# Child Safety Commission of Inquiry Submissions

The Youth Advocacy Centre (YAC) appreciates the opportunity to provide the Commission of Inquiry with feedback.

YAC is a community legal and social welfare agency for children and young people aged 10-18, particularly those involved in the youth justice system and child protection system or experiencing homelessness.

## The Department of Child Safety as an Effective Corporate

The Department of Child Safety ('the Department') is not an effective corporate parent. It is failing children in its care, particularly children who are highly vulnerable with complex issues and traumas from adverse experiences. It provides a bureaucratic and administrative- driven response of removing children from the risk of harm. It does not provide these children with targeted, child-focused interventions and support networks that continue beyond the age of 18.

The Department is further re-traumatising children, at worse contributing to their entrenchment in the youth justice system and in some cases, even death.

The case studies below highlight the lived experiences of children and young people who have been failed by the Department in its assumed parental responsibilities. The stories demonstrate the negative impacts on the lives of these children, including for some, involvement with the youth justice system.

### *Case Study 1: Mark (pseudonym)*

Mark (a pseudonym) resided with his mother. From the age of 4, he experienced neglect and abuse including sexual abuse. His mother had a drug addiction, and he would often be left his own. When he was older, he would be left to care for himself and his younger sister. If there was any food for them to eat in the house it would be mouldy and/or passed the expiration date. When there was no food at home, Mark was forced to steal food to survive. It was only when he commenced primary school that he could get one fresh sandwich a day at school. His accommodation was always unstable; they never lived in a house for more than a year.

Mark was enrolled in school, but his attendance was limited due to his poor mental health. Mark frequently attended school showing signs of illness, but when the school

tried to contact his mother, she would be uncontactable. As he could not leave the school grounds without an adult, he spent most of the day in the school office sleeping.

Numerous members of the community reported concerns about Mark's welfare to the Department. An investigation was undertaken, but he was ultimately coerced by his mother to deny any allegations of harm. Mark described his interview as short, and the welfare check was limited to checking that he had a bed to sleep in. The Department failed to check the state of the kitchen. Mark recalled that when he was 13, he hoped that the Department would return as he was ready to make disclosures about the abuse and neglect he suffered. The Department never returned.

Mark expressed to YAC that he felt the Department did not care about his welfare. During the investigation, he was not provided a safe environment in which to disclose the neglect and abuse. If the investigation had been conducted in a trauma-informed capacity, the results may have been that Mark received the help he needed.

Consequently, there was no departmental intervention. Mark shared with YAC that at the most vulnerable stages of his life, he felt abandoned by the adults at his school and the Department.

Mark remained in an environment marred with neglect and trauma. The trauma has left him with permanent mental health issues, including a diagnosis of depression and anxiety. Mark was also diagnosed with an autoimmune condition that has left him wheelchair bound. During his childhood, he only saw the general practitioner once to get treatment for his health issues.

Mark's story is one of many where the Department's inaction contributed to exposure to ongoing harm and suffering into adulthood. His experience demonstrates deficiencies within the assessment and investigation processes, which in best practice are centralised around safety, risk and harm.

The conduct of the Department in this case and many other cases does not adequately consider the child's mental health, developmental delays, disability, cultural connections, education, aspirations, behavioural presentations or general childhood needs.

Without a holistic investigation and assessment of their needs, for some children the risk factors that result in contact with the youth justice system are not addressed.

### *Case Study 2: Helen (pseudonym)*

Helen (a pseudonym) became pregnant with her first child at 15 and became subject to a long-term guardianship with the Department. Initially, Helen was placed in accommodation with her baby following her child's birth. They remained together for 6 weeks until the Department removed her baby from her and into foster care. Helen expressed that the Department failed to provide her with support in preparation and following the birth of her child, including parenting programs. They did not provide any necessities for her baby such as a pram or cot.

At the age of 17, Helen and her sibling were placed into Supported Independent Living Accommodation. The youth workers only provided transport, but did not support Helen with assistance to transition to adulthood. For example, Helen completed her housing application of her volition and with no assistance. She only met the house manager 3 times during her 3 months stay.

Helen fled the placement after another co-tenant damaged property within the house, and police were involved. Throughout this time Helen felt unsafe and vulnerable, but the Department did not provide any alternative placement following Helen's requests. This forced Helen to self-transition from care into unsuitable and unsustainable housing.

Housing services would not help her when she was 17 because she was on a Child Safety Order. She had to wait until she turned 18 to get help and by this point she was homeless.

Helen was referred to a community service when she turned 18, however, the Department did not provide her with a post-care worker and Next Step worker to help her transition into adulthood.

Helen is seeking reunification with her two young children who are under a Child Safety Order. The Department has not aided her in that process, so Helen approached YAC to make applications for programs and housing that would progress the reunification process with her children. These applications were unsuccessful due to the Department not providing supporting materials and information regarding Helen's reunification.

While the children have been in the Department's care, Helen was not notified or invited to visit when her children were in hospital. Her eldest child had many hospital admissions due to bronchial asthma and a case of pneumonia. Helen received notifications of the hospitalisation following the child's discharge from hospital. She has had limited contact with her children, though during one visit, her child's officer screamed at her while her child was present.

The Department has been unwilling to provide her with the appropriate support to enable reunification. The Department's lack of clarity around her progress on the reunification plan means she cannot communicate to housing providers the timeline they require to accept her referral. Her Child Safety Officer continually reminds her that she is a young mother, heavily implying that this is why she is unable to reunify with her children. YAC's workers have observed Helen's treatment by the Department resulting in Helen failing to support Helen rather than building her parenting capacity.

Helen has expressed to YAC that she has often felt discriminated against by the Department because of her age, saying "Child safety were focused on proving why I couldn't be a mum, and now I have to pay for it because my kids barely know I'm their mum."

Helen's experience typifies how the Department is perpetuating another generation of children in care who will be traumatised by its system. Helen is a mother willing to raise her children, though requires support for independent living and to establish her parenting skills. Helen's story demonstrates that the Department is not prioritising family and community led models of care.

It also demonstrates the existing barriers to information sharing between government departments and entities. In Helen's case, the Department's lack of timely disclosure about reunification with her children has prevented her from obtaining appropriate housing.

Finally, Helen's experience also demonstrates the detrimental impact of the Department placing her with co-tenant who was in contact with the youth justice system. This mismatch in tenancy led to her feeling unsafe. The Department's failure to provide a safe environment resulted in her homelessness.

### *Study 3: Sarah (pseudonym)*

Sarah (a pseudonym) is a 16-year-old Aboriginal girl who has been involved with the Department since she was 5 years old. Her life has been marked by chronic neglect and trauma. Born prematurely at 32 weeks to a 14-year-old mother who used cannabis and alcohol heavily during pregnancy, Sarah was diagnosed with Cerebral Palsy early in life. She has also been diagnosed with Post-Traumatic Stress Disorder, Disinhibited Attachment Disorder, Disturbance of Activity and Attention Disorder, and Encopresis. Sarah has received no treatment for any of these conditions.

Sarah's journey through the child protection system has been unstable and harmful. After being placed with a kinship carer at age 5 and subject to a long-term guardianship

order at age 8, she has cycled through unstable residential care homes. Her engagement with education has been minimal, and she has spent significant time sleeping rough, couch-surfing, and using substances. This culminated with Sarah spending 50 days in youth detention in 2024, a stark indicator of the system's failure to provide appropriate care to support her healthy development.

Sarah has experienced significant traumatic events. She was sexually abused throughout her childhood, rejected by her mother, has not had a stable living environment since she was 11-years-old, has been in and out of custody, and self-placed in and around Brisbane since she was 12 years of age. She turned to sex work to support her use of substances and alcohol. Sarah has attempted to reside intermittently with her father over the past year. However, YAC has since become aware he was sexually abusing her.

The Department has been in possession of a report from the Forensic Child and Youth Mental Health Service since 2020, recommending a two-worker solo placement for Sarah due to the high risk of suicide or death. This recommendation has not been implemented.

In 2022, Sarah received NDIS funding to support her daily living, however this remains severely underutilised. The most basic requirement, a safe and stable living environment, has not been met. As Sarah has expressed to YAC, she feels isolated from culturally appropriate and responsive community connections and lacks any strong, supportive relationships. Sarah has had significant involved in the Youth Justice system and has numerous convictions.

We also understand that both the Department and the Queensland Police Service were aware that Sarah was sexually active with a male over the age of 18 when she was approximately 14 or 15, but that no action was taken to address this.

For several years, Sarah was allocated to the South Burnett Child Safety Service Centre, and they continued to support Sarah despite Sarah 'self-placing' to Brisbane, which is almost 200 kilometres from South Burnett. In late 2024, the case work support for Sarah was allocated to a Child Safety Service Centre located in Brisbane's outer-suburbs.

In October 2024, Sarah approached a Child Safety Office in Brisbane seeking a tent and supplies to sleep rough. During this time, Sarah was the victim of domestic violence. On one occasion, a 19-year-old male held a meat clever above her head and threatened to kill her, later setting her tent on fire reportedly while she was inside, leaving her traumatised and without a safe location to sleep or supplies.

YAC understands that around this time, Sarah's circumstances were escalated internally within the Department of Child Safety as well as the Department of Housing, but YAC did not see any improvements in Sarah's life circumstances.

In November 2024, Sarah arrived at YAC's Peel Street office in acute distress. She repeatedly expressed feelings of hopelessness and anger about not having a safe home or anyone to support her. Emergency services were called after repeated verbal indication of intent to die by suicide and active self-harming using a pair of scissors she had brought with her to YAC.

With Sarah's consent, YAC contacted the Department to request an urgent placement. However, as no options were forthcoming, Sarah was subsequently admitted to the Princess Alexandra (PA) Hospital under an Emergency Examination Authority (EEA), pending assessment by a mental health clinician. She reacted with significant distress to the presence of Queensland Police Service officers, expressing feelings of betrayal and fear. This left YAC in a position of compromised rapport with Sarah, and she felt the situation had escalated without her informed consent.

Despite the Department being notified of Sarah's critical condition by YAC, no representative attended the PA Hospital to arrange crisis accommodation on 19 and 20 November 2024.

When her EEA expired on the morning of 20 November 2024, Sarah remained in hospital as a voluntary patient. With no placement arranged, her only option was to self-discharge into homelessness. That evening however, Sarah was transferred to the Queensland Children's Hospital (QCH). YAC continued to seek updates and advocate for her care but received either no response from the Department or provided with inaccurate updates; including that Sarah had self-discharged from the PA Hospital, when she was in fact transferred to QCH.

On 21 November 2024, the Department claimed to have sent an officer to QCH to discuss placement options with Sarah. However, when hospital staff went to meet the officer in reception, Sarah "absconded" from the ward. Her whereabouts were unknown for a period of time, despite both hospital staff and Child Safety being aware of her vulnerability.

Throughout this period, YAC repeatedly raised concerns with the Department about Sarah's deteriorating mental health and her growing distrust of support services. Sarah had presented to YAC seeking help, only to be involuntarily admitted to hospital—a process that left her feeling betrayed and unsupported. Despite this, Child Safety requested that YAC arrange transportation for Sarah for when she was discharged from

QCH, ignoring our warnings that our service was now compromised. Our urgent requests for assistance appeared to fall on deaf ears.

The interactions between YAC and the Department from 19 to 21 November 2024 in relation to Sarah's urgent care needs were wholly inadequate. Despite clear and repeated indications of her suicidality, Sarah's risk factors remained unaddressed. At no time did Sarah have a safe home – a fundamental human right and legal entitlement for all children. The absence of safe housing directly contributed to the activation of the Emergency Examination Order, which in turn deprived Sarah of the ability to make informed decisions about her own body. This is particularly distressing given her known history of sexually assault.

The Department's lack of coordinated action and accountability has left both Sarah and YAC staff in a position requiring ongoing, intensive safety planning. The system's inability to provide even the most basic protections continues to place vulnerable young people and frontline workers in untenable situations.

The lack of timely support from the Department, underutilisation of her NDIS funding, and her ongoing sense of being let down suggest the collaborative support has not been effectively delivered. It clearly demonstrates the current gaps of systems available to support Aboriginal and Torres Strait Islander young people with complex needs, and the current failings which require an urgent overhaul.

Sarah's experience is emblematic of a broader systemic failure; where crisis is met with containment rather than care, and where the mechanisms meant to protect vulnerable children are grossly inadequate. The current complaint systems and service responses are not equipped to meet the needs of Aboriginal and Torres Strait Islander young persons, particularly those in state care with complex and high-risk profiles.

### *Case Study 4: Beth (pseudonym)*

Beth (a pseudonym) was placed on a long-term guardianship order from birth until she was 18. Beth was placed in foster care with her nan; however, the Department placed her 5 siblings with different carers. The Department promised the family school holiday contact, but the contacts were limited and eventually stopped.

Beth recalled having meetings with Child Safety Officers, but nothing eventuated from the meetings. In her words, "They were just like, checking in to see if I had a good, safe living environment. And then, because I had a good tick because Nan was an experienced disability worker and capable foster parent, they kind of just didn't worry about it."

Beth explained that the Department never reached out, never asked if she needed extended support. Beth excelled in schooling and her nan pushed for private schooling, but the Department pushed back and never gave her the opportunities to succeed.

At age 11, Beth suffered a traumatic event during which her mother attempted to kill her. She was riding her bike down the street when her mother chased her with a butcher's knife threatening to kill her and her friends. The Department did not arrange any counselling for her following the incident. One year later, her mother committed suicide. Beth was 12 years old. She had to get the Department's approval to attend her mother's funeral.

Following her mother's death, Beth discovered that her mother lied about the identity of her father and that her nan was not biologically related to her. The Department did not help her find her biological father. Her comments below demonstrate her volatile situation:

> *"So then, you know, Mom's dead. My Dad's not my Dad, my foster family that you placed me in for the last 12 years of my life... these people that you place me since I was a baby aren't my family, and that this foster family is actually not my family, you know. And then they're like, "Oh, yep", no contact with Child Safety from them.*
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> *So then I'm, you know, 12 years old, Mom's gone like, you know, don't know, my dad, family's not my family. So then I turned to drugs like and ended up in the youth justice system. And where the [redacted] was Child Safety this whole time? You know what I mean? Like, where, where were they as a parent or as a guardian to step in. And they could have helped me when I was young and thriving and had no idea the risk going down that path.*
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> *And then, so then, after all of this, I fall into the justice system. I go to juvie three times. Child Safety is nowhere to be seen. Not at one point did they come visit me in the detention centre and be like, "Oh, [redacted]. What happened to you?". Not no one come and see me. I had no contact to child safety this whole time, right? All they did was cut Nan's payments off when they found out that I was in juvie. I didn't even know who my case manager was. And then when I turned 18, I get this random knock on the door by this case manager who I'd never met before. "We don't have all your files. We've lost your birth certificate and stuff. Here's whatever we do have, and here's your number for your next step worker".*

Beth expressed to YAC that the Department did not help her excel in her life as a child, to do activities or hobbies. She did cheerleading, but couldn't afford it, and the Department

never offered to help. Beth never got the social bonding, peer learning and positive supports from the Department.

The Department also failed Beth in transitioning adequately into adulthood. The attitude of her Child Safety Officer was, "See you later, Good luck in life."

Beth articulated to YAC the link between the child safety system. Her response below is provoking:

> *"I was a kid of the child safety system, and I was neglected and the little to no contact and care led me to fall into the youth justice system, never contacted me. I meant to be able to have a safety and a trust component, like, my life has been [redacted] you know? I mean, like, I lost my parents. Child Safety took me off my parents, you know, and he took me off my like siblings. [CS] placed us all in different homes. But then no [CS] were never there, you know, for my teenage years, from since I can remember, [CS] were never there.*
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> *But I want to look at my six siblings and my mum was in the child safety system before me, like we would. All I needed was proper, you know, connection, check ins, you know, seeing what, like, you know, what opportunities could have helped me thrive. You kept me from my family for years, like, and I'll never get that relationship back with my siblings. Like, you know, I used to feel going to school and like, everyone, especially around, like, Mother's Day and Father's Day and everyone, but like, you know, doing all this [redacted] And like, I was embarrassed, like I had no you know what I mean, like, how embarrassing. Like, everyone would be, like, talking about doing all this mom and dad stuff, or going on mom daughter days, you know what I mean? Like, I didn't have that, and I used to hurt me, like, so much, and I knew, I knew I was different, and it's just like those kids, like a kid of child safety already living away from their family is massive. Like, yeah, it's identity. You know what? I mean? Like, growing up is hard, because I always knew that, why couldn't I be like other kids and then to not have support and be told that you're too stable to be helped, to be helped. Like, you know what I mean, what the [redacted] is a girl gonna do to get some some help? Like, I was just a child trying to navigate my life.*
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> *Well, of course, they don't care at all. Like, you know what I mean, not at one point did they step in and be like, she's on an 18 year custody order. She's sitting in detention. Oh, it's just easier to leave her in there. You know what I mean? Not at one point did they come and talk to me. That's just when I was sexually assaulted, and then I had to go to court. And I had to go to court because this guy sexually*

*assaulted me, and I went with my school, my [redacted] School Support not child safety, who have guardianship, yeah, of me, and they didn't even know about it, and I got a victim to crime payout and everything over there. And where the [redacted] were they? You know what I mean for any of it, like, yeah, you know, like they were not there, that she's terrible at all, not, not one bit. And I'm one of 1000s like that.*

Beth was asked what factors contribute to children in care entering the youth justice system. Her response was:

*"The lack of support, the lack of wrap around services, the fact that you know the child and their family, and you know what they like they're going through, you've sit there and document their whole life, but you just can't do anything about it. And then [CS] wonder why we have so many deaths in custody, or so many suicides, or that no kids make it, why do you have so many kids that are in the child safety system going into the youth justice exactly like you should take a real look at yourself and think, "What the [redacted] are we doing wrong here?" Because if these were really looking after kids, this wouldn't happen, and you just take the easy route and help the kids that are easy. But I have never known of a complex, hardcore kid of my mates that has come out and been like, "yeah, Child Safety helped me, and I'm doing better in life because of Child Safety". I've not ever heard no. Just kick you to the curb and you're too complex and too hard, because they've got 80 kids on one caseload, or whatever the record they reckon, and they don't have time, and they're so called CSO (Child Safety Officer) catch ups every three months. They don't [redacted] care what happens. They say that they do, but they don't happen at all ever, like they really don't. And not one time did child safety come to court for me, not once. And I was on an 18 year guardianship order.*

*Since you know what I mean, from the day I was born in the hospital, I was on an order. Yeah, I didn't leave that hospital without an order. So Child Safety knew of me and knew my family and my siblings had already been taken so before I was born, I was already planning to go to the system. And then what [redacted] support has the system ever done for me? Yeah? Yeah. You know what I mean, like I could be dead like my mother right now, if it wasn't for like myself and my stuff, you know, yeah, like, I don't know. I just think it's [redacted], and heaps of kids end up, like, dead and [redacted] over it. And imagine if I had a kid at 16, they would have been on my case, like, you know, right away, instead of supporting me to become a mother, they would have been there to [redacted] take my kid. I just think it's disgusting. And they need a whole shake up like that needs to be rewritten. They need to be held accountable. They work alongside the human rights commissions*

*and all that. But how many human rights laws can you break in one year, you know. There's only one good worker out of, out of my whole time, and it was only a short period, and she did a few things to help my Nan, and that's it, and I'm just one. I'm one of a million kids.*

*I was reading my mom's letters a couple weeks ago and in one of the bottom I couldn't stop crying. It was like she said, "I'm so sorry, my baby girl, that I'm not there to kiss you good night and be there when, when you wake up, she goes. All I've ever dreamed of was us coming home and, you know, being stable and being able to have that family and just know that I'm, you know, I'm always, I'm always there with you, even though I'm not there".*

*If they had actually worked with my mom, who was a child of the system before me, then we could have been integrated, rehabilitated my mom could have still been here today. We could have had a family if they had worked with her, but they shunned her and made her look like a horrible mother and stuff like that when they let her down as a kid. And how is she supposed to know how to parent when no one's parented her as a kid? And then she has six of her own kids, and you didn't think not in one of six kids CS could have helped her. You know what I mean, so many opportunities, like and that's why I hate child safety, and I resent them for everything they did, and they didn't help, not once they're so quick to take us away from our family, but all they did was create more trauma. I can't say that any good cause has come out of that. I think myself and one other are doing good. So now you got four unstable adults out there, out and about, what's that gonna happen? You know what I mean? You know what's the flow on effect of what's happened? You know what I mean, you've traumatized six more kids. Like you haven't done anything, you know? I mean, where was the rehabilitation? Probably me. Probably I was the only lucky one, because I got there, you know what I mean, because of Nan, and that wasn't, that's nothing to do with them and their responsibility. That's because of the person my Nan is, you know what I mean, and the way that she raised us to be different and to rise upon it all break the cycle. Child safety get none of that clout. They didn't do none of that.*

Beth's story demonstrates the inherent issues with the Department's system in its lack of care for children with complex needs. Beth and Sarah's story prove that systemic failures by the Department not only compromise children's safety and wellbeing but also contribute to a heightened risk of their involvement with the criminal justice system.

As children navigate these broken systems, they become increasingly familiar with legal processes, but not through protection, through prosecution. This exposure, compounded by the lack of appropriate support, significantly increases their likelihood of offending and/or reoffending.

## The child safety system – a 'feeder system' to the youth justice system

YAC has represented children and young people whose criminal offending only commenced once they were in the care of the Department. This often occurs with children in care who have severe mental health and intellectual disabilities. Without medical and professional treatment, presentations of their behaviour escalate to episodes of violence that is later criminalised through police intervention. Placement related offending leads to criminal charges of wilful damage and assault.

If the Department performed its duties with due diligence, it would identify the child's health issues and provide intensive therapeutic interventions. Instead, mental and behavioural issues of children are addressed punitively.

### *Placement arrangements*

In YAC's observation, placement arrangements remain a significant persisting contributor to children and young people's contact with the youth justice system. It is well documented that the placement in residential care is a common factor associated with an increased risk of offending for maltreated young people.[1] Mismatching co-tenants and even youth workers also increase the risk of offending.[2]

Children under 16 years of age are unable to access accommodation services as, in the absence of a safe home, they are the responsibility of the Department, leading many to homelessness or couch surfing in unsafe locations and becoming involved in criminal activities. YAC has seen children as young as 12 living in nearby parks because of this gap in responsibility, leading to entrenched homelessness and involvement in the youth justice system. The Department's use of the euphemism "self-placement" hides the seriousness of this issue.

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[1]Malvaso, C., & Delfabbro, P. (2015). Offending behaviour among young people with complex needs in the Australian out-of-home care system. *Journal of Child & Family Studies*, *24*, 3561–3569.

[2] Malvaso, C., & Delfabbro, P. (2015). Offending behaviour among young people with complex needs in the Australian out-of-home care system. *Journal of Child & Family Studies*, *24*, 3561–3569.

YAC has observed numerous occasions where children and young people are not being provided with housing by the Department upon their exit from detention. Consequently, they unjustly remain in detention for extended periods of time until the Department sources housing. In other scenarios, the Department's placement for complex children is untenable. Upon release, YAC has observed that when children and young people leave detention, they do not have the necessary supports and interventions that addresses the risk factors related to their offending.

Child Safety transition officers are not playing an effective role in transitioning them into adulthood. Their involvement is far too late. They are not supported with life skills such as budgeting or assisted to undertake training courses to live independently. Some children and young people do not receive any support from the Department to prepare them for adulthood.

### *Problematic Staffing Issues*

The Department is severely under-resourced, understaffed and under-trained in what is required to support children and young people with extremely high complex needs. Staff do not have the experience of providing trauma informed care.

The overwhelming workload means that staff are not given the appropriate supervision and support. Children's case plans are not being updated, and there is a lack of meaningful engagement between Child Safety Officers and their children. Some children do not even know the identity of their Child Safety Officer. Without meaningful engagement with the child, theirs needs cannot be cared for. The role of the Department is seen to be purely administrative.

YAC staff who previously worked within the residential care system have observed Child Safety Officers criminalising behaviours of children and young people. When children and young people misbehave, they encourage a punitive response by contacting police and charging them for their behaviour. This is contrary to their policy to provide a safe, supportive and therapeutic environment for a child. There is little evidence of a system that treats children with humanity.

YAC staff have also experienced the Department acting as a hindrance to progressing a child's day to day needs. This includes school applications being completed or approvals for pro-social activities.

There is a lack of accountability for the Department's employees. Many placement and residential service providers are reluctant to report misconduct or inaction by the Department's staff due to the fear of losing funding.

## Conclusion

The above case-studies are only a very small sample of a large cohort of children failed by the Department. Most of YAC's clients have had inadequate support by the Department.

Children who offend or re-offend often face intersecting challenges, including family violence, poverty, trauma, unstable housing, substance misuse, and disengagement from education. These are not issues that can be addressed through punitive responses. They require sustained, targeted investment in therapeutic, culturally safe, and community-based supports. The Department is failing to deliver these to the children in its care.

We submit that the safety and wellbeing of children in state care must be a non-negotiable priority. We urge the Commission to consider these issues with the gravity they deserve and to recommend bold, systemic changes that place children's rights, voices, and safety at the centre of all decision-making. Without urgent structural and systemic reform, these systems will continue to perpetuate harm, leaving young people like Mark, Helen, Sarah and Beth exposed to repeated trauma and neglect.

Yours sincerely

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