Office of the Aboriginal and Torres Strait Islander Children's Commissioner

Child Safety Commission of Inquiry Submission

Youth justice and corporate parenting

23 January 2026

QUEENSLAND Family & Child Commission

OFFICE OF THE ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN'S COMMISSIONER

Queensland Government

ACKNOWLEDGEMENT OF COUNTRY

The Office of the Aboriginal and Torres Strait Islander Children's Commissioner acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging. We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

Office of the Aboriginal and Torres Strait Islander Children's Commissioner
Queensland Family and Child Commission
PO Box 15217
Brisbane City East QLD 4002
qfcc.qld.gov.au

Contents

Introduction

This submission addresses the effectiveness of the Queensland Government in its role as a corporate parent, with specific focus on how the quality of corporate parenting directly influences justice system involvement for children in out-of-home care. It contends that youth justice involvement cannot be understood as an isolated judicial response to individual behaviour (or manifestations of harm). Rather, it is frequently the downstream consequence of systemic failures in care, planning, coordination and accountability for children for whom the State has assumed parental responsibility.[i]

The submission builds on matters raised in earlier submissions by the Commissioner[ii,iii] and draws on three Children's Court case studies to demonstrate how omissions and decisions within the child protection system shape the conditions under which children enter and remain within the youth justice system. The case studies highlight fundamental questions about accountability, standards of care, and whether the State meets the expectations it would impose on any other parent.

From a child rights perspective, the outcomes described were foreseeable and preventable. Where harm is predictable on the available evidence, failure to act constitutes a breach of duty. The State, as corporate parent, is not merely a service provider. It is the primary duty bearer under the *UN Convention on the Rights of the Child* (UNCRC). This includes a positive obligation to anticipate risk, mobilise supports and prevent harm, not simply respond after escalation into detention. When the State assumes guardianship, it becomes the parent of last resort. This role carries a heightened and enduring duty to protect, nurture and advocate for the child for the duration of the child's minority, and in practical terms across their life course.

This submission demonstrates how failures in that duty have directly contributed to youth justice involvement.

Corporate parenting and justice outcomes for children in care

Corporate parenting requires the State to act as a reasonable, diligent and responsive parent would, prioritising the safety, development, wellbeing and best interests of the child as the paramount principle under the *Child Protection Act 1999* (Qld).[iv] The obligation to act in a child's best interests is not confined to a point-in-time removal decision. It is an enduring obligation that applies for the entire period the State holds parental responsibility.

This duty extends beyond legal guardianship to encompass relational care, advocacy and the active coordination of services across health, disability, education, housing and justice systems. A reasonable parent does not merely assess a child's needs; they ensure those needs are met over time, adapting responses as the child develops.

Fragmentation across these systems has been repeatedly identified as a driver of systemic harm for children in care.[v] When care is not integrated or coordinated, children's needs remain unmet, risks escalate, and behaviours that are fundamentally expressions of trauma, disability or developmental delay are increasingly managed through punitive or coercive responses rather than therapeutic support.[vi] In this context, youth justice involvement reflects a failure of corporate parenting rather than a failure of the child.

This dynamic is particularly evident in residential care settings where evidence has demonstrated that police callouts are frequently used as a behaviour management strategy, rather than as a response to criminal conduct, increasing children's exposure to the youth justice system for behaviour that would ordinarily be managed within a family home.[vii] This practice is inconsistent with the intent of the Joint

Agency Protocol to Reduce Preventable Police Callouts to Residential Care Houses[viii] and contributes to the criminalisation of children in care.

Australia is a State Party to the UNCRC. The circumstances described in this submission engage multiple Convention obligations, including:

- **Article 3** – the best interests of the child
- **Article 20** – special protection for children deprived of a family environment
- **Article 23** – rights of children with disability
- **Article 24** – right to health, including mental health
- **Article 28** – right to education
- **Article 37** – detention as a measure of last resort and for the shortest appropriate time
- **Article 39** – recovery from trauma

The following cases examined demonstrate that Queensland's systems are not meeting these minimum standards.

Case study 1: Jimmy Mansfield (pseudonym)[ix]

On 27 January 2022, Jimmy Mansfield, a 16-year-old child living in Mount Isa and under the guardianship of the Department of Children, Youth Justice and Multicultural Affairs (Child Safety), was refused bail and remanded to Cleveland Youth Detention Centre. At that time, Jimmy had already spent 44 days in unsentenced detention.

The Magistrate expressly acknowledged that Jimmy had the cognitive capacity of a five- or six-year-old child and described the conditions of his detention as "dire" and "profoundly inappropriate." While Jimmy's offending was not among the most serious, the Court found there were no bail conditions capable of mitigating risk in the absence of an appropriate placement.

Prior to his detention, Jimmy was living in a residential care placement, with Child Safety holding full parental responsibility for his care, development and protection. Over several years, multiple psychiatric, psychological and functional assessments consistently identified moderate intellectual impairment, limited emotional regulation, minimal capacity to understand consequences, and the absence of stable, pro-social relationships. These assessments repeatedly emphasised the need for coordinated specialist and therapeutic intervention rather than further assessment. The Court observed:

> *"Jimmy ultimately had no meaningful pro-social connections. His was (and is) a world of paid carers, police and lawyers and, in particular, there is no one in his life that has a positive role to play just because they care for him or love him."*

Despite holding full parental responsibility since Jimmy was ten years old, Child Safety failed to implement recommended specialist and therapeutic supports. Although Jimmy was eligible for a substantial NDIS package, those supports were largely unutilised. Child Safety advised the Court it had no intention of implementing 24-hour specialist care:

> *"The question of whether Child Safety has appropriate care in place for Jimmy, if released, is relevant to the issue of bail… As I understand matters, Child Safety has no intention of putting in place a 24-hour specialist care arrangement."*

Bail was refused not because of offending seriousness, but because the corporate parent failed to provide care capable of supporting him safely in the community.

"I will gladly revisit this question of bail if Child Safety can find more suitable placement and care arrangement for Jimmy."

Case study 2: JG (anonymised)[x]

On 2 February 2023, JG, a 16-year-old child (aged 15 at the time of offending), appeared before the Children's Court on a bail application pending sentence. Bail was granted only after previously undisclosed medical information emerged.

At the time of offending, JD was under long-term guardianship of Child Safety, having been subject to a child protection order since she was four years old. Most recently, she had self-placed with a cultural aunt, with mixed success. The Court accepted that the offending tended to occur during periods when the child was disconnected from stable accommodation, while the State remained legally responsible for ensuring her care, safety and development.

Critical information regarding JG's neurodevelopmental and psychological needs only emerged on the day listed for sentence. A medical report from a paediatric psychiatrist dated August 2019 identified diagnoses of attention deficit hyperactivity disorder, possible Foetal Alcohol Spectrum Disorder and Attachment Disorder. The Court noted that these impairments were likely to affect the child's cognitive functioning, impulse control, capacity to assess risk and ability to understand consequences.

Despite this information having existed for several years, there was no evidence before the Court that Child Safety had ensured comprehensive assessment, arranged consistent treatment or provided tailored therapeutic supports responsive to those diagnoses. The Court observed that:

"the Department responsible for her care has not properly assessed her conditions or provided her with treatment and support for them, to date. In those circumstances, it may be unsurprising that those conditions may have contributed to dysregulation and offending behaviour (relevant to risk)."

JG spent 94 days in unsentenced detention, across three separate periods, despite having no prior criminal history. Evidence presented in Court about the conditions of JG's detention at Cleveland Youth Detention Centre revealed that:

- she had attended the education unit on only one day during the entire period of remand
- for 30 of 59 documented days, she had been confined to her cell for 21–24 hours per day
- on three days, she was locked in her cell for a full 24 hours
- on 40 of the 59 days, she had less than five hours out of her cell.

Her Honour stated:

"To detain a child in a cell for such lengthy periods of time is clearly undesirable, is likely to contribute to a deterioration of a child's mental health, is likely to contribute to poor behaviour by a child and subjects the child to trauma."

"I am also satisfied that continued detention of the child in the circumstances in which she has been detained to date has the potential to expose her to further trauma and are currently serving little or no rehabilitative effect."

Case study 3: Noah Jackson (pseudonym)[xi,xii]

Noah Jackson, approximately 12 years old, appeared before the Children's Court in. Noah had been involved with the statutory child protection system from a very young age. In March 2022, Noah transitioned from kinship care into direct State guardianship, following the breakdown of a kinship placement. Noah was placed in a residential care setting, rather than a family-based or specialist therapeutic placement. From this point onward, the State assumed sole responsibility for ensuring Noah's safety, development, health care, disability supports, cultural connection and overall wellbeing. Up until October 2022 Noah had never committed an offence.

Information before the Court indicated that Noah had significant neurodevelopmental and behavioural needs, including Foetal Alcohol Spectrum Disorder and Attention Deficit Hyperactivity Disorder. There was no evidence of an integrated therapeutic care model, specialist disability-informed placement or fully implemented support plan tailored to Noah's needs.

A substantial proportion of the charges related to breach-type offences, rather than inherently serious criminal conduct. This pattern is consistent with children who have impaired capacity to comply with complex rules and conditions, particularly where those conditions are imposed without adequate support, supervision and therapeutic intervention.

While the State argued that it was in Noah's "best interests" to return to the same placement upon release from detention, the Court rejected this position, stating:

"It is difficult to see how this could possibly be correct, given that Noah committed the offences that have landed him in Cleveland YDC while in that placement. In effect, Child Safety are proposing 'more of the same' care, which obviously risks more of the same behaviour."

As a First Nations child, the Court noted the significance of Noah being detained far from family and community supports and implicitly recognised that detention and placement decisions risked compounding cultural disconnection rather than promoting stability and wellbeing.

Like Jimmy and JG, Noah's detention was not driven by escalating criminality alone, but by the absence of any viable alternative care arrangement capable of mitigating risk and supporting him safely in the community. The Court's reasoning exposes a recurring pattern: where the corporate parent cannot or will not alter a failed care environment, detention becomes the default containment mechanism.

Analysis best interests of the child and the exercise of parental responsibility

In all three cases, the State had assumed guardianship well before the relevant youth justice proceedings. The best interest's principle therefore applied not only to the original removal decision, but to the ongoing exercise of parental responsibility over many years. However, the evidence before the

Court in each matter demonstrated that:

- assessments of need were not translated into sustained, coordinated care
- placement decisions were treated as static rather than dynamic
- prior failures in care did not trigger meaningful reassessment of the State's approach.

In Jimmy Mansfield, the Magistrate explicitly recognised that the child's developmental functioning was equivalent to that of a very young child, yet Child Safety advised that it had no intention of implementing a 24-hour specialist care arrangement. The Court's finding that detention was "profoundly inappropriate" stresses that the best interest's principle had been subordinated to system convenience and placement scarcity. In JG, the Court identified that critical neurodevelopmental diagnoses had been known for years, yet had not been addressed through assessment, treatment or therapeutic planning. In Noah Jackson, the Court rejected Child Safety's assertion that it was in the child's best interests to return to the same placement that had already failed him. The Court's observation that this amounted to "more of the same" care reflects an implicit recognition that best interests require change where harm is foreseeable, not repetition of ineffective interventions. The cases show that the State has treated best interests as a formal threshold satisfied at removal, rather than as an enduring, evidence-responsive obligation governing the quality and adaptability of care over time.

All three children were Aboriginal or Torres Strait Islander children and should have had their rights protected in line with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP). Across the cases, the Court record revealed limited evidence of culturally grounded care planning, minimal engagement with community-led supports and inadequate articulation of how placements maintained connection to family, culture and Country.

In Jimmy Mansfield, the Magistrate noted the absence of information from Child Safety that would enable culturally responsive decision-making.[1] In JG and Noah Jackson, connection to family was either fragile or severed, and there was no evidence of systematic cultural planning to mitigate the harms of removal and detention. The failure to meaningfully apply the ATSICPP compounds the breach of parental responsibility, as cultural identity and belonging are integral to a First Nations child's best interests, not optional considerations.

A central feature of all three cases is that the State exercised exclusive parental authority while remaining largely insulated from scrutiny regarding the adequacy of its caregiving decisions. In ordinary child protection proceedings, parents are routinely assessed on whether they are *willing and able* to meet their child's needs. By contrast, in each of these matters the State's willingness and capacity to meet identified needs was not subject to any equivalent statutory test and courts were left to manage risk arising from those failures without the power to compel remedial care responses.

In Jimmy Mansfield, the Court's bail decision turned not on the seriousness of offending, but on the absence of an appropriate placement. This is functionally indistinguishable from a finding that the corporate parent was unable to provide safe care, yet no mechanism existed to review or remedy that incapacity. In JG, the Court explicitly linked the child's dysregulation and offending behaviour to the Child Safety's failure to assess and support her diagnosed conditions. Despite this, the only available system response was prolonged detention under harmful conditions. In Noah Jackson, the Court went further by directly interrogating the State's proposed exercise of parental responsibility and finding it inconsistent with the child's best interests. The Court's reasoning exposes a structural anomaly: even where a court identifies deficient parenting by the State, it lacks the power to require the State to parent differently.

---

[1] Ms [redacted] suggested that perhaps members of his own family could fulfill this role, but I note my summary of Ms [redacted] background facts at [13], above, which included the observation that he has "*no one in his life that has a positive role to play just because they care for him or love him.*" The material available to me does not satisfy me that there has been any material change in this aspect of Jimmy's life.

Across all three cases, parental responsibility was exercised as legal control rather than as an active, relational and responsive caregiving function. The harm experienced by each child was foreseeable on the information held by the State. Jimmy's intellectual impairment, lack of pro-social relationships and need for specialist care were well documented. JG's neurodevelopmental diagnoses had been identified years before her detention. Noah's FASD and ADHD were known, as was the failure of the residential placement in which he offended. From a child rights perspective, foreseeability triggers a positive duty to act, and the State had sufficient knowledge that failure to provide appropriate supports would likely result in escalation, dysregulation and justice system involvement.

In each case, youth detention functioned not as a proportionate judicial response to offending, but as a substitute for care the State had failed to provide. Jimmy was detained because no placement existed that could support him safely. JG remained in prolonged remand despite universal acceptance that further detention would not be imposed on sentence. Noah was repeatedly brought before the Court because his care environment was incapable of managing his needs. The courts in all three matters explicitly recognised that detention was exacerbating trauma, undermining rehabilitation and doing little to enhance community safety. These outcomes were not the product of judicial indifference, but of systemic incapacity upstream in the child protection system.

From a child rights perspective, each case represents:

- failure to provide special protection to children deprived of family care (Article 20)
- denial of disability-appropriate support (Article 23)
- deprivation of education (Article 28)
- detention not used as a last resort (Article 37)
- exposure to conditions likely to cause psychological harm (Articles 19 and 39).

This assessment of *willing and able* to must also extend to the foreseeable harms associated with State intervention itself, including the risks arising once the State assumes guardianship as corporate parent. Removal is not a neutral protective act. It constitutes a significant interference with a child's right to family life and must therefore be subject to strict necessity and proportionality tests. Removal should occur only where:

- risk in the family environment is clearly established, and
- the State can demonstrate its capacity to provide safer and better care than the environment from which the child is removed.

This requires decision-makers to explicitly consider the predictable systemic harms associated with out-of-home care, including placement instability, loss of cultural connection, educational disruption, institutionalisation, unmet health, disability and mental health needs, and heightened risk of criminalisation. Where evidence demonstrates that children entering care face elevated risks of harm and justice system contact, these factors must be actively weighed in the removal decision. Failure to do so risks replacing one form of harm with another. Current statutory frameworks do not require this comparative harm analysis to be documented or justified, creating a systemic blind spot in removal decision-making.

Systemic issues identified

When considered together, the case studies reveal key issues raised relevant to the Commission of Inquiry's terms of reference.

Effectiveness of the State as corporate parent

Both Jimmy Mansfield and JG entered statutory care at a young age, with the State assuming full parental responsibility. In each case, that responsibility extended over many years, including during critical periods of cognitive, emotional and social development. Child Safety failed to implement cultural, therapeutic, developmental and disability supports, undermining the child's best interests and highlighting systemic gaps in meeting the standard expected of a reasonable parent. Neither child received care arrangements capable of meeting their complex needs in a way that prevented escalation into the youth justice system.

Adequacy of care planning, placement stability, and support for children with complex needs

The evidence illustrates systemic fragmentation and poor coordination between child protection, disability, health and justice services. Multiple assessments identified Jimmy's needs, but no integrated, specialist care arrangements were provided, demonstrating a failure to translate assessment into effective care planning and delivery. JG's neurodevelopmental diagnoses were known years earlier, yet comprehensive assessment and treatment had not occurred. The absence of timely, coordinated and responsive supports left her without the structure, regulation and relational stability required to mitigate risk, support development and prevent escalation into the youth justice system.

Decision-making frameworks and accountability within child protection

There is no effective mechanism for the Court to assess whether the State itself was willing and able to meet a child's needs (a test routinely applied to parents). Unlike parents, the State is not subject to equivalent scrutiny in relation to its capacity to meet a child's therapeutic and developmental requirements, exposing a significant governance gap. In all three cases, judicial discretion was constrained not by reluctance to act in the child's best interests, but by the absence of viable, properly supported alternatives offered by the corporate parent.

The evidence demonstrates that the risks experienced by the children were foreseeable and well documented. Multiple assessments, diagnoses, placement histories and prior service engagement clearly identified both their vulnerabilities and the supports required to mitigate risk. The State therefore had actual and constructive knowledge of the likelihood of harm in the absence of timely intervention. Consistent with child rights principles, foreseeability gives rise to a positive duty to act. Where the State possess such information and fail to intervene, this constitutes systemic negligence rather than isolated service failure.

In these circumstances, the failure to implement identified supports represents a breach of the reasonable standard of care expected of a guardian exercising parental responsibility. Where harm is predictable on the available evidence, inaction cannot be attributed to system pressure or resource constraints. As corporate parent, the State is required to anticipate foreseeable risks and take proportionate, timely and effective steps to prevent escalation into coercive systems, including youth detention.

The subsequent justice system involvement of the children must therefore be understood not as an independent judicial outcome, but as a direct and causally connected consequence of upstream failures in care planning, service coordination and therapeutic intervention.

Insufficient oversight of individual cases

There is a critical lack of effective oversight and accountability mechanisms regarding Child Safety's actions and decisions in individual child protection cases. Despite holding statutory guardianship and parental responsibility, Child Safety's failure to adequately implement expert recommendations, coordinate supports and provide appropriate care placements often goes unexamined. This absence of scrutiny allows systemic neglect to persist unchallenged, leaving children vulnerable to preventable harm.

A significant contributor to this accountability gap is the absence of any independent body with the power to advocate for, or intervene on behalf of, individual children where the State has failed to meet its statutory obligations. The *Family and Child Commission Act 2014* expressly prohibit the Queensland Family and Child Commission (QFCC) from advocating on behalf of individual children. While the QFCC plays an important system-level monitoring and reporting role, it is legislatively constrained from intervening in individual cases, even where there is evidence of serious service failure or failure of duty by the State.

Use and quality of assessments and expert evidence in proceedings

The over-reliance on Western psychological models, without incorporating Indigenous-defined social and emotional wellbeing indicators, limited the court's understanding of the child's holistic needs. Strengthening the evidentiary base through culturally competent assessments is essential to improved judicial outcomes.

Systemic and structural drivers of harm

Across these cases, the Court frames the child's experience as an outcome of structural neglect rather than individual failure. It exposes how systemic design prioritising control and containment over therapeutic care creates cycles of detention and harm, which are preventable through effective corporate parenting. A recurring theme is the failure to properly support *willing* families to become *able* families. In many cases, children could have remained safely within their family or kinship networks if those carers had been provided with timely, adequately resourced, and culturally appropriate supports. Instead, families are often assessed against idealised standards of care without being given the practical assistance required to meet those expectations. The absence of meaningful investment in family preservation, early intervention and intensive in-home support shifts responsibility away from the State's duty to enable care, and onto families who are structurally constrained by poverty, trauma, disability or systemic disadvantage.

Comparative conclusions

The three cases examined provide evidence that youth justice involvement for children in care is often a foreseeable and preventable consequence of systemic neglect, rather than individual failure. These cases demonstrate how long-term Child Safety guardianship, when unsupported by meaningful care, assessment and therapeutic intervention, can culminate in justice system entrenchment that courts are then required to manage.

In Jimmy's case, the youth justice system ultimately determined his remand status. However, the trajectory leading to that outcome was shaped over time by the quality of care provided by the State in its role as corporate parent. Child Safety's failure to act on known disability-related needs, coordinate supports (including NDIS-funded services), and provide stable, relational and culturally safe care directly contributed to responses later characterised as criminal risk.

JG's case shows that despite being under Child Safety's guardianship since early childhood, and knowledge of her neurodevelopmental needs, JG entered adolescence without comprehensive assessment, treatment or coordinated therapeutic support. As a result, periods of placement instability, transient living and exposure to harm went unaddressed. The Court recognised that continued prolonged unsentenced detention was exacerbating trauma and serving little rehabilitative purpose.
The concerns identified in Jimmy Mansfield's and JG's cases are not isolated, but reflect a broader pattern identified by the Children's Court in Noah Jackson, where the persistence of failed placements and the absence of viable alternatives resulted in detention being used as a substitute for care. The cases raise fundamental questions for the Commission of Inquiry about accountability and standards in corporate parenting.

The evidence provided shows how shortcomings in the care provided by Child Safety function as upstream drivers of youth justice involvement and expose a troubling asymmetry: the State possesses the authority and resources to provide appropriate care and yet failed to demonstrate the willingness or capacity to do so. If a parent had exhibited the same pattern of inaction in the face of known need, their capacity to care would rightly be questioned. The absence of an equivalent mechanism to scrutinise the State's performance as a parent represents a critical gap in Queensland's child protection system. The effectiveness of corporate parenting must therefore be assessed not only by statutory compliance, but by whether the State delivers the quality of care, advocacy and coordination it would expect of any parent entrusted with a child's future.

Data context: The child protection and youth justice interface

Available data confirms that the experiences of Jimmy Mansfield, JG and Noah Jackson are not uncharacteristic. One in five admissions to youth detention are young people under a guardianship order or a permanent care order, with First Nations children significantly overrepresented (see Table 1). According to the 2024 Youth Justice Census of young people in custody,[xiii] 33% were living in unstable or unsuitable accommodation, 55% were totally disengaged from education, training or employment, and 70% had experienced domestic and family violence.[10] These figures demonstrate that youth justice involvement is deeply intertwined with experiences of care instability and systemic failure.

Table 1. Redacted

According to Australian Institute of Health and Welfare (AIHW) data,[xiv] a substantial proportion of children under youth justice supervision in Queensland during 2022–2023 were also subject to child protection orders. Overall, 25.1% of all males and 38.3% of all females under youth justice supervision in Queensland during 2022–2023 were also subject to child protection orders.

High levels of interaction with the child protection system were also evident among young people under community-based youth justice supervision. In the ten-year period from 1 July 2013 to 30 June 2023, 90% of First Nations females and 85% of all females under community-based supervision had at least one interaction with the child protection system. For males, 78% of First Nations males and 69% of all males had an interaction with the child protection system over the same period.

As involvement with the youth justice system becomes more acute, the overrepresentation of children with prior child protection involvement increases further. In Queensland, 80.8% of children in detention during 2022–2023 had an interaction with the child protection system in the ten years from 1 July 2013 to 30 June 2023. This proportion was higher for females (87.6%) than for males (79.2%). In addition, 32.6% of children in detention during 2022–2023 were subject to child protection orders, highlighting the strong overlap between child protection involvement and more intensive forms of youth justice supervision.

Accountability and oversight

The Department of Child Safety routinely assesses whether parents are willing and able to care for their children. No equivalent framework exists to assess the State's own willingness or capacity to meet a child's needs when it assumes guardianship. This represents a significant accountability gap. Oversight bodies currently lack sufficient powers to intervene in individual matters, compel action or access the data required to assess system performance. Children in statutory systems require individual advocacy capable of navigating intersecting systems and intervening where preventable harm is occurring.[11]

There is a reasonable community expectation that systems entrusted with the care and protection of children are accountable for upholding their rights.

Recommendations

1. *Establish an enforceable corporate parenting standard*

That the Queensland Government should develop and legislate a clear, enforceable corporate parenting standard, requiring the State to demonstrate that it is willing and able to meet a child's identified safety, developmental, disability, cultural and therapeutic needs while under guardianship. This should include independent verification of the State's capacity to care *before* guardianship is assumed and include enabling a mechanism for courts and oversight bodies to scrutinise the State's exercise of parental responsibility in individual cases, including where failures to act on known needs contribute to youth justice involvement and other adverse outcomes.

2. *Recognise systemic neglect and abuse as a distinct harm type*

That systemic abuse and neglect arising from failures in planning, coordination or service delivery by the State be formally recognised as a distinct harm type within Queensland's child protection framework, triggering mandatory review and remedial action.

3. *Require a comparative harm assessment prior to removal*

That removal decisions be subject to a mandatory comparative harm assessment, requiring decision-makers to explicitly weigh the risk of harm in the family environment, against the foreseeable risk of harm associated with out-of-home care. This assessment must be documented, reviewable, and include consideration of:

- placement stability
- cultural continuity
- disability and mental health support capacity
- education continuity
- risk of criminalisation.

Removal should occur only where the State can demonstrate that intervention will be more protective than remaining at home.

4. *Strengthen accountability at the child safety and youth justice interface*

Clear accountability arrangements should be established at the interface between child protection and youth justice, including:

- mandatory joint case planning for children subject to dual involvement

- shared responsibility for preventing justice system escalation
- reporting obligations where bail or detention outcomes are driven by the absence of suitable care placements.

5. *Ensure culturally safe care and application of the ATSICPP*

That decision-making affecting Aboriginal and Torres Strait Islander children be supported by evidence of meaningful engagement with all five elements of the Child Placement Principle, including connection to family, community and culture.

6. *Prohibit detention driven by system failure*

That legislation explicitly prohibit:

- remand or detention where the primary driver is absence of placement
- detention as a substitute for disability, therapeutic or housing support
- prolonged isolation for children with trauma or neurodevelopmental needs
- detention that arises directly or indirectly from removal decisions where adequate care capacity was not established.

Require judicial review where detention exceeds 14 days, independent monitoring of conditions and mandatory reporting of isolation practices.

7. *That oversight bodies be empowered to intervene in individual cases*

Oversight bodies should also be empowered to compel action from agencies, access real-time data, and issue binding recommendations, as well as publish reports on systemic failures. This should include the conduct of regular audits of corporate parenting performance, the publication of public scorecards, and enhanced parliamentary scrutiny.

8. *Embed independent child-focused advocacy*

Ensure that every child involved in statutory systems has access to independent, child-focused advocates empowered to navigate intersecting systems, raise concerns on behalf of the child, and compel responses where action in the children's best interests is delayed or absent.

Conclusion

Children should never enter detention because adults failed to protect them. Queensland now faces a choice. It can continue to operate a system that manages harm after escalation, relying on detention as a default response to unmet need. Or it can deliberately redesign decision-making, funding and accountability structures to prevent harm before it occurs through early, coordinated and rights-based intervention.

The Commission of Inquiry provides a critical opportunity to embed this shift in governance architecture. This requires moving beyond discretionary responses and adopting clear statutory duties, enforceable standards of corporate parenting, and independent oversight mechanisms capable of compelling timely action where risk is foreseeable.

A system grounded in child rights does not wait for crisis to justify intervention. It anticipates harm, mobilises support and measures success by whether children are safer, supported and connected, not by how efficiently systems respond after failure.

This Inquiry therefore has a pivotal role in repositioning Queensland's child protection system from reactive containment to proactive prevention, ensuring that detention is never used as a substitute for care, and that State intervention consistently meets the standards it demands of families.

References

[i] Australian Institute of Health and Welfare (AIHW). (2024). *Young people under youth justice supervision 2022–23*. https://www.aihw.gov.au/reports/youth-justice/young-people-youth-justice-supervision-2022-23/summary

[ii] Queensland Family and Child Commission. Office of the Aboriginal and Torres Strait Islander Children's Commissioner. (2025). *Child safety commission of inquiry – FNQ hearing*. https://www.qfcc.qld.gov.au/sites/default/files/2025-09/Child-safety-commission-of-inquiry-FNQ-hearing-Commissioner.pdf

[iii] Queensland Family and Child Commission. Office of the Aboriginal and Torres Strait Islander Children's Commissioner. (2025). *Child safety commission of inquiry – Complaints hearing*. https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Child-safety-commission-of-inquiry-complaints-Commissioner.pdf

[iv] *Child Protection Act 1999* (Qld). https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010

[v] United Nations Committee on the Rights of the Child. (2011). *General comment No. 13 (2011): The right of the child to freedom from all forms of violence* (CRC/C/GC/13). https://www2.ohchr.org/english/bodies/crc/docs/crc.c.gc.13_en.pdf

[vi] Australian Human Rights Commission. (2024). *Help Way Earlier! How Australia can transform child justice to improve safety and wellbeing*. https://humanrights.gov.au/__data/assets/pdf_file/0025/25477/1807_help_way_earlier_-_accessible_0-1-2.pdf

[vii] Queensland Family and Child Commission. (2018). *Young people's perspectives on residential care, including police call-outs*. https://www.qfcc.qld.gov.au/sites/default/files/2022-06/Young%20people%20s%20perspectives%20on%20residential%20care%2C%20including%20police%20call-outs.pdf

[viii] Queensland Family and Child Commission. (2018). *Joint Agency Protocol to Reduce Preventable Police Callouts to Residential Care Houses*. https://www.qfcc.qld.gov.au/sites/default/files/2022-06/Jointagencyprotocol.pdf

[ix] Children's Court of Queensland (Magistrates). (2022). *Jimmy Mansfield* (a pseudonym), *Re Richard Jones* (a pseudonym) [2022] QChCM 22-001. Supreme Court Library Queensland. https://archive.sclqld.org.au/qjudgment/2022/QChCM22-001.pdf

[x] Children's Court of Queensland. (2023). *Re JG [2023] QChC 3* (2 February 2023). Supreme Court Library Queensland Archive. https://archive.sclqld.org.au/qjudgment/2023/QChC23-003.pdf

[xi] Children's Court of Queensland. (2023). *Re Noah Jackson [2023] QChCM 23-007*. Supreme Court Library Queensland Archive. https://archive.sclqld.org.au/qjudgment/2023/QChCM23-007.pdf

[xii] Children's Court of Queensland. (2023). Re Noah Jackson [2023] QChCM 23-005. Supreme Court Library Queensland Archive. https://archive.sclqld.org.au/qjudgment/2023/QChCM23-005.pdf

[xiii] Department of Youth Justice and Victim Support. (2024). *Youth justice census summary – custody (2018–2024)*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/a6c6dbcf-b18f-413c-a2fb-9cd1b7bc4c84/yj_census_summary_custody_2018-2024.pdf

[xiv] Australian Institute of Health and Welfare. (2024). *Young people under youth justice supervision and their interaction with the child protection system 2022–23*. https://www.aihw.gov.au/reports/youth-justice/young-people-youth-justice-supervision-2022-23/summary