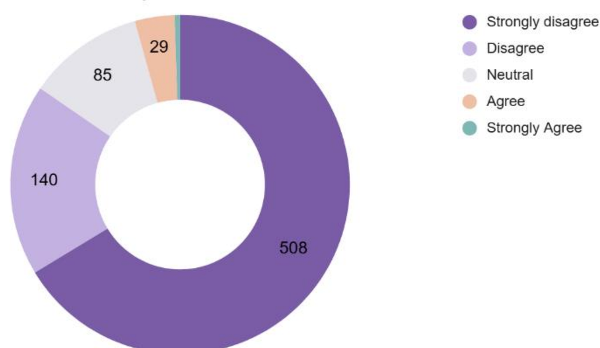
    "This record of concerns has not been de-identified and has been directly transferred from the original report as part of a time-limited Director General approved CCR completion strategy."

2. They were to enter a standard rationale into CCRs, without being made relevant to the particular case. Staff were directed to record the following:

    "An intake officer/child safety officer has considered the information provided by the notifier and the departmental history. The Decision Making at Intake Practice guide has been applied and it is determined there is no reasonable suspicion this unborn or child/ren are in need of protection now or after birth. Due to time-delays in Unify performance, a comprehensive rationale regarding the CCR screening decision is not provided. A Senior Team Leader has approved the CCR on the basis of the information recorded from the notifier and without reference to a written rationale. The Director-General has approved this time limited workload management strategy from 1 July 2025 to 31 December 2025."

Not only has Unify made the critical tasks of record keeping and decision-making transparency extremely difficult, it has placed workers in a moral juxtaposition - being directed to **not** meet their legislative requirements while also knowing that complying may have future unintended consequences. For example, if a Child Safety Officer is preparing court material in the future for a family where the information in a CCR about domestic and family violence has not been appropriately de-identified, there is a real safety risk to children and victims.

Unify is another example of an attempted reform that has missed the mark. The system was intended to be a transformational change for the child protection workforce, and there was all the potential for this to be the case. For everything Unify attempted to achieve, namely, create a person-focussed case management system that easily told the story of a child, young person or family, it has failed. Workers have been left with a fragmented system that is slow, unreliable and they simply do not trust the information contained in there.



> *"UNIFY has completely disrupted meaningful workflow and significantly impacted on capacity to work effectively. I still struggle to comprehend how a system has taken years and so much money to build and have so many foreseeable and functional issues. It would have been better spent investing that money into the department itself to do meaningful work. The system is bugged, hard to navigate and functionally did not have all documentation migrated which has significantly impacted on the safety of children. This is seen now in quality of intakes and the inaccurate information reported to CSSC's from an assessment perspective. In addition, tasks and forms take significantly longer than previous meaning we spend more time completing administration than before. I am also still so strongly reliant on ICMS to cross reference and access information due to all the gaps with UNIFY."*

NB: Prior to the Together Union making this submission, the Department-commissioned report by Deloitte has been released and details ongoing operational issues that staff are experiencing with Unify.

Independent Person/Entity

Together notes a critical legislation change that came into effect in 2018. The intent and the legislative 'wins' were real. The practice 'wins' never arrived, especially for Aboriginal and Torres Strait Islander children, young people and families, due to insufficient implementation and resourcing. Namely, the funding for Recognised Entities was re-directed to Family Participation Programs and the concept of Independent Person/Entity was introduced into legislation.

Across 78 questions and over 1000 responses, the silence on Independent Entity is alarming. Between this, and the lack of an evaluation (or a publicly available one), this is likely an indicator that the process is marginalised:

> *"Policies and legislation like Independent Persons I feel are not sufficient…I feel that speaking to families about an IP is one of those things that falls to the wayside because staff are so busy that they forget (which is another reason why co-response models like FPP are so fantastic)."*

Without public reporting, without an independent evaluation, and without resourcing to meet the demand created by mandatory referral, a genuine legislative win for Aboriginal and Torres Strait Islander families has become another obligation that falls to the wayside — important in the Act,

invisible in practice. As one respondent put it, the organisations that carry this work were "set up to fail or constantly battling to keep afloat" from the moment the Recognised Entity funding was redirected without a corresponding increase in what was being asked of them.

Voice of the child

In 2022 the *Child Protection Reform and Other Legislation Amendment Act 2022* made several specific updates to s74 of the *Child Protection Act 1999* to strengthen children's rights and align the *'Charter of rights for a child in care'* in Queensland with broader, rights-based language. These changes elevated the participation of children and young people from a practice expectation to a rights-based, legislated entitlement.

The gap between this legislative entitlement and the lived experience of children in the system is documented by the CREATE Foundation's submission to this Commission (*Submission for Safe Engagement of Children and Young People*, September 2025). Drawing on consultations with young people with out-of-home care experience, CREATE reports that children and young people feel ignored, disempowered, and excluded from decisions about their own lives.

In Together's survey, staff reveals the structural mechanism behind these experiences. Across the survey, workers identified a simple theme: **staff cannot listen to children they do not have time to see.** Workers are frustrated — they want the time to build relationships and meet their legislative obligations, and to truly centre children's and young people's voices.

"More focus on the children themselves, their needs, building relationships with them. CSO's seem to be getting lost in paperwork and forgetting what the purpose of all of this is."

"Give children and young people a real voice in every decision that affects them and make that voice carry actual power."

The convergence between what young people experience and what staff report is not coincidental. It reflects a single structural failure operating across the relationship between worker and child. The two most critical cohorts in child protection — the children the system exists to serve, and the workers the system employs to serve them — experience the same structural failure from opposite sides. Both report feeling unheard. Both report feeling undervalued. The common cause is a system that has substituted process for relationship, compliance for connection, and throughput for trust.

Investment too late and not enough

Overwhelmingly, the sentiment across survey respondents was that there is insufficient investment in early intervention, which has significantly contributed to the State's expenditure in out of home care. However, workers also report that it is an absolute must that the State invest in the children and young people currently in care - it cannot continue to neglect their ongoing safety, wellbeing and belonging.

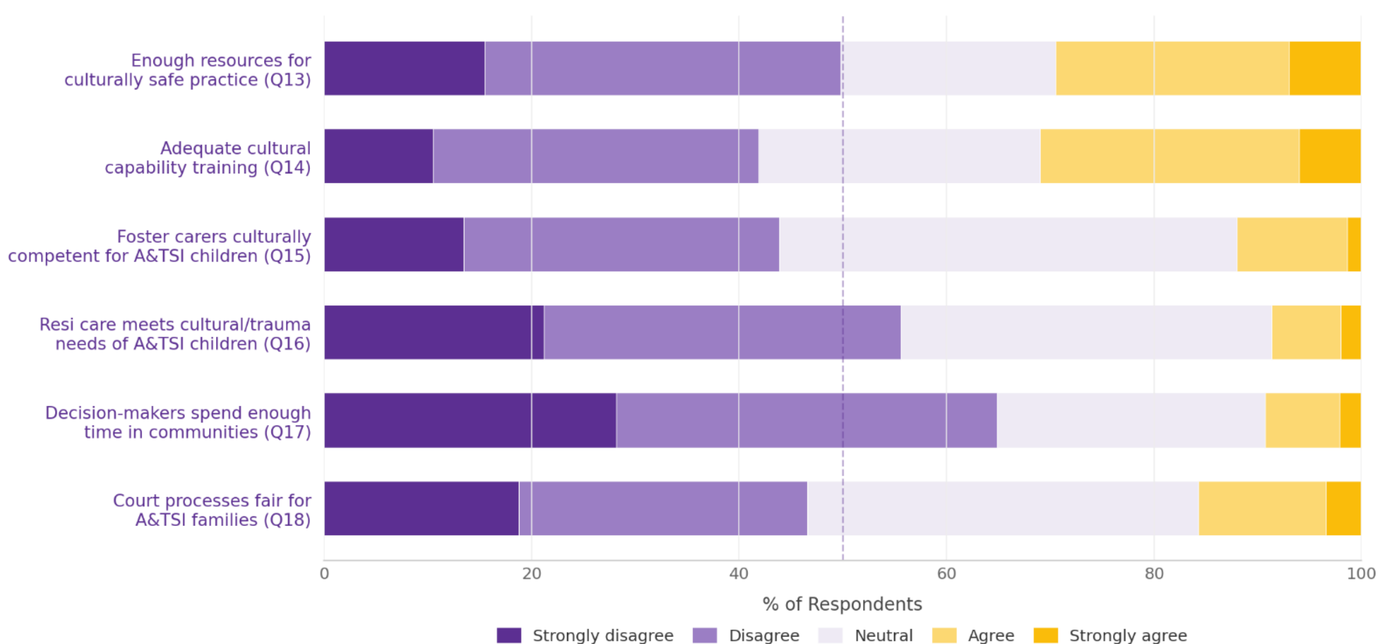
Workers are hopeful that significant investment at the early stage of children's lives, well before the child protection system is required to be involved, will result in safe and thriving children, families and communities. And that this would have a flow on impact to workloads and the engagement they can do with children and families that really do need tertiary child protection support.

Chronic under-resourcing for support of Aboriginal and Torres Strait Islander children and families

Reporting from the Queensland Family and Child Commission released in 2022-23 showed that the over-representation of Aboriginal and Torres Strait Islander children is increasing, not stabilising. Queensland has not been able to report more current data, typically provided in the Report on Government Services, due to the failed Unify implementation. There is concern that without this data there will be major gaps which could impact ongoing investment. Aboriginal Community Controlled Organisations perform critical functions for children and young people and their families, including Family Wellbeing Services (FWS) and Intensive Family Support (IFS).

55% of survey respondents did not agree that there were sufficient policies/programs culturally appropriate (Q20)

49% of survey respondents agreed that there were not enough resources for culturally safe practice (Q13)



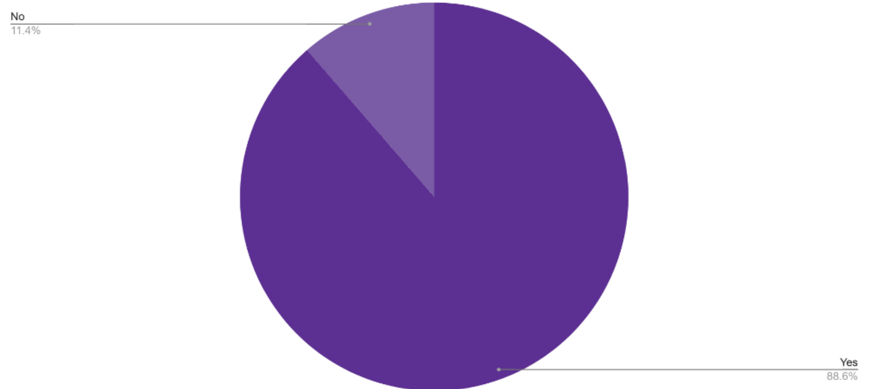
"Significantly underfunded, long waitlists and limited capacity to attend to the needs of our families (which is over 50%) very unbalanced in how funding is provided does not support in 'closing the gap'"

"These services are inadequately funded for the proportion of First Nations families"

"Aboriginal and Torres Strait Islander families need more support. The delegated authority are doing incredible work but are understaffed."

Early Intervention

In response to the question "Do you believe there is a gap in funding from the Queensland Government for the Department to provide supporting/funding for medical, disability, or other assessments within the IA stage, to support families and prevent chronic neglect (prevent the family from being screened back in)", **88.6% of respondents** believe there is a gap in funding for medical, disability, and other assessments at the IA stage. Only 11.4% said No.



Staff describe a structural design where children must reach crisis before the system will invest in them. **88.9% of respondents agreed that preventative funding is insufficient**.

Existing early intervention services are structured in ways that ensure they fail with the families who need them most. Services close after minimal contact attempts, decline referrals for being "too complex," and cease engagement when families disengage.

> *"Many preventative services close their cases after a failed attempt to make contact. No actual intervention has taken place, families aren't diverted from the system as intended"*

> *"The preventative and early intervention services are not designed to do robust reach out to people. If a family does not respond to a couple of attempts to contact them, they fall off the list."*

> *"There is insufficient capacity in the early intervention sector nor are they appropriately skilled to undertake this work as they are not tenacious or persistent enough to obtain engagement."*

Regional and remote service deserts

Workers responding to the Together Queensland survey from rural and remote areas have described a near-total absence of services — whether early intervention, allied health, disability support, or housing. This is not a marginal problem affecting a small number of families at the edge of the system. It is a structural failure that systematically increases the likelihood of children entering statutory care, and decreases the likelihood of them safely returning home.

The gap between policy intent and regional reality is not a minor implementation issue. It is a fundamental design failure. Workers in remote communities are being asked to implement reforms: the EIAA model, Safety and Support Responses, referrals to FIS and IFS, that assume a service ecosystem that does not exist where they work. Diversion is not possible when there is nothing to divert families to.

> *"Policies and legislation are made by people who don't live in our reality. Don't take into account remote, rural areas and the lack of everything that goes with it."*

Absence of services drives unnecessary removal

The evidence from workers is direct: when there is no service to refer a family to, there is no alternative to statutory intervention. When a worker identifies a concern and the only tool available is removal, removal becomes more likely, not because the family is beyond support, but because the support does not exist. **This is not a failure of individual judgement. It is the predictable consequence of a system that has never invested in the infrastructure required to make alternatives real.**

> *"I don't know what's working well. I know that there are children who continue to be at risk because we simply don't have anywhere to put them if removed and I also know that there are cases which do not need to be involved in child safety but because there is not enough support or services for the children to remain safely at home then they are removed."*

> *"Children are removed and foster carers receive funding for having these children in their care. Many families would be able to keep their children if they were afforded the same funding to care for their children in the home."*

Workers also describe an asymmetry that compounds this injustice. A family facing the same presenting concerns in Brisbane has access to FIS, IFS, counselling, DV services, and allied health. The same family in Mount Isa, or a remote community in Far North Queensland, has access to none of those things. The child protection system becomes the only door, and removal the only tool. This is not equitable. It is not safe. And it is not what the legislation intends.

> *"I sadly do not see any preventative or early interventions services — I cannot even name them."*

> *"There is a very large gap in the funding for health, disability and other assessments — there is a 6-12 month wait on a paediatrician in this region and Paeds/NDIS/Allied Health support in remote communities does not exist."*

> *"In Mount Isa we have little resources for individuals with disabilities which often means our kids and parents go without or have inadequate support."*

Reforms that assume a service ecosystem that does not exist

The introduction of the EIAA model illustrates the problem with particular clarity. The model was designed to divert families away from the statutory child protection system by connecting them with community supports. Workers broadly support the intent. The implementation has failed because the services required to make diversion real were never funded.

> *"The premise for EIAA was to offer front end support with the goal to divert families away from the CP system if their needs could be met by community organisations. There was no funding commitment or increase in funded agencies to properly support EIAA."*

"Processes for supports such as Safety and Service Response are not active and utilised as there are no providers working in that space. It was rolled out ahead of this capacity being filled."

For regional and remote workers, this failure is not abstract. The Safety and Support Response pathway that looks like a genuine option on a policy diagram simply does not exist in their community. Workers are left holding risk with no tools to address it, other than the blunt instrument of statutory intervention.

"No, not at all, and this has been the case across multiple state governments over the years. I am particularly saddened that in rural and remote areas, we have no services at all — however in more urban areas there is an over saturation of services. Our families in regional and remote areas are desperate for preventative and early intervention, as often, due to lack of services and other factors, children end up being removed and coming into care unnecessarily. We MUST do better out in the country."

The over-representation of Aboriginal and Torres Strait Islander children cannot be separated from geography

The over-representation of Aboriginal and Torres Strait Islander children in the Queensland child protection system cannot be understood separately from this geographic reality. The communities with the highest need have the fewest services, the least stable workforces, the fewest culturally appropriate supports, and the greatest distance from decision-makers.

Workers describe a system in which Aboriginal and Torres Strait Islander families are expected to engage with Family Participation Programs, Cultural Practice Advisors, and Family Wellbeing Services that are chronically understaffed and, in many remote communities, simply not available. The legislation requires active efforts. The infrastructure to make those efforts real does not exist in the places where it is most needed.

"There has been a 'one-size-fits-all' approach to funding models, staffing requirements and carer support. When logic tells us that funding models for services in Brisbane will never meet the needs of remote communities."

"There are no services for our families, no housing to have our kids reunified back to family."

Workers in these communities are not just carrying higher risk than their south-east Queensland counterparts. They are doing so in near-total isolation, without the infrastructure, the workforce stability, or the cultural resources that would allow them to practise safely. FIFO work patterns mean that relationships — the foundation of good child protection practice — cannot be built. Metropolitan-designed policies are applied to contexts they were never designed for. And children pay the price.

What workers say needs to change

Workers are clear that fixing regional and remote inequality requires structural investment, not further policy design. Specifically:

- Regional infrastructure planning must treat allied health and community services as core infrastructure, not optional additions. Asking a parent to access help 100 kilometres away with a newborn is a barrier that prevents help-seeking. That barrier is a policy choice.
- Investment must flow to Aboriginal Community Controlled Organisations in remote communities, including Family Wellbeing Services and Intensive Family Support, which are chronically underfunded relative to the proportion of First Nations families they are expected to serve.
- Reforms like EIAA must not be rolled out until the community service infrastructure required to make them work actually exists in the regions where they are being implemented. Rolling out a diversion model with no services to divert families to does not reduce risk. It creates a paper pathway that workers cannot use and families cannot access.

"For us there is a lack of doctors, services, distance, waiting times. We need FIS services for communities."

The Commission has an opportunity to name this clearly: regional and remote service deserts are not a legacy problem that will resolve themselves. They are the product of sustained underinvestment, and they require sustained investment to fix. Every year that passes without that investment means more children removed unnecessarily, more families unable to access support, and more workers carrying impossible risk in impossible conditions.

The revolving door impacts children, families and workers

Children falling through the gaps

All of the above structural barriers quite simply mean that children are falling through the gaps, and the system will never be able to recover them.

"I am very worried that the system is becoming very dangerous for children and that I am no longer able to keep them safe." — [Child Safety Officer | More than 20 years]

At the intake and assessment phase, workers are identifying that too often, families are screened in, assessed superficially (or not at all), closed without support, and re-notified when conditions deteriorate. Services close after minimal contact. Waitlists outlast intervention windows. The workforce that results from this churn is exhausted and depleted, further reducing the system's capacity to intervene effectively when families return.

"The quick review and close system is ineffective. On a significant percentage of occasions, families who have had an OA closed under a review are re-screened as new notifications within weeks to a few months."

"A great deal of IAs are closed quickly or even worse - not even investigated and just closed. They come back to us like a revolving door as the issues are not addressed early enough or at all"

“With the new IA approach, completing investigations in 30 days or less, these significant decisions can miss things like domestic violence and neglect. Decisions to take CPOs on children should not be reduced to a 30 day timeframe”

The early stages of ongoing intervention are critical to successful reunification pathways. The Department has many KPIs, but is silent on reunification. There is very little reform that has focused on reunification, and there is a single 3-page practice guide from 2022 on decision making for reunification. There was a common theme among survey responses - that reunification is one of the most rewarding parts of the work, but that effective reunification needs structured and intensive support that is hard to pay attention to within the current broken system.

I love seeing positive reunifications of which I have done a significant amount. This is never reported! i love kids and love to see mums and dads get their lives back on track and reunite with their children because that's what most kids want at the end of the day no matter what mum or dad have done.

When working with children who are subject to CPOs, I felt like I could not give the attention needed to each family to achieve reunifications or better outcomes. So many families were at a point where contact could be increased and a reunification plan developed, however, CSOs had no capacity to increase contact (if needing to supervise or assist with transporting kids) and TL was extremely risk averse, meaning families were missing out.

Workers also reported that wait lists for services in NGOs are excessive and not available at the right time for a family.

“There is not enough funding in this area to meet demand. FIS have up to 12 months waitlists, counselling has up to 6. We need these services now.” — [Child Safety Officer | 5-10 years]

Workers carrying significant psychological harm from moral injury

The resiliene of the child protection workforce must not be understated. They bring hope, compassion and determination to scenarios that most people choose to ignore. Despite many obstacles, workers unite in shared vision of children, young people and families thriving. Workers were asked to share what they would like the public to know about the role:

“That departmental employees work exceedingly hard, doing a very difficult job, that no one ever gives them public credit for, with minimal benefits for all the long hours they put in, whilst responding to some of the most complex social situations in the State. They do this work with limited resources and constant high caseloads that do not change. They do this because they care deeply about the welfare of children in our community, but it is unsustainable to think they can meet the demands without a massive shift in resources. There has been Inquiry after Inquiry but staff just want some changes now, not to see another long report end up sitting on a shelf.”

“That everyone in our department tries their best. Workloads are high, resources are low, and the people we work with are complex. Staff are under stress constantly, and you could work 24 hours a day and probably still have things to do. The community only acknowledges us when something

goes wrong and there is no acknowledgment of the nature of the work we do, the vicarious trauma we suffer, and the positive outcomes we still manage to achieve from the government, media or public."

This resilience and tireless effort is not without impact. Staff have described acute distress, including crying daily and sleepless nights. What is most concerning, is that workers have made a distinction between acute distress, burnout and moral injury. Whilst burnout is frequently reported as why people leave the Department, workers are reporting the significant negative impact on their psychological wellbeing of knowing what children need, being professionally obligated to provide it, and being structurally prevented from doing so.

"Good people leave not because they don't care – but because they cared at a level that was unsustainable within the current system."

"Passionate CSOs want to provide the best support to families and children as possible but often the system prevents that from happening. This is really hard to sit with."

Workers recommend these changes

Listening to the voices of workers and their lived experience is essential in reforming a broken system. Workers know what is needed to make sure they can achieve the outcomes they desire - engagement and support of children and families for stability. There are some key themes outlined below.

Whole of government action is a must

The child protection system is absorbing consequences of failures across multiple policy domains. Upstream social crises including housing affordability, domestic and family violence, mental health, substance misuse - the real drivers of child protection notifications.

Societal shift to prioritise the care of parents and unborn / newly born children

To effect generational change and to enable reform attempts outlined above have the best chance of success, investment needs to start before a child is born.

"If the same money was put into prevention as to residential space, there would be less incoming IAs. The priority of money allocation is appalling."

The State investing in early childhood is in the public good. This could include:

- Assisting parents to address substance abuse and mental health within a health care setting that is universally free, easily accessible and compassionate would significantly decrease the risk of involvement with the tertiary child protection system.
- Provide a basic level of financial security for all families - addressing poverty is key.
- In-home family support following the birth of a child as a right for each family, with a focus on support for the physical and emotional wellbeing for parents and child – not a punitive lens.

Regional infrastructure planning embeds allied professionals

The State undertakes significant planning for new areas of growth. This planning must move from allied health and professionals being an optional add-on to core infrastructure. Children and families in regional and remote areas need to have access to place-based interventions. Seeking help as a parent must be viewed as achievable - needing to access a service 100KM away with a newborn, is a barrier that prevents help-seeking behaviours.

> *"In Mount Isa we have little resources for individuals with disabilities which often means our kids and parents go without or have inadequate support."*

Allied professionals would include, but not be limited to:

- Aboriginal Community Controlled Organisations
- Maternity services;
- Disability support;
- Mental health services;
- Substance abuse recovery with a health framework;
- Domestic and family violence services;
- Community and neighbourhood centres.

> *"Policies and legislation are made by people who don't live in our reality, [they] don't take into account remote, rural areas and the lack of everything that goes with it."*

Adequately resource the secondary sector now and into the future

This was highlighted by workers as the most significant investment that the Government could undertake. Secondary services at the right time supports reforms like EIAA in diverting families from the tertiary sector. They support reunification efforts and increase the likelihood of long-term success. Workers want continued investment, not short-term trials or programs that only last for 6 months. Most importantly, for everyone involved, the tertiary child protection system should not become the default responder to all social issues.

> *"All other departments think Child Safety has excess money to pay for everything eg NDIS pushes back on funding children in care, Health expects Child Safety to have easy access to private psychologists etc."*

Specialist early intervention teams in the tertiary sector

Even when children are subject to child protection orders, the State has a legislated responsibility to help the parent address the concerns so that their child or children can be safely returned to their care. Research by Australian Institute of Family Studies, the *Review on timely decision making in out of home care,* indicates that reunification after a child has been in care for longer periods of time is less likely to be successful. There are parts of the child protection workforce that are passionate about reunification, where it is safe to do so, and believe that Department-focused teams could assist in achieving this more frequently, and safely, with dedicated support.

“I think that early intervention teams should be implemented across the state. Specialist active reunification staff members should be brought in at the point when the assessment is complete and handover is about to occur to ongoing intervention.”

“If there was a strong focus on early intervention and or reunification from day 1 we would observe a significant reduction of children in care.”

Having these teams within the Department builds workforce capability while also addressing core issues of families being stuck in the system. This would be a meaningful reform where staff utilise their professional skills and knowledge.

Reforms that engage front line workers in decision making

The workers who responded to this survey are not passive recipients of a broken system. They have clear, practical ideas about what needs to change and they have earned the right to be heard. Across thousands of responses, a consistent theme emerged: workers are not consulted in the design of the reforms they are expected to implement, and when they raise concerns, those concerns are not acted on.

This must change. Frontline workers hold knowledge that no policy designer, senior executive, or commission can replicate. They know what a good assessment looks like. They know what a family in genuine crisis needs. They know which reforms are working and which ones are generating paperwork without generating safety. That knowledge needs to be built into how the system designs, measures, and improves itself.

The most urgent reform in this space is to define what quality looks like and to measure it.

The system currently counts what is easy to count. Cases closed. KPIs met. Timeframes hit. It does not measure whether children feel safe, whether families are supported, whether relationships are being built, or whether reunification is being actively worked toward. Workers who slow down to do thorough, relationship-based work are penalised by a system that rewards speed. Workers who raise concerns about practice quality are told to focus on their numbers.

"Quality is not measured, it is assumed. Only quantity is measured. The pressure points within the system only reward quick surface level work that moves along 'numbers'. In this context, staff turnover, lack of experience, lack of support to pursue funding options to assist families, and many other issues compound to create a lack of outcomes."

"Measuring quality and creating a pre-eminent quality practice KPI. As mentioned previously in this survey, quantity is measured and all KPIs relate to this currently."

This is not an abstract concern. The survey data shows directly that KPI pressure at the intake and assessment stage is driving superficial assessments, premature case closures, and the revolving door that follows. Workers are not closing cases because they believe families are safe. They are closing them because the system rewards closure. Measuring the wrong things produces the wrong outcomes.

Together Queensland recommends that the Commission consider the following:

Frontline workers and their union should be formally involved in the co-design of any new performance framework. Workers know what good practice looks like. They should be the ones defining how it is measured — not having measures handed down to them that bear no relationship to the work they actually do.

Quality indicators should sit alongside, and ultimately take precedence over, throughput indicators. These could include: stability of placement, frequency and quality of contact with children, reunification rates, re-notification rates, and — critically — whether children and young people report feeling heard and safe.

Existing KPIs that actively reward poor practice — particularly closure-rate metrics at the intake and assessment stage — should be reviewed and replaced. Workers have told this survey, clearly and repeatedly, that these metrics are making children less safe. That evidence should be acted on.

> *"Pay CSOs properly so more can be recruited and people want to do the job so caseloads are lower, staff can be maintained to reduce staff turnover so CSOs can work more thoroughly to develop relationships with children, families, carers, and stakeholders, listen to children, prioritise stability reducing placement breakdowns, take responsibility for healing trauma... rather than measuring staff performance with KPIs, measure it with how they develop connection, stability, and trust with clients, and the outcomes."*

The child protection workforce has been through inquiry after inquiry. Workers are not asking for another report. They are asking for change that is designed with them, not at them — and that measures what actually matters for children.

The health and disability needs of children

Health

The Child Health Passport (CHP) model was introduced in 2007 in recognition of the limited information available about the individual health needs of children entering the child protection system. Its stated aim was to ensure every child received an annual comprehensive health assessment and that relevant health information was obtained at the point of entry into care. Nearly two decades later, the intent of that model remains aspirational rather than operational.

In 2013, the Carmody Inquiry made 121 recommendations. Recommendation 7.7 specifically required that every child in out-of-home care receive a Comprehensive Health and Developmental Assessment within three months of placement, in accordance with the National Clinical Assessment Framework. The Government accepted this recommendation, noting that Queensland already required children to have a health check within 30 days of entering care. The language was confident. The implementation fell short.

Two pilot programs — Navigate Your Health (NYH) and Strengthening Health Assessment Pathways (SHAP) — were subsequently developed to improve health assessment outcomes. SHAP demonstrated measurable success in increasing the number of children receiving health assessments. Both pilots arrived at the same conclusion: a dedicated health-specific role was required to sustain progress. The Carmody Inquiry recommended a Care Coordinator Health Officer. The NYH project recommended a Health Navigator. Neither role was created.

What followed is a pattern this submission has documented across multiple reform areas. Documents were produced. Recommendations were made. Resources were not allocated. The structural gap between policy intent and service delivery was left for frontline workers to absorb.

The residential care roadmap acknowledges the importance of working collaboratively to address barriers to children having their health and ongoing care needs met, and of implementing effective systems for documenting and sharing health-related information. This includes supporting Aboriginal and Torres Strait Islander children's connections to Aboriginal Medical Centres for their annual 715 health assessment. These commitments are not matched by the resourcing required to make them real.

The consequence is that Child Safety Officers — already managing unworkable caseloads — are expected to coordinate health appointments, track assessments, and maintain child health passports alongside their core statutory responsibilities. Health needs are consistently deprioritised by necessity, not by choice. The result is that children in the care of the state are among the least likely to have their health needs systematically monitored and met.

Disability

One in three Queensland children in the child protection system are either suspected of, or have, a diagnosed disability. This is not a marginal cohort. It is a defining feature of the population that the system exists to serve, and the system is structurally unprepared to meet it.

Child Safety Service Centres (CSSCs) face compounding pressures at the intersection of child protection and the National Disability Insurance Scheme (NDIS). Some CSSCs have attempted to address this by utilising existing Senior Child Safety Support Officer positions to assist with casework tasks related to disability. However, growth in caseload and the absence of dedicated resourcing has progressively eroded that capacity. The work has shifted to other priorities because the system has left workers with no other choice.

Specialist Services Clinicians (SSC) led by a Principal Clinician have been operating a 'hub and spoke' model – a central office program delivered by the regions. There are 15 SSCs and 1 Principal Clinician across Queensland. Initially this role was to support CSSC's identify children and young people who have a disability and support the CSSC seek access to the NDIS and support implementation of any NDIS plans. Over the past 4 years, the scope of the role has significantly increased to also include supporting CSSCs where children and young people engage in Challenging Behaviour, supporting CSSCs meet policy and procedure obligations relating to restrictive practice, supporting CSSCs implement the Suicide and Non-Suicidal Self-Injury practice guide. While the scope of the role has increased, the number of positions available to complete the work has not increased.

The South-West region provides a concrete illustration of what happens when resourcing decisions are made without regard for operational reality. Two unfunded Service Officer positions were established to support CSSCs in developing, implementing, and reviewing NDIS plans for children in care. Under the Crisafulli Government, these positions were not continued. The expectation that this specialist work would simply be absorbed by already stretched CSSCs has not been met, it has generated systemic failure.

The practical consequences are significant. When NDIS plans are not appropriately developed or monitored, supports and therapies that should be NDIS-funded are instead absorbed by CSSCs as unplanned costs. Placement decisions are made without the right supports in place, creating

instability for children and additional burden for workers. The lack of expertise in navigating NDIS — itself a complex and demanding system — within CSSCs is not a workforce failing. It is the predictable result of asking generalist practitioners to carry specialist work without specialist support.

These failures have direct financial consequences for the Department and, more importantly, direct human consequences for children. Adequate NDIS planning at the right time reduces long-term costs and improves outcomes. The absence of it drives reactive, high-cost responses that the system then struggles to fund.

Workers responding to the *Raising Voices, Reforming the System* survey expressed frustration that the health and disability needs of children in care were raised in the 2004 CMC inquiry and again in the Carmody Inquiry in 2013. The issues have not only persisted — they have grown. And there has been no additional resourcing allocated to address them.

> *"All other departments think Child Safety has excess money to pay for everything — NDIS pushes back on funding children in care, Health expects Child Safety to have easy access to private psychologists."*

This observation reflects a structural reality. The child protection system has become the default absorber of unmet need across multiple government agencies. Health, disability, housing, and mental health services routinely decline, defer, or redirect families into the child protection system without providing the supports they are responsible for. Without dedicated resourcing to manage that interface, it falls to frontline workers who are already at capacity.

Workers questioning the intention of yet another inquiry when the overdue resourcing still has not been allocated are not being cynical. They are making a reasonable observation grounded in experience. There is a significantly higher cost associated with reactivity than investment. The Commission has an opportunity to name this clearly and to recommend that it change.

Together Queensland recommends that the Commission consider the following:

Increase access to specialist practice advice for child protection and other frontline services at earlier points of intervention, providing greater linkages to mainstream services and/or brokered specialist services targeted to parents and families (not covered by NDIS).

Establish a Specialist Disability Practice Advisor/Coordinator in Service Centers

- Ensure every child with a disability has appropriate supports and services in place.
- Monitor, review, and track NDIS plans, utilisation, and service agreements.
- Advocate for adequate NDIS funding and alignment with placement agreements.
- Identify systemic gaps and escalate issues as needed.
- Make disability a standing agenda item in case planning for children in care.
- Enable this role to have the delegation to make decisions and sign service agreements about NDIS plans without needing to wait on a Senior Team Leader to do so.

Establish regional Senior Program Officer positions specialising in health outcomes

- Ensure every child in care has a current Child Health Passport containing an annual comprehensive health assessment.
- Monitor, review, and track completion of health, developmental, and dental appointments.
- Identify systemic gaps and escalate issues as needed.
- Make health a standing agenda item in case planning for children in care.
- Provide training to internal and external agencies regarding Child Health Passport requirements and processes.

Chapter Three: Law and Power — The Child Protection Litigation Model

Introduction

Together makes this submission on the child protection litigation model established by the 2016 reforms following the Carmody Inquiry. It builds on the union's prior submission on the same subject (Exhibit CA-49), and draws on the evidence placed before the Commission across multiple hearing blocks, on the professional and legislative frameworks governing child protection decision-making in Queensland, and on the experiences of frontline child protection staff as reported through the union's survey of over one thousand practitioners.

The Chapter is organised into five sections.

1. The Nature of Child Protection Decisions examines the decisions at the centre of the child protection litigation model — the statutory tests the Act requires, the professional processes through which those tests are answered, and what follows when the expertise those decisions require is misidentified.
2. The Fragmentation of the State's Legal Function addresses the institutional separation of the State's legal function between two organisations, and the effects of that separation on information continuity, decision-making coherence, and the experience of families before the Children's Court.
3. The Case for Proximity considers the role of physical proximity between legal officers and the frontline practitioners and families they serve, and why the nature of child protection legal work requires embedding as a structural feature rather than a matter of administrative preference.
4. Procedural Reform raises a discrete procedural matter arising from the current model: the universal affidavit requirement under the Children's Court Rules.
5. Recommendations sets out four recommendations for the Commission's consideration.

The Nature of Child Protection Decisions

The tests the Act requires

The *Child Protection Act 1999* (Qld) establishes the principles governing the State's intervention in family life. Section 5A provides that "the safety, wellbeing and best interests of a child, both through childhood and for the rest of the child's life, are paramount." Section 5B(d) provides that where a child does not have a parent able and willing to protect them, the State is responsible for doing so. Section 5B(e) requires that the State "only take action that is warranted in the circumstances." For Aboriginal and Torres Strait Islander children, section 5F requires "purposeful, thorough and timely" active efforts to apply the child placement principle.

When intersecting with the child protection legal system, these principles often converge on two questions. The first is whether a child is in need of protection — whether the circumstances meet the threshold at which the State's responsibility to act is engaged. The second is whether the intervention proposed is the least intrusive that adequately meets the child's protective needs.

Making informed assessments in this space requires sustained engagement with the family — knowledge of the child built through direct contact, familiarity with a parent's engagement over months of incremental and often non-linear change, and the capacity to assess risk in conditions where the available evidence will commonly not resolve the uncertainty. The consequences of these

assessments run in both directions: a child left in danger, or a child unnecessarily separated from their family.

This is predictive, relational, contextual work commonly performed under significant uncertainty. It is the domain of trained professional judgment — not as an aspirational ideal, but as a practised competency that the child protection system depends on daily and that the Act itself presumes.

What the assessment actually involves

Child protection decision-making draws on professional competencies that are complex, structured, and developed through training and supervised practice. The assessments that underpin these decisions are not ad hoc — they follow established frameworks designed to produce rigorous, evidence-informed professional judgments.

The system invests in this structure because the consequences of predictive error in child protection are severe and run in both directions. A child removed from their family when the circumstances did not warrant it is separated from their known world. Of equal concern, a child left at home when the circumstances required removal remains exposed to the risk the State identified but did not adequately address.

These decisions are always questions of degree, duration, and pathway — whether a one-year order or a two-year order, whether custody or guardianship, whether the family's trajectory supports the proposed intervention. They are also, invariably, questions of risk — balancing the consequences of excessive intervention against the consequences of insufficient intervention, assessed on the facts of each family.

The Department's own *Investigation and Assessment* practice manual directs officers to "[m]ake a professional judgement about risk of significant harm" by considering information gathered across five categories: the child, the parents, the harm, the environment, and the family and cultural context. This analysis weighs what has happened in the past, what is happening now, and what risk and protective factors are present within the family, arriving at a judgment on the balance of probability about the severity and likelihood of future harm.

These individual assessments are then subject to multi-disciplinary review. The Department's *Practice Guide: Practice Panels* (updated October 2025) describes a facilitated process in which a child safety officer presents a matter to a panel including a senior practitioner, senior team leader, child safety service centre (CSSC) manager, a "critical friend" drawn from outside the immediate team, and — for Aboriginal and Torres Strait Islander children — a cultural practice advisor. External professionals and specialist advisors in domestic and family violence and child sexual abuse attend as relevant. The panel proceeds through structured stages: case presentation, clarifying questions, formulation and hypothesis, recommendation, and action plan. Outcomes are documented in the Department's case management system, including any dissenting views.

These processes constitute a structured, evidence-informed, professionally supervised exercise of expert judgment. The professional literature recognises this form of decision-making as a core competency that child protection systems depend on — and that system design must actively protect.

Eileen Munro's landmark review of child protection in England identified professional judgment under uncertainty as the central capability on which the safety of children depends. Munro observed that

"[u]ncertainty pervades the work of child protection" and that many of the system's imbalances arise from efforts to manage that uncertainty through procedural controls. The review's first risk principle stated:

> *"The willingness to make decisions in conditions of uncertainty (i.e. risk taking) is a core professional requirement for all those working in child protection." — Eileen Munro, The Munro Review of Child Protection: A Child-Centred System (2011)*

Munro's review found that child protection systems face a persistent structural risk: the tendency to displace professional judgment with procedural and compliance-driven processes. The review concluded that "an organisational culture where procedural compliance is dominant can stifle the development of expertise," and that the growth of prescriptive guidance had "actually contributed to the deprofessionalisation of child protection, as those working in the field feel increasingly obliged to do things 'by the book' rather than use their professional judgment about children's needs." These findings led to Munro's central recommendation: that system design should protect the space within which practitioners exercise judgment, rather than channeling their decisions through mechanisms designed to eliminate uncertainty.

This analysis has direct application to the Queensland context. The structured assessment processes described above — the individual risk assessment framework, the multi-disciplinary practice panel — are precisely the kind of professional decision-making infrastructure that Munro identified as essential. They produce judgments grounded in sustained engagement with the family, informed by multiple professional perspectives, and documented through established processes. The question for system design is whether those judgments are then given appropriate weight, or whether they are filtered through a subsequent process.

The Australian Association of Social Workers (AASW) locates this form of professional reasoning at the core of social work identity. The AASW's *Practice Standards* (2023) define Standard 6 — "Exercising professional judgement" — as a foundational competency:

> *"Social workers make professional decisions on the basis of a holistic assessment of the needs, strengths, goals and preferences of people." — Australian Association of Social Workers, Practice Standards (2023), Standard 6*

The Standards describe social workers and human services professionals as operating "at the interface between people and their social, cultural and physical environments," making professional judgments by critically assessing "the quality and veracity of all relevant information," assessing "the nature and level of risk to people," and making "decisions aimed primarily at achieving the best possible outcomes for people." This is not intuition or personal opinion. It is a structured, evidence-based competency that the profession's own standards define as irreducible.

These are the competencies that the Department's structured processes are designed to produce, and that the Act presumes exist at the point of decision.

Workforce concerns over the undermining of professional decision-making

It is the broad view of frontline child protection staff that the current litigation model has undermined these professional decision-making processes — substituting the structured, multi-disciplinary assessments described above with decisions made by government lawyers who do not share the same professional training, who have not engaged with the family, and whose processes do not incorporate the interdisciplinary review that the Department's own frameworks require.

> *"DCPL overrides the assessment that CS makes which often results in less stability for children as matters take years to resolve."*

> *"Often DCPL will change what order they will seek and ignore the assessment of child safety staff."*

> *"It has undermined the expertise of CSO's child protection assessments when DCPL can ignore these assessments based on legal process rather than on what would keep a child safe."*

> *"It's our assessment, it's our affidavit. Child Safety are the experts in child protection — let us do our job."*

These concerns have been consistently reported across roles, tenure bands, and regions.

Where legal and professional judgment serve different functions

The legal function serves an essential role in child protection decision-making. Where a proposed application cannot be sustained on the evidence, where the legislation does not authorise the order sought, or where a statutory limit has been reached, the lawyer's identification of these boundaries protects the integrity of the State's position before the court. For questions of legal viability — statutory limits, evidentiary sufficiency, and legal defensibility — legal expertise is properly determinative. This is the function that legal independence exists to serve.

The distinction arises where a lawyer's assessment extends beyond questions of legal viability into predictive welfare judgment. A determination that a shorter order represents the least intrusive option may well be an attempt at interpretation of section 59(1)(e) of the *Child Protection Act 1999* (Qld), but it is in substance a predictive assessment of a family's trajectory, the reliability of a parent's engagement, and the likelihood that a child can safely return within a given timeframe. These assessments depend on sustained contemporary engagement with the family, relational knowledge of its dynamics, and the professional capacity to interpret those dynamics under conditions of uncertainty.

The Children's Court is equipped to make these assessments. A magistrate who determines a child protection application at final hearing has the benefit of sworn evidence tested through cross-examination, independent expert reports, submissions from the child's separate representative, and — critically — the passage of time, which reveals how interim arrangements have actually affected the child and whether the family's trajectory has changed. The court determines the matter on the

basis of the family's circumstances as they stand at the point of hearing, not as they stood when the application was filed.

The filing decision, by contrast, is made before any of this material is available. It is made on a documentary review of the family's current position, without the adversarial testing that legitimises the court's exercise of predictive judgment on the same questions. And because the court's determination will turn on the family's circumstances months later, the filing decision is in substance a prediction about where the family will be at that point — whether a parent's current engagement will be sustained, whether risk factors will escalate or resolve, whether the child's needs will have changed. This is not a prediction that legal training equips a person to make. Legal training assists in predicting how a court will assess a given set of facts. It does not assist in predicting what the facts will be. That prediction depends on the sustained, relational, and academically informed engagement with the family that frontline practitioners hold and that the structured assessment processes described above are designed to produce.

When the filing decision does not reflect the family's trajectory, the consequences are not merely procedural. The litigation proceeds toward an outcome calibrated to circumstances that are likely to not be reflective of the family's situation at the point where the court determines the matter. Practitioner time is consumed by a legal process directed at an order the court may not ultimately make. The child's stability is governed, for the duration of the proceedings, by a prediction that was less well-informed than it needed to be.

These two professional functions operate through fundamentally different calibrations. Legal risk calibration assesses whether a proposed course of action can be sustained before the court — whether the evidence supports it, whether the statute authorises it, whether it will withstand judicial scrutiny. Predictive welfare calibration assesses where the family is heading — whether a parent's engagement will be sustained, whether risk factors will escalate or resolve, whether the child's needs will have changed by the point of determination. Each is a legitimate and necessary form of professional reasoning. The question is which calibration should govern which decision.

A system designed to produce the best outcomes for children directs each form of expertise to the questions it is equipped to answer. Legal judgment should be preferred for questions of legal viability. Professional child protection practitioner judgment should be preferred for the predictive welfare assessments on which filing decisions depend. The current system does not draw this distinction, and in failing to do so, it enables one form of expertise to operate across the entire decision space — including decisions it is not equipped to answer.

Frontline staff describe the distinction with precision:

> *"There's a chasm of difference between the Social & Human Services Model & the Legal Model; One should never ask a plumber to fix their electrical problems."*

> *"DCPL look at things in Black and White. All of child safety is in shades of different colours, each different."*

> *"Child Safety need to be the decision makers, as child safety matters are not black and white legal matters."*

The model that best reflects both forms of expertise at their optimal is one in which independent lawyers retain the authority and obligation to refuse to advance proceedings that are not legally justified — exercising genuine legal independence at the boundary of legal viability — while operating on the Department's instruction in relation to predictive welfare judgments, where those judgments are produced through the structured, multi-disciplinary assessment processes described in this submission and are directed at equipping the State to advance a position before the court that accurately reflects the child's circumstances and needs.

The scale and nature of disagreement

Evidence given by the Director of Child Protection Litigation (DCPL) establishes that in 2024/25, DCPL took a different course of action than the one referred by the Department in 671 of 3,988 matters — a residual divergence rate of 16.4%. Only 2% of these were outright refusals to proceed. The remainder involved DCPL modifying the approach: a different order type, a different duration, different conditions. The 16.4% represents disagreement that survived the mandatory consultation process between the two offices — divergence that persisted after the practitioners had explained their reasoning and DCPL had heard it.

The divergence does not arise on whether the child is in need of protection — that question is rarely contested between the offices. It arises almost invariably on the predictive welfare questions described above: whether a two-year order or a one-year order best serves this child, whether long-term guardianship or continued custody is warranted, whether the family's trajectory supports the proposed pathway. These are, in each instance, competing predictions about where the family will be at the point of determination.

Frontline staff describe the experience directly:

> *"The Senior Practitioner and Manager endorsed an application for [short-term guardianship] and DCPL have requested we change it to [a less protective order] — after two years of the same family already being on [that order]. They have no right to ask us to change our own affidavits and put our name on it, when our assessment is the child is not safe."*

> *"Currently I am seeking long-term guardianship for three children yet DCPL have applied for a two-year order because they don't agree. This belittles my experience and assessment — I have worked with this family for over a year. I also worked with the mother 10 years ago. She has a 47-page child protection history*

> *"DCPL's principles don't align with Child Safety assessments as they don't have the same training and education in child welfare to make decisions about appropriate outcomes."*

When these matters ultimately resolve — whether through negotiated agreement accepted by the court or by a magistrate's determination at final hearing — the result reflects the family's circumstances as they stand at that point, not as they were assessed at filing. Between filing and determination, the family's trajectory unfolds: engagement is sustained or falters, risk factors resolve or escalate, the child's circumstances change. The legal process adjusts to these developments — not due to any avoidable error at the point of filing, but because the passage of time reveals what no prediction could have established in advance. That adjustment, while inevitable to some degree,

carries cost. The child's stability is governed by interim arrangements that may no longer reflect their needs. The family bears the stress and disruption of a legal process directed at an outcome that has been overtaken by events. The court's time is consumed by proceedings that require correction before they can produce the right result.

This is why the quality of the prediction at filing matters. A filing decision grounded in sustained engagement with the family — informed by the academically-based, multi-disciplinary, and structured assessment processes that the Department maintains for this purpose — is more likely to track the family's actual trajectory, reducing the scale of correction required between filing and determination. In each of the 671 matters where the filing decision diverged from the professional assessment, the litigation proceeded on a prediction made without that engagement, in place of one produced through it.

The 16.4% divergence rate has never been evaluated against child outcomes. The system does not track whether DCPL's modified positions or the Department's original assessments produced better results for the families concerned. It is therefore unknown whether the divergence represents beneficial legal correction or the systematic displacement of better-informed predictions by less well-informed ones. This is a governance visibility gap: the system has a mechanism for overriding professional assessments, but no mechanism for evaluating whether that override improves or degrades the outcomes it produces.

The Fragmentation of the State's Legal Function

Frontline child protection staff consistently report that the institutional separation of the State's legal function between two organisations causes independent harm to children and families — through information loss, disruption to continuity, widespread confusion, and delay. This concern sits independently of the displacement of predictive welfare judgments identified above.

How the system is structured

The current child protection litigation model divides the State's legal function between two offices. The Office of the Child and Family Official Solicitor (OCFOS) provides early legal advice, assists with the preparation of applications, and supports practitioners in CSSCs. DCPL, a separate statutory office within the justice portfolio, makes decisions about whether to bring applications before the Children's Court, determines what orders to seek, and conducts litigation.

A single child protection matter may involve a child safety officer and senior team leader in one service centre, an OCFOS legal officer in the same workplace, and a DCPL file lawyer and applicant lawyer in a separate office — with information, instructions, and decisions moving back and forth between them across two organisations, two reporting lines, and two sets of institutional priorities. Together submits that this fragmentation is independently harmful regardless of how the decisions within it are classified.

Frontline staff describe this structural overhead directly:

> *"Having to go through DCPL and OCFOS for court work means that our court work is going through three or four sets of hands."*

"By separating these two systems we have added a huge layer of complexity and have created a whole new layer of further adversity."

The division does not only fragment the service provided to families; it fragments the professional development of the lawyers within it.

"The problem is that it's impossible to get well-rounded experience in this space. DCPL lawyers tell us to get emergent orders that would never be granted. I'm giving legal advice to CSOs about child protection order proceedings, but I've never actually run one. We're all half a child protection lawyer."

What separation does to information

The division of the State's child protection functions between two departments — Child Safety and Justice — means that when managing proceedings in relation to a matter, a DCPL lawyer has no access to the Department's case management system, no visibility of the contemporary file notes made by the practitioners working with the family, and no access to the sourced information on which the Department's assessment is built. Many minor but collectively significant developments in a family's circumstances are never formally documented — observed shifts in a parent's presentation, a child's demeanour during a visit, the quality of a family's engagement over time — and this information can never be provided through document review at all. To compensate, the system requires every relevant piece of information that is recorded — risk assessments, contact notes, shifts in a family's circumstances — to be formally packaged and transmitted from one organisation to the other. The system attempts this. The result is fragmented: two information environments connected only by what each organisation identifies as relevant, constrained by what each has the capacity to compile, and limited by what each thinks to ask for.

The costs of this information divide — in delayed proceedings, in diverted practitioner attention, in families left waiting while two offices correspond — are by their nature undocumented and unmeasured. DCPL's own evidence before the Commission establishes that in over 73% of matters, DCPL must request additional information from the Department before it can proceed — a rate that is growing. Each request-and-response cycle consumes time and effort from practitioners who can afford neither, directed not at working with families but at satisfying the information requirements of a separate organisation.

This bifurcation of the information environment results in a loss of quality in the child protection system's judgment and decision-making. Information is omitted — sometimes because practitioners are too stretched to compile it, sometimes because procedural requirements are missed, sometimes because the practitioner did not anticipate what the lawyer would need. DCPL, working from documents alone, must reconstruct the professional reasoning that produced the Department's assessment without the benefit of direct access to the full context by which that reasoning was formed. The result is a relationship between two professional environments that functions through formal correspondence rather than shared understanding — each trying to interpret the other's work through a channel that cannot carry it, given the nature of the work.

There is no feedback mechanism within the current design that would alert the system to what has been lost. DCPL does not know what it did not receive. The Department does not know what DCPL

needed but did not request. The adequacy of the information transfer is assumed, not measured — a governance gap that renders the system structurally unable to evaluate whether its own information architecture is fit for purpose.

Frontline staff experience this information wall as a daily operational reality:

> *"DCPL doesn't have access to our system, so they don't see any case notes directly and are entirely reliant on this information being shared with them*

> *"DCPL honestly have very little knowledge or experience with regard to what is happening for the families and will often ask for unrealistic information when providing feedback for affidavits due to their lack of understanding."*

> *"They see a snapshot and have no idea about the impact of their decision-making in the area of a child's life"*

The endpoint of this dysfunction is families. Each exchange between two offices consumes time that postpones the finalisation of the State's position — and until the State's position is finalised, parents cannot access natural justice.

What cannot be transmitted on paper

Beyond the formal information wall, each handover in the system degrades a category of knowledge that cannot be transmitted through writing at all. Frontline workers who have engaged with a family for months hold contextual, relational, experiential knowledge — what the parents are like as people engaging with the system, what the child's presentation reveals about their safety, the dynamics that no summary paragraph can capture. An embedded legal officer absorbs much of this through daily proximity to that work — and generates a further layer through their own engagement: the rapport built with a parent's lawyer through negotiation, the procedural history of the matter before the court, the understanding of how a particular family navigates the legal process. But when the accumulated understanding of the practitioners and lawyers working with a family must be conveyed to a decision-maker through documents rather than direct engagement, the texture is lost. What arrives is a written reconstruction of knowledge that was formed through relationships and can only be fully apprehended through them.

> *"They don't have any relationship with the families or children we work with, so how can they possibly understand them? OCFOS are embedded in CSSCs — we work closely with them. Just the physical presence they have in CSSCs means they better understand child protection practice."*

> *"It seems like a whole lot of double or triple handling and advice from those who don't know the family other than what they read on paper."*

When the lawyer advancing the State's position before the court is disconnected from the work taking place with the family — from the practice environment in which the Department's assessment is formed and the insights that proximity alone can produce — the litigation proceeds on a documentary reconstruction of circumstances that direct engagement would have rendered differently. This is not just a function of geographic distance — it is the consequence of a design that

requires one legal officer to hand a matter across an institutional divide to another, losing in transit what can only be carried by direct engagement.

When the family moves faster than the file

In the practice space, a family's progress is tracked in real time. Practice panels assess risk and trajectory. Family group meetings review engagement. Therapeutic referrals are made, and a parent's response to them is observed over weeks and months. When a family's trajectory is positive, practitioners communicate that progress and work with the family toward a pathway home.

The institutional separation fragments this picture. The legal position advanced by DCPL is formed through a separate process, in a separate organisation, and the practice reality — the family's engagement, their trajectory, the shifts observed by practitioners over weeks and months — struggles to arrive intact across that divide. A parent who has been told by their child safety officer and embedded legal officer that their engagement is on track may, weeks later, encounter a DCPL lawyer advancing a position before the court that does not reflect that progress — because the practice reality has not yet crossed the institutional divide, or because DCPL has formed a different view of the same developments.

For families, the result is the experience of a State that contradicts itself. Clair Martin, Principal Legal Officer of the Department's internal legal service, told the Commission that the current model results in "the State advancing two different positions before the court." Parents do not distinguish between the Department and DCPL. They see the government — and the government appears to be working toward two different outcomes for their child. A parent who has spent months engaging with practitioners, attending family group meetings, and working through their case plan does not understand why a lawyer they have never met is telling the court something different.

> *"Having circumstance where there are different decisions and recommendations put to the Court... is not only unhelpful, it is outright confusing for families, who only see 'the government took my child.'"*

The divergence between what families experience in the practice space and what is advanced on their behalf in the court space is inherent to a bifurcated design. It is not a product of inadequate communication between two organisations — it is the structural consequence of requiring the State's legal position to be formed in an environment that is separated from the environment in which the State's relationship with the family exists.

A single legal body

The problems documented in the preceding sections — the loss of information across institutional boundaries, the degradation of relational and contextual knowledge at each handover point, and the experience of families who encounter a State that appears to contradict itself — each arise as a function of a system that expects two separate organisations to engage coherently with the same families while operating across an institutional divide. Over the years since the model's establishment, both offices have worked to bridge that divide — through liaison arrangements, referral protocols, and efforts at closer consultation. At best, these have produced stopgap improvements. They have not altered the underlying dynamic. The reason is that the core issue is structural: a child protection system cannot operate coherently with that degree of segregation at its centre. To the union's knowledge, no other Australian jurisdiction has adopted a comparable degree

of structural separation between the child protection legal function and the frontline practice it serves.

Combining the State's child protection legal function into a single body eliminates those boundaries. When child protection matters are held within one organisation across their lifecycle — from early advice through to final hearing — information does not need to be packaged and transmitted across an institutional divide. The lawyer's understanding of a family's circumstances does not depend on what a separate organisation has identified as relevant and had the capacity to compile. The legal position advanced before the court is formed within the same system that holds the Department's assessment of the family and the practitioners' direct engagement with it — not reconstructed, at a remove, from the documents that engagement produced.

The Case for Proximity

The argument for proximity rests on a distinction between two concepts that are commonly conflated. Legal independence — the authority to refuse to advance proceedings that are not legally justified — is constitutionally necessary. Physical and informational isolation from the practice environment is not. A lawyer can maintain the full authority of independent legal judgment while being located in the workplace where the family's circumstances are known and the professional assessments are formed.

Frontline child protection staff consistently report that the physical co-location of legal officers in service centres is essential to the delivery of responsive, effective legal support — and that the reactive, relationship-dependent nature of child protection legal work cannot be sustained from a distance. In relation to the Department's work with lawyers from DCPL, the primary and most persistently provided feedback is that the lack of geographic proximity with the lawyers running ongoing child protection order proceedings results in negative outcomes for children, families, and staff.

The nature of the work

Child protection legal work does not operate on the timetable of commercial litigation. It is reactive and immediate. A child is found in circumstances of immediate danger, and an application for an emergency order must be drafted, filed, and heard within hours. A parent's circumstances change overnight — a perpetrator of domestic violence returns to the household, a substance abuse relapse is disclosed, a child's presentation shifts — and the legal strategy must respond immediately.

The Commission has received evidence that applications for emergent orders have increased by 93% since 2016, while OCFOS has remained at 77 positions over the same period. The system already depends on lawyers who can respond immediately to unfolding crises — and that dependence is growing against a workforce that has not grown to meet it. Each application requires legal input at moments that cannot be scheduled or anticipated, in response to information that is held by practitioners who are simultaneously managing a crisis in the field.

This is not work that can be performed effectively from a distance. It depends on pre-existing relationships with the practitioners who hold the information, absorbed background context about the families they are serving, and daily working proximity that enables real-time collaboration.

What proximity enables

An embedded lawyer — a lawyer physically located in a CSSC — participates in the information environment of that workplace. Child protection work is reactive and unpredictable, and the families at its centre are deeply nuanced in their behaviours, presentation, and trajectory. Formal documentation captures the surface of this environment, but much of what informs professional understanding is carried through daily proximity — a worker noting that a parent has stopped returning calls, a new risk factor raised between desks as it unfolds, a child's concerning presentation discussed by a worker returning from a home visit.

This ambient information — constant, informal, relational — keeps the embedded lawyer's understanding of each matter current without formal transmission. It enables a lawyer to provide immediate legal input when a crisis unfolds — when staff are coordinating a removal, responding to a disclosure, or managing an emergent risk — because the family's circumstances are already understood. It enables early identification of legal issues, because changes in circumstances are absorbed through proximity rather than formal notification. The result is legal advice that is responsive, contextual, and able to keep pace with the reality of frontline practice.

> *"Having worked in other jurisdictions where the statutory body is the applicant, with internal legal teams, results in staff feeling far better supported and matters moving far more quickly through courts."*

Beyond court applications, an embedded lawyer provides daily guidance across the interconnected legal jurisdictions that child protection work touches — advice on matters that sit outside the child protection cases a lawyer is formally tracking, but that are important legal issues frontline staff navigate daily.

> *"On any given day, I'm approached by staff asking about service obligations, bail restrictions, model litigant obligations, family or domestic court orders, or even rules on trespass of private property. A significant part of embedded legal work is ensuring that frontline staff are legally informed and supported in real time. This work is rarely documented, but it is deeply important."*

A lawyer who does not share this daily environment receives a lower resolution picture of each family's circumstances — filtered through what the sender considered most relevant, compressed into written reports and case notes that flatten the detail proximity would have carried. The breadth of legal support described above cannot be replicated through scheduled consultations or email requests, because the questions arise in real time, in response to circumstances that are themselves unfolding.

For Aboriginal and Torres Strait Islander children, proximity carries a further dimension. The Act requires "purposeful, thorough and timely" active efforts (s5F). Cultural Practice Advisors are physically present in service centres, and an embedded lawyer engages with them as a matter of course. Cultural Practice Advisors widely report that they have limited understanding of the child protection order legal space, and have had no meaningful working relationship with the DCPL applicant or file lawyers responsible for matters involving the families they advise on. Active efforts within the legal function require, at minimum, a working relationship between the lawyer and the Cultural Practice Advisor. Geographic separation has prevented that relationship from forming.

Proximity must be structural

Over approximately ten years of the current model, the Department has repeatedly attempted to establish physical co-location arrangements with DCPL. Frontline officers have consistently requested DCPL attendance in their workplaces. DCPL has, in principle, supported the concept. The broad and persistent feedback of frontline staff is that these commitments have not been sustained — that arrangements are agreed to but do not survive beyond the very short term, and that the applicant lawyers responsible for pathway decisions and court appearances have never maintained any regular presence in service centres.

This is not attributable to hostility or bad faith. It is the natural consequence of a design that does not compel proximity. A lawyer who reports to a different organisation, with different institutional priorities and different performance metrics, has no structural incentive to be present in a workplace that is not their own. Directed proximity — requiring lawyers from one organisation to attend another organisation's offices — has been attempted repeatedly over many years and has not been sustained. Proximity must be structural: the lawyer must belong to the workplace.

Together acknowledges that embedding carries a governance risk: that proximity may, over time, erode the rigour of independent legal challenge. Recommendation 3 is designed to address this directly — through a structural reporting line to the Director-General that preserves institutional independence within the embedded model.

It is the firm view of the child protection frontline workforce, and the position of Together, that child protection lawyers with carriage of child protection-related proceedings should be physically located in Child Safety Service Centres — as a structural requirement of the system's design, not an aspiration pursued through co-location agreements that have repeatedly failed to hold.

Procedural Reform

The following matter is distinct from the structural arguments above but arises from the same system and compounds the problems it produces. It is presented as a discrete issue warranting targeted reform.

The affidavit requirement

Rule 13 of the *Children's Court Rules 2016* requires the litigation director to file, at the commencement of every child protection order proceeding, an affidavit exhibiting, amongst numerous documents, the Department's assessment, strengths and needs analysis, family group meeting documents, case plans, previous orders, external referrals, independent assessments, the child's birth certificate, and any child protection, criminal, domestic violence, and traffic histories of relevant persons.

In practice, this produces a document of 20 to 40 pages of sworn evidence accompanied by 200 to 450 pages of exhibits. It is prepared at the commencement of every matter — regardless of whether the parents accept the concerns, regardless of whether sufficient factual agreement exists that a streamlined process could narrow the scope of contested issues, regardless of whether the matter will ever proceed to a contested hearing.

The preparation of this material consumes, at minimum, one full working day during which the child safety officer is offline from every other child on their caseload. It passes through multiple layers of review — officer, OCFOS, DCPL — with revision at each stage:

> *"So much time of case workers taken up with writing and re-writing — from instructions from DCPL — affidavit work."*

In a system where frontline staff overwhelmingly report unmanageable workloads, this diversion of practitioner time to legal document preparation is not merely inefficient. It is a direct subtraction from the time available for the relational, preventative, and protective work that the children on their caseloads require.

The universal application of this standard at the commencement of proceedings also denies parents timely access to justice. Under the current process, the affidavit takes time to prepare — and while it is being finalised across multiple review stages, parents cannot obtain comprehensive legal advice. Legal Aid Queensland directs parents to approach them only once affidavit material is received. Upon receipt, the volume and complexity of the material overwhelms parents, particularly those without legal representation. By contrast, a system in which evidence documents were made available to parents immediately — through a portal-based disclosure model, without requiring the material to be compiled into sworn affidavit form — would give parents access to the case against them from the outset, enabling earlier engagement with legal advice and earlier narrowing of contested issues. The current process perversely impedes both.

The stakeholders most directly engaged with these documents have each acknowledged to the Commission that reform is required. DCPL's own director, in the Commission's public hearings, proposed replacing narrative affidavits with a standardised assessment report prepared by officers in the ordinary course of their work — in effect, a one-line affidavit exhibiting the existing assessment. The union's prior submission (Exhibit CA-49) proposed graduated evidentiary requirements proportionate to the nature of each matter, supported by a portal-based disclosure model that would give parents immediate access to the material.

Together supports all of these directions. The Children's Court Rules should be amended to provide graduated evidentiary requirements. Consent matters should not require the same forensic apparatus as contested hearings. An agreed-upon-facts process should be available for matters where fundamental facts are not in dispute. And the paralegal and case support worker trial, negotiated by the union and permanently funded in December 2024 — though at ratios well below the trial model — should be expanded to the trial ratio of one paralegal and one case support worker per two teams across all frontline workplaces.

Recommendations

The following recommendations are not intended as detailed implementation plans. They are structural principles for the Commission's consideration.

1. Combine the State's child protection legal workforce into a single body

The fragmentation documented in this submission is a product of the institutional separation of the legal function. It cannot be remedied by improved communication protocols, co-location agreements, or enhanced guidelines between two separate organisations. It requires a single body.

Together submits that the two workforces should be combined into a single legal service with carriage of the full spectrum of child protection legal work — from early advice through to contested hearings. The union recommends that the combined body be located within the Department of Child

Safety. A centralised hearing team may be retained as a specialisation within the combined body for matters proceeding to final hearing.

This submission recognises that the staff of both offices are skilled practitioners whose employment security must be assured through any transition. The union represents members in both services. The recommendation is directed at the institutional design, not at the individuals who work within it. Together submits that all current permanent and temporary staff of both offices should be retained through any transition to the combined model.

2. Embed legal officers in CSSCs

The combined legal body should be structured around the embedded frontline model. Legal officers should be physically located in CSSCs, co-located with the practitioners and families they serve. The ambient, relational, and constant nature of child protection legal work — documented in this submission — demands proximity as a structural feature, not as an aspiration addressed through occasional visits.

Remote legal support should continue for regional and remote areas where on-site legal officers cannot be sustained, but the default should be physical co-location.

3. Direct each form of expertise to the decisions it is equipped to answer

Together submits that the combined legal service should be designed so that each form of professional expertise — legal practice and child protection practice — is directed to the decisions it is equipped to answer.

The combined legal service should operate under a hybrid instructional model. On both the urgent protective decisions that arise in crisis conditions and the early predictive pathway decisions required at the point of filing, the legal service should operate on the Department's instruction, noting that those instructions are produced through the Department's structured assessment processes, undertaken by employed professional officers. The legal service should however maintain the authority to refuse to advance a position that is not legally justified, and this authority should be strengthened.

While the current collaborative approaches for resolving disagreement between these parties within the Department should be maintained, ultimate authority to decide on disagreements should sit with the Department's regional leadership in terms of crisis decision-making and predictive pathway decisions, and the legal service in terms of fundamental matters such as the legal justifiability of proceedings.

At its core, this framework is intended to strengthen legal independence, while disallowing a lawyer to decline to proceed on the basis that they have formed a different predictive assessment of the family's trajectory than that which has been formed by the casework team.

Fundamental to this framework is:

- The recognition that the Children's Court is the ultimate arbiter for the best outcome for families — when equipped with sworn evidence tested through cross-examination, independent expert reports, the submissions of a child's separate representative, and the passage of time that reveals how a family's trajectory has actually unfolded since proceedings were commenced;

- The recognition that child protection practitioners are best equipped to make both the urgent risk assessments required in crisis conditions — where decisions must be made immediately, with incomplete information, by professionals who are present with the family — and the predictive welfare judgments required at the point of filing, where the family's trajectory is uncertain and the assessment depends on sustained engagement in conditions where the available information will not resolve the uncertainty; and
- The recognition that government lawyers must be empowered to refuse to advance proceedings that are not legally justified, and that this authority should be strengthened within the combined model to ensure the integrity of the State's position before the court.

Finally, Together submits that the head of the legal service should report to, and only be subject to internal direction from, the Director-General of the Department. Together notes that this structural safeguard was proposed during the Carmody Inquiry, on page 482 of the inquiry's final report.

4. Reform the Children's Court Rules

The Children's Court Rules should be amended to provide graduated evidentiary requirements proportionate to the nature of each matter. Consent matters should not require the same forensic apparatus as contested hearings. An agreed-upon-facts process should be available for matters where fundamental facts are not in dispute.

Together supports a portal-based disclosure model in which evidence documents are made available to parents immediately, without requiring the material to be compiled into sworn affidavit form. This would give parents access to the case against them from the outset, enabling earlier engagement with legal advice and earlier narrowing of contested issues. The stakeholders most directly engaged with these documents have each acknowledged to the Commission that reform in this direction is required.

Chapter Four: Workforce Capacity and System Integrity

Introduction

Together makes this submission on the capacity of Queensland's child protection workforce to meet the obligations the law places on it. It draws on departmental workload data provided to the union under the certified agreement, on the department's own workload management reports, on the formal escalation of workload concerns to senior departmental leadership, and on the experiences of frontline child protection staff as reported through the union's survey of over 1000 practitioners.

The department's own Working for Queensland survey — conducted independently of the union by the Public Service Commission across 4,314 respondents in 2024 and 3,656 respondents in 2023 — confirms the pattern documented in this chapter. The WFQ finds 76% of staff overloaded with work, 82% reporting emotionally demanding conditions, and 67% reporting burnout. These figures constitute independent validation from an instrument the department itself administers and cannot characterise as advocacy data.

The Chapter is organised into eight sections.

1. The State's Obligation establishes the legal framework — what the Child Protection Act 1999 and the Human Rights Act 2019 require the State to deliver to every child in its care — and identifies the implicit assumption that the current system has the capacity to deliver it.
2. Invisible Labour documents the shadow workforce that sustains the system: the thousands of hours of unpaid labour worked, partially recorded, and structurally forfeited each reporting period — invisible to the governance systems that inform planning and funding decisions.
3. The Invalid Benchmark traces the documentary record of the 16-child caseload trigger within the Workload Management Manual, and establishes that no publicly available document provides an evidence base for it.
4. Funding Built on False Data addresses the funding formula — calibrated against a workload baseline that has not been empirically derived or outcome-validated, and an unvalidated benchmark — and why it cannot produce adequate outcomes regardless of its design.
5. The Normalisation of Risk documents the mechanisms by which the system manages its incapacity — the layered triage cascade at intake, investigation, and ongoing intervention, and the formalisation of reduced standards as operating practice.
6. The Erosion of Capability addresses the workforce's degraded capacity to deliver competent care — the turnover cycle, the acting chain that cascades instability through every level of management, and the onboarding process that places underprepared practitioners in full caseloads from day one.
7. Consequences for Children establishes the direct connection between the workforce conditions documented in this chapter and outcomes for children in the State's care.
8. What Needs to Change sets out five recommendations that flow from the evidence.

The State's Obligation: The weight of the obligation

The State's custody of a child is not an administrative arrangement. It is a legal relationship that creates enforceable obligations under the *Child Protection Act 1999*, the *Human Rights Act 2019*, and the Charter of Rights for a Child in Care.

Those obligations are dense, overlapping, and individual. The Act requires meaningful engagement with each child (s5E — "meaningful and ongoing opportunities to participate"). It requires regular contact with each family. It requires six-monthly case plan review (s51V). It requires compliance with eleven care standards (s122), including that the child experience being "cared about and valued" (s122(c)) and have access to the therapeutic services necessary to meet their needs (s122(h)). It confers twenty-one charter rights on every child in the chief executive's custody or guardianship (Schedule 1, made operative by s74). For Aboriginal and Torres Strait Islander children, section 5F requires "purposeful, thorough and timely" active efforts to apply the child placement principle — language deliberately chosen to exclude passive, aspirational, or best-endeavours engagement.

None of these are aggregated targets. Each applies to every child in the State's care, individually, and must be met concurrently with the same obligations to every other child on the officer's caseload.

The *Human Rights Act 2019* creates a parallel layer. Section 26(2) provides that every child has "the right, without discrimination, to the protection that is needed by the child, and is in the child's best interests, because of being a child." The rights to education (s36), health services (s37), cultural connection (ss27–28), and family integrity (s26(1)) all have operative force and can only be limited where justification is demonstrated under the Act's limitation framework. A system that routinely fails to uphold these rights due to under-resourcing is not engaging that framework. It is failing to meet the obligation.

The assumed capacity

The system operates as though it can meet these obligations at current resourcing. The workload management system reports reasonable workloads. The funding formula grows positions from the current baseline. The caseload benchmark defines 16 cases as the trigger for review. None of these systems has been validated against the actual obligation — against whether children receive the care, engagement, and protection the law requires.

That assumed capacity does not exist.

What the workforce reports

The union's survey of frontline child protection staff asked whether the department is adequately resourced to meet its legislative requirements. 79.3% disagreed or strongly disagreed. Only 4.7% agreed. When asked whether they felt confident they could realistically meet the expectations of their role, 58.3% said no. When asked whether their workload was manageable and allowed proper attention to each case, 83.8% disagreed.

These figures measure the gap between what the law requires and what the workforce can deliver — from the perspective of the people responsible for delivering it.

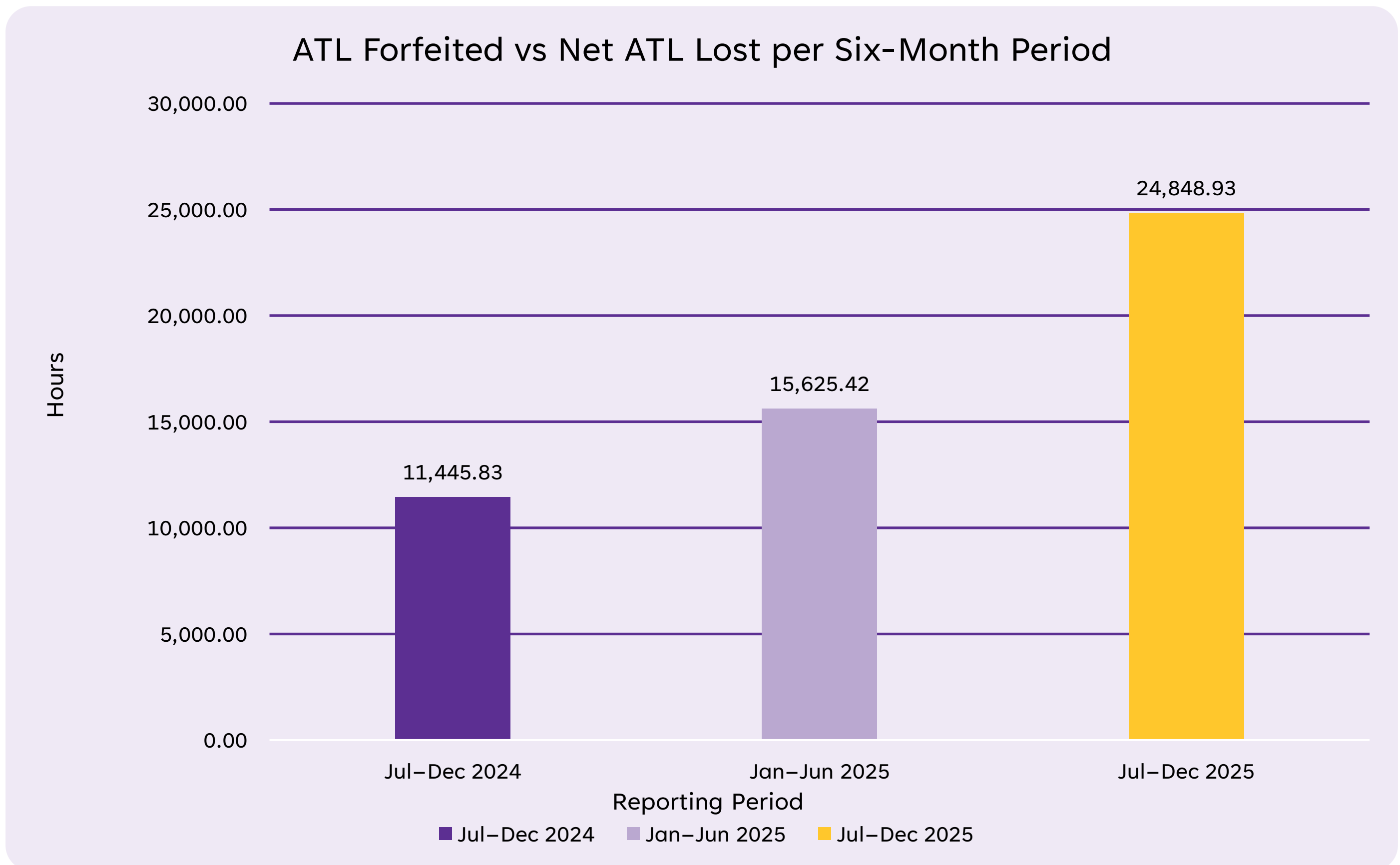
The Commission is directed to examine whether frontline staff are "resourced and supported to do their work" (ToR 3(b)(vii)) and to make recommendations on "appropriate frontline resourcing" (ToR 5(b)).

Invisible Labour - The scale of unpaid work

The department's frontline child protection workforce forfeits thousands of hours of accrued time every six months — hours that were worked, recorded, and then lost because the system structurally prevents recovery. The figure is not just growing. It is accelerating.

This is departmental data, produced by the department under its certified agreement obligations and provided to the union on a six-monthly reporting cycle. In the second half of 2024, the Service Delivery — Child and Family division forfeited 11,163 hours. In the first half of 2025, that figure rose to 12,797 hours. In the second half of 2025 — the most recent reporting period — it reached 18,801 hours. That represents a 68% increase in Child and Family forfeiture in twelve months. Across the whole department, total ATL forfeited more than doubled over the same period: from 11,446 hours to 24,849 hours — an increase of 117%.

Together notes, that there is a reporting culture within the department, that its not worth reporting the hours worked, as you never are able to access ATL due to workload pressures.



In practical terms, the most recent six-month figure of 18,801 hours represents more than 2,590 working days of unpaid labour absorbed by the Child and Family workforce in a single reporting period of 130 days.

To illustrate the scale in statutory terms: at approximately three hours per home visit — including travel, the visit itself, and documentation — 18,801 forfeited hours represents over 6,260 home visits that could have been conducted. At approximately eight hours per affidavit preparation day, it represents over 2,350 days of affidavit preparation. The cumulative Child and Family total across all three reporting periods — July 2024 to December 2025 — is 42,762 hours. The system's compliance with its statutory obligations is partially sustained through labour that is worked, structurally forfeited, and invisible to the funding systems that determine workforce size.

Why the real figure is higher

The forfeiture mechanism creates rational disincentives to record. Hours accrued above the cap are automatically forfeited each month. There is no realistic opportunity to take accrued time off, because all colleagues are equally overloaded — a day's absence doubles the following day's

workload. Staff who do record overtime report that their timesheets are questioned rather than supported.

> *"Significant impacts from scapegoating and unrealistic expectations from the role. When overtime is performed as required, timesheets are questioned."*

The Time Off In Lieu (TOIL) column in the department's own reports — the formal mechanism for recovering extra hours worked — shows zero hours forfeited across all three reporting periods and across the entire department. Not because no TOIL is worked. Because staff have stopped recording hours they know will never be recovered. The forfeiture data presented here is therefore a floor, not a ceiling.

> *"We work for free a lot. There is no such thing as 9-5 in our roles. We average 42-45 hours a week. We lose our flex after 5 days but don't have time to take it as there is no one to cover our jobs."*

> *"The department relies heavily on frontline staff going beyond the expectations of their role. Particularly in regard to the 'forfeiting' of ATL when CSOs need to work beyond normal hours to manage their caseload. No genuine effort is made by management to ensure staff have the chance to take ATL that they have accrued. This is tantamount to CSOs and other staff working for free and is widely considered an 'unspoken' arrangement."*

The forfeited hours therefore represent only the subset of unpaid labour that staff persist in recording despite these disincentives. The true volume of unpaid work is larger by a structurally significant margin.

The department's own Working for Queensland survey independently confirms this pattern. In both 2023 and 2024, approximately two-thirds of staff reported needing to work long hours to meet performance expectations (69% in 2023, 67% in 2024) — a figure worse than the Queensland public sector average in both years. The ATL forfeiture data, the union's survey, and the department's own WFQ converge on the same finding: this is a workforce that sustains statutory compliance through unpaid overwork.

The contradiction

Simultaneously, the department's Workload Management reports assert that the majority of frontline workplaces report zero employees with unresolved unreasonable workloads.

The Workload Management report operates through a two-column structure. In the first column, team leaders report to site managers the number of staff whose caseload was above the trigger point. In the second, site managers report to regional directors the number of staff with unresolved unreasonable workloads. The reduction happens between these two columns.

Across consecutive reporting periods in 2024–25, team leaders consistently reported 225 or more staff above the caseload trigger. The majority of service centres — seven or eight at a time, across multiple consecutive reporting periods — reported zero unresolved unreasonable workloads to the regional director. Not reduced numbers. Zero. This in a workforce simultaneously forfeiting thousands of hours of unpaid labour. Only a small number of service centres reported these workloads through

honestly — and their numbers confirmed what the zeros concealed: in one May 2025 report, one site reported 26 reviews and 26 unresolved; another reported 24 and 23.

All sites have the same degree of overwork. The difference lies not in conditions but in reporting practice.

This is not a recent development. The union's records of Workload Management reports extend back to 2022, and the pattern is the same across three years of data. Service centres with significant numbers of staff above the caseload trigger have reported zero unresolved unreasonable workloads — continuously, reporting period after reporting period — while neighbouring sites doing the same work with the same degree of overwork reported the majority of their triggered workloads as unresolved.

The structural mechanism

The discrepancy between the workload data and the workload reports is not attributable to individual dishonesty. It is a product of principal-agent reporting distortion — a well-documented governance failure in which the people responsible for managing a condition are the same people responsible for reporting on it.

The Workload Management Policy requires team leaders to identify staff above the trigger and centre managers to report unresolved unreasonable workloads to regional directors. But the team leaders and centre managers who report workloads are the same managers who are responsible for managing them. Reporting that workloads are unreasonable is, structurally, an admission that management has not resolved them. The incentive to report accurately is opposed by the incentive to demonstrate competence within the reporting chain. This is not a function of bad faith — it is the predictable consequence of a governance design that merges operational accountability with reporting accountability. The international literature on organisational reporting identifies this as a structural distortion that emerges from rational actors operating within incentive constraints (Kim et al. 2019; Murphy et al. 2024).

The Working for Queensland survey constitutes a third independent data source confirming the overload that the Workload Management reporting system denies. In 2024, 76% of the department's staff reported being overloaded with work — a figure produced through the Public Service Commission's whole-of-government survey framework. The department possesses the ATL forfeiture data, the union's survey results, and its own WFQ results, each confirming the same finding. The governance apparatus does not merely fail to capture the overload — it operates in direct contradiction of data the department already holds.

The department knows

The department's own executive leadership has acknowledged that this reporting is inaccurate. In September 2025, the union placed a Regional Executive Director on notice in writing, attaching both the ATL forfeiture data and the WMP reports, and asking directly: how is it possible that a workforce forfeiting thousands of hours of unpaid labour simultaneously has zero employees with unreasonable workloads?

The department's own internal records reflect the same awareness. Across consecutive Regional Consultative Committee meetings between 2024 and 2025, the department acknowledged that service centres with high caseloads were reporting zero escalations, that there was a "clear

difference in opinion" between service centres about how to apply the reporting tool, and that "managers are not escalating correctly, despite prior guidance." The discrepancy was raised, acknowledged, and left unresolved — meeting after meeting.

The union had been raising the discrepancy with the department for over two years before the formal escalation produced a change. Only after years of sustained union advocacy did senior leadership begin refusing to accept WMP reports that could not be reconciled with the underlying data. The most recent report shows only one service centre reporting zero — down from seven or eight.

The consequence extends beyond governance failure. A system that cannot accurately report its own capacity cannot demonstrate that it is lawfully discharging its statutory obligations. The measurement apparatus — the Workload Management Policy, the reporting chain, the regional escalation framework — does not capture the gap between what the law requires and what the workforce can deliver. The governance system is not merely inaccurate. It is structurally incapable of producing the information the State would need to demonstrate compliance with its obligations under the *Child Protection Act 1999* and the *Human Rights Act 2019*.

The system runs on a shadow workforce. Unpaid labour that is worked but not recovered. Partially recorded but structurally forfeited. Invisible to the reporting systems that inform planning and funding decisions.

The Invalid Benchmark - The documentary record

The number 16 — the trigger point for workload review for Ongoing Intervention child safety officers, has not been empirically derived from direct observation of Queensland practice, or validated against child outcomes. Attempts to complexity-adjust caseloads are also widely considered to have been ineffective, due to the sheer volume of the workloads held by each frontline worker in the department.

The available documentary record traces what appears to be a chain of inheritance. In 2003, the union's predecessor, the Queensland Public Sector Union, asserted to the Crime and Misconduct Commission Inquiry that 12 to 15 children was a fair caseload for an experienced worker. The CMC adopted 15, the top end of the union's range and used it to calculate a staffing shortfall. The Carmody Inquiry re-adopted 15 in 2013, its entire treatment of the question being: the CMC recommended 15, current caseloads are 20, the target has never been achieved. No independent methodology, workload modelling, or child-outcome research was conducted at either inquiry.

The current Workload Management Policy sets the trigger at 16, a figure that was not independently derived, but negotiated through the first CSYJ Enterprise Bargaining Agreement. During those negotiations, Together advocated for a maximum of 15, drawing on the lineage of previous inquiry recommendations. The Department refused to accept 15 and instead negotiated a staged reduction: the trigger point began at 18 in the first year of the EBA and decreased to 16 by the third year. The number reflects what the parties agreed to under bargaining pressure, not what the evidence established as safe. Attempts during those same negotiations to anchor the trigger in a genuine assessment of workload — including modelling how long it would take a child safety officer to meet even the minimum statutory requirements for each child on their caseload — reached an impasse. The Department was not prepared to subject the question to that analysis.

The CMC itself knew the number was not empirically derived. Recommendation 5.3 called for the department to "adopt an empirically rigorous means of calculating workloads and projecting future staffing numbers." That recommendation has never been implemented.

The issue is not that numeric caseload standards are inherently invalid. Empirically derived benchmarks do exist internationally — Yamatani et al. (2009) produced a 16–17 case figure through over 5,600 hours of direct observation across approximately 16,000 cases in the United States. The figure itself is broadly comparable to Queensland's trigger. The issue is that Queensland has never conducted equivalent local validation — has never subjected the number to the kind of empirical scrutiny that would establish whether it reflects the actual demands of Queensland's statutory framework, case complexity profile, and geographic conditions.

What the benchmark does not measure

The benchmark treats all cases as equivalent units. A family with domestic violence, substance abuse, mental health issues, and multiple children counts the same as a straightforward placement, with no meaningful adjustment for complexity, court activity, placement instability, cultural obligations, or geographic spread.

The benchmark answers the question "what workload did the parties agree was the trigger for review?" It does not answer the question "what workload allows the State to meet its duty to children?" The two questions are fundamentally different.

The body whose standards informed the CMC's original adoption — the Child Welfare League of America — has since explicitly abandoned static caseload numbers. Its current position: "a number is not sufficient." The CWLA now calls for outcome-based workload standards that account for what it takes to do the work — not an arbitrary numerical threshold.

No jurisdiction has rigorously derived caseload numbers from child-outcomes research. Queensland is not uniquely deficient. But nor can its benchmark be defended as adequate simply because the entire field has failed to solve the same problem.

What it takes to appear to meet the benchmark

Even at 16 cases, the system cannot operate within paid hours. The forfeiture evidence demonstrates that the benchmark is sustained only through systemic overwork — staff meeting it by working unpaid hours, deferring visits, and triaging which children receive attention.

> *"I will meet the expectations of my role because of my attitude — if it doesn't get done in work hours I do it out of work hours. I don't mind. And I call it 'volunteering'*

A benchmark that can only be met through unpaid labour is not a measure of capacity.

Funding Built on False Data - The formula

The department's funding model relies on workload data and planning assumptions produced by the same governance systems that are demonstrably inaccurate.

The department and Queensland Treasury have agreed a formula that automatically generates growth positions based on reported demand. That formula was derived with input from every

Regional Executive Director, the head of Statewide Services, and the Deputy Director-General — the same executives who oversee the workload management reporting system.

The formula is not designed to fix existing inadequacy. It is designed to keep pace with growth in demand. It is premised on the assumption that the current baseline is fundamentally adequate and only needs incremental growth.

If the baseline is wrong — as the forfeiture data, the reporting contradiction, and the invalid benchmark demonstrate — then growth funding perpetuates inadequacy at larger scale rather than correcting it.

Growth without infrastructure

Growth positions cover child safety officers only. They do not fund the senior team leaders, managers, administrative officers, senior practitioners, or — at scale — the new offices required to make additional frontline positions effective. More caseworkers are distributed across the same overstretched support framework.

Government announcements understandably focus on frontline numbers. Without corresponding infrastructure investment, headline CSO increases do not translate into operational capacity.

What the system does not know

This submission does not contend that Treasury has intentionally underfunded the department, nor that funding increases have not occurred. Treasury acted on the data it was given. The difficulty is that the data itself is compromised. Funding calibrated against a workload baseline that has not been empirically derived or outcome-validated cannot produce adequate outcomes regardless of the formula's design. The system does not have accurate visibility of what it is funding.

The question is not whether the system has received additional resources — it has. The question is whether the baseline from which those resources were calculated reflects the actual cost of the statutory obligation.

The system has also never modelled the ratio of frontline prevention investment to downstream placement cost, nor whether a prevention-adjusted funding baseline would reduce long-term residential care demand. The escalation from $200 million to over $1.1 billion in residential and intensive placement costs over a decade is treated as an external fiscal pressure, rather than as a potential consequence of chronic underinvestment in the frontline capacity that prevents children entering expensive downstream care.

The Normalisation of Risk - Triage as operating practice

A system that is undersized against its obligations, measured against a benchmark with no evidence base, and funded from data it knows to be false does not fail catastrophically. It degrades incrementally — through layered triage, incremental reduction of standards, and the normalisation of crisis as operating procedure.

At intake

Reports of concern are assessed against risk thresholds. Higher-risk concerns receive investigation within a 24-hour timeframe. Lower-risk concerns sit in a backlog that is not processed.

Families in the backlog are not visited. Their problems do not resolve — they intensify. The department receives repeated calls about the same family as conditions worsen. Eventually the situation deteriorates to the point where it becomes a 24-hour emergency response. The system arrives late, in crisis mode, at a situation that was once manageable.

The earlier calls — containing important contextual information — have not been processed. The responding officer works from only the most recent, most dangerous report, without access to the history of earlier concerns. The system structurally ensures that its most urgent decisions are made with the least information.

At investigation and assessment

When the pile of uninvestigated matters becomes unmanageable, the department implements "review and complete" processes — formally structured exercises in which designated staff review and close matters without conducting any investigation, on the basis that the concerns were not high enough priority and the opportunity to intervene has passed. The department is formally acknowledging that it did not investigate matters it was obligated to investigate — and framing that acknowledgement as administrative housekeeping.

The Enhanced Investigation and Assessment Approach formalises the same logic at the practice level, creating a lighter grade of investigation called "standard responses." Investigations that have been conducted for decades are reclassified as "priority responses." The standard of investigation has been lowered to match capacity, rather than capacity being raised to meet the standard.

International literature identifies a further effect of sustained caseload exceedance. Under prolonged overload, practitioners' assessment thresholds shift — they accept higher levels of presenting risk as normal because the system has normalised that acceptance (Font & Maguire-Jack 2015; Hollinshead et al. 2021). The decision to screen out a concern at intake or to close an investigation without further action is not made in a vacuum; it is made by a practitioner whose baseline for what constitutes manageable risk has been recalibrated by a system that routinely requires them to manage more risk than they can adequately assess.

At ongoing intervention

Court-based matters consume virtually all available capacity during the order-making phase — affidavits, court preparation, hearings, legal coordination. Once orders are made, families are effectively abandoned until the order approaches expiry. Parents who are expected to address the concerns that led to intervention receive no engagement, no monitoring, and no support during the life of the order, because the officer's capacity is consumed by the next court matter.

Children subject to long-term orders are chronically under-served. Staff check in only when something goes wrong. The "squeaky wheel" dynamic means children whose situations are visibly deteriorating or generating external attention receive attention. Children who are quietly suffering — stable enough not to trigger alarms but not receiving the engagement they need — are structurally neglected.

The department tracks case plan compliance against aspirational targets that are never 100%. It does not track home visit compliance at all.

When prevention cannot begin

Preventative and relational work — building relationships with families over time, identifying emerging risk before it becomes crisis, supporting parents to address the issues that led to intervention — is invisible in workload metrics. It has no deadline, no court date, no compliance trigger. When every day is consumed by crisis response, prevention never begins.

> *"We can't prioritise every case or request, there is always a more important and time consuming crisis around the corner."*

When preventative work does not happen, families who could have been stabilised instead deteriorate. Deterioration generates more reports, more investigations, more court matters, more placements. The system creates its own future demand by failing to invest in prevention today.

The pattern

Review and complete processes. The reduced investigation standard. Aspirational case plan targets below 100%. Untracked home visit compliance. Each represents the system lowering its operating standards to match its capacity. The pattern is consistent: what was once a failure becomes a policy, what was once a policy becomes a target, and what was once a target becomes aspirational.

International systems research identifies this as a failure demand cycle. When initial contact with a family does not resolve the presenting risk — because triage prevented meaningful engagement — the family does not exit the system. It re-enters at higher complexity and higher cost. Hood et al. (2016) describe failure demand as demand generated by the system's own failure to address need at first contact. Permanent triage without surge correction converts risk management into risk deferral, amplifying future statutory demand and the fiscal exposure that accompanies it. The growing demand the funding formula is designed to address is, in part, demand the system's own incapacity has created.

The Erosion of Capability - What turnover does to the system

The capacity of a child protection workforce is not reducible to headcount. It depends on the capability of the people who fill the positions — their experience, their professional judgment, and the stability of the supervisory structures above them. Turnover, acting arrangements, and inadequate onboarding mean the system is constantly losing and replacing its most valuable asset: experienced professional judgment.

A cycle of crisis and partial stabilisation

During the COVID years, many non-urban worksites were operating at 50% office vacancies — a figure confirmed repeatedly by departmental executives.

The PO2-to-PO3 reclassification, won by Together members in the 2023 collective bargaining round, represented an approximately $21,000 per year increase in starting salary and temporarily stabilised the workforce. Turnover reduced. Recruitment improved.

That stabilisation is now being unwound. The Unify system — a $183 million IT implementation rolled out in April 2025 has produced severe disruption across the workforce. Missing data has affected nearly 16,000 children's cases. Overdue child intakes have grown to 40%. Key functionality

has been descoped. The Queensland Audit Office described the situation as "sobering," noting system gaps that "potentially put children at risk." The union's own survey of over 300 staff rated Unify 1.46 out of 10.

The Unify experience functions as a diagnostic event. A system with sufficient workforce elasticity and governance safeguards would have absorbed a digital transition of this scale — as comparable jurisdictions have. That Queensland's system could not do so without severe disruption to statutory service delivery reveals the narrowness of the operating margin on which the workforce was already functioning.

The invisible absorption of departures

When a child safety officer leaves, their caseload does not disappear. It is absorbed by remaining staff. But this absorption is often invisible in tracking data. A common managerial practice: allocate half the departing officer's matters to the manager personally, or to nobody at all. On paper, remaining officers still show 16 cases. But the children on the manager's notional caseload still need responses — and when a crisis occurs, an officer goes. The workload does not change. The tracking data does.

Child safety work operates on a joint responsibility basis in practice. When a team leader and one officer are the only staff present for three days, it does not matter whose name is on a file. If a child needs a response, whoever is there goes. The workload management data — which tracks formal allocations — systematically understates actual workload during vacancy and absence periods.

The acting chain

Acting arrangements cascade instability from the top of the organisation to the bottom. In one current example, a single vacancy at Deputy Director-General level produces five successive acting-up arrangements:

- A child safety officer holds a position owned by their team leader.
- That team leader holds a position owned by the Regional Quality Practice Manager.
- That Regional Quality Practice Manager holds a position owned by the regional director.
- That regional director holds a position owned by the regional executive director.
- That regional executive director holds a position owned by the deputy director-general.

Every person in this chain is performing a role above their substantive classification. Ground-level officers are made permanent almost instantly through union agreements. Nobody above that level experiences permanency or stability. The supervisory and governance layer — the people responsible for overseeing practice quality, managing workloads, and making escalation decisions — is itself transient and unstable.

How new staff are prepared

A new officer with any prior experience in child protection or the social work field can expect to receive their full caseload on day one. The Workload Management Manual contemplates lighter

caseloads for newer staff; in practice, new staff inherit the full caseload of the person who vacated the chair. Redistributing cases to already-overloaded colleagues is not viable.

Formal training consists of two weeks total: one session soon after employment, another several months later. Beyond this, capability development depends on learning by osmosis, improvised supervision, and instruction from colleagues who are themselves overloaded and carrying informal mentoring burdens that the system does not recognise, compensate, or measure.

The department's own Working for Queensland survey reflects this investment deficit. Only 29% of staff report that their manager discusses their professional development — the lowest resource score in the entire WFQ survey. Only 37% receive informal performance feedback. The system does not invest in the capability of the workforce it retains, accelerating the erosion of professional judgment that each cycle of turnover produces.

What leaves when experience leaves

When experienced practitioners depart, what goes with them cannot be replaced by hiring. Knowledge of families — built through years of engagement and categorically different from reading case notes. Professional judgment — the accumulated pattern recognition that distinguishes a suicide-risk presentation from distress, or genuine parental compliance from performative compliance. And the informal training infrastructure: the mentoring, the modelling, and the institutional knowledge transfer that the system depends on but does not formally acknowledge.

New staff learn from other relatively new staff. The knowledge base of the workforce contracts with each cycle of turnover.

A cycle that accelerates

> *"Children hate the constant change in CSOs, as CSOs leave after realising the unachievable expectations of the role."*

> *"I'm on to my eighth team leader in under a year. If we can't look after ourselves how can we be the people who are best placed to support vulnerable children and young people."*

58.3% of respondents to the union's survey reported they could not realistically meet the expectations of their role. This included experienced practitioners. The system has degraded to the point where even veteran judgment cannot compensate for structural failure.

The department's own data confirms the attrition pattern. The Working for Queensland survey finds that 21% of staff intend to leave their position within 12 months — one in five. The primary push factors are emotional exhaustion (17%) and being expected to do more work than is reasonable (16%). The dominant destination is other Queensland government agencies (35%), not the private sector — indicating that staff leave not because they want different work, but because they want the same work under manageable conditions. In 2023, the figures were worse: 23% intending to leave, with 21% citing emotional exhaustion and 21% citing unreasonable workload.

Turnover is self-reinforcing. Experienced staff leave. Their caseloads are absorbed by remaining staff. New staff arrive underprepared. The combination of increased workload and degraded support

drives further departures among experienced practitioners. The cycle accelerates, and there is no mechanism within the current system design that would cause it to self-correct.

Consequences for Children - The causal link

Each of the workforce conditions documented above — invisible labour, an unvalidated benchmark, compromised data, normalised triage, and eroded capability — produces identifiable consequences for children in the State's care.

The Commission's Terms of Reference direct it to examine whether staff are "resourced and supported to do their work" (ToR 3(b)(vii)) and to evaluate the Department as a corporate parent (ToR 3(d)). The industrial evidence is child outcome evidence.

How workforce failure translates

Invisible labour means children's work does not get done. The hours that are forfeited are hours that would otherwise have been spent on visits, engagement, case planning, and therapeutic referrals. The system does not report this as a child safety gap. It reports "0 unreasonable workloads."

The invalid benchmark means a child safety officer with 16 children has "met the benchmark" regardless of whether any child received meaningful engagement. The benchmark has no child-outcome validation. It was never designed to ensure children receive competent care.

Triage means children are prioritised against each other. The children who most need proactive, relational, preventative engagement are the ones least likely to receive it — because proactive work has no court deadline, no compliance trigger, and no statutory timeframe.

Turnover means children experience constant changes of child safety officer. Each change breaks a relationship and forces the child to start again with a stranger. Institutional memory is lost. The new officer works from files, not from the knowledge that only sustained engagement can build.

What the workforce says about the children in its care

The union's survey asked frontline staff: if they could change one thing about how the Department acts as a corporate parent, what would it be?

> *"Time to parent. With so many children and so few staff, there is no time to spend knowing the kids, knowing their needs. If you don't know the child, how can you act in their best interests?"*

> *"CSOs represent the department to the kids. The relationships between CSOs and the children in their caseloads can make the difference between a child growing up thinking they mean something to someone, and a child growing up saying nobody cared."*

> *"Our KPIs relate to our paperwork, instead of the feedback we are getting from the families we work with. That seems wrong to me." — Frontline practitioner*

> *"Some of these kids go to school in the morning with all their belongings in a CSO's car and have to sleep somewhere new that night. How are they supposed to focus or do anything?"*

Several respondents applied the Department's own child protection framework to the Department as corporate parent — and concluded it would fail its own test:

> *"I would suggest the department cease procreating and would probably place it on a strongly supervised IPA because it does not have the capacity to adequately and safely parent the children in its care."*

The self-reinforcing demand cycle

Workforce failure produces worse child outcomes. Worse outcomes generate more demand — more reports, more crises, more court matters, more placements. More demand on an already inadequate workforce produces further failure.

The system is not merely failing to meet the obligation. It is generating the conditions under which future failure is inevitable.

Recommendations

The public conversation about child protection funding has been dominated by the cost of residential and intensive placement support care — costs that have grown from $200 million to over $1.1 billion in a decade and are projected to exceed $7 billion annually by 2030 without reform. That conversation is important, and other chapters of the union's submission address it directly. But the effect has been to draw political and funding attention to the most visible downstream cost while the frontline workforce — the system's capacity to prevent children entering expensive downstream care — has been funded against a baseline that has never been empirically validated as adequate.

The Commission is directed to make recommendations that are "appropriate and feasible" (ToR cl. 5), including on "appropriate frontline resourcing" (ToR 5(b)). The following recommendations flow from the evidence. Each is a necessary consequence of the diagnosis, not an aspiration.

Independent, evidence-based workload reassessment

The current caseload benchmark has not been empirically validated and has never been tested against child outcomes. The Commission should recommend an independently conducted reassessment of what workload allows the State to meet its obligations to children — accounting for case complexity, including but not limited to court involvement and its weighting at each stage of proceedings, placement instability and associated relational work, cultural consultation obligations under section 5F of the *Child Protection Act 1999*, disability and NDIS coordination load, geographic travel requirements, and sibling cluster compounding effects, as well as the distinction between different case types and intervention stages. This is the unfulfilled promise of CMC Recommendation 5.3 from 2004.

Recalibrated funding from a validated baseline

The current funding formula grows positions from a baseline that has never been validated as adequate. Once an independent workload assessment establishes what adequate capacity requires, funding must be recalibrated from that validated baseline — not grown incrementally from the current one. The formula must be reset, not adjusted.

Infrastructure-inclusive growth funding

Growth positions cover child safety officers only. Growth funding must include locked ratios for supporting roles — senior team leaders, managers, administrative officers, senior practitioners — and at defined scale thresholds, new offices with full infrastructure. Announcements of additional frontline numbers without corresponding infrastructure do not produce proportionate gains in operational capacity.

Technological reform of workload reporting

The governance failure — where the people responsible for managing workload are the same people responsible for reporting it — cannot be remedied by instructing managers to report honestly. That approach relies on the same reporting chain that has produced the current inaccuracies.

Workload data should be captured directly and automatically from the department's operational systems: actual hours worked versus rostered hours, case allocations, visit frequency and compliance with Chief Practitioner policy, and case plan currency. The technology removes the structural conflict and makes it impossible for the system to simultaneously report reasonable workloads while forfeiting thousands of hours of unpaid labour.

Caseload benchmarks tied to care quality

Any new benchmark must be validated against child outcomes, not workforce throughput. The system currently measures whether visits occurred, not whether they achieved anything. Whether case plans exist, not whether they reflect reality. Whether caseloads are at 16, not whether the children on those caseloads are receiving the care the *Child Protection Act* and the *Human Rights Act* require. Measurement must shift from "did it happen" to "did it work."

Conclusion

This submission has placed before the Commission the evidence of 1,102 frontline child protection workers — the people who hold this system together every day. Their evidence does not describe isolated failings or occasional shortcomings. It describes a system that is structurally incapable of delivering what the law requires, despite the commitment and professionalism of its workforce.

Across every chapter, a common pattern emerges. The legislation sets out what children are owed: safety, stability, meaningful relationships, cultural connection, and care that promotes their wellbeing across the course of their lives. The system is not designed, resourced or governed in a way that makes those obligations achievable in practice.

The residential care system absorbs children the rest of the system has failed.

84% of frontline workers say that redirecting residential care funding toward keeping children safely with families would reduce the need for residential placements. Children — including very young children — enter residential care not because it meets their needs but because the system has not invested in the alternatives. Workers describe residential care as unstable, non-therapeutic, and often harmful. The children who enter it leave with compounded trauma, not healed wounds. The billion dollars Queensland spends on residential care each year is not an investment in children's futures. It is the cost of everything that failed before they got there.

The front door does not work as designed.

The Enhanced Intake and Assessment model was premised on diverting families to community supports. Those supports do not exist at scale. Waitlists for intensive family services run 3 to 12 months. Safety and support response pathways were rolled out before providers were funded. 88.9% of workers say the Queensland Government is not funding enough preventive and early intervention services. The result is a revolving door: families are screened in, assessed superficially or not at all, closed without support, and re-notified when conditions deteriorate. The same children cycle through the system repeatedly because the system will not invest in them until they reach crisis.

The litigation model has fragmented the State's voice and weakened outcomes for children.

The separation of the Department's legal function into DCPL and OCFOS has produced a system where the people who know the family do not control the legal strategy, and the people who control the legal strategy do not know the family. Two-thirds of respondents support bringing the court process back under a single legal body embedded within the Department. Workers describe information lost between agencies, professional assessments overridden without explanation, and families confused by a system that cannot speak with one voice. The litigation model was designed to provide accountability. In practice, it has introduced fragmentation, delay, and a structural separation between legal decision-making and the relational knowledge on which child protection depends.

The workforce cannot deliver what the law requires at current capacity.

79.3% of workers say the Department is not adequately resourced to meet its legislative obligations. 83.8% say their workload is unmanageable. 58.3% say they cannot realistically meet the expectations of their role — rising to 69% among child safety officers. The caseload benchmark of 16 children has never been empirically validated or tested against child outcomes. The system's compliance with its

statutory obligations is sustained through thousands of hours of unpaid labour: 12,797 hours forfeited in the first half of 2025 alone. The Workload Management reporting system simultaneously asserts that the majority of workplaces have zero unresolved unreasonable workloads. The governance apparatus does not capture the gap between what the law requires and what the workforce can deliver. It conceals it.

The measurement of the system's performance is itself a structural failure.

KPIs measure speed and volume — how many assessments are closed per month, how quickly matters move through intake — while quality, safety, cultural appropriateness and children's lived experience go unmeasured. Workers who slow down to do thorough assessments face performance management. Cultural obligations are performed on paper but not in practice. The system does not know whether the children in its care feel safe, connected or heard, because it has never built the infrastructure to ask.

Workers are not the problem. They are the only reason the system still functions.

The workforce that gave evidence through this survey did not describe a system failing because its people have given up. It described a system in which dedicated professionals are structurally prevented from doing the work they were trained to do. Workers carry caseloads of 25 to 35 children against a benchmark designed for 16. They write affidavits at 3am because the day is consumed by crisis. They forfeit their own time because there is no mechanism to recover it and no colleague available to cover their absence. They leave not because they stop caring but because the system makes caring unsustainable.

The phrase that recurs across hundreds of survey responses is not a complaint about pay or conditions. It is this:

> *"Good people leave not because they don't care — but because they cared at a level that was unsustainable within the current system."*

This is moral injury. It is not burnout in the colloquial sense. It is the psychological toll of knowing what children need, being professionally obligated to provide it, and being structurally prevented from doing so. It is the mechanism that turns workload pressure into workforce attrition, and workforce attrition into worse outcomes for children.

What this submission asks of the Commission

This submission does not ask for incremental adjustment. The evidence demonstrates that the issues are structural, and structural problems require structural reform.

Where the system has been redesigned — such as through the creation of the child protection litigation model — those changes have introduced new harms by separating decision-making from practice and fragmenting the State's role as corporate parent. Where reform has not occurred — particularly in workload measurement, family-based care, early intervention and residential care — outdated assumptions have been allowed to persist despite clear evidence of harm.

The Commission now has the opportunity to recommend reforms that address causes rather than symptoms. Reforms that restore coherence to decision-making. That align resources with legal

obligations. That redesign care around children's needs rather than organisational convenience. That treat the people who hold this system together not as disposable inputs but as the professionals whose expertise and judgment the system depends on

> **Frontline workers are united in a single message to the Commission and the public: the system can work differently. The knowledge exists. The workforce understands what children need. Better outcomes are possible if the system is re-aligned so that professional expertise is respected, funding follows prevention rather than crisis, and the State accepts responsibility not only for custody, but for the quality of care it provides.**

The recommendations that follow flow directly from the evidence placed before the Commission and from the lived experience of the workforce that holds this system together.