

Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System

Commissioner Luke Twyford
Final Submission to the Queensland Commission of Inquiry

The Waterway

I often think of the child protection system as a single waterway, made up of four connected levels. Each level feeds the next through pipes, filters, and sudden drops. The water is always moving. It is always connected. And what happens to the water in one place inevitably affects everything downstream.

At the very top sits a vast pond called Society. This pond is wide and deep, and most of the time it appears calm. Within the pond universal systems – health, education, sports, community, keep the water together. But beneath the surface, water quality shifts constantly. When pressures such as unemployment, poverty, rising living costs, and unresolved trauma accumulate, the water becomes unhealthy. From this, contaminants begin to form - domestic violence, mental distress, substance dependence, homelessness, and child maltreatment. These pollutants are not created in isolation; they are symptoms of the pond itself struggling to stay balanced.

From Society, water flows - sometimes gently, sometimes abruptly - into a second, smaller pond called Family Support.

This pond is fed through filters designed to catch contamination early. Here, many different services and organisations work to clean the water and redirect it back upstream. They use a wide array of tools: short bursts of help, long-term supports, light-touch services, and intensive interventions. The aim is always the same - to restore the water before it becomes too polluted. But this family support pond has no clear shape. It expands and contracts with funding cycles, policy changes, workforce availability, and political attention. At times it is full and steady; at others, it is shallow or cracked dry.

There is no single caretaker or person responsible for this pond. Many agencies dip in and out, each responsible for a small section, but no one responsible for the whole. When services are unavailable, overwhelmed, or insufficient, contamination passes through untouched. When that happens, the water is forced through a gushing hose that never turns off.

This hose is called the Child Protection Intake service, and it sprays continuously into the third pond: the Child Protection System.

This pond could not be more different. It is tightly engineered, bound by rules, thresholds, procedures, and timelines. The water hits hard here, creating rapids, whitewater, and dangerous currents. This is where specialists are tasked with assessing risk, containing harm, and assisting the water, to send it back upstream in a healthier state. But the pond is hazardous - not just for the water, but for the people working in it. The currents are relentless. Workers wade in to help, only to find themselves pulled under, struggling to keep their footing. Many are exhausted, some are injured and success in this pond is defined narrowly: keep the water together, keep it moving, and do not let it spill over the edge or into the final stage.

Because the final stage is Out-of-Home Care. This is not a pond at all, but a scattered field of hundreds of buckets. Each bucket holds water that could not be stabilised earlier. Workers run between them, tipping water from one bucket to another, hoping that movement might bring calm, safety, stability and balance – but there are never enough hands. Volunteers and private providers step in to help lift, carry, and steady the load. This layer is frenetic and fragile. The buckets are easy to knock over. Sometimes water spills out and disappears from the system entirely. Sometimes it evaporates slowly, unnoticed. Success here is measured by whether a bucket can be carried back to the family support pond - whether the water can re-enter the system rather than be lost to it.

And then, inevitably, the water reaches eighteen. At that moment, whatever remains - clean or unhealthy, stable or turbulent - is tipped back into the Society pond. There is no final filter. No pause. No guarantee that the water is healthy enough to survive the journey.

And so the cycle continues.

The waterway is one system, not four.

If we want healthier outcomes downstream, we must care for the whole waterway - especially the places where responsibility is diffuse, ownership is unclear, and the water quality is allowed to deteriorate unnoticed.

Because by the time the water is drowning workers or spilling from buckets, the problem did not begin there.

It began much earlier - quietly, predictably upstream.

What we have currently is a system increasingly skewed to crisis intervention, with outcomes for children that continue to be unacceptably poor and costs that continue to rise. For these reasons, a radical reset is now unavoidable. Achieving this reset starts with recognising that it is loving relationships that hold the solutions for children and families overcoming adversity.

While relationships are rich and organic, [child protection systems] can be rigid and linear. Rather than drawing on and supporting family and community, the system too often tries to replace organic bonds and relationships with professionals and services.

Without a dramatic whole system reset, outcomes for children and families will remain stubbornly poor.

- The Independent Review of Children's Social Care,
United Kingdom, Josh MacAlister, 2022.

Introduction

Few responsibilities of government are more significant than protecting children from harm. Queensland's child protection system carries this responsibility on behalf of the community. It exercises profound authority over families – making life-altering decisions about children, their parents, and their siblings.

Over the past several decades, major inquiries, policy reforms, new legislation, and substantial increases in funding have all sought to improve how Queensland protects its children. Despite these efforts, significant challenges remain. Demand for statutory child protection services continues to grow, the number of children entering out-of-home care has increased, and the complexity of the needs experienced by children and families has intensified. These pressures expose deeper structural issues within the system. Too often, the child protection response remains heavily weighted toward crisis intervention rather than prevention. Investigative and case management practices can struggle under the weight of administrative demands and workforce pressures. The quality and consistency of care environments varies, and too many children leave care without ever experiencing the stability, relationships and opportunities they needed to thrive.

Over the past four years, I have authored and commissioned many reviews into Queensland's child protection system. I have inspected residential care homes and spent time inside the environments where some of the state's most vulnerable children live. I have listened to, and recorded, the experiences of children in care, foster and kinship carers, parents, and the frontline workers responsible for protecting and supporting them. I have examined the circumstances of more than 1,500 child deaths - 280 of whom were known to the child protection system - and I have provided three formal statements and more than 3,000 pages of evidence to the Queensland Commission of Inquiry into Child Protection. Now, as the work of that Commission draws to a close, I make this final submission to set out the reforms that I believe are necessary to strengthen Queensland's child protection system and improve the lives of the children it serves.

This final submission provides an opportunity to step back and examine our challenges in a broader way. Its intent is to consider the underlying structure of the Queensland child protection system and the conditions required for it to function effectively. It sets out a series of interconnected areas where change is most necessary if Queensland is to build a system that better protects children, supports families and delivers improved life outcomes.

The report is structured on seven key areas of reform wherein it calls on Queensland to:

- 1) Prioritise efforts to Keep Families Together
- 2) Improve the quality of child protection investigations and case management
- 3) Guarantee the quality of places where children in care live
- 4) Improve the life outcomes of children in care
- 5) Establish a system capable of transformation and continuous improvement
- 6) Reform departmental structures to support quality and improvement
- 7) Strengthen oversight and accountability mechanisms

One way to understand the reform agenda set out in this report is to view it as a structural framework for rebuilding Queensland's child protection system. The seven reform pillars are not separate initiatives. They are designed to work together, with each layer supporting the next.

7 PILLARS OF REFORM



At the top of the framework sit the reforms that most directly shape the lives of children and families. These are the four outcomes the system ultimately exists to achieve: keeping families together because it is safe to do so, ensuring that statutory interventions are high quality when they occur, guaranteeing that children who cannot live at home experience safe and stable care, and improving the life outcomes of children who grow up in the system.

These outcomes cannot be achieved through frontline practice alone. They depend on the strength of the structures that sit beneath them. For that reason, the final three reform pillars establish the institutional foundations that make the first four possible.

At the base of the framework is strong oversight and accountability. A system that exercises such significant authority over children and families must operate transparently and be subject to scrutiny, review and reflection. Oversight mechanisms ensure that failures are identified, reforms are implemented, and the voices of children and families can be heard. Without these safeguards, improvement is difficult to sustain, and public confidence cannot be maintained.

Alongside this foundation is the need to establish a system capable of transformation and continuous improvement. Child protection systems must be able to learn from experience, adapt to emerging challenges, and evolve in response to new evidence about what works for children and families. Cross-government collaboration, strong partnerships with the community sector, and transparent reporting on the wellbeing of children are all part of building a system that can improve over time rather than simply react to crises or drown under demand.

Resting on these foundations is the department responsible for delivering statutory child protection services. The department acts as the structural pillar of the system. Its organisational design, workforce capability, commissioning arrangements and leadership shape how the broader system operates in practice. If departmental structures are fragmented, unclear or poorly aligned with quality outcomes, the system above them cannot function effectively. Reforming departmental structures to support quality practice and continuous improvement is therefore essential. The department must be organised in a way that allows it to manage a complex hybrid system - where statutory authority sits with government while many services are delivered by the community sector - while maintaining clear accountability for outcomes.

Taken together, these seven reform pillars describe how a stronger child protection system can be built. The upper layers of the framework focus on the experiences and outcomes of children and families. The lower layers provide the governance, capability and accountability necessary to sustain those outcomes.

The issues discussed in this report are complex and interconnected. No single reform will resolve them. Reforming a child protection system cannot succeed if it focuses on only one part of the system. Improving investigations without strengthening oversight will not deliver lasting change. Raising expectations for care providers without ensuring that departments have the structures and capability to commission and oversee those services will not improve quality. Likewise, aspirations for better outcomes for children cannot be realised without the broader system being able to learn, adapt and hold itself accountable.

By addressing the structural conditions that shape how the system operates - how families are supported, how risks are assessed, how children are cared for, and how institutions are accountable - Queensland can build a system that is more effective, more transparent and more capable of delivering the outcomes children deserve.

Ultimately, the measure of success for the child protection system is not the number or timeliness of investigations undertaken or the volume of services delivered, it is whether children are safe, whether families are supported, and whether those who grow up in care are able to lead healthy, connected and fulfilling lives.

I believe that Queensland can build a child protection system that is not only responsive to harm but capable of upholding the commitment that every Queensland child will have the safety, stability, love and opportunity they are entitled to. This report, my past work, and my future efforts are intended to contribute to that goal.

Commissioner Luke Twyford
Queensland Family and Child Commission
31 March 2026

7 PILLARS OF REFORM

1 Prioritise efforts to keep families together

- ✓ Empower Queensland's families' portfolio to better address the social determinants of child protection involvement
- ✓ Recognise that removal is not a long-term solution and better supporting parents is in everyone's interest
- ✓ Address the drivers of intergenerational involvement and over-representation
- ✓ Allocate clearer accountability for family and parenting support
- ✓ Proactively invest in family strengthening services
- ✓ Strengthen family-solution-focused practice

2 Improve the quality of child protection investigations and case management

- ✓ Reimagine the right response to threats to children
- ✓ Improve the systems access to intelligence
- ✓ Redesign for workforce capacity: the correlation between skills and roles
- ✓ Clarifying the roles with authority within the system
- ✓ Confirm the correct, modern decision-making frameworks that all staff should apply

3 Guarantee the quality of places where children in care live

- ✓ Define and embed a clearer continuum of care
- ✓ Implement outcomes-based commissioning with incentives and penalties for quality
- ✓ Build a stronger inspection, licensing and accreditation process
- ✓ Empower the carer system
- ✓ Strengthen the capability of the care workforce

4 Improve the life outcomes of children in care

- ✓ Change the way the system views children in care
- ✓ Change the system to act on the views of children
- ✓ Embed relational practice into the sector's ways of working
- ✓ Uphold the importance of sibling relationships
- ✓ Strengthen the protection of children who are absent, exploited or missing
- ✓ Recognise Government's obligation to life-long parenting

5

Establish a system capable of transformation and continuous improvement

- ✓ Establish cross-government responsibility for outcomes
- ✓ Mandate transparency with public reporting across the system
- ✓ Strengthen oversight mechanisms for reform implementation
- ✓ Develop a whole-of-government strategy for children
- ✓ Define a whole-of-government investment plan for children

6

Reform departmental structures to support quality and improvement

- ✓ Confirm and clarify the department's role in prevention of child abuse and align investment
- ✓ Restructure the department for both central accountability and regional responsibility
- ✓ Increase internal accountability for the quality of outsourced service delivery

7

Strengthen oversight and accountability mechanisms

- ✓ Build an independent evidence base of contemporary Queensland child and family needs
- ✓ Establish a clearer and connected oversight architecture
- ✓ Introduce clearer advocacy for children in care, their parents and their carers
- ✓ Strengthen complaints and appeal mechanisms

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Part 1: Prioritise efforts to keep families together

Government cannot provide love and relationships as a service but it can take the lead in creating the environment for families, communities, public services and businesses to step forward and do much more.... We all have a part to play and it starts with love.

I hope this review leads to more people becoming mentors, supportive neighbours, foster carers, adopters, kinship carers and employers of care experienced people.

– The Independent review of children’s social care, UK, 2022.

A central theme across the work of the Queensland Family and Child Commission (the Commission) is that effective child protection systems must prioritise keeping families together wherever it is safe to do so. Evidence from the Commission’s reports, systemic reviews and advocacy work consistently shows that child protection involvement is rarely driven by a single event. Instead, it is most often associated with a cluster of entrenched social and structural factors - poverty, housing instability, family violence, parental mental ill-health, substance misuse, and community dislocation. These social determinants create environments where families struggle to meet children’s needs, and where the statutory child protection system becomes the default responder to broader social disadvantage.

It is my view that the Queensland system can do more to keep families safely together. This would require addressing the social determinants that drive child protection involvement, strengthening family and parenting support, and recognising that removal of children from their families is rarely a long-term solution to the issues that place children at risk.

Many of the challenges that lead to child protection are rooted in social disadvantage and family stress rather than deliberate harm.

– A System that Cares, 2024.

The underperformance of Queensland’s child protection system is not a story of individual failure, it is clear that dedicated professionals across government and the community sector work every day to respond to risk, support families and care for children who cannot live at home. Instead, this is a story about a system that is too often expected to respond to problems that extend well beyond its traditional scope.

The overarching theme of [the Carmody report] was clear in that parents (and families) should take primary responsibility for the protection of their children and that, where appropriate, parents should receive the support and guidance they need to keep their children safe.

- Queensland’s family support system context & drivers into statutory systems, 2024.

Empower Queensland's families' portfolio to address the social determinants of child protection involvement

A prevention-focused system recognises that many families who come to the attention of statutory services have long been experiencing cumulative disadvantage. Earlier and sustained support - delivered before concerns escalate to statutory thresholds - can reduce the likelihood that children will need to enter care.

The Commission's work has emphasised the importance of addressing the structural conditions that place families at risk of entering the child protection system. These include economic disadvantage, insecure housing, limited access to health and mental health services, family violence, and social isolation. Effective responses therefore extend beyond the child protection portfolio and require coordinated action across housing, health, education, employment, justice and community services. They also extend to the Commonwealth.

Addressing these drivers requires a policy shift that places greater emphasis on prevention and family strengthening rather than relying primarily on investigative and removal-based responses. In our Annual Report to Parliament last year the Commission identified the changing social drivers leading Queensland children into the child protection system. We listed how ongoing prevalence of domestic and family violence, mental health, substance use, and disability remain significant contributors to child and family vulnerability. We specifically called out:

- Rising rates of housing instability, homelessness, and unaffordability are putting families under strain. We spoke to the increasing number of families on the social housing register, the number of Queenslanders seeking specialist homelessness services, and the significant increase in youth homelessness (pages 11 to 17).
- Increasing impacts of parental mental health and drug use (page 18)
- Education barriers, including low enrolment, poor attendance, and high exclusion rates, are impacting outcomes for key cohorts (pages 19 to 21).
- The prevalence of child sexual abuse (page 22) and the 34% increase in child sexual abuse substantiations found by the child protection system (page 25).
- That there is a growing number of victim-survivors of domestic and family violence aged under 25 years.

We also said:

- Rates of suicide, child removal, adult incarceration and youth detention are still worsening for First Nations people since the National Agreement on Closing the Gap baseline year.
- Early supports are underfunded, fragmented and short-term relative to need, limiting their ability to prevent statutory involvement. In particular there had been a 9 per cent decrease in referrals for family support (page 37) and that investment was comparatively low (page 38).



In practice, the Child Safety system frequently operates too separately from the other systems that shape children's lives. Health services, early learning and education, mental health supports, housing, family violence responses and community services all play critical roles in determining whether children are safe and able to thrive. Yet these systems often operate in parallel rather than as part of an integrated response to children and families. The reason for this distance is often attributed to the crisis response and demand pressures that statutory systems experience, wherein service delivery and practice contracts to 'what must be done' rather than 'what can or should be done'.

What if instead of mandatory reporting, we legislated mandatory supporting?

– Luke Twyford, Child Protection Week Provocation, Brisbane 2023.

A system that focuses primarily on the identification and management of risk can struggle to address the wider developmental needs of children. While safety remains fundamental, it must be understood within a broader conception of child development and wellbeing. Children do not simply need to be protected from harm; they need the conditions that allow them to develop, learn, form relationships and build a strong sense of identity and self-worth. Rebalancing the system in this way requires a broader reconceptualisation of its purpose. Rather than viewing it solely as a child protection system, Queensland should increasingly think of it as a child safety, wellbeing and development system. Such a system would take a holistic view of children's lives, recognising that their wellbeing is shaped over time through the interaction of family circumstances, community environments and public services.

This perspective also requires a life-course and intergenerational understanding of children's needs. The experiences children have in their early years influence their development throughout childhood and adolescence, and the outcomes achieved in one generation often shape the circumstances of the next. A system focused only on responding to immediate crises cannot effectively address these longer-term dynamics.

To achieve better outcomes for children, the child protection system must therefore operate as part of a broader ecosystem of family and parenting supports and services. Effective collaboration across systems is essential if governments are to address the underlying drivers of harm and create environments where children and families can thrive.



Improved investment in family support services acknowledges the social and economic benefit of keeping families together.

– August monthly report, Residential Care Review (2023)

Recognise that removal is not a long-term solution and better supporting parents is in everyone's interest

While statutory intervention can provide immediate protection for a child, removal from family is not, in itself, a solution to the problems that brought the family to the attention of authorities. When children are removed without meaningful work to address parental circumstances, the underlying issues remain unresolved. This can result in prolonged family separation, repeated removals across siblings, and the potential for intergenerational involvement with the child protection system.

We do not achieve child safety by excluding and isolating parents; key to understanding whether the system is achieving good outcomes is by listening to their views and experiences.

- Parent Voice Survey, 2023

The act of removal is itself traumatic, and the care experience for the majority of children is rarely optimal – with placement instability, abuse in care, sibling separation rates and the life-outcomes of children in care all demonstrating system deficits.

It is my observation that child protection systems can drift toward seeing their role primarily as removing children from harm, without a sufficiently clear or sustained plan for what should follow. In doing so, there is a risk that the system attempts to substitute professional relationships and services for the natural bonds children have with family, kin and community. This can lead to fragmented and episodic interventions, where significant effort is directed toward assessment processes, referrals and professional meetings, while less attention is given to strengthening the relationships and networks around children that provide them with love, stability and belonging. A more effective system recognises that while professional intervention may sometimes be necessary, the long-term wellbeing of children depends on supporting and sustaining the relationships that matter most in their lives.

There needs to be a fundamental shift in the way children's social care responds to families who need help. Away from overlapping professionals in a fragmented and complicated process of assessing, referring and monitoring families, towards a simplified service that is more responsive, respectful, and effective in helping families. A shift from remote services to ones which build deep relationships with families and the communities they live in. Achieving this shift is central to improving the lives of children and families, identifying risks early and preventing problems needlessly escalating for families until less dignified and more costly intervention is required later.

– The Independent review of children's social care, Josh MacAlister, 2022.

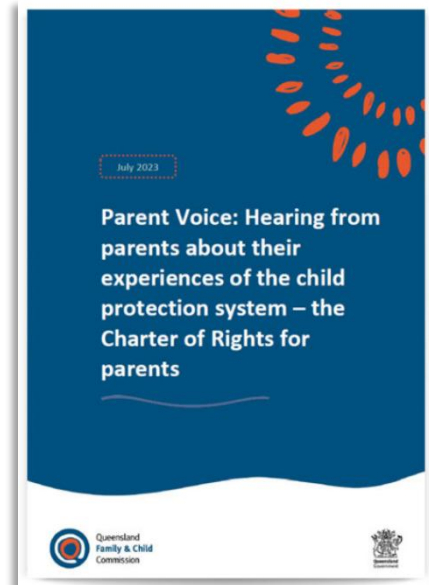
The factors that play into the decision to remove a child from their parents is necessarily focussed on the immediate safety of the child – however the actions taken following that removal are critical to the restoration and health of the family unit and our community. In many cases, children receive structured case management once they enter the statutory system, but

parents themselves receive limited coordinated support. Indeed many parents will say that the system contact they had with the child protection system falls away, or disappears, as soon as their child is removed – and that they are left alone, unsupported and with the challenges that led to the removal, now exacerbated by the additional trauma of ‘loosing’ their child.

In 2024 the Commission led an Australian first survey of parents involved in the child protection system. This survey, assisted greatly through a partnership with Queensland’s Family Inclusion Network, was a test of the new Charter of Rights for Parents. The results speak clearly to the need, and opportunity, to better support parents so that children are not caught within the child protection system any longer than is required. Of the 324 Queensland parents and family members who responded to the survey only:

- 45% had access to family support services
- 45% felt recognised and respected
- 45% had a say in the support provided to their family.

Speaking to parents clearly demonstrated the inequity, pain and inefficiency of removing children and leaving a vacuum of support.



Why is it that the bulk of government attention goes to the child, rather than the source of the concern?

Imagine if instead of removing children, we removed the parent?

Imagine if the carer role went into the child’s house and helped them keep their routines and contacts, and the parent was taken to an institution where case managers and referral services provided interventions to the cause of their behaviour?

– Luke Twyford, Child Protection Week Provocation, Bundaberg 2022.

The Commission has highlighted the importance of providing structured interventions for parents alongside services provided to children. Dedicated case management for parents can help coordinate access to housing, treatment services, parenting programs, mental health support, and other necessary assistance. This integrated support can play a critical role in stabilising families and enabling safe reunification where possible.

The Commission’s work has repeatedly highlighted that while statutory intervention is necessary to ensure a child’s immediate safety, removal itself does not resolve the underlying issues affecting a family, nor does the temporary removal of the child from the harm environment guarantee the child a lifetime of safety. Without meaningful support to address the causes of harm, families may experience repeated child protection involvement across years and across generations. The Commission’s work has emphasised that safe family preservation and reunification should remain core objectives of the system.

What we need is a system that provides intensive help to families in crisis, acts decisively in response to abuse, unlocks the potential of wider family networks to raise children, puts lifelong loving relationships at the heart of the care system and lays the foundations for a good life for those who have been in care.

– The independent review of children’s social care, Josh MacAlister, 2022.

Address the drivers of intergenerational involvement and over-representation

There are two defining characteristics of the child protection system that should worry everyone: the intergenerational nature of involvement and the disproportionate representation of Aboriginal and Torres Strait Islander children. These patterns are not the result of isolated decisions or individual cases. They reflect deeper structural conditions that shape how families experience support, opportunity and contact with government systems over time.

Evidence consistently shows that many families who come into contact with statutory child protection have had long periods of under-engagement with, or under-representation in, universal services such as health, housing, education and employment. When families are not able to access or benefit from these universal systems early and consistently, problems that might otherwise be addressed through routine supports can escalate. Over time, the absence or ineffectiveness of these foundational services increases the likelihood that families will come to the attention of tertiary or statutory systems, including child protection. In this sense, over-representation in statutory systems often reflects earlier under-representation in universal ones.

For Aboriginal and Torres Strait Islander communities, these dynamics are further shaped by the legacy of historical policies, structural disadvantage and experiences of institutional mistrust. Many families face barriers to accessing mainstream services that are culturally safe, locally responsive and grounded in community strengths. Without effective early support, challenges relating to housing instability, health, education participation, financial stress or family violence can accumulate and ultimately draw families into the statutory child protection system.

The over-representation of our children in statutory systems is as much an indicator of the failure to achieve equity for Aboriginal and Torres Strait Islander people across broader social and economic policy as it is of the performance of a single department.

- Principle Focus, 2021

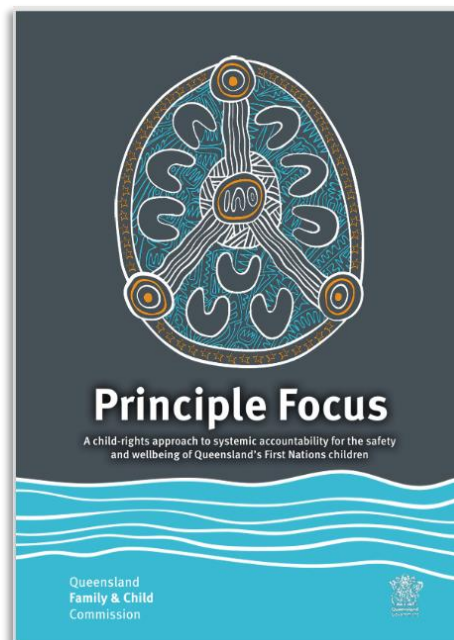
Addressing these issues requires long-term, system-wide strategies that move beyond responding to individual cases and instead focus on reforming the conditions that drive demand for statutory intervention. This includes strengthening the effectiveness and accessibility of universal services so that families are supported earlier, closer to home and in culturally appropriate ways. Health services, early childhood education, schools, housing supports and

employment pathways all play a critical role in stabilising families and promoting child wellbeing long before statutory intervention becomes necessary.

A key part of this work is investing in culturally led family support services and strengthening Aboriginal and Torres Strait Islander community-controlled organisations. Community-controlled services are often best placed to engage families, build trust and deliver support that reflects local cultural knowledge and community priorities. Expanding the capacity of these organisations can help ensure that families receive support earlier and in ways that sustain connection to culture, community and kin.

At the same time, broader social conditions must be addressed. Housing insecurity, limited access to health care, educational disadvantage and barriers to stable employment all contribute to family stress and reduce the capacity of parents and carers to provide safe and stable environments for children. Without deliberate investment across these domains, the child protection system will continue to respond to problems whose origins lie well outside its remit.

Reducing the over-representation of Aboriginal and Torres Strait Islander children in statutory child protection requires a rebalancing of effort and investment across the service continuum. Greater emphasis must be placed on strengthening community-based supports so that families are visible to and supported by systems that promote wellbeing, rather than only coming to attention when risks have escalated to the point of statutory intervention.



The disproportionate representation of Aboriginal and Torres Strait Islander children and young people is a pervasive feature of statutory child protection systems across all jurisdictions in Australia.

It is perhaps our greatest challenge and contemporary injustice.

- Principle Focus, 2021

A sustained commitment to these reforms is essential. Breaking patterns of intergenerational involvement will not be achieved through short-term initiatives or isolated program changes. It requires consistent investment, strong partnerships with Aboriginal and Torres Strait Islander communities, and a long-term focus on the social and structural conditions that shape children's lives.

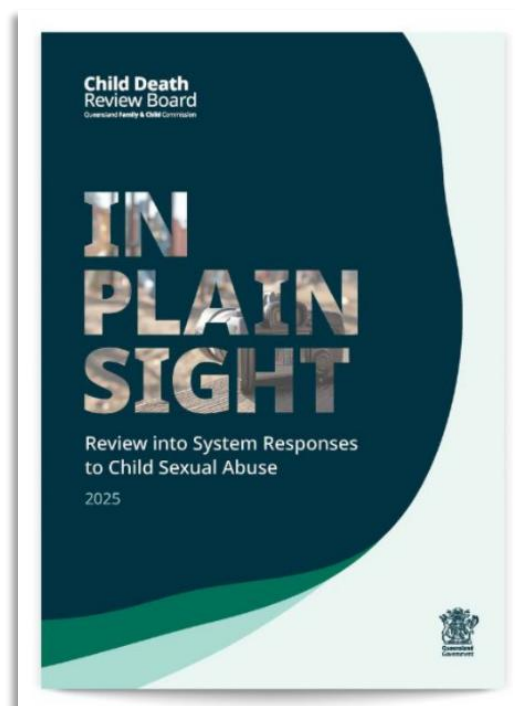
When we channel our efforts and resources into getting alongside families and providing help, it helps children. More help for families means more children staying safely at home, doing better at school, being physically and emotionally healthy, and ultimately achieving their potential (including as strong parents for the next generation). Our failure to invest in this is one of the greatest public service weaknesses. By addressing the underlying drivers of disadvantage and ensuring families are effectively supported within universal systems, governments can reduce reliance on statutory intervention and improve outcomes for children, families and communities over time.

Allocate clearer accountability for family and parenting support

Another consistent finding across Commission work is the absence of clear system leadership for family and parenting support services. Responsibility for supporting vulnerable families is often fragmented across multiple portfolios and service systems, which can dilute accountability and reduce the effectiveness of investment. The 2020 audit by the Queensland Audit Office on Family Support stated: “We found a system under pressure from high demand, and one that is not adequately structured to meet the complex, 24/7 needs of vulnerable children”.

You will not find a political leader in Australia that has not talked about children being our most precious resource, or our number one priority, however children have long been treated as diffuse, secondary considerations in the architecture of government and in national policy.
- In Plain Sight, 2025.

The Child Death Review Board review *In Plain Sight* emphasised that effective child protection requires clear leadership accountability within government, even where responsibility for protecting children is shared across many agencies and sectors. The report concluded that while safeguarding children is a collective obligation, shared responsibility must never dilute accountability for leadership and system performance. It found that fragmented governance arrangements, siloed responsibilities and unclear lines of authority allowed risks to go unaddressed. The Report argued that meaningful reform requires a government architecture in which leadership accountability is explicit - where Ministers and senior decision-makers are responsible for ensuring that prevention, intelligence, detection, response and support functions operate as a coherent system rather than as disconnected parts. The same is true for our family and parenting support system, and it is clear that Queensland needs a Minister and Director-General that is directly accountable for ensuring that the system functions holistically and effectively to protect children.



In Plain Sight, transformational recommendation 8 called for the elevation of child protection and safeguarding in government priorities. It said:

To ensure the protection of children from abuse and neglect is treated as a matter of the highest national priority, it is recommended that the Australian and Queensland Governments immediately establish dedicated and enduring governance mechanisms for children and child safeguarding. This must include:

- formally establishing clear Ministerial accountability and a permanent Ministerial Council on Child Safeguarding as a standing committee of National Cabinet, providing a cross-

jurisdictional mechanism for driving coordinated national policy, sharing critical intelligence, and progressing nationally consistent child safeguarding legislation and systemic reform, including the outstanding recommendations from the Royal Commission

- making the safety of children an explicit priority within the Queensland Cabinet process (by establishing a dedicated Cabinet Sub-committee charged with overseeing the state's responses to child abuse and neglect, ensuring accountability across portfolios, and embedding a whole-of-government approach to preventing harm and supporting recovery).

This governance reform is essential to elevate child safeguarding to a national and state leadership level, enable urgent system improvements, and ensure that past failures to protect children are not repeated.

Strengthening efforts to keep families together requires clearer central leadership for family support policy and funding, alongside stronger accountability mechanisms for outcomes. This includes ensuring that investments in early intervention and parenting support are sustained, strategically coordinated, and evaluated against measurable impacts on child safety and family stability.

Proactively invest in family strengthening services

Investment in family and parenting support services is a critical component of prevention, early intervention and support. These services help families develop practical parenting skills, address conflict within the home, connect with community supports, and access specialised services where required. Building and sustaining an equitable, effective and efficient 'child safety system' requires an overhaul of investment, commissioning and contracting. Investment reform is not just a matter for the Department, but for whole of Government, as the Department is constrained by existing budget and procurement processes, and the consequences of the proliferation of programs over successive governments.

The Commission's work highlights that effective family support must be available at multiple levels of need - universal supports available to all families, through to intensive interventions for families experiencing complex challenges. Without adequate investment in these supports, the child protection system is left to respond to crises rather than preventing harm.

There is strong and growing evidence that supports the effectiveness of investment in services earlier in the family and parenting support investment continuum, however there is typically no one size fits all approach. Improving the wellbeing of children, young people and families at population-level requires flexible and responsive systems, equipped to respond to emerging issues and challenges before they manifest.

– A System that Cares, 2024.

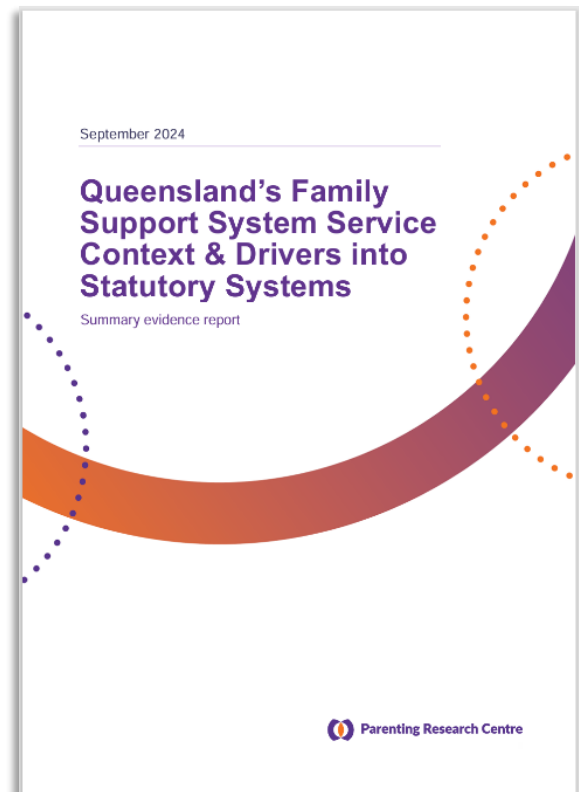
In 2024, we commissioned research presented in the report 'Queensland's family support system context & drivers into statutory systems: Summary evidence'. The data indicated that Queensland invests less in Intensive Family Support services than the national average, both in terms of expenditure per child and overall recurrent spending. In 2022–23, the rate of expenditure per child commencing Intensive Family Support in Queensland was approximately

\$13,879, compared with a national average of \$18,195, with spending across jurisdictions ranging from \$7,493 to \$25,645. A similar pattern is evident in real recurrent expenditure, where Queensland spent \$8,333 per child, compared with a national average of \$10,976, with other jurisdictions ranging from \$4,424 to \$15,440.

These figures suggest that Queensland's investment in early, intensive support for families experiencing significant challenges sits below the national benchmark. Given that Intensive Family Support programs are designed to stabilise families and reduce the need for statutory intervention, the level of investment in these services is an important indicator of the system's capacity to intervene early and prevent harm before risks escalate to the point where child protection involvement becomes necessary.

Reform of existing program investment, commissioning and contracting processes, beyond those already advanced, can drive greater public value, higher impact, and reduce undue red tape and transactions costs. There is also scope to better align and leverage federal, state and local public, philanthropic and corporate investment.

Achieving lasting improvement will depend on stronger transparency and deeper collaboration between government, service providers and communities so that responsibility for children's wellbeing is shared in practice as well as in principle. At the same time, significant changes are needed to the underlying 'plumbing' of the system - the way resources flow, decisions are made and services interact. Rebalancing the system will require a more deliberate approach to investment: driving greater value and impact from both existing and new expenditure, flattening the growth in tertiary-level responses, and strengthening investment across the prevention and early intervention continuum. It also means reducing unnecessary red tape and transaction costs, boosting system productivity, and ensuring that services are designed to work with - not against - the realities faced by children and families. Taken together, these changes are essential to building a system that functions more effectively, delivers better outcomes for children, and strengthens trust and confidence among citizens and communities.



Any new early intervention and assessment responses must be designed and delivered as part of, and with the intent of creating, a broad and integrated ecosystem of services and supports that protects and safeguards children and families. This must cut across traditional government portfolio boundaries and leverage existing investment and services

– A System that Cares, 2024

What can government do to improve family and parenting capacity and capability? – Child Death Review Board Recommendations

There is plenty of current evidence on where investment in family strengthening and parenting support would make a real, and rapid difference in Queensland. Across the last four years the Child Death Review Board (the Board) has explicitly recommended that the Government:

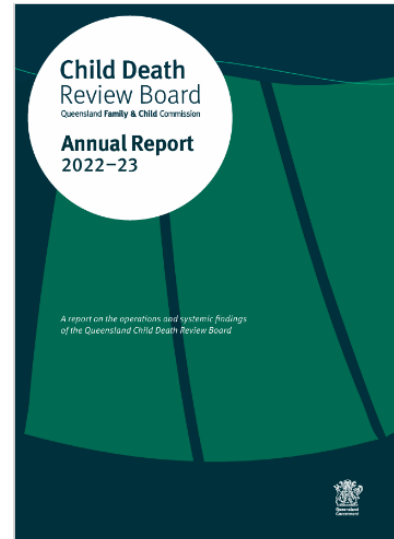
- implement and document responsive pathways for young and care-experienced parents, including dedicated early parenting programs and peer support networks
- enhance the provision of supportive, culturally safe antenatal healthcare services to ensure early engagement and continuity of care for pregnant women, particularly those at risk, leveraging Family Led Decision Making processes and early family engagement wherever possible
- establish and articulate a dedicated housing pathway for young parents (particularly mothers raising infants). This pathway should prioritise access to safe, stable and developmentally supportive housing environments that enable young families to build parenting capacity.
- develop a strategy to further integrate health and family services within early childhood education and care (ECEC) settings and public schools.
- creating integrated referral points to ensure children and their parents/caregivers identified with additional areas of need are connected to appropriate early childhood interventions, therapy or behavioural supports, including where applicable supporting families with access to the National Disability Insurance Scheme (NDIS) and ensuring they are supported while waiting for assessments and/or diagnoses
- conduct a review of remote service delivery models, focusing on equity across health, education, domestic and family violence and family support services.



- provide clear guidance that will support Child Safety to better assess the safety of children living with disabilities and/or chronic medical conditions with a specific focus on distinguishing between intentional parental neglect or maltreatment compared to deficits in the health literacy
- develop guidelines for clinicians to promote a family-centred approach to the provision of health services to children and young people, such that clinicians consider the wellbeing of siblings and can directly refer siblings into the health service, or to the clinician, if risks or health concerns are identified.
- continue to prioritise its response to the impact of family and domestic violence on Queensland children, and continue to implement the past recommendations of the Board
-



- invest in a public campaign to assist parents to understand childhood behaviour development, positive parenting techniques and the consequences of corporal punishment
- Invest in a practice guide that will support frontline practitioners in their risk assessments of children whose parents' substance use is problematic.
- invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence



- implements reform across the human services workforce to ensure it can meet the needs of children and families.
- empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces
- include within its reforms of Domestic and Family Violence services:
 - children as specific victims of domestic and family violence in their own right
 - culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence
 - the role of fathers and fathering, as promising points for behaviour change intervention.
 - extends health home visiting programs across the state as a priority to focus on parents with complex needs
 - implements or expands initiatives to create safer sleep environments for all priority Queensland populations



Strengthen family-solution-focused practice

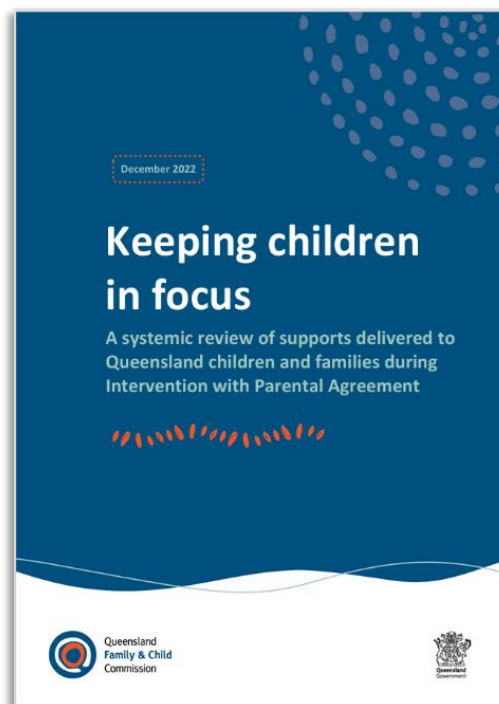
Raising children can be challenging for any family, and those challenges are often intensified by poverty, stress and other forms of adversity. It is normal for parents to need support - from extended family, friends, community networks and, at times, from government services. That support should be accessible, responsive and free from stigma. Where there are concerns that a child may be at risk of significant harm, services must be clear about those concerns, compassionate in their engagement with families, and decisive in taking action to ensure children are safe.

Families should be able to access support in partnership with services, rather than feeling that help is something imposed on them. More concerningly a request for help should not lead to compliance monitoring or child removal.

Providing supporting interventions that enable parents and families to keep their children safe is the most effective, efficient and financially sustainable way of improving outcomes for Queensland's children.
– A System that Cares, 2024.

Frontline child protection practice plays a significant role in supporting families to remain together. A stronger emphasis on family-solution-focused practice encourages practitioners to work with parents and extended family networks to identify practical steps that improve children's safety while maintaining family connections. Too often, however, the system struggles to meet the needs of families. Limited resources, an over-reliance on crisis responses and service models that do not fully recognise the importance of family and community relationships can undermine effective support. When this occurs, the system risks overlooking one of the most fundamental needs children have - the need for stable relationships, connection and care from those who love them.

Practice models that focus on strengths, collaboration and problem-solving can help families engage more effectively with services and support sustainable change. In Queensland there is a significant tool to keep families together and children out of care called Intervention with Parental Agreement. This response may be used by child safety officer when they are satisfied that parents are able and willing to work with the department to meet their child's safety and care needs without the need for a court order. The approach allows a child to remain at home with their parents, maintaining connection to their family and culture, while actions are taken to safeguard the child. It also provides an alternative to the child entering the out-of-home care system. This approach recognises that parents are often dealing with multiple pressures and may require structured support to change behaviours or stabilise family circumstances.



The Commission completed reviews of this service type in 2022 and 2025. The 2022 review involved consultation with more than 190 stakeholders, including parents, Child Safety staff, and staff from community and family organisations. Participants shared their experiences and insights about how the response operates and the circumstances in which it is most effective. The findings of the review were captured in the Commission's report, *Keeping Children in Focus*, which documented stakeholder experiences of using IPAs and the report outlined opportunities to strengthen the use of this response within Queensland's child protection system.

This review found that the policy intent for using an Intervention with Parental Agreement (IPA) is sound; however, system limitations mean this intent does not always translate into practice. These limitations arise in part because support services often prioritise children living in care and those within the statutory system. In addition, risk assessment and engagement are not always timely, and the administrative processes that apply to IPAs can reduce the ability to properly empower families and their support networks. The review found that the use of IPAs is proportionally decreasing when compared with court-ordered removals of children, a trend that appears to be influenced by broader systemic issues.

In almost every case, the best place for a child to grow and develop is with their family. Two overarching principles of the Child Protection Act 1999 (QLD) are that the State should only take action that is warranted in the circumstances to protect the child, and that the preferred way of protecting the child is by supporting their family.

– Keeping Children in Focus, 2022.

It also found that the secondary and statutory sectors require greater capacity to deliver timely and effective support to children and families. More flexible approaches are needed to promote family empowerment and the active participation of children and families in decision-making.

Finally, the review highlighted concerns about an overreliance on Child Safety Cultural Practice Advisors for support, the inconsistent use of Independent Persons during IPAs, and the lack of consistent implementation of these practices.

Revisiting the practice approach that occurs to keep child safe within their families provides a key opportunity to improve Queensland's child protection system.

Part 2: Improve the Quality of Child Protection Investigations and Case Management

Ensuring the effectiveness and credibility of the child protection system requires a strong focus on the quality of investigations, decision-making and case management. Through its systemic reviews, policy work and monitoring functions, the Commission has consistently emphasised that the outcomes experienced by children are shaped not only by legislative frameworks, but by the quality, capability and clarity of frontline practice.

When risks to children arise, the system must respond with skilled, informed and accountable professional practice. High-quality decision-making, access to reliable information and clear professional roles are essential to ensure that statutory intervention protects children while supporting families to address the issues they face.

Improving practice in this area requires attention to several interconnected elements: the way the system responds to threats to children, how information is gathered and used, the capability of the workforce, the clarity of roles within the system, and the adequacy of support for the carers and service providers who deliver care to children on behalf of the state.

Reimagine the right response to threats to children

At its core, the statutory child protection system exists to respond to threats to children's safety and wellbeing. Investigations and case management are the point at which concerns are translated into decisions about whether, and how, the State intervenes in family life. The quality of these processes is therefore decisive in determining whether children are protected.

The Commission's work highlights the need for investigations that move beyond procedural compliance to develop a comprehensive understanding of a child's lived experience. This requires practitioners to look beyond the presenting allegation and assess the child's day-to-day environment, family history, and broader social context. Central to this is the recognition of cumulative harm, where risk emerges over time through patterns of concern rather than single incidents. Without this lens, opportunities for earlier and more effective intervention are frequently missed.

Findings from the Child Death Review Board reinforce this point. Many children who experience serious harm or death have long histories of contact with the system, where individual notifications appeared low-level in isolation but collectively indicated escalating risk. Effective investigations must therefore integrate multiple sources of information - including notifier reports, historical case data, and intelligence from police, health and education - to identify these trajectories and inform decision-making.

The Board's work also highlights the risks posed by parental deception or minimisation. Where information provided by adults is not rigorously tested and corroborated, investigations may be based on incomplete or misleading accounts. Strengthening practice requires systematic verification, cross-checking of information, and a willingness to critically assess the consistency of explanations. Similarly, the insights of professional notifiers, such as teachers, health



practitioners and police, must be fully incorporated, as they often hold critical perspectives on a child's circumstances.

Child protection investigations are inherently complex. Unlike incident-based investigations, they require an assessment of safety, harm and future risk, combining factual inquiry with professional judgement and predictive analysis. This complexity demands time, skill, supervision, and access to integrated information systems. Where investigations are constrained by high caseloads, administrative burden or limited information sharing, there is a greater risk of narrow assessments and missed indicators of harm.

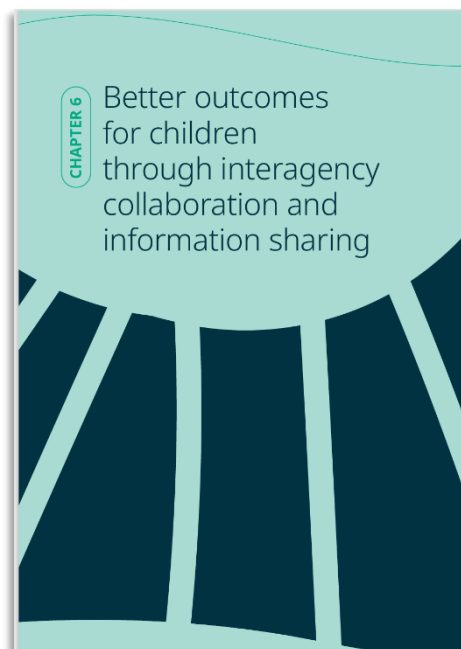
A stronger investigative model - one that emphasises cumulative harm, multi-source intelligence and rigorous analysis - is central to improving the effectiveness of the statutory response. This should be supported by investment in a specialised investigative capability within the department, with dedicated practitioners focused on complex assessments, pattern recognition and intelligence integration. Enhanced information systems and structured analytical tools are critical to enabling a more proactive, intelligence-led approach, rather than one reliant solely on intake reporting.

To support continuous improvement, the Government should commission a recurring, independent review of decision-making quality at key stages of the system, including intake, assessment and investigation outcomes. This would strengthen accountability, support learning, and ensure that investigative practice continues to evolve in response to evidence and emerging risk.

Improve the systems access to intelligence

Effective decision-making in child protection relies heavily on the availability and quality of information and good child protection responses require the involvement of practitioners from different agencies and professional disciplines working in collaboration. However, there is a tendency for child protection responsibilities to be placed solely on the statutory child safety system, rather than being viewed as a shared obligation across government and community sectors. This narrow focus overlooks the complex interplay of factors that contribute to a child's safety and wellbeing.

The Commission has regularly highlighted the need for stronger systems for gathering, sharing and analysing information about children and families across agencies and service systems. In our last Board Annual Report we stated: "Issues such as competing agency priorities, ineffective information sharing and the absence of shared accountability mechanisms continue to hinder progress. Strengthening interagency collaboration is critical, as failures in delivering effective coordinated care can lead to children falling through the cracks, exacerbating risks and delaying essential interventions. A comprehensive, efficient and ubiquitous coordinated interagency approach is widely recognised as essential for addressing these challenges".



Systemic inquiries, critical incident investigations and child death reviews highlight poor interagency coordination mechanisms and poor interagency information sharing as key issues within the child protection system despite widespread implementation.

- Child Death Review Board Annual Report 2024-25

Information relevant to child safety is often dispersed across multiple government and non-government organisations, including health services, education providers, police, and community organisations. Improving the ability of these systems to share information safely and appropriately can strengthen the system's ability to identify risk earlier and respond more effectively. The Board found that: "Out of the 39 children in this review, 67 per cent (26 children) were identified as suffering from gaps in information sharing, underscoring the prevalence of this systemic issue. Children were identified as having issues relating to information-sharing across one or more of the following areas:

- lack of proactive information sharing was identified in 41 per cent of cases (16 children)
- missed opportunities for the Queensland Police Service to share information using child harm reporting were identified in 35.9 per cent of cases (14 children)
- lack of information-seeking was identified in 15 per cent of cases (6 children)
- inaccurate information-sharing was identified in 10 per cent of cases (4 children)
- delays in information-sharing were identified in eight per cent of cases (3 children)
- information-sharing restrictions were identified in five per cent of cases (2 children).

Equally important is the development of stronger analytical capability within the child protection system itself. Information must not only be collected but interpreted in a way that supports sound professional judgement and evidence-informed decision-making.

No child should ever suffer preventable abuse because one area of government didn't have information that another area of government did.

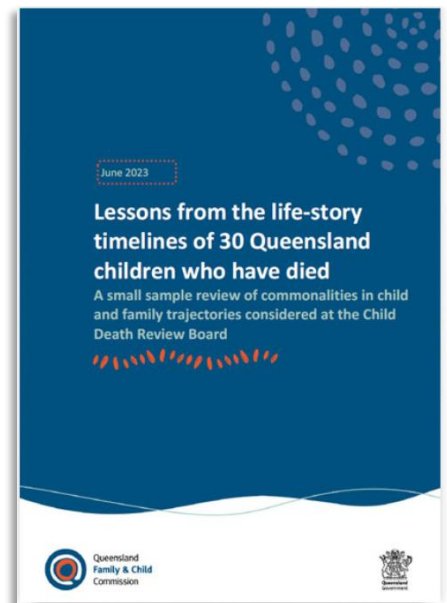
– In Plain Sight, 2025.

Privacy legislation and confidentiality concerns can create uncertainty among practitioners about what information can be shared and with whom, leading to hesitation in disclosure. Privacy legislation is often used as an excuse to withhold information when this is not actually necessary, as the legalities of information-sharing are not as prohibitive as many practitioners believe. Additionally, inconsistent data systems and incompatible IT platforms across agencies hinder seamless information exchange, resulting in delays and gaps in case coordination. Variability in professional judgment and risk assessment thresholds further complicate information-sharing, as differing interpretations of what constitutes significant risk of harm can lead to inconsistent responses.

The lessons from the cases reviewed by the Board highlight persistent challenges in collaboration and information-sharing. Despite established frameworks, interagency coordination and information-sharing remains inconsistent, often resulting in fragmented responses to child protection needs. While multi-agency meetings and mechanisms like SCAN are intended to improve collaboration, their effectiveness is undermined by irregular scheduling, inconsistent attendance and limited follow-through on actions. Case examples highlight how delays, omissions and failures to proactively share critical information can lead to missed opportunities for intervention and inadequate support for vulnerable children.

Past recommendations of the Commission and Board include:

- Board Annual Report 2024-25, Recommendation 7: The Queensland Government should produce a Statement of Intent outlining how it will enable and empower cross-portfolio accountability and information-sharing to keep children who are known to the Department responsible for Child Safety safe. This statement should embed a whole-of-system approach that recognises the shared responsibility of all agencies – not just the Department responsible for Child Safety – for identifying and responding to early risk in infants and young children. It should articulate how modern information sharing systems and clear governance mechanisms will ensure accountability for the safety of children. This Statement of Intent should be produced by March 2026 to enable consideration by the Commission of Inquiry in its final report.
- Board Annual Report 2024-25, Recommendation 4: The Minister for Families should commission work that will enhance the operational capacity, accountability and cross-agency collaboration of Suspected Child Abuse and Neglect (SCAN) teams (or another legislated, multi-agency committee) such that it delivers a legislated accountability mechanism that works across portfolios to ensure timely and coordinated responses to complex risk indicators in children and families.



Redesign for workforce capacity: the correlation between skills and roles

Workforce capability is a central determinant of system performance. Child protection practitioners operate in complex and demanding environments, requiring a combination of investigative skills, relational engagement, legal knowledge and trauma-informed practice. The Commission's work highlights the importance of a comprehensive workforce development plan that addresses recruitment, training, professional development and retention. Such a plan should ensure that practitioners receive the skills and support necessary to perform their roles effectively, while also creating pathways for specialisation and career progression within the system.

Strengthening workforce capability contributes not only to improved practice but also to greater stability within the system, reducing turnover and maintaining institutional knowledge. Across Australia there is increasing evidence that the pipeline of suitably qualified graduates (particularly social workers) is not keeping pace with demand. This shortfall is being felt across the statutory system, non-government service providers, and adjacent human services

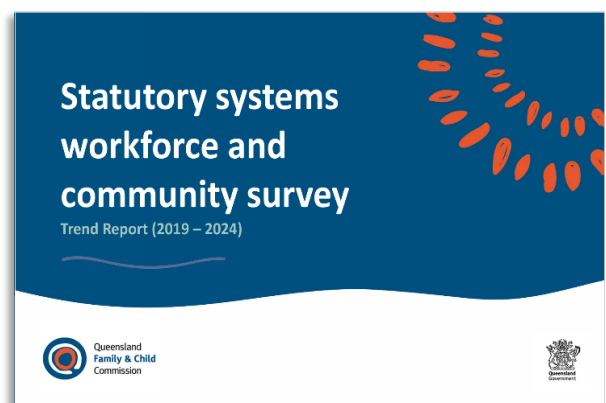
portfolios, all of which rely on a similar workforce profile. At its core, this is a structural supply issue. Universities are not producing sufficient numbers of graduates with the qualifications, readiness and inclination to enter child protection roles. Even where graduates are available, child protection must compete with other sectors (including health, mental health, disability, housing and education) that often offer more attractive working conditions, clearer career pathways or lower risk profiles. As a result, the system is not only constrained by the number of graduates, but also by its relative competitiveness in attracting and retaining them. This competition is occurring both within and across portfolios. Government agencies and funded services are effectively drawing from the same limited labour pool, creating internal displacement rather than net growth in workforce capacity. In practice, gains in one part of the system may simply reflect losses in another. This dynamic is particularly evident between statutory child protection, family support services, and residential care providers, where workforce movement can destabilise service continuity and undermine reform efforts.

Migration settings further influence workforce availability. Historically, skilled migration has supplemented domestic workforce supply in human services, including social work and community services roles. However, fluctuations in immigration policy, global competition for qualified professionals, and challenges in recognition of overseas qualifications have limited the extent to which migration can reliably address workforce shortages. Where migration pathways are constrained or slow, existing supply pressures are amplified.

In the residential care context, workforce dynamics are further shaped by industrial settings, including the application of Social, Community, Home Care and Disability Services (SCHADS) Award conditions. While these settings play an important role in establishing minimum standards and protections for workers, they also influence cost structures, role design and service viability. Providers must balance the need to attract and retain staff with the financial constraints of commissioned services, particularly in an environment where demand for residential placements is increasing and the complexity of children's needs is intensifying.

Annual surveying of frontline statutory systems staff has been undertaken by the Commission since 2019. Each year, results are reported and compared to the previous year for annual trends. In 2024, we published a 5-year trend analysis report. It found that:

Since 2019, frontline workers' views of the child protection and/or youth justice sector have become less positive across a range of factors. ...Commitment to the sector has waned over time. In 2024, 16% of workers report an intention to leave the sector over the next 12 months, an increase from 8% in 2020. Likelihood to recommend the sector as a place to work has also decreased over the past five years (39% in 2024, down from 54% in 2020).



Further to the above, the Commission's work has highlighted the need to better align professional skills with the roles required within the system. In many instances, child protection practitioners are required to perform a wide range of functions, including investigation, case planning, therapeutic engagement with families, court preparation, contract referrals, and administrative tasks related to public sector compliance. While each of these functions is

important, expecting a single role to perform all of them effectively can dilute expertise and create significant workforce pressure.

The cumulative effect of these factors is a workforce environment characterised by scarcity, competition and instability. High vacancy rates, reliance on less experienced staff, and increased turnover place additional pressure on existing practitioners and can compromise the quality and consistency of care provided to children and families.

At the heart of the issue is the recognition that high-quality professional judgement requires time, focus and specialised training. Assessing risk to a child, understanding family dynamics, interpreting complex histories of harm, and making decisions that may permanently alter the course of a child's life are among the most demanding forms of professional practice in the public sector. These tasks require practitioners who are well trained, well supervised, and able to dedicate sustained attention to analysis and engagement with children and families.

When highly trained practitioners are required to divide their time across administrative compliance tasks, routine data entry, scheduling, travel coordination, and other procedural requirements, the capacity for thoughtful professional assessment is inevitably reduced. In practice, this can mean that the most highly skilled members of the workforce spend a significant proportion of their working time undertaking tasks that do not require their level of expertise. The consequence is both inefficient use of public resources and reduced quality in the professional work that matters most. In 2025 I was informed that the typical child protection professional spent 70 per cent of their time at their desk.

This challenge is not unique to child protection. Other complex human services and professional systems have long recognised the need to structure workforces in ways that differentiate between levels and types of expertise. The medical profession provides a clear example. Hospitals and health systems deliberately organise their workforces so that highly trained specialists focus on diagnosis, clinical decision-making and treatment planning. Around these practitioners sit a structured network of roles including administrators, clinical assistants, nurses, technicians, paraprofessionals and allied health professionals. Each role contributes to the functioning of the system, but they do so in ways that are matched to their training and professional scope. This approach recognises two important realities:

- 1) specialist expertise is both scarce and expensive, and should therefore be deployed where it has the greatest impact;
- 2) professional judgement is strengthened when practitioners are supported by systems that remove unnecessary procedural burdens and enable them to focus on the work that requires their particular skills.

Child protection systems have historically developed in a different way. In many jurisdictions, the role of the child protection caseworker has expanded over time to encompass an increasingly wide range of responsibilities, and the cumulative effect has been the creation of roles that are extraordinarily broad in scope. The result is that practitioners often operate as generalists within a system that requires highly specialised expertise. This creates pressures in several ways. It can limit the time available for direct work with children and families. It can reduce the depth of analysis that practitioners are able to bring to risk assessments and case planning. It can also contribute to workforce fatigue and turnover, as practitioners experience the competing demands of professional judgement, bureaucratic accountability and administrative workload.

A more sustainable model requires a deliberate review of how capability is structured within the child protection workforce. This involves recognising that different functions within the system

require different types of skills. Administrative and compliance tasks are essential to public accountability, but they do not require the same training as risk assessment or therapeutic engagement. Similarly, investigative functions may require different capabilities from those needed to support long-term family change or to prepare complex legal material. Creating clearer differentiation between roles allows systems to invest in the right skills, in the right places. Administrative and procedural functions can be undertaken by dedicated support roles that ensure records are maintained, documentation is completed, and logistical tasks are managed efficiently. Paraprofessional roles can support family engagement, practical assistance and service coordination. Specialist practitioners can then focus on assessment, decision-making and the professional interactions that directly influence child safety and family outcomes. This approach does not diminish the importance of any role within the system. Rather, it recognises that the effectiveness of the overall system depends on how well these roles work together. A well-functioning child protection system, like a well-functioning health system relies on a coordinated workforce in which each role is designed around the capabilities required to perform it well. Rebalancing the workforce in this way also supports professional development and career pathways. When roles are clearly differentiated, practitioners can deepen their expertise in particular areas, whether investigative practice, therapeutic engagement, or specialist assessment. This strengthens the overall capability of the system and enables organisations to build teams that combine complementary forms of expertise rather than expecting a single practitioner to perform every function.

“Unmet training needs in child development, attachment and managing contact with birth families continue to affect the capability of the care system.”

– Buyer Beware, 2025

Ultimately, improving the quality of child protection practice requires more than increasing workforce numbers - or adding more expectations to overworked generalists. It requires careful consideration of how professional expertise is deployed. Ensuring that specialist, qualified practitioners have the space to undertake rigorous assessments and make well-informed decisions is central to protecting children effectively. Achieving this requires deliberate investment in workforce structures that support professional practice, including the expansion of administrative and paraprofessional roles that allow practitioners to focus on the work that only they are trained to perform. In this way, workforce design becomes a core element of system reform. By aligning skills with roles and reducing the burden of administrative work on specialist practitioners, the child protection system can strengthen both the quality of decision-making and the sustainability of the workforce responsible for safeguarding children.

Engagement by youth workers can make or break the experience in residential care. The young people shared that the overwhelming difference between a good and bad residential care experience was the staff.

– I was Raised by a Checklist, 2024

Addressing these challenges requires a coordinated, whole-of-system approach to workforce planning. This includes strengthening the graduate pipeline through partnerships with universities, expanding placement and training opportunities, and promoting child protection as a viable and supported career pathway. It also requires greater alignment across government portfolios to reduce internal competition and support more strategic deployment of workforce resources.

The Child Death Review Board recommendations that warrant action include:

That the Queensland Government implements reform across the human services workforce to ensure it can meet the needs of children and families. This reform should:

- *examine and address the shortages in core skills areas that are projected to become more pronounced over the coming decade, particularly in regional and remote areas*
- *recognise the overlap and competition that exists between departmental portfolios, and establish ways (such as exploring joint commissioning and pay parity) to help children, families and carers receive quality support*
- *promote place-based approaches, particularly in the early intervention and secondary services areas, to address local workforce issues*
- *include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers.*

That the Queensland Government implements reform across regional and remote communities of Queensland, particularly First Nations communities, to ensure there is a present human services workforce that can engage with the local community, particularly in culturally safe and engaging ways. This is to include:

- *investigating how statutory roles can be redirected to local Community-Controlled Organisations to enable local employment and service delivery*
- *empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces*
- *investigating and repurposing unspent funding for long-term vacant positions to support place-based service design and delivery in regional and remote communities to address the departmental and portfolio silos that are impacting on the ability to delivery holistic family support and early intervention.*

Clarifying the roles with authority within the system

Child protection systems bring together a wide range of actors - statutory agencies, non-government service providers, carers and courts - each with distinct responsibilities and relationships with children. While this diversity is necessary, the Commission's work consistently shows that unclear boundaries between roles and authority weaken the system's effectiveness.

Where responsibility is not clearly defined, decision-making becomes uncertain. Practitioners may be unsure who holds authority for key decisions, leading to duplication, delays, or inaction. In some cases, responsibility is implicitly shifted across the system, with multiple parties assuming that someone else will act. This diffusion of accountability can result in risks to children not being addressed in a timely way.

Clarity of roles is therefore fundamental to effective practice. Practitioners need to understand not only their own responsibilities, but also the limits of their authority and when responsibility transfers to another part of the system. When these boundaries are clear, decisions are more confident, timely and transparent. When they are not, practitioners may hesitate, over-escalate routine matters, or feel constrained in exercising professional judgement.

This issue is particularly acute for carers. Foster and kinship carers have the closest, day-to-day relationship with children and often hold the most immediate insight into their wellbeing. Despite this, they are not always empowered to make decisions or escalate concerns, even when they are best placed to identify emerging risks. Complaints and feedback data show that carers and frontline workers are often the first to hear disclosures or observe changes in behaviour, yet lack the authority or confidence to act decisively. Concerns can therefore be delayed or diluted as they move through multiple organisational layers, weakening the system's responsiveness to children's lived experiences.

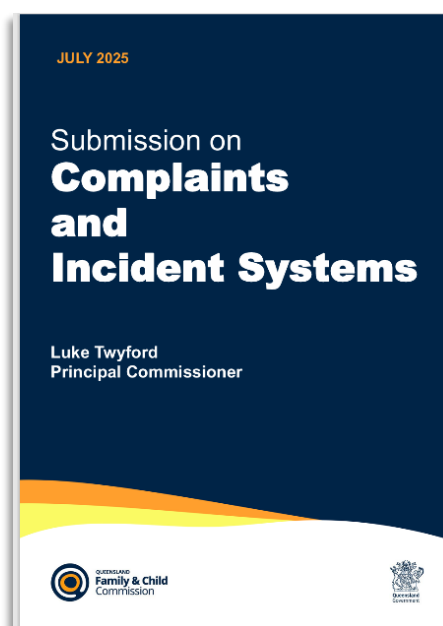
More broadly, unclear roles can dilute professional expertise. Child protection requires a range of specialised capabilities - investigation, risk assessment, therapeutic engagement and complex case coordination. When practitioners are required to perform multiple functions without clear role definition, the quality of each can be diminished. A more deliberate differentiation of roles would allow practitioners to apply their expertise more effectively, ensuring that critical functions are undertaken by those with the appropriate skills and training.

Clear delineation is also essential in the relationship between statutory decision-makers and non-government providers. As service delivery is increasingly outsourced, strong governance is needed to ensure that statutory authority and operational responsibilities remain distinct and understood. Without this, accountability can become fragmented, making it difficult to determine who is responsible for decisions affecting a child's safety and wellbeing.

For children and carers, unclear roles also reduce transparency. Navigating multiple organisations and professionals can make it difficult to know who to approach, who can make decisions, and where to raise concerns. Greater clarity improves not only internal functioning, but also accessibility and trust in the system.

At its core, an effective child protection system requires alignment between authority, responsibility and proximity to the child. Statutory agencies must retain clear legal decision-making authority, but carers and frontline practitioners must be empowered to act on the information and relationships they hold. At the same time, specialised practitioners should be supported to focus on defined functions that match their expertise.

A system-wide clarification of roles, authority and accountability - embedded in policy, contracts and operational frameworks - is therefore critical. When each part of the system understands its role and its limits, accountability is strengthened, decisions are timelier and more confident, and the system is better able to respond to risks and support the safety and wellbeing of children.



Confirm the decision-making frameworks that staff must apply

Child protection decisions are inherently complex, requiring judgements about risk, safety and family functioning in conditions of uncertainty, competing perspectives and time pressure. In this context, a clear and widely understood framework of practice is essential to support consistent, evidence-informed decision-making and effective collaboration across the system.

A well-defined practice framework clarifies decision-making thresholds, and defines the roles and responsibilities of those involved. Without this, practice can become inconsistent, overly reliant on individual judgement, and unclear in its triggers for intervention. Across too many reviews and coronial inquests the main, enduring issues continue to be:

- confusing parental capacity with willingness
- over-softening because of trauma history
- listening more to adults than to children
- undertaking snapshot assessments
- looking at past events rather than future risks.

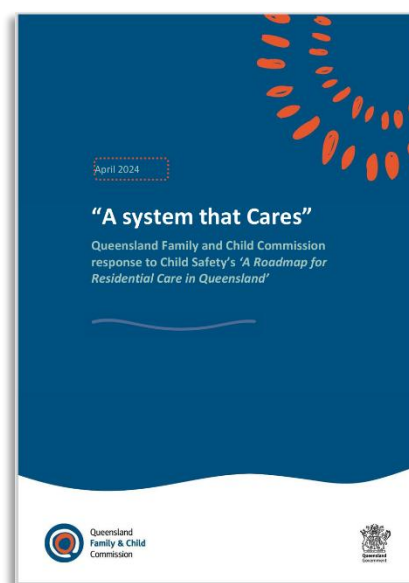
The Commission's work highlights that effective systems operate as connected networks of support, not isolated investigative functions. Children and families engage with multiple services - family support, health, education and specialist providers - and when these operate in silos, responses can be fragmented. An integrated framework links these elements, ensuring families receive the right support at the right time, from early intervention through to statutory action where required.

This includes aligning early family support, statutory investigation, and ongoing case management within a single continuum. Early services help prevent escalation, while clear pathways into investigation ensure risks are properly assessed. Once children enter the statutory system, coordinated case management supports their safety, stability and long-term wellbeing.

A strong framework also clarifies intervention thresholds, enabling practitioners to distinguish between support, investigation and protective action. This promotes proportionate responses, strengthens accountability, and makes decision-making more transparent. Equally, it defines the capabilities required across the workforce, aligning roles with specialist skills such as investigation, risk assessment, therapeutic engagement and case coordination. This ensures practitioners are equipped to perform their functions effectively and supports higher-quality decisions. Importantly, a shared framework enables effective collaboration between government and non-government organisations by providing common expectations, language and processes. It also supports system learning, allowing practice to be evaluated, improved and adapted over time.

Ultimately, an integrated practice framework provides the operating architecture for the child protection system - bringing together principles, roles, thresholds and capabilities to ensure that responses to children are coherent, timely and focused on their safety and wellbeing.

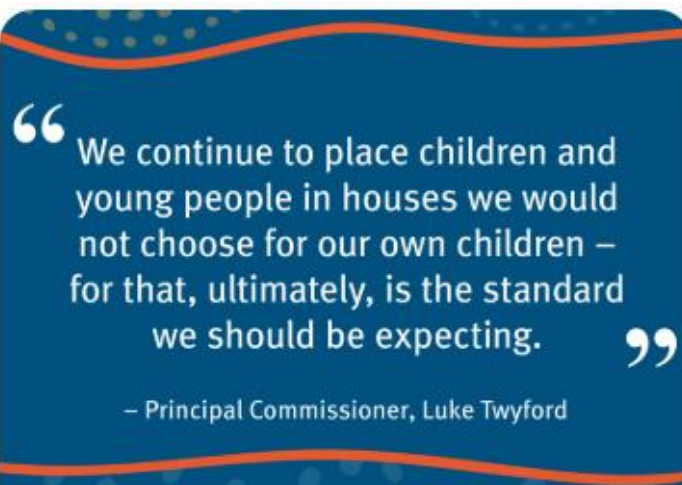
A decision making practice framework that empowers professional judgement and avoids the temptation of proceduralising humanity, is the only way to build a quality system.



Part 3: Guarantee the quality of places where children in care live

When children cannot safely remain with their families, the State assumes responsibility for their care. In these circumstances, the quality of the environments in which children live becomes one of the most important determinants of their safety, wellbeing and long-term development.

Ensuring that children experience homes where they feel safe, supported and connected requires more than simply providing a roof and basic care. Children in care may live in a variety of arrangements, including kinship care, foster care, residential care, and other supported placements. While these arrangements differ in structure and intensity of support, they share a common responsibility: to provide safe, stable and nurturing environments that meet the developmental, emotional and social needs of children. Improving the quality of out-of-home care requires a combination of robust regulatory oversight, clear commissioning arrangements, skilled practitioners, and care models that emphasise stability and relational support.



During the review the QFCC heard that young people felt they were restricted from living a ‘normal’ life due to strict policies and procedures in residential care homes. Young people said they felt their lives were risk-assessed and defined by incident-reports and corporate rules.

For too many children, there was no room for living a ‘normal’ life in a proceduralised house, and there were limited observable indicators that this was “their home”.

– A System that Cares, 2024.

Through its systemic reviews, monitoring functions and policy advocacy, the Commission has consistently highlighted the need to strengthen the quality, oversight and accountability of out-of-home care. By strengthening these aspects of the care system, Queensland can better safeguard children in out-of-home care and promote their wellbeing, resilience and sense of belonging.

Define and embed a clearer continuum of care

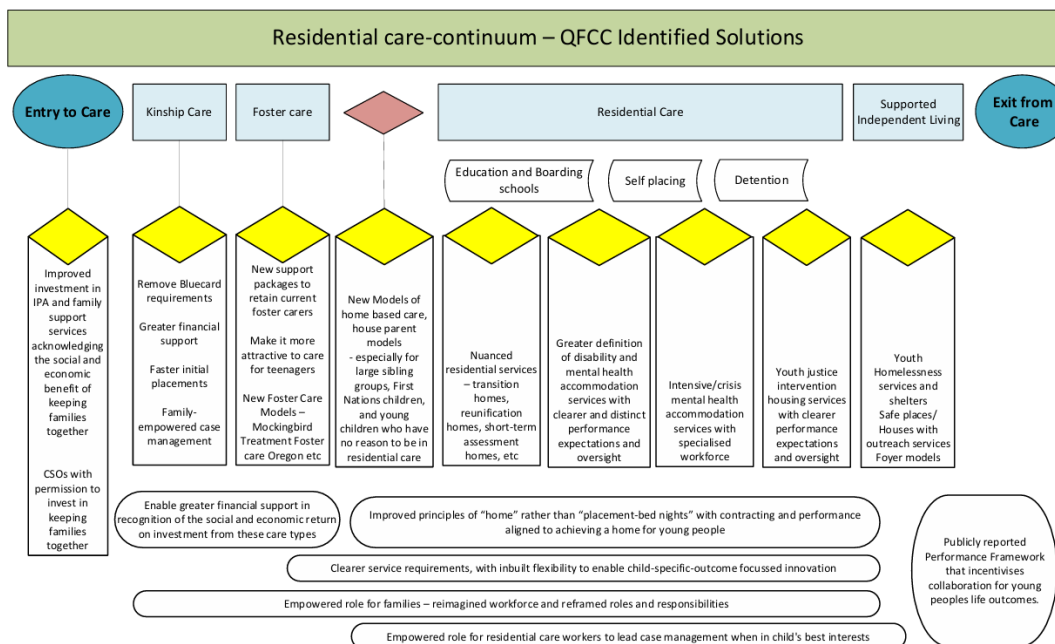
There is opportunity to make a profound difference across the system by bringing more nuance to the type of services we are seeking and committing to this specialisation.

– First Progress Report, Residential care review, 2024

Children entering the out-of-home care system often have diverse and complex needs that change over time. Some children may require relatively low-intensity support within kinship or foster care, while others may require more structured therapeutic environments or specialised residential care. The Commission’s work highlights the importance of clearly defining the roles of different providers within a continuum of care. Contractual arrangements should articulate the purpose, scope and expectations associated with different placement types, ensuring that children receive care environments that match their needs.

Throughout every step of the Residential Care review and my reports that followed I led with the need for a clear continuum of care. In *Too Little Too Late* I said:

In the first QFCC report during the Review, it was identified that the role and function of residential care had been lost. We stated that: “there is opportunity to make a profound difference across the system by bringing more nuance to the type of services we are seeking and committing to this specialisation”. This position was overwhelmingly reaffirmed at each site and house we visited. We heard that the demand pressures on the system have diluted the design intent of residential care. The QFCC documented its main observations about the design of the care system on the below continuum (see below). I said: “These observations showed the profound opportunity that exists to fill the gap between foster/kinships care and residential care with new models of care that compete with residential care in its current design”.



Residential care must be fit for purpose and be a purposeful intervention for the right child or young person at the right time in their life. The evidence gained through the review confirmed there were hundreds of children in residential care who had no clear reason or need for that type of care.

– A System that Cares, 2024.

A clearer and more differentiated continuum of care provides the foundation for a stronger, more responsive child protection system. Children and young people entering care have diverse and often complex needs, yet Queensland's system continues to rely on a narrow set of placement options. This limits the ability to match children with the right level of support at the right time. By adopting a continuum that explicitly articulates a wider range of placement types and service responses, the system becomes more flexible, stable, and effective.

A broader continuum enables better matching of needs to supports by allowing the system to:

- Provide intensive therapeutic support where it is needed.
- Offer lighter-touch or family-based care when appropriate.
- Reduce reliance on inappropriate “one-size-fits-all” placements.

A detailed continuum also creates clear pathways for children to move between levels of care as their needs change. This reduces crisis-driven decision making and provides:

1. Step-up supports when a child's behaviours or needs intensify, helping avoid placement breakdowns.
2. Step-down options when a child is ready for a more family-like or independent setting.

This reinforces placement stability while easing system pressure on high-cost, high-intensity services. A continuum that reflects diverse needs also creates more opportunities for young people to contribute to decisions about their placement. In such an environment, children feel safer and more respected because they can access care that aligns with their identity, relationships, and preferences.

When the system defines a richer set of service types - each with distinct roles, target cohorts, and supports - it also encourages diversity in service design and provider expertise. This:

- Promotes innovation as providers specialise in therapeutic care, disability-informed care, culturally-led care, reunification support, or adolescent transition services.
- Reduces bottlenecks by ensuring multiple appropriate placement pathways exist rather than funnelling children into the same limited options.
- Incentivises continuous improvement, as choice encourages providers to meet higher standards and demonstrate impact.

A nuanced continuum further clarifies the skills and expertise needed in each type of placement. This supports more targeted workforce development, including:

- Specialist training for carers supporting children with trauma, disability, or complex behaviours
- Cultural capability development for carers supporting Aboriginal and Torres Strait Islander children.

- Clearer expectations and competencies for staff working in therapeutic or residential models.

Within this context, workforce confidence and practice quality increase.

Finally, a wider range of service options reduces the inappropriate use of high-cost emergency or residential placements. Choice creates flexibility, and flexibility prevents expensive system strain. Over time, this leads to:

- More cost-effective allocation of resources.
- Better long-term outcomes (education, wellbeing, health), reducing lifetime costs to government.
- A system that can absorb demand fluctuations without crisis-driven spending.

Expanding and clarifying the continuum of care is not just about adding more placement types - it is about building a system that is adaptable, child-centred, and capable of meeting contemporary challenges. More choice leads to better matching of needs, improved stability, stronger workforce practice, greater innovation, and ultimately better outcomes for children and young people.

Implement outcomes-based commissioning with incentives and penalties for quality

A defining feature of the child protection system in Queensland is that much of the direct service delivery, particularly out-of-home care, is provided by non-government organisations. In practice, this means the system operates as a hybrid model: statutory authority remains with government, while many aspects of service delivery are outsourced to external providers. It is now true that the main skill required within the department of child safety is contract management and procurement.

The Commission's work highlights the importance of recognising and managing this reality explicitly. Effective oversight, clear contractual arrangements, strong performance monitoring, and collaborative partnerships are essential to ensuring that outsourced service delivery achieves the intended outcomes for children.

It is our strong opinion that historical methods of government service and program evaluation are not fit-for-purpose when considering the goal of residential care is to provide leadership in the raising of children. Ultimately many of the impacts of residential care service delivery eventuate in adulthood.

– A System that Cares, 2024.

The commissioning arrangements through which out-of-home care services are funded play a significant role in shaping the quality of care delivered. Traditional contracting approaches often focus primarily on service inputs (such as the number of placements provided) rather than the outcomes achieved for children.

The failing to understand, after months of consistent feedback, that the generic contracts and related service standards were causing harm, frustration and inefficiency is discouraging.
- Too Little Too Late, 2024.

The Commission has emphasised the potential for outcome-based commissioning models to drive improvements in care quality. Such models place greater emphasis on the stability of placements, the quality of relationships experienced by children, their educational and developmental progress, and their sense of safety and belonging. Aligning funding and performance monitoring with these outcomes encourages service providers to focus on the factors that most directly influence children's wellbeing.



Government contracting arrangements have continued unchanged, relying on generic residential care contracts and service standards.... The current funding and service model is failing the children it is meant to protect.
– Buyer Beware, 2025

In *A System that Cares*, the Commission provided a new performance framework for residential care that considered and covered the lifelong outcomes and house-specific elements of a quality system. We said:

The QFCC recommends that any performance framework include measures that apply at multiple levels across the residential care system including: 1. measures of the impact on an individual child; 2. measures relevant to individual houses; 3. measures relevant to individual providers (i.e. across their multiple houses); 4. regional measures (i.e. across multiple providers and houses in a geographic area); and 5. lifetime measures (i.e. outcome measures for young people after leaving residential care). The performance framework must also include all life domains for young people in care – and explicitly meet the Rights of Children in Care set out in the Act - thus recognising the state's obligations to young people in care.

In *Too Little Too Late* I recorded that:

During the Review, PeakCare's submission stated that the contemporary model of residential care is not reflected in any minimum service standards or service design specifications. Sector experts further expressed concern about the quality of licensed and unlicensed models and there was a strong narrative regarding the different

monitoring and expectations between the two. In my advice to the then Minister I stated that: “As with any performance system, the residential care industry needs:

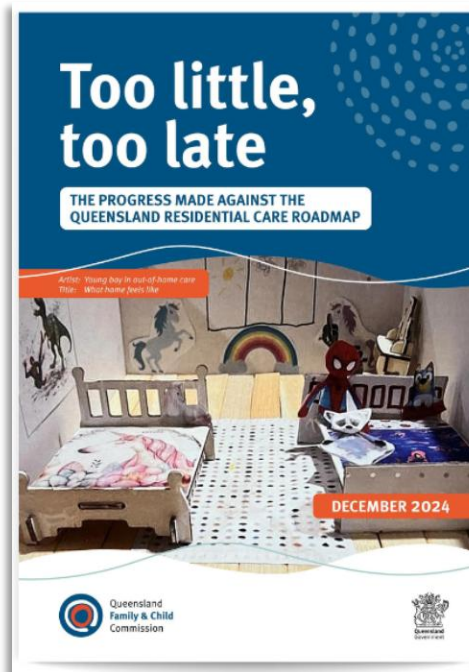
- clear expectations;
- defined responsibility and accountability;
- incentives to exceed expectations (including disincentives for failing to meet expectations);
- active monitoring, quality assurance and outcome measuring; and
- clear feedback/communication loops”.

Build a stronger inspection, licensing and accreditation process

A critical mechanism for ensuring quality in out-of-home care settings is the presence of robust inspection, licensing and accreditation frameworks. These frameworks establish minimum standards for safety, governance and service delivery, and provide an independent mechanism for assessing whether care providers are meeting those standards. Where children are placed in the care of organisations outside their immediate families, the State retains a continuing responsibility to ensure that those environments are safe, stable and capable of supporting children’s wellbeing. Effective inspection and regulatory oversight are therefore essential components of a child protection system that seeks to safeguard children not only through investigation and intervention, but also through the quality of the environments in which they live.

The Commission’s work has highlighted the importance of regulatory systems that move beyond administrative compliance to focus on the lived experience of children. Too often, regulatory processes concentrate primarily on whether organisations have appropriate policies, procedures and governance structures in place. While these elements are important, they do not on their own guarantee that children experience safe, nurturing and supportive care. Inspections must therefore examine how services operate in practice. This includes assessing whether children feel safe in their placements, whether they have trusted relationships with carers and staff, whether their cultural and emotional needs are being met, and whether their voices are heard in decisions affecting their lives. Achieving this requires inspection approaches that incorporate direct engagement with children and carers, observation of day-to-day practice, and analysis of outcomes over time. Regulators must be able to see beyond written policies and examine the quality of interactions between children and adults, the stability of placements, and the ways in which organisations respond to incidents or concerns. When inspections are grounded in the lived experiences of children, they provide a far more reliable indicator of the quality and safety of care environments.

International experience demonstrates the value of such approaches. In England, the national inspection authority, Ofsted, operates a comprehensive inspection regime for children’s social



care services, including foster care agencies, residential children’s homes, and local authority children’s services. The system combines regular inspections with public reporting of findings and clear expectations for improvement where services fall short of required standards. Services are assessed against a structured framework that examines leadership and governance, the quality of care provided to children, safeguarding practices, and outcomes for children and young people. A key feature of the Ofsted model is its focus on the lived experience of children. Inspectors engage directly with children and young people, speak with carers and staff, review case records, and observe daily practice within care settings. The aim is not simply to verify compliance with regulatory standards, but to develop a holistic understanding of whether children are receiving high-quality care and support. Inspection reports therefore provide detailed analysis of how services operate in practice, highlighting both strengths and areas requiring improvement.

Minimum standards are needed to ensure residential care houses feel more like homes and less like workplaces.

– A System that Cares, 2024.

Another important aspect of the Ofsted approach is the requirement for structured improvement planning where services are found to be underperforming. Where inspections identify weaknesses, organisations must develop and implement formal improvement plans addressing the issues identified by inspectors. These plans are monitored through follow-up inspections and regulatory oversight, ensuring that concerns identified during inspection lead to tangible improvements in practice. In serious cases where services are judged to be inadequate, enforcement powers allow regulators to impose conditions, restrict operations, or ultimately close services that cannot meet required standards.

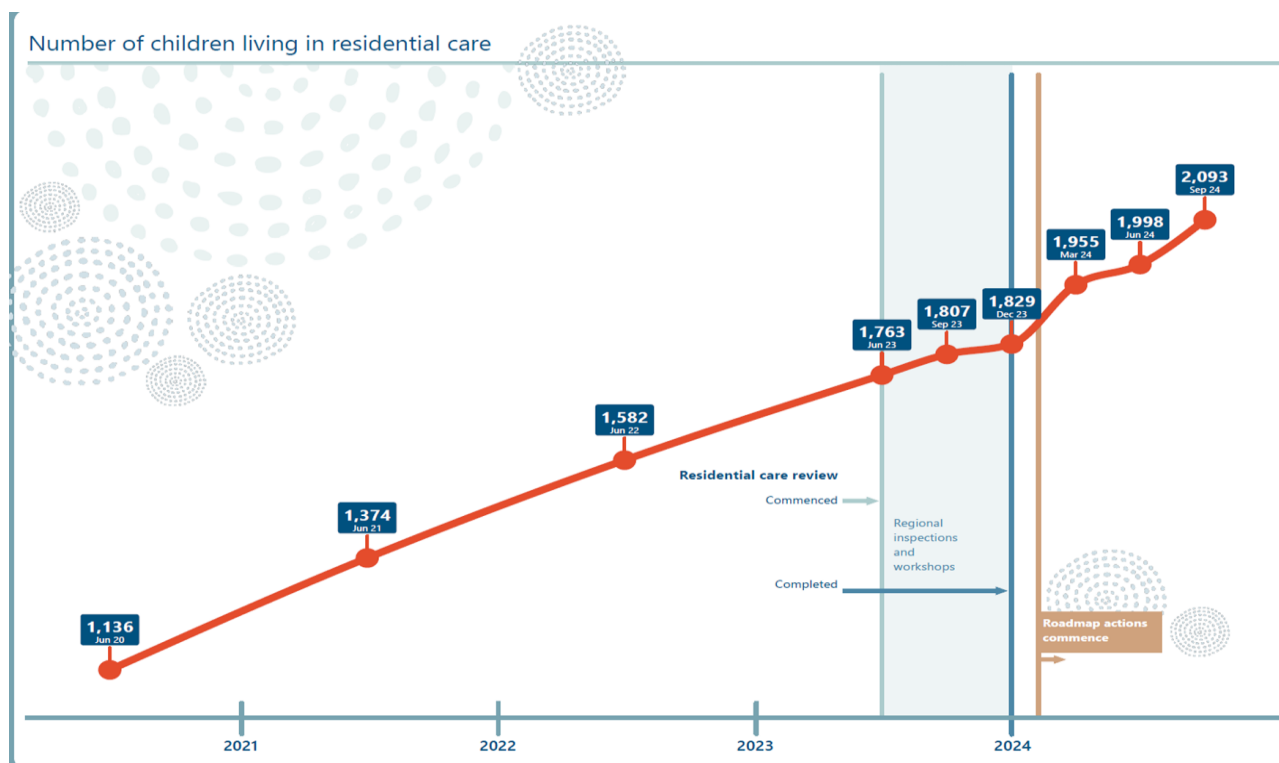
Adopting elements of this model would strengthen Queensland’s capacity to ensure the quality-of-care environments provided to children. As the out-of-home care system increasingly relies on non-government organisations to deliver foster care, residential care and therapeutic services, the State must ensure that strong regulatory mechanisms are in place to oversee the quality of those services. Regular, independent inspections of care providers - combined with transparent public reporting and improvement planning - would provide a clearer picture of how services are performing and where reform is needed.

A strengthened inspection framework would also contribute to greater transparency and accountability across the care system. Publicly available inspection reports enable governments, service providers, carers and the community to understand the quality of services being delivered to children. This transparency creates incentives for continuous improvement while also ensuring that systemic issues can be identified and addressed at a sector-wide level.

There is substantial return on investment to be made through reform to the multi-billion-dollar residential care industry.

– Residential care review – October 2023 monthly report

The statistics below show a clear temporary period where there was a visible reduction in the use of residential care in Queensland. This was the period when the Child and Family Commission, PeakCare and QATSI CPP were visiting each regional office and asking senior leaders to explain their use of residential care. This suggests that external accountability was effective at shifting behaviour, and the sharp increase once inspections ceased shows a department culture reverting to form. The connection between inspections and behaviour cannot be overstated.



Importantly, inspection should be understood not only as a regulatory tool but also as a mechanism for driving learning and improvement across the sector. High-quality inspection frameworks identify examples of effective practice and share those insights across services, helping to lift the overall quality of care. When inspections are conducted with a focus on learning as well as accountability, they become an important driver of professional development and organisational improvement. In this way, a stronger inspection regime, drawing on the design principles of the Ofsted model, would reinforce the broader objective of the child protection system: to ensure that every child placed in care experiences an environment that is not only safe, but supportive of their development, identity and long-term wellbeing.

The Queensland model has largely outsourced both service delivery and market responsibility. Providers operate in siloes, pricing varies with limited transparency, and funding is disconnected from child-centred outcomes. The government has not developed the mechanisms to influence market behaviour, enforce minimum standards across providers, or direct investment toward system goals.

– Buyer beware, 2025.

Empower the carer system

When children and young people are unable to live safely at home, foster carers provide more than accommodation - they offer stability, safety, and a sense of belonging within a family environment. This form of care is uniquely positioned to support healing and development, particularly for children who have experienced trauma, abuse, or neglect.

Foster care operates at the relational core of the child protection system. It is where policy, funding, and service delivery converge most directly with the lived experience of children. A contemporary foster care system must therefore do more than recruit carers; it must actively recognise, support, and reciprocate the commitment foster carers make every day.

There have been numerous and profound social changes since the current model of foster care emerged in child safety systems across the Western world. The QFCC community survey, the Growing Up in Queensland Report, and the Foster and Kinship Care Association's survey of carers all point to shifts in household dynamics, economies and motivations of the Queensland population which can shape the appetite to nominate to be a foster carer.

– Second Progress Report, Residential Care Review.

Across Australia, the foster care system is undergoing a profound shift. The number of approved foster carers is declining, while the number of children and young people placed in residential care continues to rise. Although the pace and scale of this trend vary across jurisdictions, the direction is consistent - and concerning. Without deliberate and sustained intervention, this trajectory risks reshaping the care system in ways that are less relational, more institutional, and ultimately less effective in meeting the long-term needs of children.

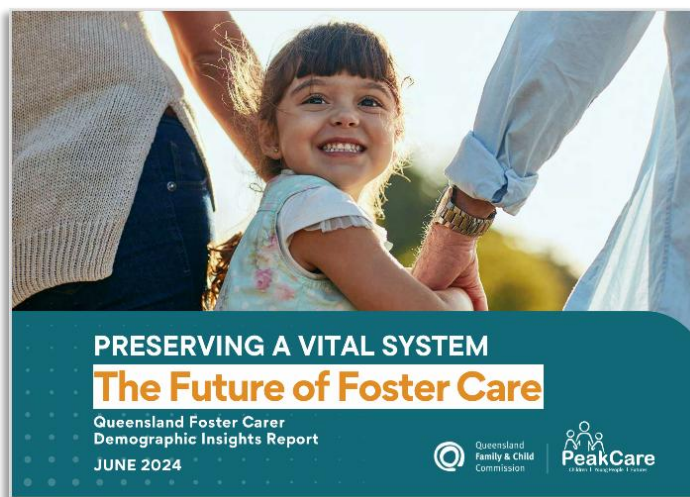
Understanding the drivers of this change is critical. Equally important is the need to articulate a clear, forward-looking strategy to modernise foster care over the next decade. This is not simply a workforce issue; it is a structural challenge that goes to the heart of how care is conceived, valued, and delivered within the broader child and family services system. The Commission has highlighted the importance of strengthening support for carers, including reviewing the adequacy and structure of carer allowances to ensure that carers are not financially disadvantaged in providing care. Financial support alone is not sufficient; carers also require training, practical assistance and access to professional support to manage the complex needs many children bring into care.

We are running out of carers... Traditional pools of foster carers continue to shrink, which exacerbates the urgency to develop flexible and contemporary foster care models that can better meet the evolving needs of children and young people in our contemporary society.

– Raising expectations, 2024.

In 2023 the Commission partnered with The Demographics Group and Peakcare to undertake a detailed demographic analysis of Queensland's foster carer population. The resulting report drew on multiple data sources to identify emerging trends, risks, and opportunities. The ten opportunities outlined provide a practical and strategic roadmap for sustaining and strengthening foster care into the future. This includes acknowledging the increasing complexity of children's needs, the emotional and practical demands placed on carers, and the broader societal changes affecting family life, workforce participation, and community connection.

The decline in foster carers is not occurring in isolation. It is compounded by a longstanding underinvestment in alternative models of care, particularly professionalised, in-home options that can provide intensive, tailored support to children with higher needs. As a result, pressure is shifting toward residential care. While residential settings play a necessary role in the continuum of care, they are not designed to absorb the volume or diversity of need currently emerging.



This creates a system-level risk: children who would benefit most from stable, family-based or therapeutic home environments are instead placed in institutional settings due to a lack of available carers. Over time, this dynamic has led to a cycle of escalating demand, rising costs, and diminished outcomes.

There is a compelling economic argument for investing in foster care. The cost of adequately supporting, retaining, and growing the foster carer workforce over the next decade is significant - but it is far outweighed by the cost of a system without them. Without sufficient foster carers, governments face increased reliance on higher-cost care models, alongside poorer long-term outcomes for children. These outcomes, across health, education, employment, and justice, carry substantial social and fiscal consequences that extend well beyond the child protection system. Investment in foster care is therefore not discretionary. It is foundational to system sustainability, fiscal responsibility, and, most importantly, to the wellbeing of children and young people.

Rising costs of living, changing social trends, fewer available spare bedrooms, generational value shifts, an increased geographical separation of potential foster carers and foster children, and a declining middle-class suggest a diminishing pool of potential foster carers in Queensland. In this environment, relying on old ways of recruiting foster carers is unlikely to be successful at the scale needed - therefore, systemic reform is essential.

- The Future of Foster Care, 2024.

Foster carers remain the backbone of the child protection system. They are the individuals and families who step forward to provide care, stability, and love at times of profound vulnerability. Their contribution is both deeply personal and systemically critical. From lived experience, the impact of foster care is clear. Children who have experienced harm can, through consistent and compassionate relationships, begin to rebuild trust, develop resilience, and reimagine their futures. Foster carers are often the first step in that journey. Yet the environment in which foster care operates is changing. Fewer individuals are entering or remaining in the system, and the factors influencing this shift are complex - ranging from demographic trends and workforce pressures to changing social norms and expectations.

Carers must also be better equipped to navigate government systems – not just Child Safety, but also Health and Education – as the people performing the adult-advocate role for children in their care.

– A System that Cares, 2024.

There is sufficient evidence to show that disempowered and disenfranchised carers leave the system. The task for the government therefore is to place more trust and more support in the people raising the children in state care. It makes absolutely no sense that we trust a carer to have children in their house for 365 days of the year, but don't trust them to go on a camping weekend, or take them to the General Practitioner, without prior approval.

The challenge ahead is both immediate and long-term. The three-year-old child entering care today may require stability, support, and connection for the next two decades. This reality demands a system that is not only responsive in the moment, but also capable of sustaining relationships over time.

- The Future of Foster Care, 2024.

Strengthen the capability of the care workforce

The quality of care experienced by children is directly influenced by the skills, training and stability of the workforce providing that care. In residential care settings in particular, workers are often required to support children with complex trauma histories, behavioural challenges and significant emotional needs. The Commission's work highlights the importance of ensuring that workers in these settings receive appropriate training, professional supervision and ongoing support. Building a skilled workforce capable of delivering trauma-informed and relationally focused care is essential for improving outcomes for children.

It was absolutely evident throughout the course of site inspections that the more stable the workforce was at a house, the better their team dynamic was – and the better the care they provided.

These homes automatically and intrinsically felt more home-like and more caring. Based on this I advised the then Minister that: “the development of a residential care workforce strategy provides a key opportunity to pave the way to a future direction for the system and sector – but it must be guided by the other actions in the Roadmap – including the development of new care models, service expectations and changed power dynamics regarding the voice of children and young people.

– A System that Cares, 2024.

Strengthening workforce capability can help reduce placement instability, improve the consistency of care provided to children, and support more effective collaboration between carers, service providers and statutory agencies. Government should uplift its expectations of the residential care workforce to reflect the complexity, risk and importance of the role they perform in the lives of children and young people. Residential care is not a low-skill, supervisory function; it involves supporting children who often have experienced significant trauma, disrupted attachments and complex behavioural needs. These environments require staff who can exercise sound judgement, build therapeutic relationships, manage risk in real time, and respond to crises in ways that are both safe and developmentally informed.

The Commission's work indicates that current expectations do not always align with this reality. Inconsistent qualification requirements, variable training standards and high workforce turnover can limit the system's ability to provide stable, skilled and therapeutic care. Where expectations are too low, there is a risk that residential care becomes focused on containment rather than recovery, and that opportunities to support children's long-term wellbeing are missed.

The development of a residential care workforce strategy provides a key opportunity to pave the way to a future direction for the system and sector.

– A System that Cares, 2024.

Uplifting expectations would signal a shift toward recognising residential care as a specialised area of practice requiring defined capabilities. This includes stronger minimum qualifications, ongoing professional development, and clearer practice standards grounded in trauma-informed and culturally responsive care. It also requires clearer role design, so staff are supported to focus on relational and therapeutic work, rather than being overwhelmed by administrative or crisis-driven demands.

Higher expectations must be matched by appropriate investment. This includes improved remuneration, stronger supervision and leadership, and workforce structures that promote stability and retention. Without this, efforts to raise standards will not be sustainable.

Importantly, elevating the capability of the residential care workforce strengthens the system's ability to respond to some of its most vulnerable children. It improves safety, reduces placement instability, and creates environments where children can build trust, develop skills and experience consistent care. In this way, uplifting expectations is not simply a workforce issue - it is central to improving outcomes for children in care.

The Australian Child Maltreatment Study provided ample evidence of the heightened risk young people with a trauma background are exposed to and stakeholders agreed that the residential care system needs to address these issues to create environments that encourage positive relationships and ensure children and young people feel loved, safe and cared for.

– A System that Cares, 2024.

Part 4:

Improve the Life Outcomes of Children in Care

Protecting children from harm is only the starting point. There are now over 12,000 children in state care in Queensland, and the way the system parents them will have a profound impact not only on those 12,000, but on their partners, their children, their neighbours and the Queensland community.

Parenting is a long-game. It is built on consistency, patience and relationships that develop over time, not on short-term compliance or crisis response. For children who have experienced trauma, instability or disrupted attachments, this long view is even more critical. Progress is often uneven, trust is hard-won, and setbacks are part of the process. What matters is the presence of stable, capable adults who remain engaged, respond thoughtfully, and continue to invest in the child's development over time. This has direct implications for the child protection system.

If parenting is a long-game, then out of home care cannot be structured around short-term shifts, high staff turnover, or a focus on immediate behaviour management alone. It must be designed to provide continuity of relationships, intentional therapeutic support, and a workforce equipped to think beyond the immediate to the child's long-term trajectory.

The system must support children to build strong relationships, succeed in education, develop a sense of identity and transition successfully into adulthood.

We want a future where there isn't such a vast difference in outcomes between kids in care and kids living at home with their parents.

– Rights, Voices Stories, 2021

Change the way the system views children in care

Children who enter out-of-home care often do so as a result of significant adversity. While the immediate role of the child protection system is to ensure their safety, the long-term responsibility of the state extends much further. The goal must not simply be to keep children safe while they are in care, but to ensure they have the opportunity to thrive and experience the same life chances as other children.

Through its systemic reviews, monitoring activities and policy advocacy, the Commission has emphasised that improving outcomes for children in care requires a shift in both policy and practice. This includes a stronger focus on children's rights, greater investment in long-term supports, and a recognition that the state assumes the long-term responsibilities of a parent when it takes a child into care.

Improving outcomes begins with changing how the system views and treats children in care. Too often, policy and practice approaches frame these children primarily through the lens of risk, vulnerability or behavioural challenge. They are counted as "cases" on a "caseload" and they receive transactional "interventions" and "referrals". Socially the children are referred to as "resi-

kids” and public sentiment polarises from deep compassion for the “abused child”, to deep fear and resentment of the “problematic teen”.

Government should consider a whole-of-government plan that explicitly outlines how it will meet the needs of children in state care that includes responsibility and accountability for each Director-General and Department in Queensland.

– A System that Cares, 2024.

The Commission’s work has highlighted the importance of viewing children in care as capable individuals with rights, strengths and potential. Systems that adopt this perspective are more likely to prioritise education, relationships, participation and personal development, rather than focusing solely on risk management. This shift in attitude also reinforces the idea that children in care should receive the same opportunities, encouragement and aspirations that any caring parent would seek for their own child.

So often the people running systems are thinking about the risks to themselves as public servants or as residential care workers, the risk to organisations, the risk to funding contracts, the risk, the risk, the risk... and that reduces a young person’s life to burdensome paperwork or checklists or compliance checks.

Children raised outside of the care system aren’t raised this way, so why is it so for children in care?

–Luke Twyford, CREATE Foundation Conference speech, 2024.

Changing how we see children in care begins with how the State understands its own role. If government assumes parental responsibility, it must also embrace the core principles of parenting including care, commitment, advocacy and, fundamentally, love. This is not a soft concept; it represents not only how the parent treats their child, but how it allows or permits others to talk about the child. When these principles are embedded in policy and practice, they shape not only how decisions are made, but how children are valued.

At the same time, there is a need to reshape the public narrative. Too often, children in care are seen through a deficit lens - defined by risk, behaviour or system involvement - rather than by the adversity they are overcoming and their potential to thrive. Proactive efforts to tell a different story are essential: one that highlights resilience, celebrates progress, and builds community understanding of the complexity of their experiences. This is not about minimising risk, but about restoring balance and dignity to how these children are perceived. Central to this shift is the visibility of role models. There are adults with lived experience of care who have gone on to lead, contribute and succeed across many fields, as well as carers and practitioners who embody the very best of what care can look like. Yet these stories are not consistently elevated or recognised. Identifying and amplifying these role models, people who demonstrate what it means to both receive and provide good care, can play a powerful role in changing expectations, inspiring children, and building public confidence in the system. Creating this visibility requires deliberate effort. It means partnering with care-experienced people to share

their stories safely and authentically, recognising and celebrating excellence within the care system, and ensuring that positive narratives are embedded in public communication.

When children can see what is possible, and when the community can see the value and humanity in their journeys, it shifts both aspiration and accountability. Ultimately, a system grounded in care, reinforced by a more balanced public narrative, and strengthened by visible role models, is better positioned to support children not just to be safe, but to feel valued and to thrive.

Young people said they felt their lives were risk-assessed and defined by incident-reports and corporate rules...They felt their significant life events were procedural and process-driven.

– A System that Cares, 2024.

Change the system to act on the views of children

A consistent finding across the Commission’s work is that children and young people are too often positioned as passive recipients of care, rather than active participants in decisions that shape their lives. Historically, child protection systems have been adult-driven, with limited mechanisms for children’s views to meaningfully influence decision-making. This approach not only diminishes children’s rights but also weakens the quality and effectiveness of care.

Empowerment must therefore be understood as more than consultation. It requires the deliberate design of structures, practices and cultures that enable children’s voices to be heard, taken seriously, and acted upon. When children are engaged as participants, their lived experience becomes a critical source of insight - informing risk assessment, placement stability, and the design of supports that respond to their individual needs.

...the system needs bold reform; children and young people must have greater involvement in decisions that affect them; and transitioning to adulthood should be an ongoing learning process, not a single event

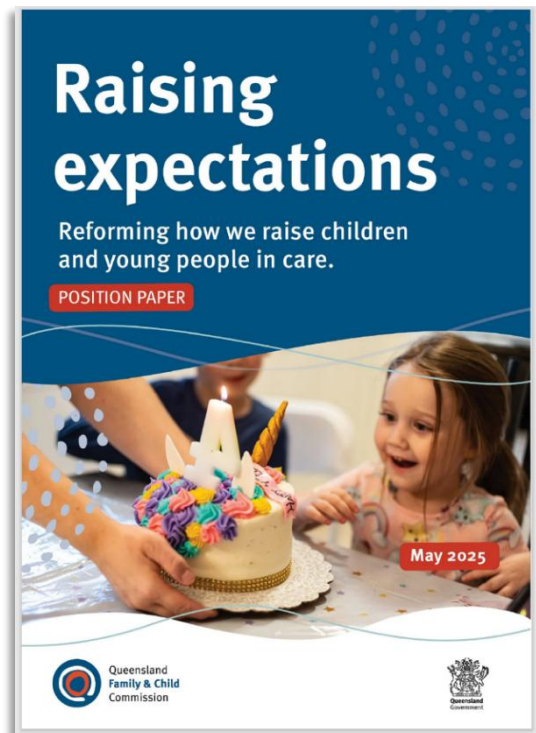
– Luke Twyford LinkedIn

Embedding children’s voices within both service delivery and oversight processes helps ensure that care systems remain responsive to the needs of those they are designed to support. The experiences of children in care, as documented in reports such as “Too Little, Too Late” and “A System That Cares”, underscore the consequences when children’s voices are overlooked.

During the review the Commission heard that young people felt they were restricted from living a 'normal' life due to strict policies and procedures in residential care homes. The stories and statements we collected were harrowing. Young people said they felt their lives were risk-assessed and defined by incident-reports and corporate rules. The profound statement from a young person that they felt like "they were raised by a checklist" underscored the bureaucratisation of care. We heard of young children having their bikes, scooters and skateboards confiscated because of work health safety laws. We heard of young people who had never had a birthday cake. For too many children, there was no room for living a 'normal' life in a proceduralised house, and there were limited observable indicators that this was "their home". They described the need for personal effects and personalisation in a residential care home to support them to establish their own space and to feel connected to where they are staying.

Evidence from the Commission's reviews demonstrates the consequences of failing to embed children's voices in decision-making. Children and young people have consistently reported feeling excluded from conversations about their safety, placements and future planning. Decisions are frequently made about them rather than with them, contributing to disengagement, instability and unmet needs. In a home where you are devalued, disconnected and disempowered the overwhelming tendency will be to leave.

Meaningful empowerment requires a shift from one-off or transactional engagement toward structured and consistent participation. Participation must be embedded in core practice. Children's views should be routinely sought, documented and visibly considered in decisions about where they live, how they are supported, and what their future looks like. These experiences matter. They are not peripheral concerns but direct indicators of system performance. A care environment that does not feel like a home cannot deliver the stability, identity and connection that children need to heal and thrive. This is not a procedural requirement - it is central to delivering safe, effective and responsive care.



They treated me like a person - a whole person - with my own voice, my own dreams, and my own imperfections. They let me grow and learn, not by forcing me to fit a script, but by letting me figure out who I was. I could laugh, cry, mess up, and start over again without fear of judgment. I could simply be.

That's something Resi never gave me. Resi taught me to survive, but living with my carer taught me what it feels like to live.

For the first time in my life, I wasn't just another "case" or a problem to be solved.

– Young Person introduction, Too Little Too Late, 2024

A central reform priority is the creation of genuinely home-like environments within out-of-home care, particularly in residential settings. This requires rebalancing system settings - such as risk management, funding models and workforce practices - so they enable, rather than constrain, the creation of spaces where children feel a sense of ownership and belonging. Supporting children to have personal belongings, to shape their own spaces, and to make choices about their daily lives is fundamental. These elements are not incidental; they contribute to identity formation, emotional security, and preparation for independence. They also signal to children that they are not temporary occupants of a service, but individuals with a recognised place and stake in their environment.

Importantly, embedding personal ownership within care settings can also shift system behaviour. When children's belongings and connections to place are prioritised, there is a stronger incentive to maintain placement stability and to approach placement changes with greater care and deliberation.

Empowerment must extend beyond individual casework into the broader design and oversight of the system. Children's feedback should inform

service delivery, performance monitoring and reform efforts. Their perspectives provide a unique and essential lens on the quality and effectiveness of care. This includes integrating children's voices into quality assurance processes, service standards and commissioning frameworks. It also requires moving beyond small-scale or symbolic engagement toward approaches that reflect the ongoing, relational nature of care - more akin to how a parent listens to and responds to their child, rather than how a system consults with external stakeholders.



Too often we forget or fail to acknowledge that young people in care are indisputably the experts of the Child Safety system. After speaking to over 200 workers and conducting 16 site visits, it was the daylong workshop with young people with residential care experience that provided the richest and most pragmatic solutions to the contemporary problems being discussed in the review.

– QFCC Response to the Residential Care Roadmap, April 2024

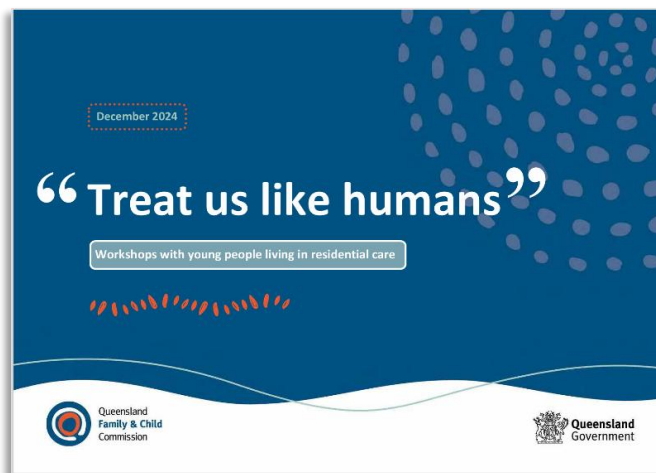
The children in care I have spoken to want to know why I can book a day with them to hear about their lives, but the Director-General and the Minister cannot. They want to know why they can't make a report card for each of their workers, why they don't get to tell someone about the quality of the homes they have stayed at – and what incidents they have experienced and what would have prevented them. In practice, this means the child protection system must move from tokenistic consultation to structured, consistent, and meaningful engagement.

The evidence is clear: systems that fail to empower children risk perpetuating harm, disengagement and instability. In contrast, systems that prioritise participation foster trust, resilience and stronger relationships between children, carers and practitioners. When children feel heard and respected, they are more likely to engage positively with those around them, to develop a sense of agency, and to navigate their experiences in care with greater confidence. This, in turn, contributes to improved placement stability, better developmental outcomes, and a stronger foundation for adulthood.

Empowering children and young people is therefore not an optional enhancement - it is a core requirement of an effective child protection system. It demands a shift from process-driven care to relational, child-centred practice, where children are not only informed about decisions, but actively shaping them.

By ensuring children are heard, respected, and supported to participate, the system honours their rights, strengthens protective outcomes, and lays the foundation for a care

experience that is truly child-centred and relationally informed, in line with the principles outlined in both “Too Little, Too Late” and “A System That Cares”.



Sadly, the approach taken has not empowered young people in the system, and instead transactional and one-off engagement opportunities with small numbers of young people have been pursued. Arrangements to engage young people in care still look far more like a department engaging with adult customers, rather than a parent engaging with their child.

- Too Little Too Late, 2024

“Choice and voice” emerged as a critical theme, demonstrating that young people want to have a say in what happens in their life. Unfortunately, overwhelmingly participants told us this does not occur, and that rules and regulations are prioritised over their needs and wants.

– Treat us like humans, p4

Embed relational practice into the sectors ways of working

Care is not a placement. Care is a relationship

– Raising Expectations, 2025

Research and practice experience consistently demonstrate that stable, supportive relationships are among the most important protective factors for children in care. The Commission has emphasised the importance of practice models that prioritise relational approaches - focusing on trust, consistency, emotional support and connection.

This is your job, but it's my life.

- *Young Person in care speaking about the role of youth workers*

Relational practice is an approach to working with children, families and communities that places the quality of relationships at the centre of all interactions, decisions and interventions. Rather than privileging compliance, process or transactional engagement, it recognises that trust, connection and understanding are the primary mechanisms through which safety is established and sustained. It requires practitioners to see the person in the context of their lived experience, including trauma, culture and relationships, and to work collaboratively with children and families rather than acting upon them.

At its core, relational practice reflects a shift in orientation - from asking what is wrong and how it should be fixed, to seeking to understand what has happened, what matters to the child, and how safety can be built alongside them. This involves consistent, respectful engagement over time, an ability to attune to emotional and behavioural cues, and a commitment to exercising statutory authority in ways that preserve dignity and connection. It does not remove the need for decisive action or the exercise of power, but instead reframes how that power is applied, ensuring it is used with care, transparency and accountability.

The effectiveness of relational practice is well supported by evidence and practice experience. Trust is a precondition for disclosure; without it, children and families are less likely to share critical information about harm, risk or need. Neuroscientific insights further demonstrate that individuals experiencing stress or trauma require a sense of emotional safety before they can engage in higher-order reasoning or decision-making. Relational approaches therefore create the conditions necessary for meaningful participation and informed decision-making. In addition, when individuals are actively engaged in processes that affect them, they are more likely to understand, accept and sustain agreed actions. This is particularly important in child protection contexts, where imposed solutions often fail without genuine engagement.

During the review providers and staff expressed concerned that “kids in residential care need more attention and connection but our model gives them less”.

– A System that Cares, 2024.

Relational practice also enables a more sophisticated understanding of behaviour. It recognises that many behaviours of concern are adaptive responses to trauma and adversity, and that responding solely through compliance or control can reinforce harm or disengagement. By contrast, relational approaches reduce the risk of re-traumatisation and support longer-term healing and stability. They also contribute to strengthening the broader network of relationships surrounding a child, including family, carers, educators and community members, which are critical to ongoing safety and wellbeing.

We heard that the impact of high caseloads for Child Safety means officers “can’t get the opportunity for meaningful engagement with children for assessments” and that because Child Safety’s primary focus at the start of the case is on safety, risk and harm, “the rest of the child’s needs fall away until someone more diligent picks up on [the needs]”. “If we got the first bit right [investigation and assessment] then we have a better understanding of what is the best option for the child.

– A System that Cares, 2024.

The work of Jarrod Wheatley has been influential in articulating the centrality of relationships in statutory practice. Wheatley emphasises that relationship is not an adjunct to the work but its foundation, observing that “relationship is not the soft part of the work – it is the work.” This framing underscores that assessment, decision-making and intervention are all mediated through the quality of engagement between practitioners and those they serve. His further observation that “people change in the context of relationships, not in the context of forms” highlights the limitations of process-driven approaches when they are disconnected from genuine human connection.

In practice, relational approaches are demonstrated through clear and transparent communication, consistency in action, and a stance of curiosity rather than judgement. They require practitioners to acknowledge and navigate power imbalances, to remain engaged even in the context of conflict or statutory intervention, and to prioritise the experience of the child or family alongside procedural requirements. These are not peripheral skills but core capabilities that determine the effectiveness of the system as a whole.

Whatever their age, ongoing nurturing and responsive relationships provide children and young people with a sense of safety and security, giving them confidence and empowerment.

– A System that Cares, 2024.

Relational practice should therefore be understood not as an optional or supplementary approach, but as the primary means through which child protection and safeguarding systems achieve their objectives. It enables systems to move beyond procedural compliance towards responses that are experienced as fair, humane and effective, and that ultimately create safety through connection.

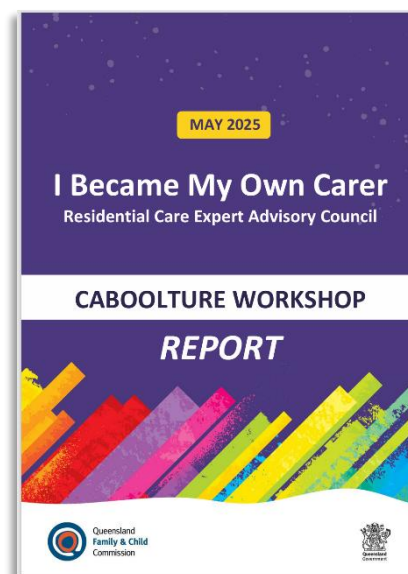
Relational practice models recognise that children who have experienced trauma or instability may require time and consistent support to develop secure attachments with caregivers and professionals. Care environments that emphasise relationships rather than purely behavioural management are more likely to support children's emotional development and sense of belonging.

Children in care experience the system primarily through their relationships with carers, youth workers and other frontline adults. These relationships are central to children's safety, wellbeing and sense of stability, yet carers are not always empowered to respond to concerns or contribute fully to decision-making.

In the report *I became my own carer*, we recorded the views and voices of young people living in residential care. Within that report I reflected:

Young people in residential care are calling for more than service improvements - they are demanding a fundamental shift in how the care system sees and supports them. They want to be equipped with real-world skills, supported in achieving their goals, included in decisions, and treated with dignity. They want care that offers a real childhood, fosters meaningful connections, and prepares them for adulthood.

We heard from young people who are actively working towards becoming qualified youth support workers. Inspired by their own experiences in care - both positive and negative - they want to support others in the way they wish they had been supported. Their goal is to use their lived experience to help create safer, more understanding environments for future generations, proving that, with the right guidance, young people in care can become powerful agents of change.



The child protection system must shift from the current process - driven and bureaucratic model which leads to children being caught in a cycle of uncertainty affecting their mental, emotional, and physical wellbeing. The system must pivot to an approach that is deeply relational, child-centred, and focused on long-term, holistic outcomes for children where all relevant departments - health, education, justice, housing, and others - align in their approach to supporting children in care. This cross-portfolio approach to corporate parenting was recommended in the Child Death Review Board Annual Report 2023-2024, and called for a commitment from each portfolio head regarding their commitment to children in care beyond the core business of each department, and committing to broad whole-of-government coordination to provide a stable upbringing for children in the care of the state.

- Raising Expectations, 2025

Uphold the importance of sibling relationships

Sibling relationships are often among the most enduring and significant relationships in a child's life. For children entering care, siblings frequently represent one of the few stable connections to their family identity, shared history, and sense of belonging. Maintaining these relationships can be critical to a child's emotional wellbeing, identity formation, and resilience, particularly in the context of disrupted family circumstances.

One young person shared their story of barriers to family contact. Although approved for regular visits, the residential care model dictated these visits could only occur if the co-tenant also attended. As a result, many visits were cancelled due to issues with the co-tenant. The young person did not see their siblings for over two months. The provider did not have reasonable contingencies to ensure family contact could proceed for this young person whilst still considering the needs of the co-tenant.

– I was Raised by a Checklist, 2024.

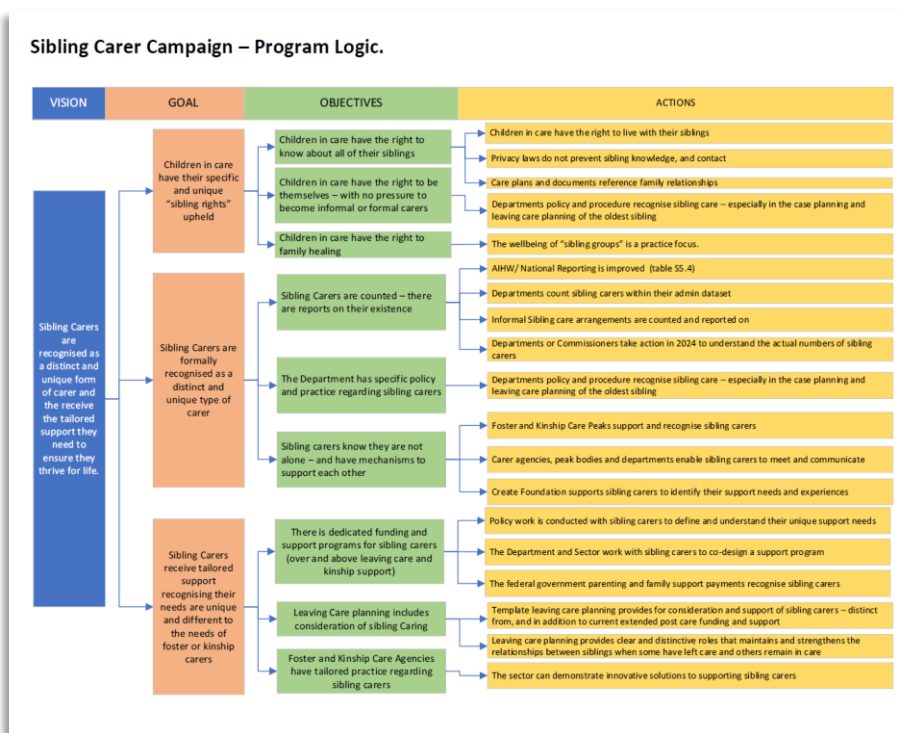
The Commission has consistently highlighted the importance of recognising sibling relationships as a core aspect of children's wellbeing. Research and practice evidence demonstrate that children who are able to maintain meaningful contact with their siblings experience greater stability, stronger attachment, and improved developmental outcomes. Conversely, when siblings are separated without good reason or supported contact is limited, children can experience feelings of loss, isolation, and diminished self-identity.

The Commission has championed the need for policy frameworks and operational practices that prioritise sibling connections. Wherever possible and safe, siblings should be placed together in care or, where co-placement is not feasible, supported to maintain regular, meaningful contact through visits, shared activities, and ongoing communication. This approach requires that placement decisions, case planning, and resource allocation explicitly consider sibling relationships as a central factor, not a peripheral one. The commission is a current sponsor of a national sibling carer campaign. The Campaign calls for all Governments to guarantee that:

- 1) Children in care have their specific and unique 'sibling-rights' upheld
- 2) Sibling Carers are formally recognised as a distinct and unique type of carer
- 3) Sibling Carers receive tailored support recognising their needs are unique and different to the needs of care leavers and/or kinship carers.

In line with this focus, the Commission's Sibling Carer Campaign has sought to raise awareness, advocate for systemic change, and develop practical strategies to support carers and practitioners in maintaining sibling connections. The campaign highlights innovative practices, such as dedicated sibling placements, visitation planning, and trauma-informed approaches to maintaining sibling relationships even in complex or high-risk cases. It also emphasises the need for training and guidance for carers and staff to understand the developmental and emotional significance of sibling bonds, and how these relationships can be nurtured even in challenging care contexts.

Protecting sibling relationships is not only a matter of relational wellbeing - it is a critical component of broader child protection outcomes. Children who maintain strong connections with siblings are more likely to experience a sense of continuity, stability, and belonging, which in turn supports resilience, healthy emotional development, and positive long-term outcomes. The Commission's work demonstrates that sibling-focused practice should be embedded across the child protection system, from policy and placement decisions to case management and carer support, to ensure that sibling relationships are consistently recognised and protected.



By prioritising sibling connections, the system can enhance the relational stability of children in care, support their identity and sense of family, and mitigate some of the trauma associated with separation. The Sibling Carer Campaign exemplifies how targeted initiatives, informed by research and lived experience, can drive systemic improvement and reinforce the principle that the wellbeing of children in care is inseparable from the relationships that matter most to them.

Strengthen the protection of children who are absent, exploited or missing

Children in care are often among the most vulnerable in the community, and many face additional risks beyond those that initially brought them into the child protection system. Some children experience episodes of going missing from placements, become involved in exploitation, or encounter forms of harm that remain invisible to formal systems. These risks highlight the critical importance of proactive, coordinated and child-centred responses that go beyond standard case management.

The Commission has emphasised that protecting these children requires a holistic approach that combines timely intervention, collaboration across agencies, and a deep understanding of the child's lived experience. In particular, the Commission's work has highlighted that children who go missing or are at risk of exploitation often do so in response to unmet needs, trauma, or a lack of connection and stability within their placements. Responses must therefore extend beyond simple protective measures to include therapeutic support, relational engagement, and strategies that strengthen the child's sense of belonging and safety.

The Special Rapporteur is concerned that there is inconsistent oversight of the situation of children placed in out-of-home care facilities, which increases the risk of children going missing and exposes them to the risk of sexual exploitation and abuse.

- United Nations Special Rapporteur, 24 February 2025

A key contribution of the Commission in this area has been the publication of the Absent from care insights paper and the development of the “When a Child is Missing” toolkit, which provides practical guidance to agencies, carers, and practitioners on preventing, responding to, and managing instances where children are absent or at risk. The toolkit encourages consistent practice across the sector, emphasises the importance of coordinated responses between child protection services, police, education providers and community organisations, and identifies steps to mitigate risk while keeping children safe. By outlining clear roles and responsibilities for each agency and practitioner involved, the toolkit helps ensure that responses are timely, proportionate, and grounded in an understanding of the child’s needs and experiences.

The Commission’s work has also highlighted that incidents of missing or exploited children rarely occur in isolation. Patterns of vulnerability often emerge over time, and effective responses require access to information, cross-agency intelligence, and systemic oversight. By strengthening data sharing and inter-agency coordination, the child protection system can identify at-risk children earlier, intervene more effectively, and tailor responses to the individual needs of the child.

The Board holds legitimate concerns, that for example, given the recent actions to strengthen ECEC, and the known number of infants in Queensland residential care, the threats to children may have already moved to a new sector or alarmingly, continues undetected in other sectors.

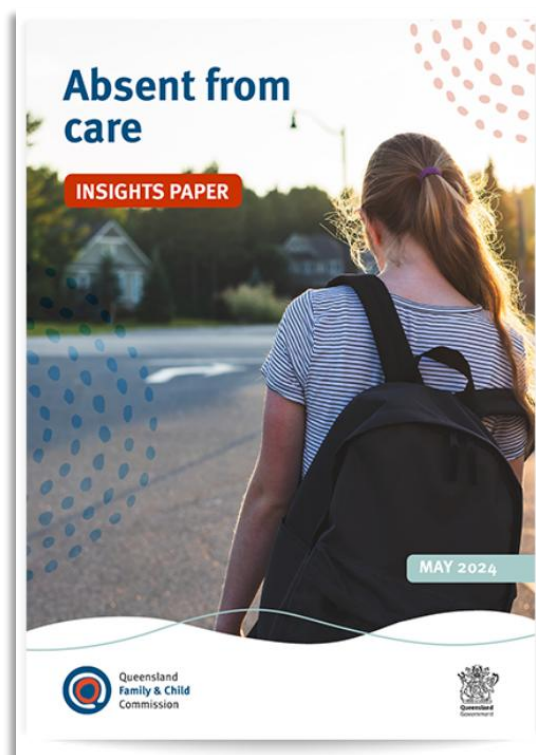
- In Plain Sight, 2025

Importantly, responding to absent or exploited children is not solely about enforcing compliance or imposing restrictions. The Commission emphasises that effective interventions must combine protection with support, recognising that children are often navigating complex trauma, disrupted attachments, or unmet developmental and emotional needs. Approaches grounded in relational care, trauma-informed practice, and child-centred decision-making are more likely to keep children safe, rebuild trust, and reduce the risk of future harm.

Through its monitoring, research and policy advocacy, the Commission has reinforced that a system capable of protecting children who are missing, exploited, or invisible requires clarity of roles, well-supported practitioners, and strong coordination across all parts of the child protection system. The “When a Child is Missing” toolkit exemplifies this approach, providing a practical framework for ensuring children are located quickly, supported appropriately, and kept safe while their underlying needs are addressed.

Responding to absent, exploited, and invisible children requires a multi-layered approach: robust prevention strategies, coordinated and evidence-informed responses, and ongoing support that addresses the underlying causes of vulnerability. By embedding these principles across the child protection system, Queensland can ensure that all children in care - especially those most at risk - receive the protection, stability, and care they need to thrive.

The findings of the Royal Commission into Institutional Responses to Child Sexual Abuse highlight the heightened vulnerability of children in residential care to sexual exploitation, and the need for a more deliberate, coordinated and intelligence-led response. These recommendations recognise that sexual exploitation is often complex, hidden and facilitated across multiple environments, requiring system-wide alignment between child protection, law enforcement and service providers. Strengthening prevention, detection and response therefore depends on both integrated operational strategies and a shared understanding of the nature and scope of the risk. It recommended that:



All state and territory governments should develop and implement coordinated and multi-disciplinary strategies to protect children in residential care by:

- a. identifying and disrupting activities that indicate risk of sexual exploitation*
- b. supporting agencies to engage with children in ways that encourage them to assist in the investigation and prosecution of sexual exploitation offences (12.14)*

....

Child protection departments in all states and territories should adopt a nationally consistent definition for child sexual exploitation to enable the collection and reporting of data on sexual exploitation of children in out-of-home care as a form of child sexual abuse (12.15).

Nine years later this work has not occurred.

Taken together, these recommendations underscore the importance of both operational coordination and conceptual clarity. Without shared definitions, consistent data and aligned responses, sexual exploitation remains difficult to identify, measure and disrupt. Implementing these reforms would strengthen the system's ability to recognise patterns of harm, support children to safely disclose their experiences, and ensure that perpetrators are identified and held to account. Ultimately, they point to the need for a more proactive, intelligence-informed and child-centred approach to protecting children in residential care.

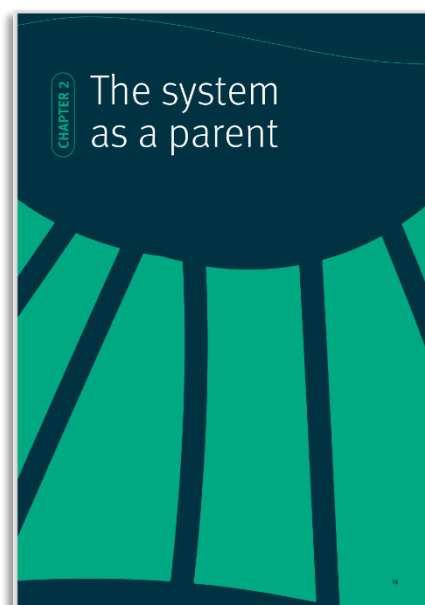
Recognise Government's obligation to life-long parenting

A successful child protection system not only safeguards children's immediate needs but also ensures long-term stability, development, and opportunity.

- Raising expectations, 2025.

Supporting children in care requires recognising that parenting is inherently a long-term responsibility. When the state assumes the role of caregiver, it must also accept the long-term obligations that come with that role. Programs and supports designed to assist young people transitioning from care into adulthood are an important example of this principle. Initiatives such as extended support arrangements, financial assistance and ongoing access to services acknowledge that young people leaving care often require additional support as they establish independence.

The Commission's work highlights the importance of initiatives such as extended post-care support programs, targeted financial assistance and long-term service access - ensuring that young people leaving care are not expected to navigate adulthood without support.



Like most other parents, the state should be investing in the asset base of children in care. These personal assets – beds, rugs, desks, toiletries, linen, electronic equipment, posters/art, luggage, sporting gear – are all elements that will aid the transition to independent living and provide a more stable platform for the day the young person is “exited from care”.

– A System that Cares, 2024.

Ultimately, improving the life outcomes of children in care requires a system that behaves in the way a good parent would. This means providing stability, encouragement, opportunity, and long-term commitment. It involves celebrating achievements, supporting education and aspirations, and maintaining relationships that provide emotional security and a sense of belonging.

In Raising Expectations, I said:

If Australia wished to change life outcomes and strengthen social prosperity, any person with a care experience - of any age - could be provided with priority access to selected services. This would recognise both the enduring impact of harm experienced in childhood and the particular role government has played in shaping their early lives.

Applying this support retrospectively acknowledges the consequences of “government parenting”, including multiple placements, missed family contact visits, unapproved school excursions, and the anxiety associated with the “end of care cliff”.

Applying this support prospectively would encourage the care system to raise children as if they are “in care for life”. This would shift the focus toward supporting career aspirations, nurturing hobbies and interests, investing in a child’s worldview, strengthening identity and belonging, and enabling a gradual and supported transition to independence.

A system that adopts this mindset moves beyond reactive crisis management and instead focuses on the lifelong wellbeing of children. Placing children’s rights, relationships, and opportunities at the centre of policy and practice ensures that children in care are not only protected from harm but also supported to thrive, develop resilience, and reach their full potential.

To achieve this, the system must also embrace transparency, acknowledge vulnerabilities, and foster a culture of learning. Transparency is essential to build trust, both with children and families and within the broader community. Children, carers, and practitioners should understand how decisions are made, what standards are expected, and how concerns can be raised and addressed. Transparency also supports accountability, making it easier to identify when the system is failing and to take corrective action.

When we think about how a parent should care for their child, time and age are inconsequential. My children are fast becoming adults, yet they rely on me today just as much as they did in their first year of life. And they can expect to receive support from me for as long as I am able to provide it.

Likewise, I am a few years past 21 - we won’t say how many - and I still need my parents’ advice, guidance and support. A young person doesn’t stop needing love and support when they wake up one morning at age 22.

Support for children and young people should not abruptly end at any age. It should continue for as long as it’s needed. If a parent’s role is enduring, shouldn’t support for children in care endure, too?

I’d like to see Queensland offer support to people with a care experience for as long as they need it, throughout their entire lives. I would like them to know they can try and fail, because they have a safety net around them. I’d like them to be able to access the guidance and support I know my kids will receive.

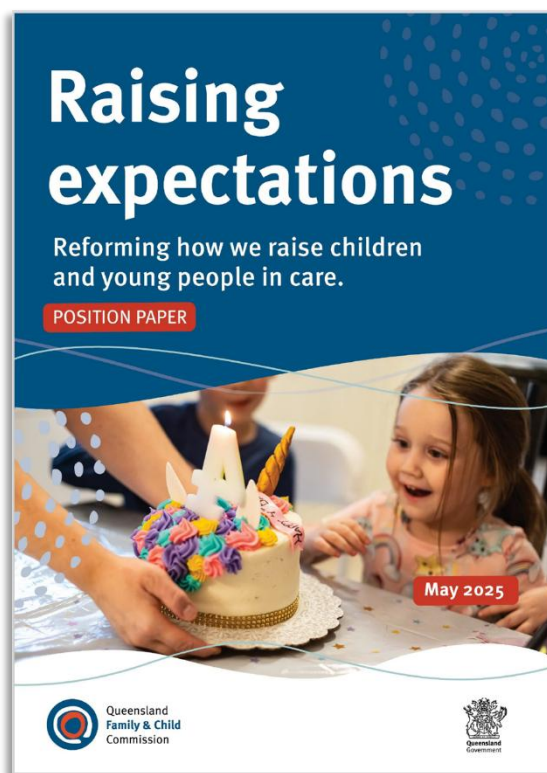
- Luke Twyford, Speech Reimagining out-of-home care support, 2023.

Recognising system vulnerability is equally important. Children in care are among the most disadvantaged and exposed populations, and their safety and wellbeing rely on the ability of the system to respond quickly to risk, prevent repeated harm, and ensure continuity of care. Acknowledging the limitations of the system - including workforce pressures, information gaps, and inter-agency fragmentation - allows leaders and practitioners to proactively mitigate risks rather than ignoring or reacting only when failures occur.

A learning culture complements both transparency and vulnerability. By systematically reviewing cases, analysing patterns, and applying lessons from both successes and failures, the system can improve continuously. Learning should occur at multiple levels:

- Individual practice, where caseworkers and carers refine their approaches based on evidence and reflection.
- Team and organisational levels, where agencies identify trends, address recurring issues, and share best practice.
- System-wide, where insights inform policy reform, resource allocation, and service commissioning to strengthen the overall network of support for children.

Embedding these principles ensures that the system is adaptable, responsive, and accountable, capable of both protecting children from immediate harm and supporting them to achieve positive long-term outcomes. A transparent, self-reflective, and learning-oriented child protection system not only responds to crises but actively cultivates environments in which children in care can flourish, mirroring the consistency, care, and guidance they would receive in a nurturing family.



The review and re-development of national standards must centre the very human experience of parenting and reflect ‘what a good parent would do’.

- Raising Expectations, 2025

Part 5: Establish a System Capable of Transformation and Continuous Improvement

Systems under sustained pressure - particularly those tasked with managing high risk - tend to become defensive in both culture and practice. In child protection, where the consequences of failure are severe and highly visible, this dynamic is especially pronounced. Decision-making environments characterised by scrutiny, time pressure and accountability for adverse outcomes create strong incentives to avoid error, manage exposure and demonstrate procedural compliance. Over time, this can shift the system's centre of gravity from learning and improvement toward risk containment and self-protection.

To conclude my formal advice, I posed the question “Can a system reform itself?”. Nearly 18 months on from the review’s commencement, the answer in this case, is no.
- Too Little Too Late, 2024.

Management and leadership research describes this phenomenon through the concept of “organisational defensive routines,” first articulated by Chris Argyris. These routines are patterns of behaviour and decision-making that organisations adopt to avoid embarrassment, blame or threat, often by suppressing dissent, limiting transparency or deferring difficult conversations. In practice, this can manifest as risk-averse decision-making, over-reliance on process, and a tendency to prioritise defensibility over effectiveness.

In high-pressure public sector environments, these dynamics are reinforced by structural factors. Research shows that bureaucratic rigidity, formal accountability mechanisms and cultures of risk aversion can create conditions that are “hostile to creative thinking” and inhibit innovation. Where performance is judged against compliance with rules rather than outcomes, practitioners are less likely to experiment, adapt or exercise discretion, even where doing so would better meet the needs of children and families.

These defensive conditions have a direct impact on reform and innovation. Reform efforts introduced into defensive systems often encounter passive resistance, reinterpretation or superficial compliance. Initiatives may be formally adopted but not meaningfully embedded in practice, as attention is diverted toward managing perceived risks associated with change rather than realising its intended benefits. Research on innovation implementation highlights that emotional tension, lack of trust and disengagement can redirect staff attention away from reform efforts and toward self-protective behaviours. This helps explain why implementation failure is a persistent feature of pressured systems. Reforms are layered onto existing structures without addressing the underlying cultural and behavioural dynamics that shape how work is done. Addressing this requires more than new policies or program design. It requires deliberate leadership action to reduce defensiveness and create conditions for learning. This includes fostering environments where challenge is encouraged, mistakes are examined rather than concealed, and accountability is balanced with support. It also requires aligning performance expectations with outcomes rather than procedural compliance alone, and ensuring that reform efforts are accompanied by the trust, capability and clarity needed for implementation.

Ultimately, a system consumed by risk will struggle to reform itself unless it can shift from a culture of defence to a culture of learning. Without this shift, even well-designed reforms are likely to be diluted in practice, limiting their impact on the safety and wellbeing of children.

In *Too Little Too Late* I found that:

1. Action has not been sufficiently bold or broad ranging
2. Action has been too slow and has not adequately recognised the impact of delay on children in residential care homes
3. A culture of fear and defensiveness has impacted transparency and skewed priorities
4. Young people are still excluded from the reforms and continue to live in substandard homes

For Queensland, transformation within the child protection and family support system requires more than isolated reforms within a single agency. It requires stronger collaboration across government, deeper partnerships with the community sector, and clearer strategic direction for how governments invest in and measure outcomes for children. Establishing these foundations is essential if the system is to move beyond reactive responses and develop a sustained capacity for improvement.

...it is clear that the Department is not leading bold, urgent and impactful change to the residential care system. Instead, I have found an ongoing propensity to continue tinkering with the current ineffective system. Actions taken have invariably been those that benefit the Department, rather than those that benefit the children. ...More importantly, I continue to meet young Queenslanders who live in homes that are not loving, caring or safe. Ultimately I conclude that the Department has not taken steps to implement the bold actions required to reimagine and rebuild “a system that cares”.

- *Too Little Too Late*, 2024.

Establish cross-government responsibility for outcomes

The safety and wellbeing of children cannot be achieved by the child protection system alone. Children’s lives are shaped by a wide range of government services, including education, health, housing, justice, and community services. Each of these sectors plays a critical role in influencing long-term outcomes, from supporting learning and development to safeguarding physical and mental health and ensuring access to safe housing and social participation.

The Commission has consistently emphasised the importance of cross-government responsibility for children in care. I believe that better outcomes are achieved not through isolated interventions, but through coordinated policies, shared accountability, and sustained collaboration across government portfolios. When agencies operate in silos, children in care are at risk of experiencing fragmented services, inconsistent support, and repeated transitions between systems that do not communicate effectively.

Recently at the November 2024 Transition to Adulthood Month event in Ipswich I was approached by one of the young girls who bravely stood up and spoke about her time in residential care at the 2023 Ministerial Residential care Review Roundtable.

“Whatever happened with that?” she asked.

- Too Little Too Late, 2024.

Evidence reviewed by the Board demonstrates the consequences when cross-government responsibility is lacking. Many children and young people did not have their basic and fundamental needs met, with essential systems such as health, education, and housing less involved in their lives than the justice system. Practitioners who had close care and connection to these young people often struggled to implement solutions, while adults in the broader community were able to exploit them. The Board concluded that a fundamental recalibration of social responsibility is required to ensure that children in state care are prioritised across all aspects of government service delivery.

We recommend the Department of the Premier and Cabinet (DPC) facilitate the publication of commitments from each portfolio Minister or Director-General regarding their commitment to children in state care. This public commitment should include responsibilities regarding the core business of the portfolio, as well as broader employment, training, economic and work placement opportunities.

- 2023–24 Child Death Review Board Annual Report

The Board’s recommendation highlights the urgent need for public, portfolio-wide commitments that embed the interests of children in care into the core functions of every government department. Such commitments signal that children in care are a shared societal and governmental responsibility, not the responsibility of child protection practitioners alone.

Achieving this vision requires a whole-of-system approach in which all government workers - from bus drivers, schoolteachers, housing officers, and librarians - recognise children in state care as partially their responsibility to support and safeguard. It means ensuring that access to services is fair, equitable, and attentive to the specific vulnerabilities of children in care, rather than treated as generic service delivery. Every interaction should contribute to safety, stability, and opportunity.

Embedding cross-government responsibility also requires clearer governance mechanisms, shared outcomes, and accountability frameworks. Portfolio leaders should be required to articulate their commitments, monitor performance, and report publicly on how their policies and programs improve the lives of children in care. Coordinated planning, joint service delivery, and cross-agency data sharing can further strengthen accountability and ensure that children experience consistent, supportive and connected services across their childhood and adolescence.

Ultimately, the Commission and the Child Death Review Board envision a system where children in care are not overlooked by broader society or government. Instead, through shared responsibility and systemic accountability, Queensland can ensure that all children in care have their needs prioritised, feel supported across multiple domains of life, and experience a continuity of care and opportunity that reflects their rights and potential.

In alignment with the In Plain Sight recommendation, Queensland should allocate clearer Ministerial accountability and cabinet priority for the holistic safety and wellbeing of Queensland's children – and explicitly those in State care. The factors that influence children's safety and wellbeing span multiple areas of public policy, including housing, health, education, justice, community services and economic policy. As a result, no single agency can deliver improved outcomes for children in isolation.

The Education, Health, Police, Housing, Justice and Communities portfolios all play a primary and significant role in the lives of young people – and having frontline workers, Executives and Ministers in those areas recognise that children in state care should be treated like “their children” would go a long way in changing the life outcomes for children in care.

– A System that Cares, 2024.

Mandate transparency with public reporting across the system

A system capable of transformation must also be capable of measuring its performance and learning from the results. Transparent reporting on the wellbeing of children across Queensland is therefore a critical component of system improvement. Transparency is a foundational element of self-reflection and system improvement. Greater transparency also supports informed public discussion about child protection policy and helps ensure that reforms are grounded in evidence rather than anecdote.

A co-design process to create a transparent performance framework that is holistic and focussed on the life outcomes for young people in residential care should be finalised this financial year.

– A System that Cares, 2024.

The Commission's work has highlighted the importance of regular and accessible reporting on key indicators relating to children's safety, wellbeing and life outcomes. Transparent reporting should include information on the performance of statutory services, the quality of out-of-home care placements, and the broader conditions affecting children and families across Queensland.

The Commission's monitoring functions play an important role in providing independent insight into how children are faring across a range of indicators, including safety, health, education and social participation. Regular, accessible reporting allows policymakers, service providers and the broader community to understand both progress and ongoing challenges. Transparent reporting also strengthens accountability by ensuring that governments and service systems remain focused on improving outcomes for children over time.

Together, these elements form the foundation of a system capable of sustained transformation and improvement.

By strengthening cross-government collaboration, building effective partnerships with the sector, establishing clear strategic direction for children, aligning investment with priorities, and maintaining transparent reporting on outcomes, Queensland can create a child and family support system that continually learns and adapts in pursuit of better outcomes for children.

During the process of the regional forums, the Commission noted significant sensitivity about data held regarding residential care. We also noted a clear gap between the data held by providers and the Department, and the opportunity for all parties to be more transparent about the current outcomes being achieved across the system.

– Residential care review: September 2023 monthly report, p. 10.

A system committed to improvement must also be transparent about its performance. Regular reporting on key indicators - such as investigation quality, placement stability, workforce capability and outcomes for children - provides valuable insight into how the system is functioning.

Transparent reporting strengthens accountability within the department is therefore an essential component of building a child protection system capable of delivering consistent, high-quality outcomes for children.

There are many profound reasons why the Department needs to bring transparency to the residential care, and indeed, the out-of-home care system. In *Too Little Too Late* I said:

“The defensiveness and fear that is pervading their interactions with the sector and their regulators is hampering best practice – and more fundamentally the defensiveness is protecting a system that is not optimal. There are many good philosophies that demonstrate that behaviour change starts with admission – Nhat Hanh says “true change comes not by trying to suppress what is wrong but by acknowledging it and working through it”. Covey says “when we accept our flaws, we can work to overcome them”. Duhigg says “to make progress you have to admit where you are failing, and only then can you chart a path forward”. For the Department to mark every item of the 31 Action items in the Roadmap (including 19 first year actions) as being “implemented” or “on track” while there are no new models or service standards, no new performance framework, and while the number of young people in residential care has grown by 19 per cent is a failing in transparency and system accountability”.

Importantly this lack of transparency fundamentally impacted a reform plan and I recorded that *“Throughout the completion of the Review, and the implementation of the Roadmap, this culture of defensiveness and lack of transparency has impacted the speed and success of implementation. The governance board established to monitor and support implementation has been denied knowledge on the current numbers of children in care, and number of care providers – meaning that at the July and September meetings the members used the March public data”*. If Queensland wishes to successfully deliver a sustained improvement to its child protection system, there must be vastly improved transparency on its reform intent, and its implementation status.

It is my strong view that the Queensland Government should strengthen transparency, accountability and system learning by adopting a shared child and youth wellbeing outcomes framework and mandating a public reporting mechanism on the safety and wellbeing of Queensland children and families. This should include:

1. Adopting and operationalising a shared child and family wellbeing outcomes framework, based on the Nest Child and Youth Wellbeing Framework, to guide policy, program design, service delivery and investment decisions across government and the community sector.
2. Mandating (under section 40 of the Queensland Family and Child Commission Act 2014) an annual public report on the wellbeing of Queensland children and families, drawing on the established Growing Up in Queensland reporting framework already produced by the Queensland Family and Child Commission.
3. Using the report to track progress against shared wellbeing outcomes, providing a transparent and accessible overview of how children and young people are faring across key domains of wellbeing and safety, and thereby establishing a Centre of Excellence to translate emerging science, evidence and lived experience into improved policy, program and practice design, and to support workforce and organisational capability development across the child and family system.

Strengthen oversight mechanisms for reform implementation

Over the past decade, the child protection and family support system has been the subject of extensive review, inquiry and reform. These processes have generated a substantial body of recommendations, many of which are well-founded, evidence-based and widely supported, however, the impact of these reforms is not determined by their intent or design, but by the discipline and consistency of their implementation.

After 6 months of review and planning, and 10 months of implementation, it is not clear what benefit children living in residential care have received from the Review or the Roadmap. - Too Little Too Late, 2024.

The Commission’s work highlights a persistent gap between reform commitment and reform delivery. Too often, recommendations are accepted in principle but diluted in practice - losing clarity, momentum or fidelity as they move through complex governance, funding and operational environments. This creates a cycle in which new reviews identify similar issues to their predecessors, not because solutions are unknown, but because implementation has been partial, inconsistent or unsustainable. In Too Little Too Late I found that:

The residential care review started with bold intentions. It would reform the system to prevent children under 12 being placed in residential care; it would halve the number of placements (as a proportion of placements), and it would increase the quality of care provided to the then 1,763 young people who lived in care..... In their design each of these deliverables would provide a pathway for a higher quality, lower volume residential care system. One year on, none of the above first year actions have been completed, and the lack of new models of care against new service standards with a new performance framework means that the old system continues to operate – and its use has grown. In my travels I have met staff in the child safety department that do not know how the Roadmap should change their practice. Providers of residential care services have asked where the reform is up to. Young people say they can see no difference.

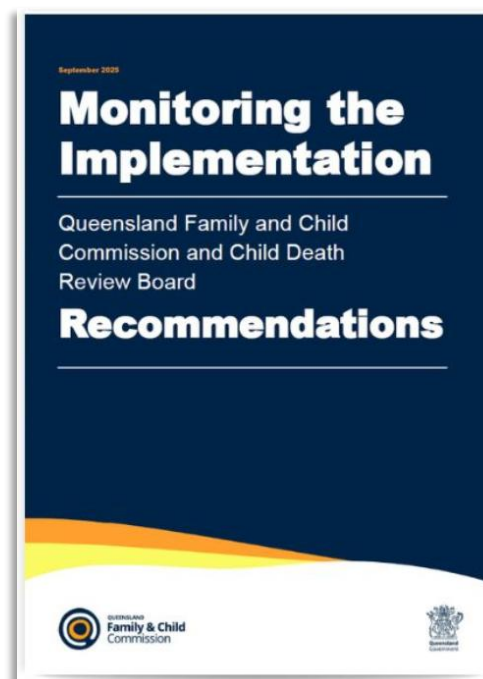
- Too Little Too Late, 2024.

Strengthening implementation mechanisms is therefore central to achieving meaningful and lasting reform. This begins with greater precision at the point of commitment. Reform actions must be clearly defined, with explicit objectives, deliverables and success measures. Ambiguity at this stage creates downstream risk, allowing reforms to be interpreted variably across agencies and regions, and limiting accountability for outcomes.

Clear allocation of responsibility is equally critical. Implementation requires identifiable ownership at both the agency and executive level, supported by governance structures with the authority to coordinate across organisational boundaries. Given the inherently cross-system nature of child protection - spanning health, education, justice and community services - effective implementation cannot rely on siloed accountability. It must be actively managed through shared frameworks, joint planning and collective oversight.

Timeframes must also be realistic, transparent and enforced. Open-ended or loosely defined timelines contribute to reform drift, where priorities shift and delivery is deferred. In contrast, staged implementation plans, with defined milestones and regular reporting, provide structure and maintain momentum. They also enable early identification of barriers, allowing for timely course correction rather than retrospective explanation.

Monitoring and evaluation are essential components of this architecture. Implementation should not be assessed solely on whether actions have been completed, but on whether they have achieved their intended impact. This requires the development of meaningful performance indicators, supported by data systems capable of tracking change over time. Importantly, these



measures should include both system-level indicators and the lived experiences of children, young people and families.

Transparency plays a critical role in reinforcing accountability. Public reporting on reform progress - grounded in clear, accessible metrics - helps to maintain focus and build confidence in the system's capacity to improve. It also creates an external discipline, ensuring that commitments made in response to reviews and inquiries are not lost amid competing priorities.

Finally, effective implementation requires a culture that values learning as much as compliance. Reform in complex human services systems is inherently iterative. Not all initiatives will succeed as intended, and some will require adaptation in response to emerging evidence or changing circumstances. Embedding mechanisms for feedback, reflection and continuous improvement ensures that implementation remains dynamic and responsive, rather than rigid or procedural.

Without these structured approaches, there is a significant risk that reform efforts will continue to under-deliver, resulting in fragmented change, uneven practice and missed opportunities to improve outcomes for children and families.

Strengthening implementation mechanisms is therefore not an administrative exercise; it is a foundational requirement for translating policy intent into meaningful, system-wide impact. A Government and a departmental strategy for quality transformation can provide a structured framework for achieving these improvements. Such a strategy would articulate clear quality standards, establish mechanisms for monitoring and evaluation, and support the adoption of evidence-informed practice models. Importantly, a quality transformation strategy must also create a culture that encourages learning and improvement, where feedback from children, families, practitioners and service providers informs ongoing reform.

The implementation approach for the Roadmap had two distinct options: one focused on immediate action by creating new services and models and refining them through iteration and evaluation, while the other approach involved further consultation, research, and small pilots to build an evidence base before taking action. The first approach prioritised the immediate well-being of children in a suboptimal system, while the second primarily served the interests of bureaucrats and treasury by minimising professional risk and effort. It appears that at some point after the Roadmap's launch, the second, more cautious approach supplanted the first, shifting the focus away from urgent systemic change.

– Too Little Too Late, 2024.

Develop a whole-of-government strategy for children

One of the challenges in improving outcomes for children is the fragmentation of policy initiatives across different portfolios and agencies. While many government programs aim to support children and families, these efforts are not always aligned within a coherent overarching strategy.

The Commission has highlighted the value of developing a whole-of-government strategy for children that articulates a shared vision for children's wellbeing across Queensland. Such a strategy would establish clear priorities, identify key outcomes for children, and guide coordinated policy development across government. By aligning initiatives across portfolios, a whole-of-government strategy can help ensure that investments and reforms work together to improve outcomes for children rather than operating in isolation.

The Queensland Government should establish a long-term, whole-of-government Intergenerational Plan for Queensland's Families to guide coordinated action across health, housing, education, justice, and child and family services. The plan should provide a coherent, cross-sectoral framework for supporting children and families to thrive, preventing adversity where possible, and addressing the structural factors that contribute to intergenerational involvement in statutory systems. This should include:

1. Developing a whole-of-government, cross-sectoral Families Strategy that brings together policy, investment and reform efforts across sectors to provide a concerted, coherent and evidence- and experience-informed approach to supporting children and families.
2. Introducing legislative mechanisms to strengthen collective stewardship of the child and family system, similar to those contained in the Child Wellbeing and Safety Act 2005 (Victoria), requiring the heads of key Queensland departments to work together to address gaps, duplication and unintended harms arising from fragmented service systems.
3. Co-developing a whole-system statement of operating principles that sets out what families should expect in their interactions with government and community services, informed by frameworks such as the Ten Principles of Intensive Family Support developed through The Promise Scotland.
4. Embedding intergenerational and prevention-focused outcomes within the plan, ensuring that policy, service design and investment decisions are aligned to improving long-term wellbeing for children and families and reducing future demand on statutory systems.

Define a whole-of-government investment plan for children

A whole-of-government investment plan for children would provide a clearer picture of how resources are allocated across prevention, early intervention, statutory responses and post-care support. Such a plan would enable governments to assess whether funding is balanced appropriately across the system and whether investment decisions are supporting long-term improvements in outcomes. This approach also creates greater transparency about the resources dedicated to children's wellbeing and would support more informed decision-making about future investments.

The Commission's work highlights the need for a transparent, outcomes-focused investment framework that links expenditure to impacts for children and families across the service continuum. This includes clearly demonstrating how resources contribute to prevention, early intervention and long-term wellbeing, while enabling government to assess effectiveness and adjust investment in response to evidence.

Funding models must evolve from short-term, siloed allocations to dual-purpose, outcomes-based structures that support both early intervention and responsive care. This includes integrated commissioning across Justice, Health, and Education, reflecting the real-world complexity of children’s lives and incentivising coordinated responses.

- Buyer beware, p36

The Queensland Government should strengthen the strategic investment in holistic family and parenting support through a coordinated, long-term approach to prevention and early intervention that aligns funding, improves system effectiveness, and ensures communities are actively involved in shaping local solutions. This should include:

- Developing a Prevention and Early Intervention Investment Framework, informed by models such as Victoria’s and the recent recommendations of the Productivity Commission.
- Commissioning an investment review to document the existing Commonwealth and State funded family, child and youth early intervention programs, as well as parenting and family support services and include in this study the return on investment of current parenting support expenditure.
- Developing long-term, outcomes-focused, multi-agency investment plans to achieve a better balance of funding toward prevention and early intervention, reduce duplication and gaps across programs, and improve system performance.
- Engaging local communities in investment decisions, including through the development of long-term regional investment plans to ensure programs are fit for purpose and context, and trialling pooled funding arrangements at regional and place-based levels across related State, and where appropriate Commonwealth and philanthropic, funding streams.

Part 6: Reform Departmental Structures to Support Quality and Improvement

The effectiveness of the child protection system is shaped not only by legislation and frontline practice, but also by the organisational structures that govern decision-making, accountability and resource allocation. Organisational arrangements within departments must support quality practice, strong workforce capability and effective management of the hybrid model in which government retains statutory authority while outsourcing many services to be delivered by non-government organisations.

A system that aspires to deliver better outcomes must therefore examine how departmental structures support prevention, enable strong operational leadership, and create the conditions for continuous improvement. Reform in this area is not primarily about expanding bureaucracy, but about ensuring that the organisational architecture of government is aligned with the outcomes it seeks to achieve.

Confirm and clarify the department's role in prevention of child abuse and align investment

Clarifying the department's role in the prevention of child abuse and neglect is fundamental to a more effective and sustainable system. While statutory services are designed to respond to harm, long-term reductions depend on strong prevention and early intervention. At present, the department's role in this landscape is not consistently defined. This creates ambiguity in leadership, accountability and system coordination. Greater precision is required. This includes clearly articulating the department's role in shaping early intervention strategy, coordinating with universal and targeted services, and ensuring that insights from statutory practice inform upstream responses. Without this clarity, prevention risks becoming diffuse resulting in fragmented effort and missed opportunities to intervene earlier.

Clarity is equally critical at the system level. If the department is not the lead agency for prevention, responsibility must be explicitly assigned elsewhere, with clear accountability for policy leadership, investment coordination and outcomes. In this model, strong interfaces with the statutory system are essential to ensure that intelligence about risk, service gaps and escalation pathways informs prevention efforts, and that families can move seamlessly across service tiers.

If the department is to play a central prevention role, this must be matched by clear expectations and effective use of system levers. Investment, commissioning, practice frameworks and performance settings must be deliberately aligned to support early intervention. Without this, funding will continue to be drawn toward crisis response, reinforcing demand on the statutory system rather than reducing it. Importantly safeguards will be required to prevent the erosion of prevention capacity. In high-demand environments, resources are often redirected to meet immediate statutory pressures, creating a cycle that further limits early intervention. Without deliberate system design, this dynamic can result in a cycle where increasing demand on the statutory system further reduces the capacity to invest in prevention, which in turn drives additional demand. Dedicated funding, explicit performance measures and strong governance arrangements are necessary to ensure prevention remains a sustained priority.

Ultimately, clarity of responsibility - whether within the department or elsewhere - is a precondition for an effective prevention system. It enables purposeful leadership, coherent

investment and meaningful accountability, and supports a shift from responding to harm toward reducing the conditions that give rise to it.

Ultimately, clarity of responsibility for prevention - whether located within the child protection department or elsewhere - is a precondition for an effective child protection system. It enables purposeful leadership, coherent investment, and meaningful accountability. It signals a shift from managing risk at the point of crisis to actively reducing the conditions that give rise to harm. In doing so, it supports a more coherent, efficient and child-centred system - one that is capable not only of protecting children, but of preventing harm before it occurs.

Restructure the department for both central accountability and regional responsibility

Child protection systems operate across diverse communities with different social, cultural and geographic contexts. Effective responses therefore require both strong central leadership and the flexibility for regional decision-making. My experience has highlighted the importance of departmental structures that combine clear central accountability with meaningful regional responsibility. Central leadership is necessary to establish policy direction, maintain consistent standards, control market leavers and ensure system-wide performance oversight. At the same time, regional structures allow services to respond to local conditions, build relationships with community organisations, and tailor interventions to the needs of local communities and families. Balancing these elements can strengthen both consistency and responsiveness within the system.

In Queensland's child protection system, decisions about how children are supported and protected should occur as close as possible to the children, families and communities concerned. Those who work directly with children - frontline practitioners, carers, community organisations and local service partners - are best placed to understand risk, relationships and the practical realities of a child's life. For the system to function well, authority and responsibility for action must therefore sit at the frontline, enabling those closest to children to make timely, informed decisions and to tailor support to local circumstances.

This requires a deliberate shift away from a proceduralised and rule-based model where families and communities are expected to fit within rigid bureaucratic processes. Instead, the system should be organised around children's needs, with resources, professional discretion and collaborative decision-making located at the local level. Local teams and partner organisations must be empowered not only to deliver services, but also to shape how those services operate in practice, including involving children, families and communities in the design and delivery of support.

However, empowering local decision-making cannot mean diffusing accountability. In a high-performing system, accountability for outcomes must be clearly centralised. The centre must hold responsibility for the overall performance of the system: whether children are safer, whether families receive effective support, and whether services operate consistently and fairly across the state. Central leadership should set clear expectations, monitor performance, ensure transparency, and intervene where systemic problems emerge. This approach combines decentralised responsibility with centralised accountability. Those closest to children must have the authority to act, while the centre remains accountable for whether the system as a whole protects children and supports families effectively.

There will also remain areas where state-level coordination and intervention are essential. Some challenges, such as system-wide accountability, workforce capability, performance monitoring, the operation of the care market, and cross-agency collaboration, cannot be resolved by local actors alone. In these areas, strong central stewardship is necessary to set the conditions for effective practice across Queensland. The guiding principle should therefore be clear: action happens locally, accountability sits centrally. By empowering those closest to children to act, while holding the centre responsible for outcomes, Queensland can build a child protection system that is both responsive to families and accountable for the safety and wellbeing of children.

Increase internal accountability for the quality of outsourced service delivery

A defining feature of Queensland's child protection system is that a substantial proportion of frontline service delivery sits outside government. Foster care, residential care and a wide range of family support services are delivered by non-government organisations, while the statutory authority for decision-making remains with the State. This has created a hybrid system in which accountability for outcomes remains public, but delivery is largely outsourced.

The scale of this model is significant. Approximately 75 per cent of the Department's out-of-home care expenditure is directed to external providers. In effect, the Department's primary business is no longer direct service delivery, but commissioning, purchasing and overseeing services. This represents a profound shift in operating model—one that has not always been matched by a corresponding shift in capability, culture or accountability settings. Traditional professional training pathways, particularly in social work, do not emphasise commissioning, market stewardship or contract management. Yet these are now central to achieving outcomes for children.

Restoring value in these sectors requires a new generation of economic thinking: one that blends market discipline with public accountability, strengthens the state's purchasing capacity, and places public outcomes at the heart of funding design. Only then can we ensure that the vast public investment in essential services translates into real, lasting public value.

– Buyer beware, 2025.

The implication is clear: the Department must strengthen its internal accountability for the quality, safety and effectiveness of the services it purchases. Outsourcing does not dilute responsibility. Rather, it heightens the need for strong internal disciplines that ensure public funds translate into safe, consistent and high-quality care. The current system will only deliver sustained improvements if the Department treats commissioning and oversight as core business, rather than administrative functions. Strengthening internal accountability requires a deliberate uplift across several interconnected mechanisms.

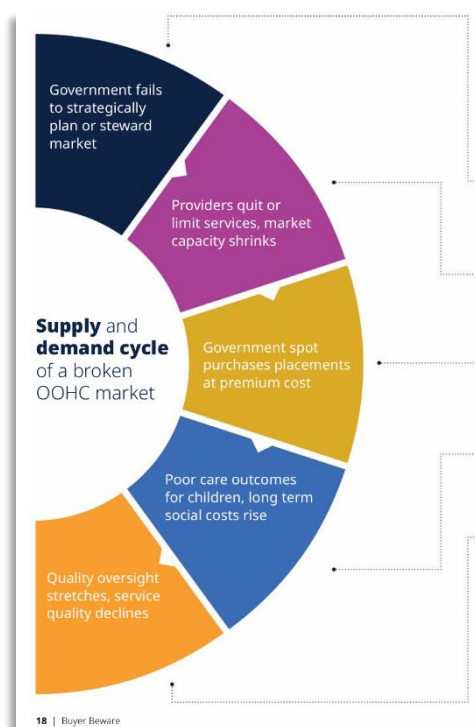
First, the Department needs a more mature commissioning framework. This includes clearly articulating the outcomes it is purchasing, aligning funding models to those outcomes, and designing service systems, not just individual contracts, that respond to the needs of children

and families. Commissioning must move beyond transactional procurement toward strategic market stewardship, where the Department actively shapes the service landscape, signals expectations and intervenes where quality or capacity is insufficient.

Second, contract management must be significantly strengthened. Contracts should set unambiguous expectations regarding safety, quality, workforce capability and practice standards; however, the existence of contractual clauses alone is insufficient. The Department requires a professionalised contract management function, with staff who are skilled in relational contract management, performance monitoring, provider engagement, risk identification and escalation. This includes the ability to interrogate data, test provider assurances and respond decisively where performance falls short.

Third, robust quality oversight mechanisms are essential. This involves establishing consistent, system-wide approaches to monitoring service quality, including regular audits, practice reviews and direct engagement with children and families about their experiences of care. Quality oversight should not rely solely on provider self-reporting but incorporate independent verification and triangulation of information. Critically, oversight must be capable of identifying early warning signs of deterioration in service quality, rather than responding only after harm has occurred.

Fourth, the Department must strengthen its use of data and intelligence. In a distributed service system, visibility of risk depends on the ability to aggregate and analyse information across providers, regions and service types. This includes developing integrated data systems, enhancing analytical capability and ensuring that insights are translated into operational decisions. Without this, the Department remains reliant on fragmented information and is unable to exercise effective system stewardship.



The stewardship role of government in such an environment is not optional. It cannot be outsourced. It requires an active presence in the market, with clear direction, commissioning intelligence, price and quality monitoring, and investment in systemic reform. Queensland has not embraced this role. Its failure to do so has led to a market that is both structurally weak and financially unsustainable.

– Buyer beware, 2025.

Fifth, Departmental governance arrangements need to explicitly recognise commissioning and oversight as core functions. This includes clear lines of accountability at senior levels for the performance of outsourced services, as well as mechanisms to ensure that information about provider performance informs executive decision-making. Commissioning, contract management and quality assurance functions should be structurally embedded and sufficiently resourced, rather than dispersed or secondary to other priorities.

Delivering on these mechanisms requires a corresponding uplift in workforce capability. The Department needs to invest in developing a cadre of professionals with expertise in commissioning, procurement, contract law, data analysis and market management, alongside strong practice knowledge of child protection. This is not about replacing social work expertise, but complementing it with the skills required to operate effectively in a mixed delivery system. Building this capability may require new roles, targeted recruitment and structured professional development pathways.

Finally, there must be a cultural shift in how accountability is understood. The Department must see itself not only as a statutory decision-maker, but as the steward of a complex service system. This means taking active responsibility for the performance of that system, including the services delivered by partners. Where quality is insufficient, accountability rests not only with providers, but with the Department's own commissioning decisions, contract settings and oversight practices.

Recognising and supporting commissioning and oversight as core departmental capabilities will strengthen accountability and improve the quality of services delivered across the sector. In a system where most care is outsourced, the effectiveness of government is ultimately defined not by what it delivers directly, but by how well it designs, purchases and governs the services delivered on its behalf.

Queensland's residential care system is at a tipping point. Despite significant expenditure, outcomes for children remain inconsistent, and the system continues to operate in a reactive, fragmented manner.

Escalating rates of children entering OOHC, rising costs, and fragmented service delivery reflect a system that is reactive rather than responsive. The increasing complexity of children's needs, coupled with the instability of placements and casualisation of the workforce, demands a fundamental shift - not just in how services are delivered, but in how the system is designed, governed, and funded.

– Buyer Beware, 2025.

Part 7:

Strengthen Oversight and Accountability Mechanisms

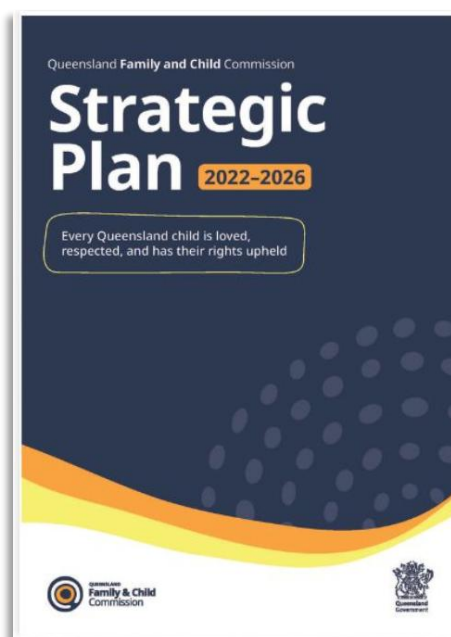
Strong oversight architecture, effective implementation of reforms, and accessible complaints and review processes are essential safeguards within a system that holds significant power over the lives of children and families.

A high-functioning child protection system requires strong oversight and clear accountability. Systems that exercise significant authority over children and families must operate transparently and be subject to independent scrutiny. Oversight serves several distinct but interconnected purposes. It promotes transparency, ensures that reforms are implemented as intended, provides mechanisms for evaluating system performance, and offers pathways for children, families and carers to raise concerns when systems fail to meet their needs. Strengthening these mechanisms is essential for maintaining public confidence and ensuring that the system continues to improve over time.

Public systems that aspire to accountability and excellence cannot rely solely on compliance-based or siloed mechanisms. A holistic model that integrates complaints, advocacy, evaluation, oversight, incident response, performance monitoring, legal appeals, and administrative review is required to enable Queensland to not only to detect failure but to learn, improve, and transform the child protection system.

– PCMR Submission to COI complaints and incidents, 2026.

Taken together, this approach recognises that oversight is not simply about identifying problems after they occur. It is about creating a connected architecture that enables information from complaints, reviews, investigations and performance monitoring to inform system-wide reform. When these mechanisms operate in isolation, insights are fragmented and opportunities for improvement are lost. When they are integrated and actively used, they strengthen accountability, support better decision-making and help ensure the system evolves in response to the experiences of children and families.



Build an independent evidence base of contemporary Queensland child and family needs

A child protection and wellbeing system can only function effectively if it is informed by relevant, reliable and accessible information about the lives of children across Queensland. Through our 2024 Growing Up in Queensland Report, the Commission demonstrated that a comprehensive source of data on children's wellbeing is readily available, and that it is not regularly or routinely collected and curated. By compiling this data we were able to tell the regionalised story of child and family wellbeing drawing on the Australian Research Alliance for Children and Youth (ARACY) Nest Wellbeing Framework. This framework identifies the key conditions children require to thrive – individually, as a family, and within a community. These domains include good health and development, learning and engagement, positive relationships, participation in community, access to material basics, and a strong sense of culture, identity and belonging. Safety is one of these domains, but it cannot be separated from the others.

The Growing Up in Queensland Report and the associated Data Explorer provided a shared evidence base for government, service providers and communities to understand emerging risks, identify inequities and monitor whether policies and interventions were making a meaningful difference.

Without this evidence foundation, decision-making risks being driven by isolated incidents, incomplete information or institutional assumptions rather than by the real experiences of children. Reliable statewide information allows leaders to track trends over time, compare outcomes across regions and population groups, and focus attention on the factors that most influence children's safety, health, development and connection to family and culture. In this way, a trusted evidence base becomes essential not only for accountability, but also for ensuring that the child protection system - and the broader service system around it - responds to the actual conditions shaping children's lives in Queensland.

We need to recognise that children's safety is deeply connected to other dimensions of their wellbeing. By being explicit about the emerging and forecast needs of children and families, governments and communities can put in place prevention and early intervention strategies that reduce reliance, demand and pressure on the statutory child protection system.



The increasing reliance on residential care reflects pressures across the broader child protection system, including family stress, limited early intervention and declining availability of family-based care.
- A System that Cares, 2024

Establish a clearer and connected oversight architecture

Given the high stakes and life-long consequences of the decisions taken to intervene in families, and to remove, 'place' and reunify (or adopt) children, it is appropriate that the whole child safety system is under constant and robust public, stakeholder and official monitoring and accountability mechanisms.

The intent of the QFCC's oversight function is to conduct objective analysis to identify changes to laws, policies, programs and services that can improve outcomes for children, their families, and the community.
- QFCC Oversight Framework, 2023.

This oversight of child protection systems must operate at multiple levels, ranging from broad societal oversight to attention on individual incidents. Together, these different forms of oversight create a comprehensive framework that supports both systemic improvement and individual accountability.

- 1. Whole-of-society / Cross-portfolio oversight:** At the broadest level, oversight focuses on societal trends, intergovernmental coordination and cross-portfolio outcomes that affect children, young people and families.
- 2. Whole-of-system / Portfolio oversight:** This level focuses on the performance and coherence of an entire service system within a portfolio.
- 3. Programs and policies within a portfolio:** Oversight at the program or policy level evaluates specific interventions, funding initiatives, or policy instruments to ensure they are effective, evidence-informed and having the intended impact (or no unintended impact).
- 4. Cases and individuals:** Oversight at this level ensures accountability for the management of specific clients, families, or cohorts, providing direct line-of-sight into service delivery.
- 5. Incidents, complaints, and single decisions:** The most granular level of oversight addresses specific events, complaints, or individual administrative or operational decisions.

By structuring oversight functions across these levels, governments and agencies can ensure that oversight activity is proportionate, strategically focused, and integrated. Broad system-level oversight identifies trends, gaps and priorities, while granular oversight ensures accountability, fairness, and responsiveness at the individual level. Together, these layers of oversight can create a comprehensive framework that supports both systemic improvement and protection of individual rights – however if they are not coordinated or connected, they can create a tangled mess of reports and recommendations with little public-value or system improvement.

Aligning oversight activity to the appropriate level ensures resources are targeted effectively, accountability is maintained, and reforms are informed by evidence at every scale. Across these five levels the methodology and activity of oversight are vast, broad and specialised. They can include:

- 1. Public reporting and transparency functions** – Publishing findings, data and performance information to inform government and the community and support system-wide accountability.

2. **Policy and legislative advice** – Providing expert input to inform the development, implementation or reform of laws, policies and system design.
3. **Research and evidence generation** – Conducting or commissioning studies to build the evidence base on what works, for whom, and under what conditions.
4. **Standards development and benchmarking** – Establishing and maintaining practice, service or system standards, and comparing performance across jurisdictions or against agreed benchmarks.
5. **Outcomes measurement and performance reporting** – Developing and applying frameworks, indicators and metrics to assess progress against child, family and system outcomes.
6. **Thematic or systemic analysis** – Aggregating insights across multiple cases, reviews or datasets to identify recurring issues and drivers of system performance.
7. **Inquiries** – Broad, often independent examinations into systemic issues, typically resulting in public reports and recommendations for reform.
8. **Evaluations** – Structured assessments to determine the effectiveness, efficiency and impact of programs or policies against intended outcomes.
9. **Program logic and design assurance** – Reviewing the design of policies and programs to ensure they are evidence-informed, coherent and aligned to intended outcomes.
10. **Implementation assurance** – Monitoring and assessing whether reforms, recommendations or funded initiatives are being implemented as intended and achieving expected impacts.
11. **Continuous improvement and learning systems** – Embedding feedback loops, reflective practice and adaptive learning approaches to support ongoing system improvement.
12. **Data analysis and intelligence** – Examination of quantitative and qualitative data to identify trends, risks, patterns and emerging issues.
13. **Monitoring and compliance activities** – Ongoing oversight of performance and conduct to track whether organisations or systems are meeting legal, policy or performance requirements.
14. **Audits** – Independent examinations of processes, records or systems to assess compliance with legislation, standards or financial requirements.
15. **Practice and quality assurance reviews** – Assessing the quality and consistency of frontline practice against standards, frameworks or best practice expectations.
16. **Inspections** – On-site assessments of facilities, services or environments to ensure they meet required standards of safety, quality and care.
17. **Client and stakeholder surveys** – Structured tools used to systematically gather feedback from children, young people, families, carers and service providers about their experiences, outcomes and satisfaction.
18. **Experience and satisfaction measurement** – Ongoing collection and analysis of user-reported experience and satisfaction data to assess service quality and identify areas for improvement.
19. **Lived Experience / Voice of the child and family mechanisms** – Deliberate approaches to capturing and elevating the perspectives of children, young people and families, particularly in relation to safety, participation and wellbeing.
20. **Real-time feedback systems** – Tools that enable immediate or near real-time input from service users (e.g. after interactions or service delivery) to inform responsive improvements.

21. **Client journey mapping and experience analysis** – Examination of end-to-end service interactions to understand how individuals experience the system, including pain points, barriers and critical moments.
22. **Sentiment analysis** – Analysis of qualitative feedback, complaints, surveys and other inputs to identify prevailing attitudes, perceptions and emerging concerns within the service system.
23. **Community and cohort consultations** – Targeted engagement with specific groups or communities to understand lived experience, cultural context and service accessibility.
24. **Feedback loop and co-design processes** – Structured mechanisms that ensure client feedback informs service design, policy development and continuous improvement.
25. **Regulatory enforcement** – Actions taken to address non-compliance, including directions, sanctions, penalties or prosecutions.
26. **Reviews** – Targeted examinations of specific issues, cases or functions to identify strengths, weaknesses and opportunities for improvement.
27. **Investigations** – Formal inquiries into specific incidents or allegations to establish facts, accountability and potential breaches.
28. **Complaints handling** – Mechanisms for receiving, assessing and responding to concerns raised by individuals about services, decisions or conduct.
29. **Appeals and merits review** – Processes that allow individuals or organisations to challenge decisions and have them reconsidered on their merits.
30. **Dispute resolution** – Processes such as mediation or conciliation that assist parties to resolve disagreements without formal litigation.
31. **Advocacy** – Activities that promote and protect the rights, interests and voices of individuals or groups, particularly those who may be vulnerable or disadvantaged.

This ordering moves from shaping and assessing the system as a whole, through assurance of implementation and performance, to regulatory oversight, and finally to mechanisms focused on individual cases, rights and redress.

We have a responsibility to provide oversight, advocacy, and advice on matters affecting children and families, and the systems they interact with. Through our evidence-based and comprehensive approach, we make recommendations that are grounded in research and informed by lived experiences, quantitative data, case studies, and extensive stakeholder feedback. This approach provides for practical, realistic, and effective recommendations to government to address the complex challenges facing children and families.

- QFCC Recommendation Monitoring Report, 2025.

In Queensland there is a complex ‘super-structure’ of internal and external accountability mechanisms. This has evolved over decades, but has not itself been subject to scrutiny holistically or systemically for its performance or public value. Usually, these internal and external bodies and processes are operating simultaneously and in parallel.

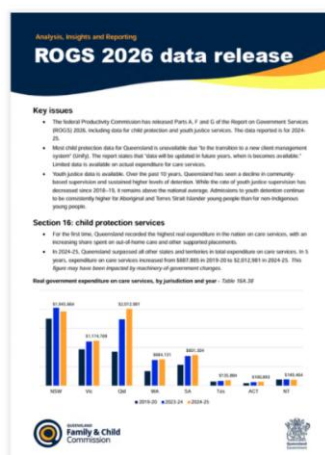
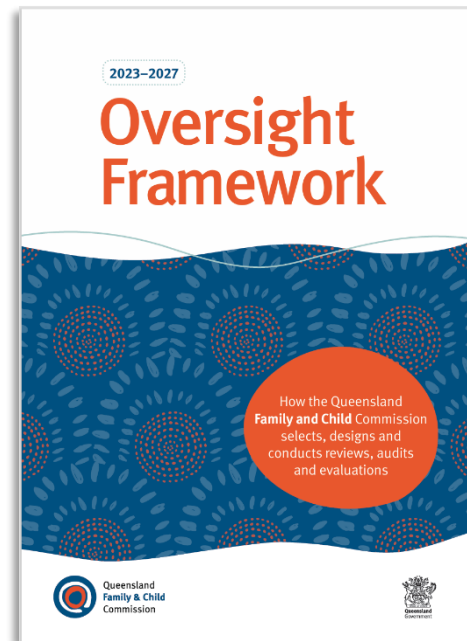
I believe there is a clear need to revisit the appropriate ownership and connection of the 5 layers of oversight, and 31 potential oversight activities as they are currently placed across the Queensland statutory landscape.

Strengthening oversight and accountability mechanisms is essential for building a child protection system that is transparent, responsive and capable of ongoing improvement. By enhancing transparency, ensuring that reforms are effectively implemented, establishing a coherent oversight architecture, and maintaining accessible complaints and appeal processes, Queensland can reinforce the accountability of the institutions responsible for protecting children and supporting families.

The current accountability environment within the child protection and family support system is characterised by a high volume of oversight activity. Departments are required to respond to multiple, concurrent requests for information, as well as to draft and final reports, findings and recommendations arising from a range of statutory oversight bodies. These processes are an essential feature of a transparent system; however, they also require substantial resources to manage effectively. In practice, this has led to an accumulation of overlapping requests, reviews and reform agendas. Agencies are often responding to multiple oversight processes simultaneously, sometimes without sufficient alignment between them or regard to existing recommendations already in train. The result can be a form of systemic overload - where effort is dispersed across competing priorities, and the capacity to focus on implementation and sustained improvement is diminished.

There is now an opportunity to reorient this “super-structure” of accountability toward a more coherent and outcomes-focused model. At its core, this requires a shift from process-driven accountability to a stronger, collective focus on the life outcomes of children and young people - specifically their wellbeing, safety, development and resilience - as well as the capacity of families to flourish.

A clearer oversight architecture would help ensure that these functions are effective, integrated, complement one another and do not produce gaps.



Report on Government Services (ROGS) Child protection and youth justice data intel brief

Our *ROGS 2026 data release* brief contains data from the Productivity Commission's 2026 *Report on Government Services*, specifically relating to child protection and youth justice services. Focussing on data available for Queensland, the report summarises key findings from the data release.

Read the paper below.

Introduce clearer advocacy for children in care, their parents and their carers

Independent advocacy is a critical mechanism for ensuring that the rights, interests, and wellbeing of children remains visible within complex systems. Both families in the child protection system and children in the out-of-home care system often navigate multiple agencies and service providers, and without independent voices, their concerns can be overlooked, minimised, or delayed. Advocacy mechanisms provide children with a pathway to raise concerns, challenge decisions, and seek support when their needs are not being met, ensuring that their lived experiences are recognised and acted upon.

Empowering children requires a multi-faceted approach. Children should have access to independent advocacy services, ensuring they can raise concerns and express preferences without fear of reprisal or dismissal. They need clear, age-appropriate information about their rights, the processes affecting their care, and the avenues available for support and complaint. Children should also be actively involved in planning for their education, living arrangements, and long-term goals, with their views documented and taken into account alongside professional assessments.

– A System that Cares, 2024.

The Commission has consistently highlighted the importance of strong, independent voices that can represent children's interests both at an individual level - supporting children to have their views heard in decisions about their care - and at a systemic level, identifying patterns of risk or gaps in service delivery. Advocacy not only empowers children to participate in decisions affecting their lives, but it also plays a critical role in informing systemic reform, helping the broader child protection system to respond proactively to emerging issues.

While Queensland currently operates the Community Visitor Program to provide independent oversight and advocacy for children in care, the Commission's work suggests that the program is not resourced to ensure consistent advocacy for all children. Community visitors provide valuable monitoring and support, but coverage is limited, and children with complex needs or less visible placements may not consistently have access to these services. As a result, some children lack an independent avenue to express concerns, raise complaints, or influence decisions affecting their lives and when they do the result is often transactional rather than systemic. This highlights the need to consider a future role for a dedicated children's advocate within the child protection system. Such a role would extend beyond monitoring to actively support children in care across the state, ensuring that every child has access to independent advocacy, advice, and representation.

A children's advocate could also play a strategic role, using insights gathered from individual advocacy to inform policy, improve system responsiveness, and strengthen accountability.

A legislated child advocate could provide an independent, systemic, and child-centred mechanism to address these issues, ensuring that children's voices are heard and that systemic obstacles are actively resolved. A legislated child advocate would be formally empowered to:

- Receive and investigate complaints from children in care, including concerns about placement, care quality, education, health, or wellbeing.
- Escalate systemic issues to the relevant agencies and, where necessary, require remedial action.
- Ensure timely interventions for children experiencing repeated or severe issues, including frequent placement disruptions, neglect of standard-of-care requirements, or prolonged absence from care or school.
- Coordinate cross-agency responses, facilitating cooperation between child protection, education, health, housing, police, and community organisations to remove barriers to care and support.

Legislative backing would formalise the advocate's authority, providing a clear mandate to intervene where the system is failing children, rather than leaving advocacy reliant on voluntary cooperation or limited programmatic oversight. It would also establish independence from the agencies delivering care, safeguarding the advocate's ability to challenge systemic inertia or institutional constraints.

A child advocate could be alerted automatically to critical triggers, enabling proactive responses rather than reactive interventions. Examples include:

- Children who experience frequent placement changes, which research shows can significantly disrupt attachment, stability, and wellbeing (i.e. any child who has more than 10 placements in total, or more than 3 in a year could be reported to the Advocate)
- Children involved in repeated standard-of-care concerns, including issues raised by carers, teachers, or health professionals.
- Children who have contact with the justice system, including arrests or periods of detention.
- Children who go missing from placements, highlighting safety risks or unmet needs.

By receiving such alerts, the child advocate could investigate, coordinate service responses, and work with agencies to unblock systemic constraints, ensuring that children do not continue to experience repeated harm or missed opportunities for support. The advocate could also establish a dedicated complaints mechanism accessible to all children in care, and could proactively host or hold events for care experienced young people. This model would allow the advocate to act as both an individual and systemic voice, ensuring that the concerns of one child can trigger improvements that benefit the wider care population.

Beyond individual advocacy, a legislated child advocate could provide strategic insights into systemic weaknesses, including patterns in placement instability, gaps in service provision, and emerging risks to children. By publishing regular systemic reports, the advocate could inform policy reform, resource allocation, and legislative change, ensuring that the child protection system evolves in response to evidence and lived experience. By providing this statutory authority, Queensland could move toward a child protection system that is proactively child-centred, recognising that the State has a continuing responsibility to remove obstacles to their wellbeing.

Strengthen complaints and appeal mechanisms

Effective oversight depends not only on the existence of complaints and review mechanisms, but on the clarity, accessibility and coherence of those pathways. In Queensland, children, families and carers interact with a range of complaint and appeal bodies across the child protection, community services and administrative review systems. While this reflects a comprehensive oversight environment, the Commission's work suggests that the complexity of these pathways can create confusion about where to go, what each mechanism is responsible for, and what outcomes can be expected.

Children, families and carers must be able to raise concerns about decisions, services or conduct in a way that is straightforward and understandable. This requires clear articulation of the different pathways available - complaints, internal reviews, external oversight, and legal appeals - and the purpose and scope of each. Without this clarity, individuals may pursue inappropriate pathways, experience unnecessary delay, or disengage altogether when the system appears too complex to navigate.

The Commission's work highlights that effective complaints and appeal mechanisms must be independent, transparent and responsive, and accessible to children and young people as well as adults. However, accessibility is not achieved through availability alone. It depends on clear communication about what each pathway can and cannot do, the types of issues it is designed to address, the timeframes involved, and the possible outcomes. Establishing consistent expectations across the system is critical to building trust and ensuring that people feel confident their concerns will be heard and acted upon.

Greater clarity would also strengthen system accountability. When roles and expectations across complaint and appeal bodies are well defined, duplication is reduced, gaps are minimised, and matters are more likely to be resolved at the right level and at the right time. It also supports more effective coordination between oversight bodies, enabling systemic issues to be identified and escalated where necessary.

Importantly, complaints and appeals are not only mechanisms for individual redress - they are a vital source of system intelligence. Patterns in complaints can reveal emerging risks, service failures or unintended consequences of policy and practice. However, this function is weakened when complaints are dispersed across multiple pathways without a clear framework for aggregation, analysis and learning.

There is therefore a strong case for Queensland to provide greater system-wide clarity on complaint and appeal pathways, including their purpose, thresholds, and expected outcomes. This could be supported through a more integrated framework that guides individuals to the appropriate mechanism, aligns expectations across agencies, and strengthens the system's ability to learn from feedback.

By simplifying navigation, clarifying roles, and strengthening coordination, Queensland can ensure that complaints and appeal pathways operate not only as safeguards for individuals, but as an integral part of a responsive, transparent and continuously improving child protection system.

Conclusion

“The most fundamental thing we could do to improve the world is be better parents....to our kids, and all Queensland kids.”

– Luke Twyford, LinkedIn, 2024

Queensland has the opportunity to transform its child protection system from one that reacts to harm into one that actively fosters safety, wellbeing and opportunity for every child. The seven system resets I believe are necessary are for the system to:

- 1) Prioritise efforts to Keep Families Together
- 2) Improve the quality of Child Protection Investigations and Case Management
- 3) Guarantee the quality of places where children in care live
- 4) Improve the life outcomes of children in care
- 5) Establish a system capable of transformation and continuous improvement
- 6) Reform departmental structures to support quality and improvement
- 7) Strengthen oversight and accountability mechanisms

These seven reform pillars provide a checklist for system change - linking the structures, governance and workforce capability that underpin the system with the experiences and outcomes that matter most to children and families.

Realising these reforms will require sustained leadership, cross-system collaboration, and a willingness to confront the complex social and intergenerational challenges that place children at risk. It will demand a system that listens to children and families, applies professional expertise where it matters most, and learns continuously from experience.

If these foundations are established and maintained, the system can move beyond managing crises to creating conditions in which children thrive, families are supported, and communities are strengthened. The ultimate success of the child protection system must be measured not by reports or processes, but by the real lives of children: their safety, their sense of belonging, their developmental and educational progress, and their ability to grow into confident, capable adults.

This is the vision that guides the reforms proposed in this report - a vision of a system that upholds the safety, dignity and potential of every child in Queensland.

Young people living in residential care are calling for change, not just for themselves, but for their younger siblings, friends, peers and for all children who will enter the child protection system in the future.

- Luke Twyford, LinkedIn



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