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22nd January 2026

Dear Commissioner, Honourable Paul Anastassiou KC,

Re: Commission of Inquiry into Queensland's Child Safety System: Corporate Parenting and Connections to Youth Justice

Submitted by: YFS LTD

This submission is made in response to the Commission of Inquiry's invitation to examine the effectiveness of the Department as a corporate parent to children in the care of Queensland's Child Safety system, and the links between the Child Safety and Youth Justice systems. As per the Commission's request, it focuses on the experiences of YFS clients who are or have been in the care of the Child Safety system, along with the perspectives of practitioners, carers, and legal advocates who support them.

Our organisation works with approximately 7,200 clients annually across the Logan region and surrounds. We directly assist young people in care and post-care to develop the knowledge, skills, connections, and resilience to live independently and participate in society, including those with disabilities, complex trauma, and significant mental health issues. We also provide free legal support for young people in care engaged with the Youth Justice system. In supporting these clients, YFS has seen firsthand the extensive physical and psychological harm experienced by young people throughout their time in care, and the additional cultural harm experienced by First Nations young people.

Drawing on lived experiences of young people and the insights of YFS staff which are reflected in numerous sector reports, particularly those from the Queensland Family and Child Commission (QFCC) and Child Death Review Board (CDRB), this submission highlights pivotal failures in the Department's conduct as a corporate parent that substantiate the notion that elements of the Child Safety system function as a 'feeder system' to the Youth Justice system. It also proposes a series of reforms that seek to protect the health, wellbeing, and future prospects of young people in care.

We wish to acknowledge the personal contributions of young people in the three (3) case studies provided. These case studies demonstrate some of the key gaps experienced by young people in the current system. This submission platforms the young peoples' voices in the hope they will catalyse changes for the benefit of other young people currently in the care system.

We expand on the themes below in this submission, but in summary, regarding the existing corporate parenting framework that heightens young people's risk of engagement with the Youth Justice system, we recommend:

1. **An independent review of the Department's service coordination / accountability framework**

   We propose that the gaps between agencies responsible for meeting the diverse needs of children contribute to engagement with the Youth Justice system. Accordingly, we recommend an independent review of existing service coordination frameworks to amend these gaps. We believe that an integral component of this review is the establishment of a statutory corporate parenting accountability framework with identified executive leads and role-specific duties across agencies, with an increased role for community organisations. This model ensures continuity, stability, and accountability through effective cross-agency collaboration that recognises the efficacy and retention of community-based responses. This should also be underpinned by recommendation two's theme of establishing relationship continuity, rather than occupancy targets.

2. **Reforming residential care models by shifting performance targets from occupancy to relationship continuity**

   The Child Safety system should transition to therapeutic housing models with stable clinical support in smaller homes and prevent placement closures driven solely by trauma or disability-related behaviours. These reforms reflect the inability of current models to meet the emotional and developmental needs of young people, often resulting in further harm. This additionally supports recommendation three that ensures practical First Nations cultural identity and self-determination pathways.

3. **Establishment of practical First Nations cultural identity and self-determination pathways within the Child Safety system**

   These pathways should be led by Aboriginal and Torres Strait Islander community-controlled organisations, recognising the inability of state-level agencies to meet the diverse cultural needs of First Nations youth. These pathways will facilitate meaningful connections to Country and community as key factors in the long-term wellbeing of First Nations young people.

4. **Increased government investment into high-retention community-based initiatives (e.g. Transition to Adulthood)**

   Community-based initiatives have demonstrated success in responding to key risk factors prevalent in the Child Safety system, such as disengagement from education and community, complex trauma, and placement instability, to mitigate contacts with the justice system.

5. **Establishment of an accessible outreach body, similar to the Community Visitor program**

   This program is essential to reconnect high-risk young people exhibiting progressive signs of disengagement with necessary support services. Outreach programs fill an urgent gap in the Child Safety system, recognising the accountability of the Department for young people exhibiting resistance to dominant care options (i.e. self-placing young people).

6. **Strengthened disability identification and response mechanisms**

   The Department must implement routine developmental screening, timely assessment of suspected disabilities, disability informed residential care, and dedicated NDIS liaison support. These improvements close a long-standing practice gap and reduce the risk of Youth Justice involvement.

7. **Embedding youth voice and co-design across the system by establishing a Lived Experience Advisory Council for Child Safety**

   The involvement of young people with care experience should be mandated in service design, tender evaluation and workforce training, alongside the inclusion of each young person’s care team in decision-making within Youth Justice proceedings. These reforms address the significant gaps in understanding of the needs of young people in care and the current operation of the Child Safety system.

The Department as Corporate Parent: Meeting Community Expectations

‘Corporate parenting’ refers to the State’s statutory responsibility under the Child Protection Act 1999 (Qld) (“the Act”) to assume “all the powers, rights and responsibilities in relation to the child that would otherwise have been vested in the person having parental responsibility for making decisions about the long-term care, wellbeing and development of the child”.[1] The State as a corporate parent must consider the safety, wellbeing, and best interests of the child as paramount,[2] and make decisions that guarantee long-term stability, cultural identity, physical and mental health, education, and participation in decision-making whilst in care.[3] For First Nations children, these responsibilities include ensuring familial and cultural connections are prioritised through care and justice proceedings to support self-determination.

Corporate parenting responsibilities additionally entail supporting children’s transition out of care toward independence, up to the age of 25. As corporate parent, the State is legally obligated to facilitate effective collaboration between support entities to meet the diverse needs of children in care in a timely manner.[4] Collectively, these provisions establish corporate parenting as a binding legal framework requiring the State to provide nurturing, stability, and advocacy for every child in care.

Despite the extensive responsibilities outlined in the Act, YFS observes significant and concerning gaps between these duties and the realities for children with care experiences engaged with our programs. These gaps include but are not limited to:

- Placement instability and relational inconsistency
- Compliance bias and lack of persistence
- Lack of facilitation of cultural connections for First Nations children
- Discontinuity of care for basic health and development needs
- Lack of support service coordination

These gaps are informed in part by recent reports surrounding the Child Safety system, but more importantly by the experiences of young people engaged with YFS who have been in contact with Child Safety and Youth Justice. The case studies below are recent, deidentified examples from the cohort of young people being supported by YFS Legal, and in YFS’ Next Step Plus (NSP) and Extended Post Care Support (EPCS) programs which support young people aged 15 to 25 years who are in out-of-home care or have had a care experience after they were 12 years of age. These cases depict a pattern of negligence, relational inconsistency, instability, and disregard for cultural needs, intensifying existing trauma-driven risk factors for engagement with the Youth Justice system.

Case Study 1

A young woman, currently 20 years of age, has been supported in the NSP program since she was 18 years of age. She has been supported to apply for the National Redress Scheme and has shared the below story with her Youth Development Coach.

- At 15 years of age, she was in a foster care placement with two male carers. She reports that due to her “challenging behaviours”, her foster carers requested that she be moved, and she was subsequently placed within a residential care provider (“YLO”).
- The young person reports that it is her understanding that the foster carers were “good friends” with a senior person at YLO, and that there was “no confidentiality” about her situation as details were regularly shared with the former foster carers about her circumstances.

[1] Child Protection Act 1999 (QLD) s 13. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.
[2] Child Protection Act 1999 (QLD) s 5A. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.
[3] Child Protection Act 1999 (QLD) s 5B - 5BA, Sch 1. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.
[4] Child Protection Act 1999 (QLD) s 7. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.

- While living with YLO, she met an older male through friends. On one occasion, she met with him during the day and later returned to the residential. When she returned to the residential, she reported discovering bruising and welts all over her body while in the shower. She reports she wasn't drinking when she met him but cannot remember anything about meeting with him, and therefore believes she was drugged.
- She requested for one of the youth workers at YLO to take photos of the bruising and welts which they did, but she reports that "nothing progressed" after that. The young person is not aware of what happened after she told the youth workers.
- Sometime later, when she was 15, she was diagnosed with a sexually transmitted infection, which YLO was aware of as they supported her to attend the GP for diagnosis and treatment. At this point, the young person had not engaged in any consensual sexual activity prior.
- A few weeks later, she started experiencing heavy vaginal bleeding while she was at the residential. YLO supported her to attend a GP where she had a blood test, and it was confirmed that she was miscarrying and had been 6 – 8 weeks pregnant.
- The young person reports that she is aware there was communication between her former foster carers and YLO about this miscarriage and STI, and she was told that it would be in her best interests that she did not disclose what had occurred.
- YLO took the young woman at 15 years of age to have an Implanon bar (for contraceptive purposes) inserted, and she was told that this was "so this doesn't happen again".
- At 18 years of age, after leaving care, she was supported to attend the CSSC to pick up her identity documents (birth certificate). During this visit to the CSSC, the Child Safety Officer at the time took the young woman into a room and said that she would like to "formally apologise for the sexual abuse that she experienced while in care". This had not been arranged prior with the young person or her Youth Development Coach at YFS.

The above case highlights:

- "Challenging behaviours" are not met with persistent care, but with relational inconsistency, support withdrawal and anti-social behaviour from residential workers leading to heightened risk and severe harm.
- Young people's health concerns are met with indifference and a lack of consistent follow-up until significant health risks arise.
- Previous behavioural concerns directly impact young people's access to and quality of essential healthcare.
- Young people are routinely subjected to behaviour that perpetuates harm, with residential workers and Child Safety Officers exhibiting a damaging lack of knowledge of trauma-informed practice.

Case Study 2

A young woman, aged 17 years and 9 months was being supported in the EPCS program in September 2024.

- The young woman met with her EPCS Coach in person on a regular basis and on a number of occasions was supported in conversations with her Child Safety Officer by phone and in person.
- She had been couch surfing and sleeping rough for a period of months, after choosing to leave a SIL placement approximately two years earlier, due to trauma she experienced there, including sexual harassment from a male residential youth worker and his threats made to her not to report it.
- She advised she did not report the incident at the time due to threats made by the male support worker.

- She further states that she had reported the incident to her CSO approximately one year later and was told by her CSO that the Police would contact her. However, she reports that she never had any follow up contact from Police about the incident.
- She stated that she did not feel comfortable to raise it again with Child Safety because she felt they did not support her and had not taken any action.
- In September 2024, during a conversation with a new CSO, she was encouraged to stay a night at emergency accommodation in [redacted]
- The young woman told her CSO that she did not feel safe to return to a placement like this due to her previous experience of being sexually assaulted in the SIL accommodation.
- The Child Safety Officer responded with the following statements across two conversations (where YFS staff were present):
    - "That was a while ago now, you need to move on."
    - "That would not happen in a placement now because all carers have blue cards."
    - "Why do you keep bringing this up?"
- These statements were raised by our service with the Team Leader and CSSC Manager and Regional Practice Leader to address as a practice issue.

The above case highlights:

- The inability of residential care facilities to guarantee the physical and mental wellbeing of young people resulting in placement instability, including self-placing, increasing risks of harm.
- Existing figures in the Child Safety system fail to provide sufficient care and emotional support as key aspects of a 'corporate parenting' model, leading to disengagement and harm.
- The lack of care and trauma-informed practice around disclosures of abuse can cause significant psychological harm and perpetuate ongoing trauma.

Case Study 3

A young Aboriginal male, aged 16 years, was being supported by NSP and another YFS youth program. He regularly met with his Youth Development Coach in person and had been self-placing for a period of over 12 months, couch surfing with a former foster carer, and in unsafe locations with unsafe adults. The young man expressed concerns about incidents which had occurred when he was approximately 10 years of age in a residential care placement; he wished to know what Child Safety had done when they became aware of the incident, what they did to intervene and whether he is eligible for financial compensation.

YFS contacted the CSO and Team Leader to advise that the young man was seeking further information regarding his time in care, at which point the CSO advised that her Team Leader had "reviewed the file" and "everything was above board". The following details were, however, provided.

- The young man, at 10 years of age had been involved in a sexual act with an older young person (2 – 3 years older) at the residential placement on more than one occasion, which the young man now understands as sexual assault.
- Following the assault, the young man began absconding from placement on a regular basis as he did not feel safe. This resulted in multiple calls to police to locate him or list him as a missing person.
- Around this time, the young man began self-placing with his mother and other unsafe adults rather than in a placement, at which point his behaviour was characterised as "defiant".
- Between the ages of 12 – 14, he was rarely provided a placement as his behaviour was described as challenging, and he would scarcely stay at the placement.

- During this time, he also had several charges relating to stealing vehicles, robbery and breaking and entering. He participated in a range of Youth Justice programs and restorative justice conferences after being remanded in custody at BYDC for approximately a week.

After requesting a meeting to discuss how the Department would provide a supportive response to this young man now that he is seeking further information, the following occurred.

- The Team Leader opened the meeting by asking "Has [young person] been talking about his sexuality or whether he was exploring his sexuality at the time?" He also said that according to what he had reviewed, he believed that the young person was "the perpetrator".
- The Team Leader advised that the incident had been reported to Police and that he would follow with a QPrime number so that the YFS Youth Development Coach could support the young man with a Victim Assist application.
- This case was raised with the Senior Practitioner at the CSSC, due to concerns about the Team Leader's attitude and misconceptions about harmful sexual behaviour.
- The Senior Practitioner reviewed the file and advised that, contrary to the information provided by the Team Leader, the matter had not been reported to the Police.
- The Senior Practitioner further advised that the Team Leader had said he believed the young man was "financially motivated" to raise this again.
- The Senior Practitioner advised that while there is evidence on the file of an "Incident Report" there are no corresponding notes to outline:
    - What steps the Department took to ensure the young person's safety at the time of the incident.
    - What steps the Department took to offer support to the young person (medically, psychologically or emotionally).

The above case highlights:

- Residential care facilities lack the intensive supports to safeguard young children against severe harm.
- Experiences of harm whilst in care are not met with suitable trauma-informed responses, resulting in disengagement and subsequent (Child Safety facilitated) engagement with the justice system.
- A lack of persistent care in the face of "defiant" or "challenging" behaviour drives placement instability and relational inconsistency, characterised by contact with unsafe individuals and increasing engagement with Youth Justice.
- The absence of frameworks to address complicated trauma-driven behaviours results in missed opportunities to facilitate cultural connections and learning, which compounds adverse effects for First Nations young people.
- Trauma-driven behaviour (resistance, disengagement, criminality) shapes perceptions of young people and their experiences (including experiences of harm) by key figures in the Child Safety system, resulting in re-traumatisation.

Case Study 4

An Aboriginal girl, aged 17 years, was being supported by YFS Legal after being remanded in custody and coming under the care of Child Safety.

- The young person came under the care of Child Safety for the first time following exposure to domestic and family violence, which led them to homelessness and committing offences for financial gain.

- After being remanded in custody, the young person's release was delayed as Child Safety was unable to source suitable accommodation.
- Child Safety informed YFS that given the young person's age, and that they were currently 'safe' in custody, they would not be a priority for placement given other young people may need to be removed from immediate harm.
- When placement was eventually sourced, the young person (having never been in the care of Child Safety before) was placed in a 'no technology' house.
- The young person did not adjust well to this placement and left after a few days resulting in multiple breaches of bail.
- YFS had previously attempted to liaise with Child Safety to find alternate accommodation or address the young person's concerns, to no success.
- The young person ended up back in custody, and Child Safety could again not locate suitable alternate placement.
- Despite the initial placement being unsuccessful, and no other changes having been made, the young person was re-released to the same placement.
- This ultimately resulted in further breaches of bail conditions, charges and involvement in the Youth Justice system.

The above case highlights:

- The Child Safety system does not acknowledge the serious harm inflicted on young people by the Youth Justice system, both psychologically and to their future prospects. This includes the characterisation of a 17-year-old Aboriginal woman in custody as 'safe'.
- Residential care models are not responsive to the specific and contextual needs of individuals in their care, producing further harm and driving engagement with Youth Justice.
- The Child Safety system lacks procedural safeguards to protect young people from foreseeable and ongoing engagement with Youth Justice.

Placement instability and relational inconsistency

Placement instability and relational inconsistency emerge as defining and deeply harmful features of the Child Safety system. Many children engaged with YFS reported cycling through dozens of residential staff and multiple Child Safety Officers throughout their time in care, eroding trust, predictability and the stable relationships essential for healing and engagement. This instability is intensified by structural issues such as shift arrangements, high staff turnover (due to industry retention and recruitment issues), staff skill and training discrepancies, and co-tenant changes that cannot sustain long-term relational work, resulting in children repeatedly forming and losing connections with caregivers, practitioners, and fellow residents.

YFS also notes that care models vary between residential care providers, contributing to instability, inconsistency, and disengagement. This is exhibited clearly in discrepancies surrounding the use of technology in care facilities. Young people moving between facilities are already subjected to intense changes, including location, peers, carers, and education. Restricting their use of technology further disrupts their support network and routine, disconnecting them from the consistency of friendships and social life which are already limited by placement with residential care providers. These discrepancies prevent children from establishing routines, norms, and long-term connections, which lead many young people to abscond from placements to regain a sense of normality and freedom.

The CDRB documents numerous cases in which children experienced frequent placement breakdowns, long periods without any allocated placement, repeated episodes of self-placing, and extended time in unsafe environments, often despite clear evidence that relational continuity was critical to their safety and

wellbeing.[5] Children in residential care in particular struggled to build trusting relationships due to the high churn of rostered staff, limited therapeutic capacity, and care models that failed to provide the relational security needed for recovery from trauma.[6]

These pressures are most pronounced as children in care approach adulthood. Although this cohort (young people aged 15-17) are perceived as less dependent than younger children, they too require intensive supports to facilitate sustainable long-term independence post-care. Placement and relational consistency are paramount in ensuring that young people preparing to exit care have the necessary supports and resources to pursue independence without fear of homelessness, exploitation or feeling the need to resort to criminal activity.

YFS delivers the NSP and EPCS programs as part of the Transition to Adulthood (T2A) initiative to support young people transitioning out of care achieve independence. This initiative demonstrates a recognition of the vulnerability of this cohort by the Department, and an acknowledgement of the greater retention and success rates of community organisations. However, T2A and similar initiatives are severely under-resourced and cannot support the amount of young people at-risk of homelessness and engagement with the justice system.

Together, the evidence depicts a system that routinely fails to offer the stable caregiving relationships that replicate parental care, with placement instability, relational fragmentation, and inconsistent care models not only undermining young people's emotional, developmental and cultural needs but directly contributing to escalating risk, disengagement from services, and poor long-term outcomes.

Compliance bias and lack of persistence

In YFS' experience, placement instability and relational inconsistency are intensified by the Child Safety system's compliance bias and lack of persistence in caring for young people with complex needs. Young people in care who present as compliant are often prioritised, while those who resist or avoid engagement receive reduced attention, follow-through and care, contrary to the obligations of a corporate parent. The Child Safety system fails to provide *repeated,* developmentally appropriate opportunities for children to demonstrate their willingness to pursue regular healthcare, education, and cultural connections. Children who are compliant with initial efforts from support workers more readily establish the connections and relationships needed to facilitate ongoing care, opportunity, and wellbeing. Children who are initially non-compliant are labelled as 'complex', 'difficult' or even 'violent' and are not given sufficient opportunities to review their decisions, despite resistant behaviour being developmentally typical for adolescents, and often trauma-driven.[7]

The procedural, risk-focused approach to care that is entrenched in the Child Safety system (discussed in detail below) undermines relational practice, creating a climate in which support staff de-prioritise and disengage from young people who exhibit initial resistance. Rather than persisting with these children, attempting to increase engagement or adjust approaches to care, as would be expected of actual parents, these young people are prematurely written off resulting in missed health checks, uncompleted assessments, unaddressed developmental and therapeutic needs. The CDRB similarly finds that many high-risk young people whose behaviours reflected trauma, disability or unmet needs – absconding, substance use, school refusal, or aggression – were met with system withdrawal, placement closures, or exclusion from services rather than sustained, coordinated, therapeutic engagement.[8]

This bias toward compliant children is further reinforced by capacity constraints and high workforce turnover, which collectively incentivise workers to prioritise those who are easier to stabilise rather than those whose trauma-based behaviours require persistence, adaptation and stronger cross-agency coordination. As a result, the system repeatedly fails to act as a parent would – persisting, modifying approaches and ensuring

[5] CDRB. (2024). "Annual Report 2023-24." https://www.qfcc.qld.gov.au/board/publications.
[6] CDRB. (2024). "Annual Report 2023-24," p. 32. https://www.qfcc.qld.gov.au/board/publications.
[7] CDRB. (2024). "Annual Report 2023-24," p. 37. https://www.qfcc.qld.gov.au/board/publications.
[8] CDRB. (2025). "Annual Report 2024-25," p. 64. https://www.qfcc.qld.gov.au/board/publications.

continuity – and instead allows non-compliant young people to fall through the gaps into homelessness, exploitation or Youth Justice pathways.

Lack of facilitation of cultural connections for First Nations children

YFS also observes a concerning pattern of the Child Safety system failing to facilitate meaningful cultural connection for First Nations children in care, despite this being a core legislative obligation and a fundamental aspect of corporate parenting. Many Aboriginal and Torres Strait Islander young people with care experiences who are engaged with YFS have reached late adolescence with minimal knowledge of their mob, cultural identity or family connections. They possess little to no direction in obtaining a Certificate of Aboriginality, reconnecting with community, or engaging cultural practitioners, with these tasks being routinely delayed until after leaving care or never meaningfully progressed due to staff turnover, capacity constraints, or lack of cultural expertise.

Disrupted attachments, trauma, and the absence of stable, culturally anchored relationships compound poor outcomes for First Nations children, and residential care settings frequently lack the consistency, relational connection and cultural responsiveness required to nurture identity and belonging.[9] The QFCC further reinforces that children in care describe feeling culturally disconnected, unseen and unsupported.[10] The system's procedural, compliance-driven approach structurally undermines relational and cultural work rather than embedding it as a non-negotiable component of care.[11]

Collectively, the evidence demonstrates that the State's statutory role as corporate parent is not being met; cultural identity work is too often incidental, inconsistent, or entirely absent, leaving First Nations children to transition into adulthood without the cultural grounding, kinship ties, community connection, or identity-affirming experiences that Queensland legislation explicitly recognises as their right.[12]

Discontinuity of care for basic health and development needs

Amongst the cohort of people supported by YFS' NSP and EPCS programs, many young people initially present to YFS having gone years without routine health checks, such as essential GP assessments, dental and optometry assessments. Other clients report speculative remarks around developmental or behavioural concerns throughout childhood without formal diagnostic follow-up (e.g. ADHD indicators identified but never pursued through assessment or intervention). These experiences are echoed by the CDRB that documents children in care often experienced inconsistent or absent follow-up and difficulty accessing specialist care, along with several children with suspected neurodevelopmental conditions (e.g. FASD) never receiving formal assessment despite years of system involvement.[13] Dual-order young people supported by YFS Legal also consistently describe inadequate food and nutrition throughout their time in care.

As suggested above, this pattern is indicative of a broader "checklist" approach to corporate parenting, as identified by the QFCC. Responsibilities surrounding the foundational needs of children are treated as thresholds that can be disregarded once met, rather than ongoing, responsive and case-dependent mandated obligations. Children consistently expressed that they were explicitly aware of the stringent procedural and risk-oriented approach to their lives.[14] While on an emotional and psychological level this is severely detrimental, it also infringes on basic safety and wellbeing needs of children in care. Although early interventions may occur once, often they are not sustained as children grow and their needs evolve. Needs as fundamental as nutrition are also met with bare minimum approaches, rather than the flexibility and accessibility required to ensure wellbeing.

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[9] CDRB. (2024). "Annual Report 2023-24," pp. 51 & 64; CDRB. (2025). "Annual Report 2024-25," p. 66. https://www.qfcc.qld.gov.au/board/publications.

[10] QFCC. (2023). "I was raised by a checklist," p. 8. https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/residential-care-review.

[11] QFCC. (2023). "I was raised by a checklist," p. 5. https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/residential-care-review; QFCC. (2025). "Raising Expectations: Reforming how we raise children and young people in care." pp. 8-9. https://apo.org.au/node/331448.

[12] Child Protection Act 1999 (QLD) Sch 1. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.

[13] CDRB. (2024). "Annual Report 2023-24," p. 33. https://www.qfcc.qld.gov.au/board/publications.

[14] QFCC. (2023). "I was raised by a checklist," p. 5. https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/residential-care-review.

This dynamic is most pronounced when children resist initial opportunities for treatment or diagnosis. Such resistance, although developmentally normal for adolescents,[15] is frequently interpreted as "complexity" resulting in reduced prioritisation rather than the persistent engagement a reasonable parent would provide, and the protection of rights to self-determination and therapeutic support outlined in the Act.[16] Young people consequently transition toward adulthood with unaddressed health, developmental and therapeutic needs, undermining their wellbeing and contributing to poorer outcomes across education, housing stability, and engagement with prosocial supports. This discontinuity represents a critical gap in the State's corporate parenting responsibilities and highlights an urgent need for systemic reform to ensure sustained, developmentally attuned care across childhood and adolescence, and early adulthood.

Lack of support service coordination

YFS also notes that children in the care of the State frequently experience poorly coordinated, fragmented and inconsistent support service responses, even when their needs are complex, well-documented and urgent. The diverse and complex needs of children in care require extensive and effective interagency collaboration. However, the Department fails to meet the needs of young people in care through ineffective support service coordination and a lack of accountability to its role as 'corporate parent'. Although this role is well established in theory, practical frameworks that ensure outcomes for at-risk young people are severely limited, with support services lacking direction and an understanding of their roles resulting in inaction, finger-pointing, and further harm to children in care.

This lack of coordinated action is also identified by the CDRB which documents persistent barriers to interagency collaboration, particularly at the frontline level, exacerbating risks and delaying essential interventions.[17] Children with developmental concerns, suspected disability, acute mental health needs, or escalating risk behaviours routinely fell through service gaps due to closed referrals for "non-engagement," unclear responsibility between agencies, poor information sharing, and an absence of a lead accountable actor to guarantee practical outcomes.[18]

Multi-agency systems intended to protect children often operate in silos, without the therapeutic intent or structured coordination required to meet children's needs. As a result, children in state care are too often left to navigate disconnected systems on their own, with the absence of a unified, proactive and accountable support response contributing directly to avoidable harm and poor long-term outcomes, including engagement with the justice system.

'Feeder dynamics' from Child Safety to Youth Justice

From YFS's experience, it is evident that failures of the Child Safety system to adequately fulfill the role of 'corporate parent' drives children in care into contact with the Youth Justice system through systemic gaps that consistently leave high-risk young people without the stability, therapeutic support or coordinated interventions needed to prevent escalation. Unmet developmental and disability needs, unpredictable placement arrangements, disrupted education, and relational instability are widely recognised as independent contributors to heightened engagement with the justice system. Under a 'corporate parenting' framework that not only systematically fails to mitigate these factors but responds to them with system withdrawal rather than increased support, young people are subjected to ongoing trauma and psychological harm which escalate problematic behaviours and potential contact with the justice system.

Relational inconsistency and placement instability, including long-periods where young people are self-placing, expose children in care to unsafe adults, criminal exploitation and environments where offending becomes survival behaviour.[19] The CDRB documented young people accumulating dozens or even hundreds of police interactions, with one child having 259 police and youth co-responder contacts and 44 arrests yet still lacking a coordinated therapeutic or disability informed response – illustrating that the system's failings directly contributed to entrenched justice involvement.[20] The CDRB also highlights that

[15] CDRB. (2024). "Annual Report 2023-24," p. 37. https://www.qfcc.qld.gov.au/board/publications.
[16] Child Protection Act 1999 (QLD) Sch 1. https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010.
[17] CDRB. (2025). "Annual Report 2024-25," Ch. 6. https://www.qfcc.qld.gov.au/board/publications.
[18] CDRB. (2025). "Annual Report 2024-25," p. 107. https://www.qfcc.qld.gov.au/board/publications.
[19] CDRB. (2024). "Annual Report 2023-24," p. 23, 26 & 39. https://www.qfcc.qld.gov.au/board/publications.
[20] CDRB. (2024). "Annual Report 2023-24," p. 23. https://www.qfcc.qld.gov.au/board/publications.

high-risk behaviours linked to trauma, neurodevelopmental disorders or substance use were too often treated as disciplinary issues rather than indicators requiring intensive care, leading to placement breakdowns and punitive responses to behaviour that would, in a family setting, be met with support and supervision.[21]

In YFS' experience, some of these behaviours are not only treated as disciplinary issues by the Child Safety system, but are criminalised, creating a direct pipeline to Youth Justice. When trauma-driven behaviour escalates physically, often despite earlier opportunities to de-escalate through trauma-informed responses, young people can be charged with various offences, including common assault. While YFS does not condone such behaviour, we recognise that it typically occurs during heightened or dysregulated episodes for children with complex needs, which are intensified by inadequate emotional supports and outlets in care facilities. For a young person in family care, not only are such episodes less likely, but they often do not result in police intervention.

Collectively, the evidence demonstrates that when the Child Safety system fails to provide safety, stability and sustained care, it creates the very conditions – homelessness, untreated disabilities, crisis-driven behaviours, police led responses – that push children into the Youth Justice system, making the State's failure as corporate parent a significant driver of justice involvement for vulnerable young people.

Finally, we acknowledge the YFS staff who have contributed to this submission, [redacted] We thank them for their work, insights and commitment to keeping young people safe, and advocating for a better future.

Thank you for the opportunity to make a submission on this topic.

Sincerely

Christopher John

Chief Executive Officer

Ash Simpson

Chief Impact Officer

[21] CDRB. (2025). "Annual Report 2024-25," p. 66. https://www.qfcc.qld.gov.au/board/publications.