transforming corrections to transform lives

Mr Paul Anastassiou KC

Commissioner, Inquiry into Queensland's Child Safety System

29 March 2026

Dear Commissioner,

This submission is made on behalf of the *Transforming Corrections to Transform Lives* (TCTL) Centre at Griffith University. It supplements our earlier submission dated 1 August 2025, which addressed the complaints system regarding children in care.

About TCTL

The TCTL Centre was established to support incarcerated mothers and their children to have safe, dignified and fulfilling lives. Incarcerated mothers and their children are among the most vulnerable members of our community and are at risk of ongoing contact and adverse outcomes across multiple systems unless their support needs are met. Our program addresses the known links between maternal incarceration and risks of adverse outcomes for children, including their involvement with child protection and justice systems.

Currently, our Transform Lives Program (TLP) is actively supporting 45 mothers and more than 90 children in Queensland. Of those children, one third are under Child Safety orders.

Our program staff provide direct support to these children by, for example, facilitating contact with their mothers, accessing health and disability diagnoses, screening, and support plans (in many cases we fund these assessments and recommended therapies/supports), supporting children to engage or re-engage with school, supporting healing from trauma, delivering play based and art-based therapy, and anything else needed to support the child, including collaborating with other services.

Where children are subject to Child Safety orders, most of these supports are actually the responsibility of the Department and its officers, and our program staff spend considerable time and energy in following up with those officers to ensure they perform their role. Unfortunately, due to there being limited places in our program, many other women and children do not get this assistance.

This submission is based on our considerable experience working with families currently involved with, or at risk of involvement with, the Child Safety system. We have been systematically recording those experiences in a detailed log of system issues, from 1 January 2024 (when our program began) to date. That log records, in de-identified entries, interactions between our program team while supporting families in our program, and government agencies with which they interact, including with Child Safety.

Scope of submission

This submission draws on our log of issues to identify key problem areas in the operation of Queensland's Child Safety system, as they impact on our program participants and staff. These issues relate largely to the Inquiry's Terms of Reference (b) system effectiveness in keeping children safe and (c) systemic and policy failures in providing support to at risk families and children.

Based on this log of issues, we have identified occurrences where Child Safety system problems or barriers have had adverse effects on mothers and children in our program. Based on relevant literature about system barriers, we have categorised those problems into five main themes:

1. ***Unnecessary interruptions to case planning –*** e.g., Child Safety failing to schedule or cancelling meetings with mothers and/or program staff with minimal notice, impacting the development of case plans, maternal-child contact and maternal-caregiver liaison/information sharing, noting that current Child Safety policy requires Child Safety officers to make reasonable efforts to involve parents in case planning.
2. ***Limited accountability for performing key responsibilities –*** e.g., shifting a Child Safety responsibility (such as transporting of children for maternal visits; transportation of children to school from OOHC placements) to other services with limited capacity (such as our program); failing to assess and address children's mental health, behavioural and disability needs through coordinated assessments, with children missing out on much needed NDIS and therapeutic support.
3. ***Inconsistent application of policy –*** e.g., not conducting home visits when required, sharing information without consent, inappropriate communication methods, styles, and language, unclear and poorly communicated decisions, arbitrary decisions around reunification timelines that are not supported by policy.
4. ***Information silos –*** e.g., not responding to requests for information where consent has been given for its sharing, not communicating key decisions about children to mothers and vice versa.
5. ***Administrative inefficiencies and delays –*** e.g., lengthy delays in Child Safety responses to applications, requests for information and follow up contacts, failure to comply with commitments given to parents (e.g., to progress NDIS and other support applications, delays in completing school enrolment processes).

It is important to note that some mothers experience many of these problems on multiple occasions. Over time, repeated obstacles such as these impact mothers' capacity and willingness to continue engagement with Child Safety systems. From a Child Safety perspective this may reduce individual officer workloads, but interruptions to the maternal-child relationship, even when the family is living separately, has adverse long-term outcomes for everyone involved and undermines the policy objectives of the Department. Further, it creates inefficiencies and increased costs for the Department and across agencies when problems are not addressed, become compounded, and create cumulative harm.

Overall, our record of system issues shows that Child Safety often does not comply with its own policy mandates (e.g., holding family group meetings, providing copies of case plans to parents, notification to parents of important information about their children in the care of the agency). When interactions do occur with incarcerated mothers, unfortunately officers often fail to communicate appropriately (e.g., refusing to conduct face-to-face meetings, turning off cameras during online interactions, use of derogatory language). Structural factors such as resource constraints, staff turnover and significant caseloads play some part in these failures, but so too do poorly trained and supervised staff, poor understanding of legislative and policy frameworks, and in some cases, a failure of local management to adequately supervise and follow up on complaints.

What needs to be done?

There are clear needs for a larger, and more well trained and equipped, Child Safety workforce. This should include:

- Reduced caseloads to ensure Child Safety Officers have sufficient time to perform their duties in respect of each child, including supporting mother-child contact when a mother is in prison. Sufficient time should be allocated to Child Safety Officers to meet with mothers in prison and to conduct family group meetings that are inclusive of incarcerated mothers, as well as ensuring the needs of children in OOHC are being met.
- Ensuring Child Safety Officers receive specific training to understand the impacts of incarceration on both mothers and children, including training on the impacts of trauma on incarcerated women and their children, and training on appropriate communication styles, particularly when discussing contact and reunification plans with mothers.
- Developing a minimum standard for case management that centres on co-ordinated, complex case management and building accountability around delivery of this standard. This should be complemented by the provision of training in case management across multiple agencies and systems, including specific advice on how to engage with the corrective services, NDIS, mental health services, and schools, to facilitate better outcomes for children.
- Holding Child Safety Officers accountable for delays in complying with mandated timeframes, such as those relating to communications with parents about participation in family group meetings and the provision of case plans. A mother's incarceration is no excuse for non-compliance, and if barriers exist, Child Safety should work closely with Queensland Corrective Services to overcome them.
- Holding Child Safety Officers accountable for their responsibility to facilitate approved maternal contact with children, including facilitating a child's participation in playgroups and visits in prison when suitable, organising the child's transport, and once mothers are released, scheduling child interactions for locations mothers can easily access by public transport.

Thank you for the opportunity to make this submission. We are happy to discuss these matters further if required.

Yours sincerely

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Distinguished Professor Susan Dennison

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Director, Transforming Corrections to Transform Lives Centre

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