From Pressure to Purpose:

Reforming Child Protection in Queensland



Child Safety

Commission of Inquiry

Child Safety
Commission of Inquiry

22 May 2026

The Honourable David Crisafulli MP
Premier and Minister for Veterans

By email: premier@ministerial.qld.gov.au

Dear Premier

In accordance with the Commissions of Inquiry Order (No. 1) 2025, notified in the Queensland Government Gazette Extraordinary No. 16 on 23 May 2025, as amended by the Extraordinary Queensland Government Gazette published on 13 February 2026, I have undertaken the inquiry as directed. Accordingly, I submit the Commission's Report. The Report comprises of the Executive Report and seven Companion Reports.

The Commission's report is simultaneously submitted to the Honourable Attorney-General and Minister for Justice and Minister for Integrity, and the Honourable the Minister for Families, Seniors and Disability Services and the Minister for Child Safety and the Prevention of Domestic and Family Violence.

I wish to express my sincere thanks and appreciation for having been entrusted by the Queensland Government to conduct this Inquiry into a matter of such importance.

Yours faithfully,
Paul Anastassiou

Paul Anastassiou

Commissioner

Child Safety
Commission of Inquiry

22 May 2026

The Honourable Amanda Camm MP
Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence

By email: families.services@ministerial.qld.gov.au

Dear Minister

In accordance with the Commissions of Inquiry Order (No. 1) 2025, notified in the Queensland Government Gazette Extraordinary No. 16 on 23 May 2025, as amended by the Extraordinary Queensland Government Gazette published on 13 February 2026, I have undertaken the inquiry as directed. Accordingly, I submit the Commission's Report. The Report comprises of the Executive Report and seven Companion Reports.

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Commissioner

Child Safety
Commission of Inquiry

22 May 2026

The Honourable Deborah Frecklington MP
Attorney-General and Minister for Justice and Minister for Integrity

By email: attorney.general@ministerial.qld.gov.au

Dear Attorney

In accordance with the Commissions of Inquiry Order (No. 1) 2025, notified in the Queensland Government Gazette Extraordinary No. 16 on 23 May 2025, as amended by the Extraordinary Queensland Government Gazette published on 13 February 2026, I have undertaken the inquiry as directed. Accordingly, I submit the Commission's Report. The Report comprises of the Executive Report and seven Companion Reports.

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Commissioner

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: This report, Companion Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Commissioner's Foreword

'Life is a fine balance between hope and despair'. That is the allegorical theme of 'A Fine Balance', a novel by Rohinton Mistry.1 What does a novel about the travails of two Indian tailors have to do with the child safety system in Queensland? Nothing directly, but abstracted, a great deal. Words like 'complex', commonly used to describe the system have become almost meaningless. Even the ubiquitous word 'system', for want of another, does not tell us much about the subject. This Inquiry is about children, parents, family and kin. It is about their lives, experiences, aspirations and challenges. It is about their communities and their cultural and relational connections. And it is about the state trying to be something it is not- a natural parent. That is why the best medium for understanding the challenges faced by child safety system is to be found in great works of literature and what they teach us about the human condition, rather than in the taxonomy found in the reports of great inquiries.

The child safety system cannot be understood merely as a bureaucratic government structure with all of its allied policies, practices and procedures, good or bad. Rather, it requires an understanding of the stories of children taken into the care of the state. Each child's story is singular and yet inseparable from the stories of their families, kin and culture, and inseparable from the wider Queensland community. Thus, any analysis of the child safety system must be founded upon the life journeys of the children taken into state care, viewed through their eyes and with their needs and interests always paramount. This Report seeks to tell a narrative story following the notional journey of a child taken into the care of the state, pausing to dwell on the elements of the child safety system as they are encountered by children in the course of their journey.

To understand the system, it is essential to listen to the stories of the children and to the stories of all those involved in their care. Their stories traverse the full spectrum of human experience; of hope and despair, and all that lies between those feelings. Aimee's story alone is proof of that. It is a story of triumph over despair and yet it also illuminates nearly all of the systemic failings of the child safety system.

There are many ways in which the core challenges of the child safety system may be characterised. There is no shortage of labels, but many have become degraded of meaning to the point where they obscure more than they reveal. This Report aims to be plain speaking, including those topics which raise uncomfortable or sensitive issues often elided in the discourse concerning child protection.

The child safety system has one single priority, the wellbeing and best interests of children in state care, otherwise known as the 'paramount principle'. The success of the child safety system is to be measured against that overarching principle. To give effect to it requires all decisions and actions affecting children in care be evaluated against the needs and best interests of the child in question, as and where found, without

the overlay of any other objective, and without straining to align any decision or action with any other pre-conceived notion of a desirable outcome.

The evidence before the Commission has revealed that too often decisions and actions taken on behalf of children do not give effect to the paramount principle. When this occurs, it is a grave failure of the state's duty to children, who by definition are vulnerable to decisions made for them, and on their behalf. That being said, the Commission's remit is critique, not criticism of any individual working within the Department or other government agencies engaged in the child safety system. The Commission is cognisant of the stresses faced daily by human actors called upon to protect children at risk of harm. The individual and collective toll upon them cannot be overstated. They confront hostility and face the risk of violence. When they must intervene, invariably the human environment is emotionally fraught. In short, they are the frontline first responders of the child safety system, and they deserve recognition.

If the work of the Commission is to be of any utility, as it is hoped it will be, the Commission must not shy away from critique of the present system, nor should it be timorous in expressing its conclusions. The Commission accepts it must identify the evidence upon which it has arrived at conclusions. It also accepts that no suggestion as to reform can rise higher than the quality of the reasoning upon which they are founded. The field of study upon which the Commission has embarked is broad and multi-disciplinary. It raises many nuanced issues which in turn create a large spectrum for reasonable disagreement. The Commission hopes that by exposing its reasoning others who may wish to offer their own critique of any conclusions or recommendations expressed in the Report will be assisted to do so. On the ground that the Commission should fully expose its reasoning and on the ground that the timeframe for this Report has been truncated, the Commission invokes where necessary, and generally, the defence 'if I had more time, I would have written a shorter [Report]'.

A conclusion about which there is no dispute is that a happy and nurturing childhood does not leave us in adult life. As adults, we rejoice in holding on to all that is good in our childhood and hope always to retain something of its natural optimism. Bob Dylan's famous song 'Forever Young' perfectly captures that feeling: *"May God bless and keep you always, may your wishes all come true, may you always do for others and let others do for you. May you build a ladder to the stars and climb on every rung. And may you stay forever young; may you stay forever young."* Sadly, we know that the opposite is also true, childhood harm never leaves us either.

As may be expected, important issues have been robustly debated within the Secretariat. The conclusions and recommendations contained in this Report may not all be universally shared within the Secretariat. Accordingly, I make it clear that I alone take responsibility for the opinions and recommendations in this Report.

The success of this Inquiry is for others to judge in due course. Ultimately, it will depend upon whether the recommendations that are made, if implemented, help reduce the number of children taken into state care and contribute to a child safety system which is kinder to, and more nurturing of, children who are by unfortunate necessity taken into care.

I wish to acknowledge that I am personally indebted to all those who have assisted me in conducting this Inquiry. In particular I wish to thank Senior Counsel and Junior Counsel assisting me and all of the staff of the Secretariat. They are too numerous to name individually here.

Finally, I wish to say that being entrusted to conduct this Inquiry into a subject of such importance has been a singular honour, for which I am both humbled and grateful in equal measure.

Paul Anastassiou
Commissioner
Brisbane, 22 May 2026

Chapter 1

Executive Summary

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 1: Executive Summary

1.1 Introduction: Understanding and reforming an intransigent system

Perhaps the most striking feature of Queensland's child protection system is that it has been interrogated, analysed and commented upon intensely over the last several decades. There is a standing commission with oversight of the system, the Queensland Family and Child Commission (QFCC); numerous specialist non-government bodies which represent various actors in the system; Aboriginal and Torres Strait Islander Community-Controlled Organisations (ATSICCOs) which seek to give voice to the particular interests of Aboriginal and Torres Strait Islander children and their families; and the Department of Families, Seniors, Disability Services and Child Safety (the Department), which is a very substantial bureaucratic undertaking. This Inquiry is the fourth in a series of Commissions of Inquiries in Queensland, commencing with the Forde Inquiry in 1999,[1] the Crime and Misconduct Commission Inquiry in 2004,[2] and the Carmody Inquiry in 2012-2013.[3] And yet, despite the best endeavours of all concerned, individually and collectively, the child protection system continues to fail children and the community in serious respects.

Against this background, this Commission regards its overarching duty as being to ascertain, and help overcome, the forces which continue to repel attempts to initiate and entrench reform. An allied objective is to identify real and practical reforms with the potential to produce entrenched change at all levels of the child protection system.

As at March 2025, there was approximately 13,568 children in care in Queensland,[4] far higher in aggregate, and proportionately, than any other state in Australia.[5] This is a measure of failure. One measure of success is the opposite, a smaller number, and proportion, of children requiring state protection. The problem is more acute for Aboriginal and Torres Strait Islander children who are grossly overrepresented in the child safety system. An empirical measure of success includes reducing the duration or length of time that children remain in state care. A qualitative measure is whether the recommendations help to create a system which produces better outcomes for

[1] Leneen Forde, *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (Report, May 1999).
[2] Crime and Misconduct Commission, *Protecting children: an inquiry into abuse of children in foster care, Crime and Misconduct Commission* (2004).
[3] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013).
[4] See the spreadsheet provided by the Department of Children living away from home by child safety region, placement type, order type and age grouping (DFS.0001.0001.0269).
[5] Productivity Commission, '16 Child protection services: Table 16A.23' F Community Services: Report on Government Services 2026 (Data, 29 January 2026) <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/> Note: Queensland did not provide 2025 data due to the Department's transition to a new client management system.

children in state care and more robustly protects them, their families and the community. These better outcomes include ensuring stability of placements, the permanency of care, and safe reunification of children with their original families. Another measure of success is improving the suitability of care for each child by offering an improved suite of options for the care and nurture of children in care.[6] If successful, a collateral benefit will be that Inquiries of this nature will not be required with such frequency, or at all.

The Commission is conscious that the utility of its recommendations cannot rise higher than the quality of its analysis of the child protection system. That analysis raises some politically and culturally sensitive issues which may be uncomfortable. The Commission has sought to confront these issues. To do otherwise would be a failure to discharge its duty 'to make a full and careful inquiry in an open and independent manner.' The duty of the Commission is to identify, understand and confront the factors which alone and in combination contribute to continuing systemic failure, and to replace them with 'enablers' that systematically strengthen families and ensure the safety and wellbeing of children. That requires the Commission to form opinions and to express them, even when those opinions may not align with the widely held views of significant participants within the system.

The Commission's recommendations are integrated and interdependent. This reflects the inescapable fact that the child protection system is both internally interconnected and operates inside a broader Australia wide socio-economic and cultural context. There is simply no single reform that is capable of producing lasting improvement, no tweak or tinkering will change the present trajectory of the child protection system.

There are, however, some manifest failings that are capable of immediate rectification which will produce a material improvement in the care of children and a substantial reduction in the ballooning cost of the system.

1.2 Reforming the Residential Care system

The first of the Terms of Reference, clause 3(a), is directed at reforms to the residential care sector and the causes of the growth and reliance on what has become a billion-dollar sector.[7] When this Inquiry was announced,[8] the Queensland Government identified the residential care sector as one of its major concerns. The Commission's investigations have confirmed that the Government

[6] See, discussion of the 'purpose' of the system in Chapter 2.8 of this report.
[7] By 2024-25, the annual cost of placing children in residential care in Queensland had reached in excess of $1.1 billion dollars; See Companion Report 4: Understanding and Reforming the Residential Care System.
[8] Queensland Government, 'Commission of Inquiry into Queensland's broken Child Safety System', (Joint Media Statement, 18 May 2025) <https://statements.qld.gov.au/statements/102583>.

was rightly concerned about this sector. In short, the excessive cost of this sector has not resulted in better outcomes for children and their families, nor improved the safety of children and the wider community.

The Commission has considered all aspects of the sector, discussed in Companion Report 4: Understanding and Reforming the Residential Care System. The main causes of the growth of the residential care sector are briefly stated.

The first is that government policy relied too heavily on residential care rather than investing in a timely and sustained way to enhance the availability of family-based care through kinship care and foster care. Because of the failure, increasing reliance on residential care was inevitable and unavoidable. The growth in the residential care sector was exacerbated as demand for child protection continued to increase and the availability of kinship and foster carers declined (the former in relative terms; the latter in absolute terms).

Second, the quality of residential care was allowed to deteriorate and its cost to grow exponentially due to a 'just-in-time' procurement policy. That policy entailed engaging third-party residential care providers upon short-term, fee-for-service arrangements under a funding model known as Individualised Placement and Support (IPS). A common feature of these arrangements was that IPS-only residential care providers were not required to be licensed, nor were they subject to the oversight and monitoring mechanisms imposed on providers engaged under a long-term Outsourced Service Delivery (OSD) contract. Providers falling into the latter category are required to be licensed (or to be on their way to becoming licensed) and to meet important quality standards. They are also subject to regular review and inspection by the Department through both announced and unannounced visits, third-party audit powers and processes to recover unspent funds.

Third, the very high cost of residential care was significantly increased because of a failure to appropriate sufficient funds through the annual budget process, in advance of each financial year, to meet the known increasing demand. This resulted in the IPS funding model being used by default, given the lack of insufficient budget appropriations year-on-year to support long-term OSD arrangements. The IPS funding model was never intended to be deployed in this way. It was supposed to be used to meet unexpected demand that could not be reasonably anticipated and more particularly to procure bespoke residential care services designed to meet the needs of children and young people with complex needs. Instead, it became a default model applied widely for the procurement of residential care services.

Further, the combined effect of inadequate annual budget appropriation for OSD arrangements and the consequent necessity to use IPS funding led to an escalating number of unlicensed residential care providers and for-profit providers taking an increasing market share, and ballooning costs of providing residential care services.

The consequences of increasing reliance on residential care generally, as well as the increasing number of unlicensed providers has led to a deterioration in the quality of care for children overall. It has also highlighted systemic failures in the Department's approach to commissioning, procurement and licensing. Collectively, they point to government failing to meet its commissioning and procurement obligations, and failing to steward the market through forward procurement plans in the face of known increasing demand.

A significant theme of this Report is that family-based models of care are very widely regarded as far preferable from the child's perspective to residential care. In most instances, it is also some 10-15 times less expensive than a residential care placement. This theme is discussed in greater detail later in this chapter and in Companion Report 4: Understanding and Reforming the Residential Care System.

The massive cost of residential care and lack of prudential oversight of unlicensed providers has led to scandalous revelations in the course of this Inquiry. The cost blow-out of the residential care sector commenced in about the 2019-2020 financial year, by which point there was already a $70m deficit.[9] By no later than mid-2020, internal modelling completed by the Department as part of the Care System Investment Plan (CSIP), and external modelling undertaken by the Queensland Treasury Corporation (QTC), clearly revealed to government that the ballooning cost of this sector would continue on an exponential trajectory unless it took action to invest at scale in family-based care. By that time, it was known within government that the cost of residential care would be exacerbated by a year-on-year failure to appropriate sufficient funds through the annual budget process for OSD-funded care arrangements.

It was also known within government that there was a serious and growing risk to children and the community caused by the increasing number of unlicensed residential care providers because those providers engaged on an IPS-only basis were subject to limited oversight. Clearly, these risks are borne directly by the children placed with unlicensed providers. The escalating number of 'self-placing' children is in large measure a side effect of the failed residential care model. Unfortunately, the act of 'self-placing' is literally and figuratively an exit poll of the system's users,

[9] Queensland Government, *Child Safety Deficit – Overview of additional funding provided to address the child safety deficit* (Table 2025 – 2026) (DFS.0376.0001.0001).

dissatisfied with what the system has to offer. Those children remain the most vulnerable and susceptible to abuse, not least being sexual exploitation.

The Commission's recommendations are referred in each chapter of this Report, at the end of this Report in Chapter 11, and compendiously on the Child Safety Commission of Inquiry website. In relation to residential care, the overarching recommendation is that this Government should re-focus its efforts and resources to promote family-based care in potentially effective ways, and consequently reduce the upward trajectory of residential care. This requires co-ordinated and concurrent actions at all stages of the child safety continuum, and at all inflection points — before a child enters the child safety system, immediately upon a child being taken into care, and at all times thereafter until the child is reunified, provided with a long-term stable placement, or has transitioned to adulthood. The Commission recommends that all models of family-based care should be prioritised over residential care. This includes, where appropriate, adoption.

The Commission has also made a number of recommendations in relation to the manner by which the Department procures residential care services and monitors unlicensed and licensed providers.

1.3 Fixing a broken system; safer children and communities

Many of the causes of system failure, most in fact, are not readily measurable quantitatively and none are distinct or separate. Rather there is a multiplicity of factors, human and structural, that aggregate and fission within the bureaucracy of government.

1.3.1 Why have earlier attempts to reform the child protection safety system failed?

Before turning to the factors which combine to cause system failure, it is essential to grapple with the system's resistance to change. The Commission has identified several predominant reasons the child safety system has developed a resistance to change.

Holistic integrated reform is essential to durable systemic reform

The first reason earlier inquiries have failed to yield material improvement is because sound suggestions have not been implemented fully and holistically within a whole of system approach.[10] A key analytical premise of this Report is 'systems thinking'. This is an approach to

[10] This subject is addressed in Chapter 2.7 and 2.8 of this report.

the analysis of the causes of failure and to the methodology of implementing lasting reform. Without integrated, carefully stewarded reform across the entire spectrum of the child protection system, including concerted efforts to support families and prevent children from going into the child safety system in the first place, the recommendations of this Commission will likely prove as inutile as those of its predecessors.

The paramount priority of the child protection system must remain focused on the wellbeing and best interests of each child in care. The system has become distracted by compliance driven processes and unduly complex court processes.

The second cause of failure is when the child safety system unwittingly loses sight of its main priority: the safety and wellbeing of children in state care. This factor is amorphous, intangible and it is difficult to detect all of its manifestations.

There are several overarching themes that arise repeatedly throughout this Report. First, and most importantly, is that the system is concerned with the care and nurture of children. This need hardly be said and yet despite the ubiquitous use of phrases such as 'child focused' or 'wrap around care', there are many examples of the child's wellbeing becoming a lost focus. In part this is because the Department has developed a tendency to contort itself in compliance-driven processes and procedures.[11]

One manifestation of this misdirected emphasis has been the Department's insistence that it should be the final decision maker in relation to court applications for the removal of children and the principal decision maker in relation to the reunification or long-term placement of children. The Department has in practice approbated and reprobated the court process; on the one hand it has accepted that the court is the proper authority to remove children into state care, but on the other, whenever possible it has endeavoured to ensure that it alone is the decision maker in relation to reunification or long-term placement. The evidence indicates that the Department has a tendency to adopt its own priorities in relation to permanency options, favouring by default long term guardianship of the Department over other options given higher priority under the permanency hierarchy prescribed in section 5BA(4) of the *Child Protection Act 1999* (Qld) (Act).[12] This approach has entailed almost entirely eschewing adoption under the *Adoption Act 2009* (Qld) as an option, no child in care has been adopted since 2019.[13]

[11] See Chapter 10 of this report and Companion Report 7: System Enablers.
[12] Transcript, Evidence of Corinne Porta (20 November 2025) 2427:46:2428:4, 2481:24, 2428:26-2428:35; Transcript, Evidence of Corinne Porta (21 November 2025) 2482:11.
[13] CA-56, *Adoption from care of children subject to child protection orders,* tendered 5 February 2026, 109; Transcript, Evidence of Clair Martin (4 February 2026) 3979:7-14, 3985:33 – 3986:14.

The focus of much of the Department's frontline work is upon compliance and court-related processes. This focus detracts from the ability of frontline officers such as child safety officers to build trusting relationships with the children and families they are responsible for. The distraction from core duties has been exacerbated by a bifurcated, duplicative and overly complex court process. The analysis of the interaction between the Department, the court process and the misdirecting effects of these factors is the subject of the Companion Report 2: Child Protection Litigation.

The Commission recommends a wholesale redesign of the court process with several objectives in mind, including allowing the Department to focus on its core role of fostering a trusted relationship with children in state care, with their families and with kinship and foster carers. A fundamental objective of these recommendations is to refocus the Department's priority activities upon the protection, nurture and wellbeing of children in care.

Insufficient focus on known proximate causes of harm to children

A third important reason for the failure to achieve a significant reduction in the number of children in state care has been an ongoing failure to focus upon the proximate causes of harm to children and to take targeted measures aimed at those proximate causes. The known proximate causes are alcohol and drug abuse, gambling, and their companions, mental health decline, violent behaviour and especially domestic violence. These causes have other close allies, including socio-economic and cultural alienation, poor health, passive welfare, purposelessness as well as the full gamut of educational, economic and social disadvantage.

The Commission strongly supports early intervention and early help strategies aimed at supporting vulnerable families to care for their children and avoid, whenever possible, the removal of children into state care.[14] The Commission is also strongly supportive of doing all that is possible to support families to facilitate the earliest possible reunification or long-term placement of children. The suggested wholesale reform of the court process is also aimed at supporting this objective.

However, the Commission considers that the missing piece in the strategies aimed at prevention has been a failure to directly confront known proximate causes of harm to children. Generally, the emphasis of programs aimed at assisting vulnerable families has been to provide family support. These programs, while most certainly needed, are not sufficiently targeted at the proximate causes of harm to children, namely alcohol and drug abuse, exposure to domestic violence, and an ongoing state of purposelessness exacerbated by passive welfare. Without a

[14] See the discussion of targeted early intervention in Chapter 5 of this report and in Companion Report 1: System Functions.

targeted attack on those proximate causes, early intervention and early help programs will not be potent enough to have a material impact on reducing the causes of child harm and changing behaviour which threatens the wellbeing of children. There is a tendency in the discourse concerning child safety to treat these direct causes like the proverbial 'elephant in the room'.

The Commission in April 2026 received a submission from the Cape York Institute (CYI), which tackles these uncomfortable issues head on. The CYI offers an approach which combines community-led responsibility with protective measures involving restricting access to alcohol and where necessary imposing conditions upon access to passive welfare. These measures have been developed over time by the CYI and implemented through a locally controlled Family Responsibilities Commission. They have proven to be successful and have the potential to be implemented more broadly.

The lamentable over-representation of Aboriginal and Torres Strait Islander children in the child safety system is a scourge which must be tackled head on, as the CYI suggests. The Commission strongly supports the approach advocated by the CYI. This approach is discussed in Chapter 4 of this Report, concerning the over-representation of Aboriginal and Torres Strait Islander children.

The Commission acknowledges that the approach implemented by the CYI, particularly the ability to control access to alcohol through licensing measures, may not be practically feasible in urban areas. However, the focus upon targeted programs aimed at drug and alcohol abuse should be prioritised generally in both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander communities. The effects of drug and alcohol abuse are not confined to any racial or cultural group. The general approach of speaking candidly about, and targeting, the proximate causes of behaviours which lead to and exacerbate harm to children should be embraced and adopted generally in the design of all programs aimed at prevention. The silence as to these subjects must cease, as a first step towards changing the behaviours which result directly in harm to children. The proximate causes are undoubtedly uncomfortable subjects, but those causes will continue to undermine the implementation of the best-intentioned early targeted intervention and family support programs unless and until they are explicitly targeted.

The tension between statewide duty and local decision-making

The fourth and fifth reasons are largely concerned with reforms that have failed to reduce the number of Aboriginal and Torres Strait Islander children in care. The fourth reason lies in the insistence that programs and interventions concerning Aboriginal and Torres Strait Islander children be locally determined. This sets up a tension between coordinated government action at a state-wide level and fragmented local solutions. This is a complex and politically sensitive

topic. The resolution of this tension requires a sophisticated exploration of what self-determination means in the context of the child protection system and how best to give it real and practical effect. This topic raises questions of a constitutional nature, including establishing a coherent foundational theory for the legitimacy of the authority of local bodies, the boundaries of such authority and a model for accountability to the communities over which they might exercise authority, to mention but a few. These questions are outside the Commission's terms of reference and beyond its analytical capacity. They are foundational political questions. They are also questions which extend beyond 'cultural authority' used in the sense of appreciating the unique cultural norms and practices of particular Aboriginal and Torres Strait Islander communities, and beyond the capacity to understand those matters through cultural capability training. They extend beyond an understanding of traditional cultural decision-making structures and hierarchies to include questions about how traditional 'authority', properly understood, would apply in the modern context of government responsibility at the state and federal level; who would be subject to that authority; and how the decisions makers would be accountable and to whom.

At present, the discourse concerns cultural authority in a traditional sense, without addressing the broader foundational questions. This is evident from the fact that delegation to an ATSICCO is generally limited to the delegation of certain specific powers, such as the power under section 82(2) of the Act concerning placement with a parent, and under section 88(2) concerning contact between the child and the child's community. More particularly, it is evident from the fact that presently such delegations are specifically referable to an individual child and subject to ongoing consent on the part of the child's parent or parents, even though by definition authority is not limited by assent to it. These conditions reflect, properly, that the authority, and accountability, of the ATSICCO in a constitutional sense has not been established, for the reasons referred to above. While these limitations upon the scope and conditions of delegated authority persist, it is questionable whether delegated authority contributes more than it detracts from improved outcomes for Aboriginal and Torres Strait Islander children having regard to the underlying tension between government state-wide responsibility and fragmented local community-led solutions. While this tension continues, it is likely to continue to have the Sisyphean effect described by the CYI as 'death by a thousand consultations'.[15]

Adopting unassailable assumptions

The fifth reason reform has been because of the pervasive agreement to, and adoption of, certain uncontestable truths. This phenomenon is nuanced and diffuse, but its impact as a pervasive

[15] This issue is discussed in Chapter 4.2 of this report.

impediment to substantive reform should not be underestimated. In the history of human affairs, doctrine and belief, though intangible, have just as often resisted change as led to it, even when the available evidence has long demonstrated there is good reason to question the wisdom of the prevailing doctrine.

In the context of the child safety system, some doctrinal propositions have been given legislative mandate. In other instances, underlying doctrinal opinion is applied more subtly, through tacit bureaucratic assent manifest in the outcome of decisions. The latter are more dubious as they do not represent express policy made into law. They are also potentially more potent impediments to reform because they are tacit and flourish under the cover of bureaucratic process and procedures.

The relationship between the paramount principle in section 5A of the Act and the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) in section 5C brings into focus the contest between two separate but related principles which have legislative mandate. This relationship is discussed in Chapter 5, the essential point being that these principles are capable of clashing. In the Commission's view, if the wellbeing of children is truly to be the centre point of the child safety system, the paramount principle should remain just that. This requires that real and genuine evaluation of the individual child's best interests must take precedence over the pre-determined benefits assumed to be conferred upon Aboriginal and Torres Strait Islander children by the application of the ATSICPP. If it is believed that there is no capacity for any clash between these principles, subject to their full application, as has been contended by some advocates,[16] or that for Aboriginal and Torres Strait Islander children the paramount principle in section 5A should yield to the ATSICPP, the Act should be amended to say so expressly.

For reasons discussed in Chapter 5 and Companion Report 1: Functions of System, the Commission considers the amendments made in 2017 to the paramount principle in section 5A, which introduced the notion of assessing the best interests of a child ***'both through childhood and for the rest of the child's life'*** is practically incapable of being evaluated and applied save essentially as an exercise in speculation. More importantly, the amendment obscures the primacy of section 5A, particularly when it falls to be considered in the context of Aboriginal and Torres Strait Islander children. This is because elliptically it gives license to assumptions which accord with the ATSICPP. The amendment distracts from the real inquiry which is to evaluate the child's best interests, not to assume, or give weight in an abstract sense to assumptions which

[16] QATSICPP, *Submission to Child Safety Commission of Inquiry* (August 2025); Office of the Aboriginal and Torres Strait Islander Children's Commissioner et al, *Joint Statement urging governments to protect and fully implement the Aboriginal and Torres Strait Islander Child Placement Principle* (Statement, 3 March 2026).

may not accord with the actual circumstances of the child in question. As said above, if for Aboriginal and Torres Strait Islander children the ATSICPP is to be the paramount principle, the Act should say so. For these reasons the Commission recommends that the above amendments to the paramount principle be removed.

As discussed in Chapter 5 and Companion Report 1: Functions of System, evidence before the Commission concerning the Department reunification and placement decisions has revealed a tendency to give tacit priority to achieving the objectives of the ATSICPP in priority to an evaluation of the child's best interests. This opaque priority has been revealed in several of the case studies and is an example of the danger of bureaucratic decision making as an impediment to reform.[17] Those examples also reveal the danger of predetermined assumptions, here what is in the best interests of Aboriginal and Torres Strait Islander children, being elevated to a status that protects them from, or at least discourages, genuine scrutiny. This protected status is usually tacit, though uncharacteristically in the case of Ellen, a Departmental manager stated that 'she did not agree with permanent care orders for Aboriginal children being made to non-Aboriginal carers, and that this would never have been a discussion point under her oversight' reveals what more often goes unsaid. Such unscrutinised decisions, based upon predetermined tacit assumptions, result in decisions made contrary to the paramount principle and therefore fortify the need for court scrutiny of reunification and long-term placement decisions, as discussed in Chapter 5. For the above reasons, the Commission considers pre-determined assumptions about the best interests of Aboriginal and Torres Strait Islander children represents both a risk to the safety of Aboriginal and Torres Strait Islander children as well as an intangible impediment to reforming the child safety system.

There are other examples of assertive dogma prevailing in the child safety context. The ATSICCO sector ubiquitously pressed the contention that the delegation of authority inevitably yields better outcomes for Aboriginal and Torres Strait Islander children. The issue of delegated authority is further discussed in Chapter 4, and especially at Chapter 4.5.

The Commission does not dispute that a well-crafted program to be undertaken by an ATSICCO has the potential to produce good outcomes for Aboriginal and Torres Strait Islander children. However, the Commission questions the reasoning that delegated authority will, *per se*, lead to better outcomes, or that such outcomes cannot otherwise be achieved. The arguments in support of delegated authority as a self-executing means of achieving better outcomes for Aboriginal and Torres Strait Islander children rely upon vague and poorly explained reasons.

[17] See, case studies of Aimee and Jarred.

Those reasons are founded essentially upon assertedly uncontestable contentions as to cultural knowledge. The reasoning is impenetrable because the character of cultural knowledge is not susceptible to question for racial or cultural reasons. By its own definition, this reasoning defies the need for evaluation of programs which are claimed to be in furtherance of the assumed truth As discussed in Chapter 4, the Commission sought the results of evaluations of certain programs but was not provided with any.

A further consequence of entrenched assumptions in the context of the child protection system is that it creates vested interests in particular truths and among groups dedicated to advancing them. This consequence is manifest in the common positions concerning delegated authority advanced by the ATSICCO sector and allied organisations and peak bodies throughout the course of this Inquiry.

The ATSICCO sector and allied peak bodies have formed a coalition of interest groups which support the solutions based essentially upon the same common assumptions. Delegated authority is the principal example. There is no reason to criticise a coalition formed to advance a common cause. Rather the question again comes back to an evaluation of the effectiveness of the proposed solutions.

If reform in the future is to be effective, pervasive assumptions, within the Department and among the interest groups, must be exposed. They must be open to real and genuine debate and evaluation if paramount interests of children are to be at the centre of the child protection system.

The need for accountability, feedback and learning systems is considered in Chapter 10 of this Report, and Companion Report 7: System Enablers.

Central themes and their relationship to a broken system

It is effectively impossible to discuss one element of the child safety system without divagating to other related topics. For this reason, the Commission has sought to analyse the system by reference to the central themes which should inform the priorities of the system. This Report, allowing for unavoidable digressions, discusses the Commission's analysis in a sequence which mirrors the notional journey of a child through the stages of the child safety continuum.

In keeping with this approach, the unifying and critical theme is the paramount principle, about which it is unnecessary to say anything further at this stage.

Family based care is preferable to residential care

The second overarching theme is that family-based care is generally preferable to residential care. This is uncontroversial, essentially because it is generally the case that family-based care

provides children with better opportunities for continuity and stability, and, most importantly, better opportunities for attachment to a suitable adult than does non-family-based care. From a resources perspective, the cost of residential care is many times greater than the family-based care, with likely worse outcomes for the child.

For these reasons, the Commission has given priority to investigating all aspects of the present system that operate as disincentives to family-based care and to the ways in which the system might be reformed to facilitate and support family-based care. Accordingly, the Commission commenced its inquiries by hearing from foster carers and kinship carers about their experiences of caring for the children and their dealings with the Department.

Removing disincentives to family-based care: Listening to the experiences and complaints of carers and children

The evidence indicated that carers were generally very dissatisfied with their interactions with the Department. While not all complaints are justified and some may be captious, the carers' complaints presented to the Commission did not fall into those categories. Indeed, the complaints reinforce the need for a much better complaints system as discussed in Chapter 7, and Companion Report 3: Models of Care. The Commission was struck by the absence of a practice within the Department to survey carers about their experiences or concerns as carers. This is a commonplace practice in areas of service delivery of far less significance than child protection.

The Department's practice is to rely upon foster and kinship agencies to generally manage its relationship with volunteer carers and to be the conduit through which feedback reached the Department. The Commission regards this approach as unsound having regard to the critical role performed by carers. Further, in the context where the Department is the sole buyer of the services provided by foster and kinship agencies, objectively those agencies are inherently subject to a conflict of interest when it comes to reporting dissatisfaction, particularly when the dissatisfaction concerns the carers' dealings and relationship with the Department itself.

Removing disincentives to family-based care: Fostering foster and kinship carers

The above sub-heading is not intended as a double entendre. Kinship and foster carers are the best hope for the future of family-based care. To maintain and improve the number of carers to help meet the increasing demand for child protection, their role needs to be supported in every reasonably practical way, including better financial supports and different models of paid kinship and foster care discussed in Chapter 7 and Companion Report 3: Models of Care. But another

equally important way to support and encourage kinship and foster carers is to remove policies and practices that demoralise or undervalue carers.

Some of the disincentives are embedded in the Department's standard operating procedures and result, unsurprisingly, in a high degree of dissatisfaction on the part of carers. A clear example in this category is the Department's policy of not consulting with, indeed excluding input from, foster carers in relation to significant decisions which bear upon the permanency and wellbeing of children in their care. For instance, in relation to the reunification, or decisions relating to a change of placement in circumstances where the child is happily settled in the existing placement.[18] The Department was unapologetic about this policy. However, the Commission does not share that view. Kinship and foster carers with the day-to-day care of children, self-evidently, should be generally, and genuinely, consulted in relation to such decisions. It is they who are likely to have the best understanding of the child's needs, strengths and weakness, as is the case with any parent generally.

The Commission heard evidence of many other complaints that are attributable to a lack of real appreciation by the Department of the vital role played by voluntary kinship and foster carers. Some may on their face seem trivial or insignificant, but they combine to cause frustration, which in turn becomes a significant disincentive. The Commission heard evidence from many carers who described their frustrations in trying to engage with the Department about a range of day to day matters which of themselves may be thought of as the usual vicissitudes of daily life. However, but when getting the ordinary things done involves constant back and forth with the Department, when telephone calls and emails go unanswered, it becomes an intolerable burden for the carer. The particular circumstances are as variable as the needs of different children, but the pattern described by witness was broadly the same: an exhausting 'run around' to get basic things done for the child where Department approval is required. A common complaint concerned the failure to respond in a timely fashion to attempts by the carer to communicate with the Department.[19]

An important feature of the Department's relationship with foster and kinship carers which must not be overlooked is that carers are vulnerable to the Department in several important significant ways. First, and most importantly, they are vulnerable to the Department, including its responsiveness, in meeting the child's needs, particularly in relation to medical issues. The second is that their reputations are vulnerable to Departmental assessments of their suitability as carers. This factor has two significant consequences. The first is that it can lead to reticence

[18] See Companion Report 3: Models of Care; See case study of Ellen.
[19] Transcript, Evidence of Witness H (8 September 2025) 118:33-118:35 and (9 September 2025) 208:27-208:30.

on their part to voice complaints, lest from their perspective it provokes an adverse reaction or assessment by the Department. Further, if there are concerns raised by the Department, whether they are reasonable or not, carers are vulnerable to the quality of the investigative process the Department initiates and controls. The evidence given by Witness G and Witness L in Toowoomba exposed a combination of these factors.[20] Leaving aside that the concern proved to be unjustified and should not have been framed as if it was as a child harm investigation, it also created a material reputational risk for the carer.[21] The process led to the carers deciding not to continue as foster carers. This example underscores the importance of a complaints process that deals fairly with carers while also protecting children.

The Court process

The court process is integral to the integrity of, and confidence in, the child safety system and to achieving the best outcomes for children. First and foremost, it is indispensable to public confidence in the system, particularly against the historical background of the stolen generation. There must be no rational doubt that a child's removal was necessary nor whether there were other reasonable alternatives in the circumstances. The court system must not function as an impediment to reunification or long-term placement, preferably with kin or other family-based carers. The jurisdiction of the court should be adapted to what the Department refers to as the 'human services framework', which means essentially the social context in which it operates. Court processes and procedures should be designed to facilitate early reunification with family or kin, whenever possible. The court should have a greater role in overseeing and directing the Department's actions at the earliest stages to achieve reunification where possible, and otherwise permanency, preferably in long-term family-based placement.

The Commission has concluded that the present jurisdiction which bifurcates responsibility between the Office of the Child and Family Official Solicitor (OCFOS) and the Director of Child Protection Litigation (DCPL), and between emergent orders and child protection orders, is unnecessarily complex and operates as an impediment to enabling the timely and agile adaption of the court process to achieve objectives consistent with the child's best interests. The present system is asymmetric in the sense that a child is only removed into state care with court approval, but that generally the court is not involved in long term placement decisions or reunification decisions. Those decisions are potentially as consequential as the decision to remove the child in the first place and carry significant risk. Court oversight would allow scrutiny of such important

[20] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4215.
[21] See, case study of Helen and Patrick.

decisions and evaluation of the child's best interests. Such oversight will reduce the risk of harm to children at the critical decision-making point of reunification or long-term placement. It will also reduce the risk of reunification or placement decisions being made without impartial evaluation of the objective circumstances. The evidence before the Commission has revealed that there is good reason to require the court to scrutinise reunification and long-term placement decisions.[22]

Court approval of carers and the Blue Card requirement

The court's involvement in reunification and long-term placement decisions provides an important opportunity for the court to evaluate whether a person is a suitable kinship or foster carer notwithstanding that they may not have, or be able to obtain, a Blue Card.

The Commission has eschewed rehearsing the debates that have occurred in relation to the Blue Card requirement generally, noting that legislation has been passed but not yet implemented in relation to this requirement. However, the Commission considers that, in the context of the child protection system, the community should have confidence in a process in which the court is able to evaluate whether a proposed carer is suitable. More specifically, the protective factors that may be fashioned by court order together with ongoing oversight by the Department allows for a more robust protection of the child than the generic Blue Card requirement. The Commission considers that reform in this respect, which may be implemented initially without requiring legislative change, has the potential over a short time frame to significantly increase the number of kinship carers, with the consequential effect of reducing reliance on sub-optimal residential care facilities, often presently operated by unlicensed providers.

1.4 A Guide to help navigate the remainder of this Report.

Readers wishing to continue with the Executive Summary can jump to Chapters 5 to 11, which are, in effect, an executive summary of the chapters contained within each of the separate Companion Reports.

For readers who want to continue reading the Executive Report, its structure reflects the Commission's systems-based approach to understanding and reforming Queensland's child protection system. It moves intentionally from establishing shared foundations and diagnosis,

[22] See case studies of Aimee and Jarred.

through examination of system functions and experiences, to the identification of structural enablers and a sequenced pathway for reform.

Chapters 2 and 3 establish the foundations for the report. Chapter 2 set outs the purpose, scope, and methods of the Commission, the historical and systemic context in which the Commission has conducted the Inquiry, and the analytical framework that underpins its work. The next chapter, Chapter 3, examines the foundational principles that govern the child protection system, early intervention and family support, organisational culture, and the State's role as corporate parent and the exerciser of authority and responsibility. Together, these two chapters provide the conceptual and ethical grounding for the analysis that follows.

Chapter 4 discusses the over-representation of Aboriginal and Torres Strait Islander children.

Chapters 5 to 8 examine how the child protection system operates across the child and family continuum. Chapter 5 focuses on the key functions in the child safety system — targeted intervention and family support; intake and assessment; and placement and casework decisions once children are in State care. These functions determine whether risks to children are promptly and adequately addressed, whether parents engage positively with the system, whether unnecessary escalation can be avoided, and whether the child's best interests are adequately promoted over time.

Chapter 6 focuses on the child protection litigation model and the court process, including legislative, structural and procedural reform to simplify litigation pathways that are child-centred, strengthen judicial oversight and ensure that State intervention is proportionate, accountable and reviewable.

Chapter 7 explores the care continuum, including family-based and non-family-based care, secure care, and future care options. It focuses on different models of care, the state of the residential care market, and the financial and governance conditions that have shaped both.

Chapter 8 addresses permanency, including adoption and the intersection between child protection and youth justice.

Collectively, these chapters focus on children's and family's experience of the system and how decisions, made at different points in time, shape safety, stability, and long-term outcomes.

Chapters 9 and 10 shift the focus from experience to system function and design. Chapter 9 examines the complaints system and whether the current framework enables concerns to be heard, assessed and acted up in a way that protects children and supports improvement. Chapter 10 explores the core functions underpinning and enabling the functioning of the child

protection system and, in particular, examines whether current structures, operating models, and governance arrangements support the system's intended purpose. It addresses leadership, governance, and accountability; workforce, culture, and practice capability; funding, commissioning, and market design; and information, technology, learning, and feedback systems. The analysis in this chapter identifies where structural features of the system enable or constrain effective practice and sustained improvement. It also considers the system-level enablers required to support reform: those conditions necessary for coherence, learning, accountability, and continuous improvement across the entire system.

Chapter 11 sets out a proposed pathway for reform, including sequencing and implementation considerations. This chapter supports practical action and sustained change, recognising that meaningful reform requires clarity of purpose, disciplined sequencing, and ongoing stewardship.

In addition to the main report, the Commission has produced a series of companion and supporting materials, covering detailed analyses of specific system components, case studies and vignettes, and summaries of submissions received. These materials provide further depth and evidence to support the findings and recommendations set out in this report.

Chapter 2

Introduction

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 2: Introduction

Approach and Overview

Children who enter Queensland's child protection system are already among the most vulnerable members of the community. They rely on the State and the many organisations and individuals who work within the system to keep them safe, nurture their development, and support their sense of belonging and stability. This report is concerned with whether the current child safety system in the State of Queensland is fulfilling that responsibility, and, where it is not, how to redesign it so that it can.

2.1 Purpose of the Commission

The Commission of Inquiry into the Child Safety System (referred to in this report either as the Commission or the Inquiry) commenced work on 1 July 2025 as a full, careful, open, and independent inquiry. Its task has been to investigate systemic issues within Queensland's child safety system, to identify systemic weaknesses, and to recommend reforms to better protect vulnerable children.[23]

In particular, the Commission has examined:

- the relevant state legislation, most significantly the *Child Protection Act 1999* (Qld) and the *Adoption Act 2009* (Qld)
- the policies, processes, procedures and practices of the Department of Families, Seniors, Disability Services and Child Safety (referred to in this report as the Department)
- policy and systematic failures affecting the safety and wellbeing of children, and reforms required to better support families and protect children at risk
- the operation and reform of the residential care system
- the effectiveness of the Department in its role as corporate parent.

The Commission has investigated how the child safety system operates for all those involved in it. This includes how the system works for Aboriginal and Torres Strait Islander children, their families and communities; how children, families, and carers experience decision-making and service delivery; the availability and effectiveness of early intervention programs; the operation of different models of care—including residential care, foster care, and kinship care; the

[23] Adopting the approach in the United Nations *Convention on the Rights of the Child*. In this Report, a 'child' is a person under the age of 18 years.

mechanisms available for raising concerns and complaints; and the extent to which the Department and those responsible for caring for children are held accountable for their decisions and actions.

2.2 The Commission's scope, constraints and methods

The Commission proceeds from the premise that Queensland's child protection system is not failing for lack of effort, commitment, or reform intent. Rather, the evidence suggests that the system's current design no longer reliably supports its intended purpose. Therefore, this report asks not only what is going wrong but what kind of system would deliver consistent care to vulnerable children over time.

The Terms of Reference for this Inquiry, reproduced in full in Appendix 1, are broad and permit a comprehensive examination of Queensland's child safety system. They require the Commission to inquire into systemic issues affecting the safety and wellbeing of children, including the operation of the statutory child safety system, the effectiveness of governance and oversight arrangements, and the adequacy of supports available to children, families, and carers.

The Terms of Reference originally required the Commission to provide its Final Report to Government by 30 November 2026. On 12 February 2026, in separate parliamentary statements, the Attorney-General, Minister for Justice and Minister for Integrity, and the Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence announced that the Commission would bring forward its recommendations and deliver its Final Report by 22 May 2026 so that reform of the child safety system could 'begin without delay'.[24]

The Government's commitment to prompt consideration and implementation of the Commission's recommendations is welcome. At the same time, the truncation of the Commission's timetable by approximately six months has necessarily constrained the depth to which some matters could be examined, assessed, and reflected upon. Where the Commission has identified that an issue would benefit from further detailed investigation or analysis, the relevant chapter of this report will note it.

Importantly, the expedited reporting date has not prevented the Commission from undertaking a rigorous and comprehensive examination of the significant aspects of the child safety system captured by the Terms of Reference. From the outset of the Inquiry, the Commission had

[24] Queensland Parliament, *Private Members' Statements*, Legislative Assembly, 12 February 2026, 230-232.

accelerated the inquiry program, coincidentally enabling it to gather extensive evidence, consult widely, and analyse both current practice and historical reform efforts within the truncated timetable. But for this fortunate coincidence, the Commission could not have addressed the significant systemic issues to the extent that it has been able to do so.

Having regard to the breadth of the Terms of Reference, the nature of the challenges facing the child safety system, and the requirement to examine case studies relating to child safety and wellbeing, the Commission's investigative approach comprised multiple, complementary elements: broad consultation across Queensland; formal public hearings; the receipt and analysis of submissions from interested individuals and organisations, targeting scoping inquiries; and a detailed review of relevant academic and grey literature. This mixed-methods approach enabled the Commission to examine not only how individual parts of the system operate, but how those parts interact in practice, and how past reforms have shaped current outcomes.

Total number of public hearings (July 2025-May 2026)	6 (hearing blocks)
Locations for hearings	Brisbane, Cairns and Toowoomba
Hearing days	50 (including opening and closing hearing)
Number of witnesses	70
Total number of exhibits	217
Total length of transcripts	5665 pages
Total number of Notices issued	246 Notices to Produce 152 Notices to Attend/Summons to Attend
Total number of submissions	1193 submissions in total: • 1002 from individuals • 191 organisations
Other engagement	• Youth forums, youth surveys • 132 children and young people took part in our online youth survey. • Two Youth Voices forums in Cairns and Toowoomba (over 50 young people and children across the two session). • Regional visits (Cairns, Yarrabah, Townville and surrounds)

Table 1.1: Hearings, Notices and Submissions at a glance

The Commission is satisfied that the evidence gathered is sufficient to support the findings and recommendations set out in this report.

2.3 A history of reform

Over the past thirty years, child protection has been subject to extensive reform at both state and national level. This reform has occurred through a combination of legislative change, machinery-of-government reform, and extensive external scrutiny, including state and federal inquiries and reviews. Most notable among these inquiries and reviews have been:

- the Human Rights and Equal Opportunity Commission's 1997 report *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*
- the 1999 *Final Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (the Forde Inquiry)
- the Crime and Misconduct Commission's 2004 report: *Protecting Children: An Inquiry into Abuse of Children in Foster Care* (CMC Inquiry)
- the Child Protection Commission of Inquiry report (Carmody Inquiry), *Taking Responsibility: A Roadmap for Queensland Child Protection*, released in 2013
- the Final Report of the *Royal Commission into Institutional Responses to Child Sexual Abuse*, released in 2017, and
- the Queensland Family and Child Commission's 2025 report *In Plain Sight: Review into System Responses to Child Sexual Abuse.*

The recommendations arising from these inquiries prompted significant reform, including the introduction of new legislation, the *Child Protection Act 1999* (Qld), the creation of the Department of Child Safety and the Department of Communities in 2004 (which merged in 2009 to become the Department of Communities, Child Safety and Disability Services), and amendments to the *Child Protection Act 1999* in the period 2004 to 2006, and again in 2010, 2014, 2016, 2017, 2021 and 2022.

Oversight mechanisms and statutory bodies were also established and refined over time, including, in 2004, the Child Death Case Review Committee (replaced with child death case review panels in 2014, and then by the Child Death Review Board in 2020), and the establishment of the Queensland and Family Child Commission (QFCC) in 2014, which replaced the Commission for Children and Young People and Child Guardian (CCYPCG) following the recommendations of the Carmody Inquiry.

These reforms reflect the sustained governmental and community recognition of both the seriousness of child harm and the complexity of protecting children within a statutory system. They also demonstrate a consistent effort to strengthen legal frameworks, governance arrangements, and oversight mechanisms in response to emerging evidence and changing expectations.

At the national level, successive attempts have been made to promote greater consistency and shared responsibility for child protection across jurisdictions. This includes the endorsement of the *National Framework for Protecting Australia's Children 2009–2020* (*Protecting Children is Everyone's Business),* followed by the *National Framework for Protecting Australia's Children 2021–2031* (*Safe and Supported*), both of which emphasise prevention, early intervention, and coordinated cross-system responses to child harm.

The reform history outlined above demonstrates that child protection in Queensland has been characterised by successive waves of reform, reflecting sustained attention, commitment, and effort at both state and national levels. Yet, despite this prolonged period of reform activity, an unacceptably high number of children continue to live in out-of-home care in Queensland.

This history presents an important analytical challenge. It suggests that we cannot attribute the difficulties confronting the child protection system solely to the absence of reform, nor can we resolve them through isolated legislative or structural change. A central question for the Commission is why repeated reforms have not fundamentally altered outcomes for children and families, and what this indicates about the way the broader child protection system has configured responsibility, authority, and accountability.

A timeline of major child protection reforms in Queensland is set out at Appendix C.

2.4 The scale and nature of child harm

Child harm occurs across a range of contexts in Australia. It includes harm experienced within families, harm perpetrated by adults in positions of authority or trust, and harm that occurs within institutional, community, and service-delivery environments. Over recent decades, national and state-based inquiries have repeatedly documented the prevalence and seriousness of harm to children and its enduring consequences for individuals, families, and communities. This body of work has led to substantial child protection and safeguarding reform in Queensland, including the recently introduced Child Safe Standards,[25] the establishment of the Reportable Conduct

[25] These ten standards were introduced from 2025 with implementation overseen by the Queensland Family and Child Commission.

Scheme,[26] and the evolution of reporting and oversight schemes aimed at responding to harm and improving accountability within the broader child protection system.

The Australian Child Maltreatment Study (ACM) is the first national study to estimate the prevalence of the five recognised forms of child maltreatment: physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic and family violence.[27] Similar to the findings of past child protection inquires and reviews, it illustrated not only the scale of child maltreatment in Australia but also its complexity and cumulative nature.

The growing number of children in Queensland[28] subject to statutory intervention and in out-of-home care indicates that abuse occurring within familial relationships remains a significant and enduring contributor to child harm and the number of children needing the statutory child safety system. However, the insidious nature of child maltreatment recognised across these past inquiries, reviews, and studies indicates that the population of children affected by maltreatment may be far larger than the cohort who enters the child safety system and that there are harm factors that sit beyond the reach of statutory intervention alone. While the statutory child safety system plays a critical role in responding to serious and immediate risk, the prevalence and nature of child maltreatment highlight the importance of prevention, early intervention, and coordinated responses across the broader child protection system.

How this report uses the terms child protection system, child safety system, and child protection functions

The **child protection system** refers to the broad system of shared responsibility for protecting children from harm and promoting their safety and wellbeing. Children exist within families, communities, non-government and Aboriginal and Torres Strait Islander community-controlled organisations, and government agencies responsible for health, education, police, youth justice, courts, and community services. Past inquiries have consistently shown that serious harm often occurs not because there was no system involvement, but because multiple parts of the child protection system were involved without shared understanding, coordination, or accountability. The **child safety system** refers to the statutory system that is the primary focus of this Inquiry, reflecting the Terms of Reference. It includes the Department's statutory responsibilities, commissioned

[26] Queensland has introduced a nationally consistent Reportable Conduct Scheme (to commence soon) which is overseen and regulated by the Queensland Family and Child Commission.
[27] Ben Mathews, 'The Australian Child Maltreatment Study: National Prevalence and Associated Health Outcomes of Child Abuse and Neglect' (2023) 218(6) *The Medical Journal of Australia* 53–551.
[28] The number of children in out-of-home care has increased from 7,999 in 2011/12 to 10,092 in 2023/24. These figures are drawn from the Productivity Commission's 'Report on Government Services' for 2013 and 2025 (noting 2024-25 data is not available for Queensland due to the transition to a new client management system during that financial year).

services and internal functions, and the governance, workforce, information, and accountability arrangements through which the State seeks to protect children and support families. The Department plays a central leadership and stewardship role within the system. **Child protection functions** are the statutory functions exercised within the child safety system when a child reaches a threshold of harm or risk. These include investigation, court intervention, removal, guardianship, and other coercive powers exercised under the *Child Protection Act 1999* (Qld). These functions involve the State's most intrusive powers and carry clear legal and ethical responsibilities. Accordingly, while this report focuses on the effectiveness of the child safety system, it should not be taken as an assessment of one department in isolation. Rather, it is an opportunity to reflect on how the child safety system operates within, and contributes to, the broader child protection system, and how we can strengthen collective responsibility, leadership, and accountability in the interests of vulnerable children.

2.5 Framing the system: shared responsibility, clear accountability

The Commission has focused primarily on the child safety system, most notably the statutory child protection functions and, in some instances, funded non-government providers. While this focus reflects the Terms of Reference, it is critical to acknowledge that children's safety and wellbeing do not sit within a single agency or service system. Children exist within families, communities, and institutions, their safety shaped by collective actions, or inaction, of the broader child protection system, including health, education, police, courts, and community services.

Focusing on one agency provides an important but partial view of children's experiences. Past inquiries and reviews have consistently shown that serious harm often occurs not because of a lack of involvement from parts of the system, but because multiple parts of the system were involved without shared understanding, coordination, or accountability. The Carmody Inquiry highlighted that over-focusing on the statutory child safety system risks obscuring the shared responsibility of the broader system for prevention, early intervention, and wellbeing. Similarly, the Crime and Misconduct Commission Inquiry into abuse in foster care and the Queensland Family and Child Commission's report *In Plain Sight* demonstrated how fragmented responsibilities, poor information-sharing, and unclear leadership allows risks to remain visible yet unacted upon across systems.

Strengthening a single part of the child protection system in isolation is insufficient. Children's safety depends on a culture of protection and collective responsibility, where all agencies understand their role in protecting children and take responsibility for outcomes within their remit. At the same time, effective system functioning requires clear leadership. Multiple reviews have reinforced the need for a lead agency with the authority, capability, and mandate to bring together information across the system, to see the full picture of a child's life, and to act proactively and responsively when risks emerge. Without this, responsibility diffuses, and accountability dilutes.

While the Commission's focus has been on one part of the child protection system—the child safety system — the report should not be taken as an assessment of one department alone but as an opportunity to reflect on how the entire child protection system functions together to nurture and protect children. Lasting reform requires shared responsibility across government and partners, supported by strong systemic leadership and clear lines of accountability. Only through collective action across policy, practice, and culture can Queensland move beyond managing risk to ensuring children are safe, supported, and able to thrive within their environments.

2.6 Responses and responsibilities in the child safety system

The State of Queensland performs two distinct but interrelated roles within the child safety system, one at a system level and the other at an individual level.

At a system level, the State establishes the legislative and policy framework that governs tertiary child protection in Queensland, and is responsible for funding, overseeing, and coordinating the institutions, services, and programs that comprise it. In this capacity, the State exercises a governing[29] function and performs a stewardship role,[30] with responsibility for ensuring that the child safety system is coherent, effective, and capable of protecting children and promoting their wellbeing.

[29] In this sense, 'governance' broadly means the interaction between governments, businesses, and non-profit organisations in policy formation and implementation, and includes regulating, providing, and distributing: see Kees Kersbergen and Frans Waarden, "'Governance" as a Bridge between Disciplines: Cross-Disciplinary Inspiration Regarding Shifts in Governance and Problems of Governability, Accountability and Legitimacy' (2004) 43 *European Journal of Political Research* 143–171; David Levi-Faur (ed), *Oxford Handbook of Governance* (2012).

[30] 'Stewardship' is the art of getting things done amidst a complex and dynamic context.' It 'is a core ability for agents of change when many minds are involved in conceiving a course of action, and many hands in accomplishing it', Organization for Economic Cooperation and Development, *Systems Approaches to Public Sector Challenges: Working with Change* (Report, 2017) 60, adopting the definition found in Bryant Boyer et al, *Legible Practises: Six Stories about the Craft of Stewardship* (Report, 2013) 7.

At the critical individual operational level, the State assumes the role of corporate parent for children whose removal from their families and placement in state care is ordered by the Childrens Court. In this role, the State assumes responsibility for the day-to-day care, protection, and wellbeing of children in out-of-home care (OOHC), including decisions that affect their safety, stability, and development.

The State is not a natural parent, nor is it inherently suited to the relational, individualised, and continuous task of parenting. Designing and administering a system capable of meeting the diverse, complex, and evolving needs of children in care is, therefore, intrinsically challenging for the State. As this report explains, the task of acting as a corporate parent constitutes a 'wicked problem' — that is, one that requires the State to deploy structured systems, rules, and resources to respond to highly individual and nuanced needs within a dynamic and complex environment.

Historically, statutory child protection was meant to operate as an intervention of last resort, engaged when children faced serious harm or unacceptable risk. Over time, however, with the child safety system increasingly engaging with families experiencing chronic vulnerability, unmet service needs, and cumulative harm, the practical scope of statutory involvement has expanded. This expansion has occurred within a broader child protection system context and does not reflect a formal redefinition of the statutory role. Nonetheless, it has altered how the child safety system functions and has implications for its capacity to fulfil its core protective purpose.

Recognising both the inherent complexity of the State's role as a corporate parent and the evolving demands placed on the statutory system does not diminish the State's responsibility. Rather, it emphasises the importance of a child safety system deliberately designed to support children in care to be safe, nurtured, and supported to achieve their best potential. This should remain the overarching goal of the child safety system.

The Commission's central task is to examine whether the current child safety system is achieving that objective and, where it is not, to identify the reforms required for it to do so. This necessarily entails consideration of the State's broader governing and stewardship responsibilities, including the effectiveness of the statutory framework, the performance and oversight of the Department, and the coordination of the roles played by non-government organisations and other system participants.

2.6.1. The paramount principle as the governing standard

The purpose of the child safety system is simple: to nurture and care for children in need of state protection as would a reasonable natural parent. This formulation aligns closely with the State's role as a corporate parent for children who enter the statutory care system and has become

known as the paramount principle.[31] While the Terms of Reference focus primarily on the statutory or tertiary system, the paramount principle applies across the full continuum of responses to children and families.

The paramount principle requires that, in all decision-making within the child protection system, the best interests of the child are the number one consideration. This obligation extends beyond individual statutory decisions to encompass the design and operation of policies, programs, and service responses that shape children's experience of the system over time.

It is useful here to bear in mind that the profile of a typical child entering the system—the 'every child' reflected consistently in the evidence before the Commission—is a child who:

- is known to services early and whose family struggles to access sustained support
- enters care following escalation of harm
- experiences instability through multiple placements
- spends time in residential care
- intersects with the youth justice system, and
- exits care without secure foundations for adulthood—often to see the same cycle repeated in the next generation.

The 'every child' is not an outlier narrative. Rather, this profile reflects patterns consistently seen across submissions, hearings, and oversight reporting.

At each point along this continuum, the child safety system responds to the child as they present in that moment. What is less visible is how earlier system responses—including the availability, accessibility, and effectiveness of prevention and early help for families—have shaped the child's circumstances before statutory intervention from the State. The paramount principle, therefore, demands attention not only to moment-specific risk assessments, but to whether children and families receive timely, sustained support capable of preventing escalation and reducing harm. Early help is a critical expression of the paramount principle in practice. Where effective, it can reduce the need for statutory intervention, minimise disruption to children's lives, and expand the State's capacity, as corporate parent, to provide stable, therapeutic care to those children who do enter the tertiary system.

The paramount principle provides the guiding standard for the Commission. It is the standard by which system design, governance arrangements, and practice across the child protection

[31] Chapter 6.2 of this report discusses the paramount principle in detail.

continuum gets assessed. The chapters that follow will consider its application across time, rather than at isolated decision points.

However, it is important to keep in mind that the statutory meaning given to the paramount principle in section 5A of the *Child Protection Act 1999* (Qld) must be applied specifically and individually to a child when deciding what decisions should be made for the child in question about all matters affecting the wellbeing of the child—from removal to placement and reunification. Although the paramount principle is the overarching guiding moral norm for the child protection system, the State must evaluate it on an individual basis when required to make specific decisions on behalf of a child in its capacity as the child's corporate parent.

The statutory meaning of the paramount principle, its relationship to the Aboriginal and Torres Strait Islander child placement principle, and how it should be understood and applied when the State is acting in its capacity as the corporate parent for an individual child is discussed in Chapter 3.4.

2.7 Framework for analysis and reform

The Commission has examined a multi-layered and highly interdependent child safety system. It involves legislative frameworks, government decision-making, service systems, professional judgement, and the experiences of children, families, and carers. Over time, successive reforms have sought to address discrete elements of this system, often in response to failures or pressures. However, the persistence of systemic problems indicates that the State needs a more coherent and integrated approach to analysis and reform.

Therefore, the Commission has adopted a structured framework to guide both its examination of the current system and the development of a reformed system. This framework applies 'systems thinking' to understand how the entire child protection system operates, how its components interact, and how past reforms have produced both intended and unintended consequences. In reforming the system, systems thinking focuses on the purpose of the reformed system and appraises reform proposals by asking whether they will contribute to achieving the purpose.

Together, these elements provide the foundation for the Commission's analysis and recommendations. They enable the Commission to move beyond isolated issues or procedural fixes to consider how we may redesign the system to make it coherent, sustainable, and capable of delivering meaningful and lasting change. In practical terms, this means examining how decisions, incentives, and information flow across the system, shaping children's experiences over time. The following sections 2.7.1 and 2.8 explain these two elements further.

2.7.1 Systems thinking

Efforts to improve child health, safety, and wellbeing occur within a complex child system where the extent and form of collaboration between the many participants affect the wellbeing of children. So complex are child safety systems, including those in Australia, that policy problems in child protection are often described as 'wicked' in that they present a puzzle, highly resistant to definition or resolution. Consequently, the Commission's overarching framework is 'systems thinking', which is a well-developed approach for analysing and resolving complex public policy problems in child safety systems.[32]

Systems thinking views complex problems as interconnected systems, emphasises the relationships and interactions between various components, and enables policy-makers to address problems by making a range of coordinated and interrelated responses involving a wide range of government and non-government organisations, and trade-offs between conflicting goals.[33] In its Inquiry, the Commission has used systems thinking for two purposes: first, to look back at how the child protection system currently operates and the effects of past reforms; and second, to look forward and propose new approaches.

In using systems thinking to analyse the current system, the Commission has sought to understand and articulate the problem, which includes defining the boundaries of the system and examining its elements, dimensions, and dynamics. Even though the Terms of Reference focus on the tertiary statutory protection system, the Commission has concluded that the tertiary system and the factors that contribute to it not achieving its intended purpose cannot be properly understood in a vacuum. Thus, we must give attention to the primary 'prevention' system and the secondary 'early intervention' system. The Commission has also sought to analyse the root causes behind the problem and to identify the leverage points where interventions (legislative changes, procedural change, policy changes, behavioural shifts, technology changes etc.) are likely to have a significant impact on the operation of the system.

In analysing the dynamics of the child safety system to understand how it is working, the Commission has drawn on three key 'systems ideas'.[34] First, the waves of reform to the system over the past thirty-odd years have caused 'ripple effects', some of which have led to unintended

[32] Productivity Commission, *Enabling a Public Health Approach to Protecting Children* (Report, December 2021)17; Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010); David Lane et al, 'Blending Systems Thinking Approaches for Organisational Analysis: Reviewing Child Protection in England' (2016) 251 *European Journal of Operational Research* 613, 614–622.
[33] Organization for Economic Cooperation and Development, *Systems Approaches to Public Sector Challenges: Working with Change* (Report, 2017).
[34] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010).

consequences.[35] The second useful systems idea is 'requisite variety',[36] or, as Munro expressed, 'children's needs and circumstances are varied so the system needs to offer equal variety in its response.'[37] A good example is whether there is enough variety in the available care options in the tertiary system to cater for the almost infinite variety of needs of the children entering the system—see the discussion in Chapter 7 of this report.

The third important systems idea is the concept of 'feedback' and its contribution to how the system 'learns'.[38] Feedback is information gathered about the performance of a process or system to assess whether it is performing as required, and whether measures need to be taken to improve its performance. Linked to the notion of feedback is the concept of 'loops' of learning, which enable corrective action to redress malfunctioning parts of, or imbalances or problems in, the system.[39] The Commission proposes (in Chapter 10) that the broader child safety system should institutionalise the use of feedback and the development of outcome and output indicators to enable the system to self-regulate to improve children's experience of care.

2.8 The purpose of the reformed child safety system

Over time, Queensland's child safety system has become a patchwork of reform—a safety net that is unevenly woven. In places, the net contains gaps through which children and families fall without timely or sustained help. In other places, it tightens in ways where interventions are poorly matched to a child and their family's circumstances, sometimes producing unintended harm.

The result is a system that often operates as designed but not always as intended. It may be capable of responding at points of acute risk yet be unable to do so consistently in ways that benefit the children it is there to protect.

The task of this Commission, therefore, has not been to propose reform for its own sake, but to identify where and why the safety net fails, including where responsibilities fragment, where accountability diffuses, and where information is insufficient to support sound decision-making. Its focus is on strengthening the structures, responsibilities, and information flows necessary to

[35] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010) 13; David Lane et al, 'Blending Systems Thinking Approaches for Organisational Analysis: Reviewing Child Protection in England' (2016) 251 *European Journal of Operational Research* 613-614.
[36] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010) 14; Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964, 3975.
[37] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010) 23.
[38] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010) 14.
[39] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis* (Report, 2010) 72.

enable the child safety system to function as a coherent whole, capable of producing healthy, safe, and flourishing children.

2.8.1. From patchwork reform to purposeful system design

Before considering solutions, it is essential to be clear about the purpose of a reformed child safety system. System design cannot be effective unless anchored to a shared and explicit objective. As has been observed, 'any truly systematic analysis … must hold "purpose" as its most fundamental starting point and touchstone and never deviate from it'.[40] In turn, 'every part of the system's structure must … be appraised in terms of its fit with this purpose'.[41]

The Commission accepts that the purpose of the child safety system must be bold and aspirational for sustained and meaningful change in outcomes for children in Queensland. Drawing on the child protection literature and the core principles set out in the *Child Protection Act 1999* (Qld), the Commission has articulated an overall purpose for the system, which is then particularised in this report for early help for families, for children entering and living in care, and for young people transitioning from care.

The Commission proposes that the purpose of the reformed child safety system is to aim to give every child who comes within any part of the system support and care that is responsive to their individual circumstances; provide stability, permanency, and a sense of belonging in a place and community that 'feels like home'; and where they feel safe, valued, and accepted, with an ongoing, loving, and nurturing attachment to at least one adult, that enables them to 'achieve developmental, physical, cognitive, emotional milestones'.[42] The system must support children to flourish, build increasing levels of competence, develop their sense of autonomy, and 'reach their full potential by growing up safe and supported, free from harm and neglect'.[43]

The Commission has approached the redesign of the child safety system with this purpose clearly in view: ensuring children are safe and well and supporting them to thrive within families and communities. This has required careful attention to how the system supports positive change in the lives of children and families over time. Services, programs, and decisions are essential components of the system, and their value lies in the contribution they make to children's safety, stability, wellbeing, and development.

[40] Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964-3965.
[41] Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964, 3972.
[42] Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964, 3974-3975.
[43] Council of Australian Governments, *The National Framework for Protecting Australia's Children 2021–2031* (Report, 2021) 8.

Achieving those outcomes depends fundamentally on the people who work directly with children and families. As Cullin observes, effective child protection systems are built from the frontline. It is frontline workers' skill, judgement, experience, and ability to build trusting relationships that determine how the system operates.[44]

As the Commission considers both early help for families and statutory responses, the frontline includes workers across the Department, family support services, and organisations that provide entry points to help. To do their job well, these workers must be properly supported, with clear roles, sound decision-making frameworks, adequate resources, and access to a range of responses. The system must offer sufficient flexibility in early intervention options, and in the care and therapeutic options within the tertiary system. This will better enable responses to be tailored to children's individual safety, care, and wellbeing needs.

The boundaries of the child protection system examined by the Commission are, necessarily, extended to include early intervention for vulnerable and 'at risk' families and children. The frontline must be enabled and must possess the 'requisite variety' to meet the complex demands that they face.[45] This entails providing these workers with sufficient training, knowledge, other resources, supports, and support functions (collegial support; carefully crafted procedures, decision-making processes and rules; and role clarity). There should be the 'requisite variety' in the early intervention options, and in the care and therapeutic options in the tertiary system, so that children can receive bespoke care that addresses their specific needs and enables a successful return to their families or to adulthood. Achieving those outcomes depends fundamentally on the people who work directly with children and families.

[44] Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964, 3973-3975.
[45] Joel Cullin, 'If We Look at Child Protection Reform through the Lens of Systems Science, What Do We See? (2022) 52 *British Journal of Social Work* 3964, 3974-3975.

Chapter 3

Foundations for Understanding the System

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 3: Foundations for Understanding the System

3.1 Introduction

This chapter sets out the foundational concepts and governing themes that underpin the Commission's analysis of Queensland's child safety system and establishes the context for interpreting the Commission's findings. It identifies the key ideas that inform how the evidence has been considered and how the analysis throughout the report is to be understood.

These themes are not presented as standalone, nor are they confined to certain functions or parts of the child safety system. Rather, they provide a way of reading the whole report by drawing attention to the factors that consistently influence how the system operates across different settings and over time.

The material before the Commission indicates that the matters under examination are best understood at a level broader than individual cases or discrete service responses. They involve questions about the role of the State—particularly, the expectations placed on it and the standards against which its actions should be assessed. These questions shape how the evidence has been approached and how the Commission has framed its conclusions. As discussed in Chapter 2.7 and 2.8, the Commission has used systems thinking to look at how the child protection system currently operates and the effect of past reforms on its operation, before looking forward to proposed new approaches.

This chapter, therefore, sets out the foundational reference points for the report. It outlines the concepts that guide the Commission's consideration of the child safety system, and more broadly the child protection system, across prevention, early help, and the statutory continuum. It explains the concepts that underpin its assessment of whether the child safety system is consistently oriented towards the long-term interests of children.

The themes addressed in this chapter include the paramount principle (defined in Chapter 2) and its application across time; the State's role as corporate parent; the exercise and delegation of authority; system culture and professional judgement; and the distribution of responsibility across government and non-government actors. Together, these themes provide a shared lens for understanding the chapters that follow.

Importantly, this chapter does not seek to resolve these issues in isolation. Nor does it duplicate analysis undertaken elsewhere in the report. Instead, it establishes a common foundation for the

Commission's examination of how the system operates, how it has evolved through successive reforms, and why certain patterns of outcomes persist despite sustained effort and investment.

By making these underlying assumptions and governing principles explicit, the Commission aims to support clearer reasoning about reform. Without a shared understanding of what the child safety system is designed to do, who holds responsibility, and how decisions are meant to be guided, efforts to improve individual components of the system risk reinforcing existing fragmentation rather than producing lasting cohesion.

This chapter first sets out the conceptual and policy frameworks that inform the Commission's analysis, before examining core system themes, including corporate parenting, authority and delegation, organisational culture, and shared responsibility. Together, these elements establish the foundation for the analysis that follows.

3.2. The National Framework for protecting Australia's children

Australia has a national approach to protecting children, based on two frameworks. The first — *Protecting Children Is Everyone's Business* — covered the decade 2009 to 2020.[46] The second and current framework, *Safe and Supported*, covers the decade 2021 to 2031.[47] The National Framework sets out a nationwide approach to substantial and sustained reduction in child abuse and neglect. Its ten-year strategy for the Commonwealth, the state and territory governments, and the non-government organisation (NGO) sector is designed to help them work together to protect children. The framework is delivered in rolling five-year action plans. There is also a specific action plan for Aboriginal and Torres Strait Islander peoples.

The current National Framework identifies four priority groups**:**

- children and families with multiple and complex needs
- Aboriginal and Torres Strait Islander children experiencing disadvantage or who are vulnerable
- children and/or parents/carers with disability experiencing disadvantage or who are vulnerable

[46] Council of Australian Governments, *Protecting Children Is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020* (Report, 2009).
[46] Council of Australian Governments, *Protecting Children Is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020* (Report, 2009).
[47] Council of Australian Governments, *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* (Report, 2021) 26, 36.

- children who have experienced abuse and/or neglect, including children in out-of-home care and young people leaving out-of-home care and transitioning to adulthood.

The National Framework aims to improve outcomes for these groups through actions in four focus areas:

- a national approach to early intervention and targeted support for children and families experiencing vulnerability or disadvantage
- addressing the over-representation of Aboriginal and Torres Strait Islander children in child protection systems
- improving information-sharing, data development, and analysis
- strengthening the child and family sector and workforce capability.

The National Framework supports commitments under the National Agreement on Closing the Gap and aligns with the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*, and the *National Aboriginal and Torres Strait Islander Early Childhood Strategy*.[48] As the following sections show, many of the issues confronting the Commission align with the focus and priorities of the National Framework.

Therefore, this report does not treat the National Framework as an external reference point but as part of the shared policy context within which both Queensland's child protection and safety systems are expected to operate.

[48] Council of Australian Governments, *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* (Report, 2021) 6.

How the National Framework is used in this report

The National Framework for Protecting Australia's Children sets out four interconnected focus areas to guide national action over a ten-year period. These elements provide an important shared policy context for this Inquiry.

However, this report does not examine the four elements of the National Framework as discrete 'pillars' within this chapter. This is deliberate.

The chapter is concerned with the foundational conditions that shape how the child safety system behaves, including how authority is exercised, how responsibility is understood, how decisions are made under uncertainty, and how learning and accountability operate across the system. These conditions influence whether any framework, including the National Framework, can work in practice.

The four focus areas of the National Framework will be reflected throughout the report. This approach reflects the Commission's view that the National Framework is best understood not as a checklist to be implemented but as a set of commitments whose effectiveness depends on underlying system design, culture, leadership, and accountability. This chapter establishes that foundation.

3.3 The Public Health Framework

The Public Health Framework is introduced here because it provides a nationally recognised structure for understanding prevention, early help for families, statutory intervention and system-caused harm, and underpins the organisation of later chapters of this report, particularly those addressing early help and system stewardship.

The original National Framework, *Protecting Children Is Everyone's Business*,[49] adopted the public health approach to child protection. Broadly speaking, the 'public health' model is an epidemiological approach used in various disciplines and fields and requires government and non-government organisations, and public communities jointly to take responsibility for addressing a problem and developing and implementing solutions. It seeks to prevent or reduce the incidence of a social problem, including illness, by defining and monitoring the extent, and

[49] Council of Australian Governments, *Protecting Children Is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020* (Report, 2009).

then the causes, of the problem, and identifying and seeking to eliminate or reduce risk factors by applying evidence-based measures that have been found to be effective.[50]

Interventions are described in terms of four levels of prevention: primary, secondary, tertiary, and quaternary, with primary prevention the priority.

Primary prevention aims to prevent problems occurring in the first place by targeting measures (universal services and supports) at all members of the population to address the social determinants (the known underlying risk factors) of the problem before it affects anyone.

Secondary prevention entails programs specifically targeted at those at immediate risk of harm or those in need. It addresses the risk factors. Forms of secondary prevention – targeted intervention and family support, and supporting pregnant women – are examined in Chapter 4 of this Executive Report and in Companion Report 1: Functions of System.

Tertiary prevention aims to prevent further harm to those for whom the risk has materialised, and to redress harm that has occurred. In Queensland, tertiary prevention falls within the statutory child safety system.

Quaternary prevention, adapted from the 'first, do no harm' principle in medicine, aims to ensure that those protected by the system do not experience secondary harm (unintended outcomes that do more harm than good) from the system itself. Quaternary prevention is an important issue in the Queensland child safety system. As discussed later in this report, an assumption behind the statutory process of removing children who are exposed to a risk of harm that is above the statutory threshold, and placing them in out of home care, is that that removal process, and the care system itself, will not cause further harm to the children who have been moved into care. Many parts of the Report — and especially Chapter 7 of this Executive Report and Companion Report 3: Models of Care — explore this issue.

The current National Framework, *Safe and Supported*,[51] reiterates Australia's commitment to a blended public health approach to protecting Australia's children, focusing on primary (preventive) provision of high-quality universal services and supports, together with high-quality

[50] Australian Institute of Family Studies, 'Defining the Public Health Model for the Child Welfare Services Context' *Practice guides* (Web Page, 22 December 2014) <https://aifs.gov.au/resources/practice-guides/defining-public-health-model-child-welfare-services-context>; Australian Institute of Criminology, *The Public Health Approach to Crime Prevention* (Policy paper, 2003).
[51] Council of Australian Governments, *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* (Report, 2021).

secondary supports targeted at 'vulnerable' and 'at risk' families.[52] Primary, secondary prevention and particularly tertiary intervention are examined in Chapter 5 of this report.

3.4 The State as corporate parent: role, responsibility and limits

When the State removes a child from the care of their parents under statutory authority, it assumes responsibility for that child's safety, wellbeing, and development. This responsibility is commonly described as 'corporate parenting'. While the term itself is not expressly used in the *Child Protection Act 1999* (Qld), the concept is embedded throughout the statutory framework and reflected in judicial interpretation, inquiry findings, and accepted principles of child protection practice.

Corporate parenting captures more than legal custody or placement responsibility. It reflects an expectation that the State will act towards children in its care as a reasonable parent would do, attending not only to the child's immediate safety but to longer-term stability, development, identity, relationships, and sense of belonging. This includes decisions made over time, across multiple domains of a child's life and often under conditions of uncertainty and complexity.

Acting as a reasonable parent also requires the State to respond to the trauma children experience, including trauma arising from harm prior to intervention and from removal itself. A reasonable parent with the means to do so would seek timely therapeutic support, stability, and continuity of care. Evidence before the Commission suggests that when these needs are not met, the consequences extend beyond immediate wellbeing, shaping children's long-term outcomes and, in turn, the demands placed on future systems of support.

The corporate parenting role is, therefore, both protective and developmental. It requires the State to safeguard children from harm while also creating the conditions in which they can grow, heal, and thrive.

3.4.1 A dual role: system stewardship and parenting responsibility

In fulfilling its responsibilities to children in care, the State operates in two distinct but interrelated roles: system steward and corporate parent.

First, the State acts as a steward of the broader child protection system, within which the child safety system operates as a core statutory component. In this role, it establishes the legislative

[52] Council of Australian Governments, *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* (Report, 2021); Lauren Lines et al, 'How Are Responses to Child Abuse and Neglect Conceptualised in Australian Policy' (2023) 145 *Children and Youth Services Review* 106794.

framework, allocates funding, commissions services, sets policy directions, and oversees performance and accountability arrangements. Stewardship requires the State to ensure that the entire system is coherent, capable and aligned with its purpose.

Secondly, the State assumes the role of corporate parent for individual children who have been removed from their families. In this role, the State is responsible for decisions that affect a child's daily life and long-term trajectory, including placement, education, health care, cultural connection, permanency planning and transition to adulthood.

These two roles are inseparable in practice; however, it is important that where the State is acting in the capacity of the child's parent that that role is not conflated with broader preventive objectives, as discussed at section 6.2.3. The quality of corporate parenting experienced by children is shaped by how the system is designed, resourced, and governed. At the same time, the experience of children in care provides the clearest test of whether stewardship arrangements are effective.

This duality creates an inherent tension. Parenting requires continuity, relational knowledge, responsiveness, and the ability to tailor decisions to the individual child. Systems, by contrast, tend to rely on standardisation, delegation, procedural consistency, and risk management. Navigating this tension is one of the central challenges of corporate parenting in a statutory system.

Recognising this challenge does not diminish the State's responsibility. Rather, it stresses the importance of deliberate system design that supports rather than constrains the exercise of parental responsibility at scale.

3.4.2 Corporate parenting as a 'wicked problem'

The task of parenting through a statutory child safety system is frequently described as a 'wicked problem', meaning one that is complex, dynamic, and resistant to simple solutions.[53] Children in care often have diverse, intersecting needs arising from trauma, disrupted attachments, disability, mental health concerns, cultural disconnection, and socio-economic disadvantage. Their circumstances change over time, as do the risks and opportunities they face.

At the same time, this system operates within tight legal, procedural, and accountability constraints. Decisions are made under scrutiny, with incomplete information and with serious

[53] Australian Public Service Commission, *Tackling Wicked Problems: A Public Policy Perspective* (Australian Public Service Commission, 2007).

consequences if error occurs. These conditions inevitably shape behaviour, incentives, and priorities within the system.

Such pressures are often intensified by public and media response to critical incidents, which can drive political reactivity and reinforce risk-averse system settings that prioritise defensibility over long-term developmental outcomes.

Understanding corporate parenting as a wicked problem helps explain why reform efforts that focus narrowly on law, policy, or organisational structure have struggled to deliver sustained improvement. It also explains why compliance-heavy responses, while understandable, may inadvertently crowd out relational practice, professional judgement, and long-term planning.

However, complexity does not excuse poor outcomes. Describing corporate parenting as a wicked problem is not a justification for failure but a rationale that supports system-level solutions—addressing culture, authority, accountability, information, and workforce capability. These solutions are required if children's outcomes are to improve consistently.[54] (In this context, culture refers to organisational and system culture, not to the cultural identities or practices of Aboriginal and Torres Strait Islander peoples).

3.4.3 What corporate parenting requires of the system

If the State is to fulfil its role as corporate parent, the child safety system must be capable of supporting decisions that accord primacy to the child's interests, are developmentally informed, and sustained over time. The evidence before the Commission indicates that this requires several foundational system conditions.

These include:

- clear authority and accountability so that responsibility for children's safety and wellbeing is not diffused or obscured through delegation or organisational boundaries
- stable, skilled, and supported workforces, capable of exercising professional judgement and building enduring relationships with children, families, and carers
- information systems that follow the child, enabling continuity of knowledge, learning from experience, and informed decision-making across time and placements

[54] Brian Head and John Alford, 'Wicked Problems: Implications for Public Policy and Management' (2015) 47(6) *Administration & Society* 711.

- structures that prioritise long-term outcomes, including stability, permanency, cultural connection, and successful transitions to adulthood, rather than short-term procedural compliance
- systems that are responsive within children's developmental timeframes, and that actively listen to and incorporate children's views, needs, and expressed wishes in decisions that affect their lives
- governance and oversight arrangements that promote learning, transparency, and improvement rather than defensiveness and blame.

These conditions do not sit within a single policy or program. They cut across service delivery, commissioning, leadership, culture, and accountability. As such, corporate parenting is best understood not as a discrete function but as a through-line that connects all parts of the child safety system.

3.4.4 Why corporate parenting matters for reform

The effectiveness of Queensland's child safety system can ultimately be judged by how well the State fulfils its role as corporate parent. This is not measured solely by statutory compliance or procedural outputs, but by the experience and life trajectories of children who grow up in the State's care.

Evidence before the Commission indicates that when corporate parenting responsibilities are fragmented, overly proceduralised, or insufficiently supported, children are more likely to experience instability, delayed decision-making, and disrupted relationships. Conversely, where systems are designed to support continuity, learning, and child-centred judgement, better outcomes are achievable, even in complex circumstances.

For this reason, corporate parenting is not treated in this report as a standalone legal concept. It is a foundational theme that has informed the Commission's analysis of care, permanency, culture, workforce capability, governance, accountability, and system design in the chapters that follow.

Later chapters return to corporate parenting in more detail, examining how the State's responsibilities are exercised, how accountability is maintained, and how system structures either support or undermine the delivery of safe, stable, and nurturing care. The next section establishes the conceptual framework for that analysis.

3.5 Authority, delegation and decision-making in a complex system

In considering the evidence before it, the Commission has identified the relationship between authority, delegation, and decision-making as a core theme for understanding how Queensland's child safety system operates and how reforms intended to change it are experienced. While these terms are often used interchangeably, the Commission considers they perform distinct functions within a statutory system, and that confusion between them can obscure both reform intent and practical impact.

Authority refers to where legal responsibility and accountability for decisions ultimately sit. It determines who is answerable for outcomes, where risk and liability are borne, and how the paramountcy of the child's best interests is applied. In a statutory child safety system, authority carries not only decision-making power but also exposure to scrutiny, consequence, and ongoing responsibility for outcomes for children.

Delegation is the mechanism through which authority is exercised by others within the system. It does not alter the legislative framework or the standards that apply to decisions; rather, it changes where authority is enacted and by whom. As such, delegation has system-level implications. It reshapes governance arrangements, redistributes responsibility, and can materially alter how accountability, risk, and support are experienced.

Decision-making is the practice through which authority and delegation are given effect. It encompasses how concerns are interpreted, what information is considered, whose perspectives are included, how risk and protective factors are weighed, and how decisions are implemented and reviewed over time. In both the child safety and child protection systems, decision-making is cumulative and occurs across multiple points in time, rather than as a single event.

3.5.1 Authority and accountability in statutory child protection

The distinction between authority and decision-making is particularly important within the child safety system, where decisions often involve significant intrusion into family life and have enduring consequences for children. Authority locates ultimate accountability for these decisions and anchors responsibility for ensuring that statutory power is exercised lawfully, proportionately, and in the best interests of children.

As discussed earlier in the chapter, the State's role as system steward and corporate parent means that authority cannot be understood solely as a technical or legal construct. It is also relational and moral, carrying responsibility for the longer-term outcomes experienced by children across their lives. Where authority is exercised at a distance from the child's experience, or without clear lines of accountability, there is a risk that responsibility becomes fragmented or obscured.

3.5.2 Delegation as a system-shaping mechanism

Delegation is often supported as a means of improving responsiveness, participation, or cultural legitimacy in decision-making. However, delegation is not a neutral administrative act. It directly reshapes how statutory power is exercised and experienced across the child safety system.

Where authority is redistributed through delegation without corresponding clarity, resourcing, information access and support, responsibility may be shifted without adequate protection, oversight, or control. Conversely, where delegation is tightly aligned with system design, governance arrangements and workforce capability, it has the potential to support more informed, proportionate, and contextually responsive decisions.

From a systems perspective, the effectiveness of delegation depends less on the existence of a delegated function than on how delegation interacts with decision-making pathways, accountability mechanisms, and organisational culture. These interactions are examined further in later chapters of this report.

It is important that delegated authority is exercised with integrity and that the delegate is not actually or ostensibly affected by any bias or interest that is not consistent with the paramount interests of the child. Actual or apparent biases must be considered to ensure public confidence in the exercise of delegated authority.

3.5.3 Participation, shared decision-making and power-sharing

Over time, concerns about over-representation, system mistrust, and the limitations of state-centred decision-making have led to an increased emphasis on participation, collective decision-making, and shared responsibility within the child safety system, particularly in relation to Aboriginal and Torres Strait Islander children and families.

This shift is reflected in the development of a layered participation and decision-making architecture, encompassing supported family participation, collective assessment, and shared statutory decision-making at different points along the child protection continuum. These

approaches seek to recognise Indigenous culture, family knowledge, and community-held participation as integral to assessing risk and responding to concerns.

Participation mechanisms can materially improve the quality and breadth of information available to decision-makers. However, participation alone does not alter where authority sits or how competing considerations are ultimately resolved. Without accompanying changes to authority and accountability, participation risks becoming procedural rather than substantive.

Reforms that move beyond participation to involve shared or delegated authority, therefore, engage directly with statutory power. As such, they carry consequential implications for risk, scrutiny, accountability, and system support. Understanding these distinctions is critical when assessing both the intent and the impact of reforms that seek to redistribute decision-making within the child safety system.

It is also essential to distinguish powers or authority that may be properly exercised administratively and therefore potentially delegable from authority that ought to be exercised by the judicial arm of government. Some of the necessary powers, which may be profoundly intrusive in the lives of children and their families, are of such a consequential nature that they warrant the exercise of judicial power to ensure public confidence in State power.

3.5.4 The statutory concept of Delegated Authority as an illustration of shared authority

Delegated Authority (DA) provides an important illustration of how delegation can be used to alter where statutory authority is exercised within the child safety system. Enabled through amendments to the *Child Protection Act 1999* (Qld), DA allows specified statutory child protection functions and powers, ordinarily exercised by the chief executive, to be delegated to the chief executive officer of an Aboriginal and Torres Strait Islander community-controlled organisation (ATSICCO) in relation to an Aboriginal or Torres Strait Islander child.[55]

DA reflects a policy response to longstanding concerns about the over-representation of Aboriginal and Torres Strait Islander children in the child safety system, the limitations of consultation-based approaches, and the need to strengthen cultural legitimacy and self-determination in decision-making. It represents a deliberate shift away from purely advisory models, recognising that meaningful change requires not only participation in decisions but

[55] Delegated Authority is a legislative mechanism that allows specific statutory child protection functions and powers, ordinarily exercised by the chief executive under the *Child Protection Act 1999* (Qld), to be delegated to the chief executive officer of an Aboriginal and Torres Strait Islander community-controlled organisation in relation to an Aboriginal or Torres Strait Islander child. Once delegated, the Aboriginal and Torres Strait Islander entity assumes legal authority and accountability for the specified decisions, within the existing statutory framework.

authority at key decision points. The reform is intended to improve the quality, proportionality, and cultural legitimacy of statutory decisions.

At the same time, the Commission recognises that delegating authority raises fundamental questions about the appropriate location of coercive authority within the statutory child safety system. Decisions involving compulsion, removal, or court intervention engage the State's most intrusive powers and carry significant legal, ethical, and human consequences. The exercise of such powers requires clear lines of accountability, robust safeguards, and the capacity to manage risk, scrutiny, and liability over time.

Therefore, from a systems perspective, DA can be understood as a form of shared statutory authority rather than a settled or universally applicable model. Its operation highlights the need to distinguish between cultural understanding, relational influence, and statutory decision-making power, which perform different roles and are not interchangeable. The Commission considers that clarity in these distinctions is critical if authority is to be exercised in a way that ensures the child's interests are paramount and legally sound.

Importantly, DA does not operate in isolation. It sits within a broader architecture of participation and collective decision-making, including mechanisms that support family involvement, cultural authority, and shared assessment at different stages of the decision-making continuum. The Commission considers that ATSICCOs have the potential to play an important role in early help, family-led decision-making, cultural brokerage, and support.

3.5.5 Implications for system design and reform

The issues examined in this section highlight that reforms involving authority, delegation, and decision-making cannot be assessed in isolation. Their effectiveness depends on alignment between legal authority, delegated responsibility, and everyday decision-making, as well as on the broader system conditions in which they operate. It is important to consider the scope for delegated authority within the tertiary child safety system. The removal of a child into state care is an intervention by the State predicated on the child being in need of state protection. It is not a consensual or collaborative exercise of power. The State assumes significant duties to the child and must, therefore, carefully distinguish between authority it should retain, authority that should be exercised by the judicial arm, and authority that may beneficially be conferred on participants such as ATSICCOs. Further, delegated authority should not be supported on the rationale that it provides the opportunity for different decision-makers to participate in the child safety system. Rather, it must be evaluated against the broad objective that the delegate is able to achieve better outcomes for the child.

Changes that redistribute authority without corresponding investment in capability, clarity of roles, information-sharing, and governance risk shifting responsibility without improving outcomes. Conversely, where authority, delegation, and decision-making are coherently aligned, reforms have greater potential to support proportionality, accountability, and improved experiences for children and families.

These dynamics reinforce the importance of viewing authority and delegation as matters of system design, not simply program or practice change.

3.6 Culture, professional judgement and system behaviour

This section examines organisational culture as a foundational condition that shapes how Queensland's child safety system behaves. It provides an analytical lens for understanding how decisions are made under pressure, how information flows, how uncertainty is managed, and how responsibility is experienced by those working within the system

Culture is not treated here as a discrete topic or matter of individual attitude. Rather, it is examined as a system-level phenomenon that emerges from the interaction between leadership priorities, accountability settings, procedural requirements, and workforce conditions. As such, culture both reflects and reinforces system design.

The purpose of this section is to identify dominant and recurring cultural patterns evident in the evidence before the Commission and to explain how those patterns influence system behaviour and outcomes. It establishes an interpretive foundation for later chapters that examine statutory decision-making, professional authority, workforce capability, governance, and accountability.

3.6.1 What we mean by organisational culture

Organisational culture is a well-established concept within organisational management and human services literature. It is commonly understood as the shared values, norms, assumptions, and patterns of behaviour that shape how work is undertaken within an organisation, how decisions are made, and how individuals interpret their roles and responsibilities. Culture is not static. It is learned, reinforced, and reproduced through everyday practice, leadership priorities, systems of accountability, and responses to risk and error.[56]

[56] Edgar H Schein, *Organizational Culture and Leadership* (Jossey-Bass, 1992); Addisalem Tadasse Bogale and Keneisa Lemi Debala, 'Organizational Culture: A Systematic Review' (2024) 11(1) *Cogent Business and Management*; Dan Denison, Levi Nieminen and Lindsey Kotrba, 'Diagnosing Organizational Cultures: A Conceptual and Empirical Review of the Culture Effectiveness Surveys' (2012) 23(1) *European Journal of Work and Organizational Psychology* 145.

In the context of statutory child protection, organisational culture is particularly influential. Decision-making routinely occurs under conditions of uncertainty, high risk and emotional intensity. Workers are required to exercise judgement in circumstances where information is incomplete, time is limited, and the consequences of error may be significant. In such environments, culture operates as a guide to action, shaping what is prioritised, what is questioned, and what is avoided.

While organisational culture is intangible and cannot be measured directly, it can be analysed through its manifestations. These include observable features such as decision-making frameworks, professional norms, patterns of communication, responses to scrutiny, use of discretion, approaches to risk, and the design and operation of policies, manuals and compliance systems. Culture may also be inferred from how organisations respond to feedback, mistakes, dissenting views, and external perspectives.

The literature indicates that organisational culture has explanatory and predictive value. Because culture influences how organisations respond to challenges and opportunities, understanding cultural patterns can explain why systems behave as they do and why reform efforts succeed or fail. In complex human services systems, structural or procedural change that does not attend to underlying culture is unlikely to produce sustained improvement.

This section draws on organisational and child protection literature to support its analysis. In particular, it draws on work that examines how organisations process information, manage uncertainty, and respond to error, including typologies that distinguish between cultures characterised by learning and adaptability and those dominated by compliance, defensiveness or fear of blame.[57] These frameworks are not applied mechanistically, nor are they used to label the Department of Families, Seniors, Disability Services and Child Safety (the Department). Rather, they provide interpretive tools to help us understand how particular cultural features may emerge, become entrenched, and interact with system design, leadership priorities, and workforce conditions.

Importantly, this analysis proceeds on the basis that organisational culture is neither uniform nor immutable. Large organisations may exhibit different cultural characteristics across functions, regions, or points in time. Individuals may resist, adapt to, or work around dominant cultural norms. For that reason, the focus of this section is on dominant and recurring patterns

[57] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22; Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123.

that emerge across multiple sources of evidence and are sufficiently persistent to influence system-level behaviour and outcomes.

3.6.2 Typologies of culture and where the department sits

The Commission does not approach organisational culture as a fixed or monolithic attribute, nor does it seek to categorise the Department by applying a single label. Rather, the Commission uses established typologies of organisational culture as interpretive tools to understanding how patterns of behaviour, decision-making, and information flow arise and are sustained within complex systems.

In this section, the typologies developed by Westrum and applied by Munro in child protection contexts are used to illuminate how cultural dynamics operate within the Department, particularly under conditions of pressure, scrutiny, and risk.[58]

Organisational culture typologies

Pathological: Information is suppressed, blame dominates, failures are hidden.

Bureaucratic: Information flows through formal channels; compliance and procedural defensibility are prioritised.

Generative: Information is sought; learning, shared responsibility, and improvement are supported.

Westrum identifies three broad organisational culture types: pathological bureaucratic, and generative. These are distinguished primarily by how information is processed, how responsibility is understood, and how organisations respond to signs of trouble or opportunity.[59] These typologies are not intended to describe organisations as wholly one type or another. Rather, they offer a structured way of analysing tendencies, incentives, and constraints that shape behaviour at different levels of an organisation and under different conditions.[60]

The evidence before the Commission indicates that many of the Department's cultural characteristics align most closely with features of a bureaucratic culture, including an emphasis on standardised processes, clearly bounded roles and responsibilities and a preference for procedural consistency and rule adherence. In such environments, information tends to move through formal channels, and organisational attention is oriented towards procedural defensibility rather than adaptive problem-solving. [61]

[58] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22; Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123.
[59] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22-ii24.
[60] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22-ii24.
[61] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22-ii23.

Importantly, both Westrum and Munro caution that bureaucratic cultures operating under sustained pressure may exhibit pathological tendencies, particularly where fear of blame, external scrutiny, and punitive responses to error are present. In these conditions, information that challenges prevailing assumptions or exposes uncertainty may be suppressed or avoided and decision-making may become increasingly defensive. [62]

By contrast, generative cultures are characterised by active information-seeking, shared responsibility, learning from failure, and innovation in service of organisational purpose.[63] Munro emphasises that such features are especially important in child safety systems where uncertainty is inherent, and learning is essential to improving safety and outcomes.[64]

The Commission does not suggest that generative features are absent within the Department. Rather, the evidence indicates that generative practices are not consistently supported or structurally embedded and are often crowded out by compliance and risk-management demands. As both Westrum and Munro observe, organisational culture is mutable rather than static, and can shift where leadership priorities, accountability settings, and information flows are realigned towards learning and mission outcomes.[65]

This interpretive framework underpins the Commission's later analysis and recommendations. It is not used to attribute fault but to clarify the cultural conditions that shape system behaviour and to identify what must change if professional judgement, learning, and child-centred practice are to be consistently supported.

3.6.3 Why culture matters for system design and reform

The cultural and structural dynamics described in this chapter have material consequences for children, families, carers, and the overall performance of the child protection system. These consequences do not arise from individual failure or lack of commitment by practitioners. Rather, they are the predictable outcomes of a system in which professional authority, procedural compliance, and risk defensibility are structurally prioritised over relational engagement, deliberative judgement, and learning.

For children and families, the effects are most evident in the quality and continuity of engagement. Evidence before the Commission indicates that time spent on compliance activity

[62] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22-ii23; Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123, 126.
[63] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22-ii24.
[64] Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123, 126.
[65] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii22, ii26; Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123, 126, 129.

reduces opportunities for sustained, meaningful interaction with children, particularly those subject to long-term orders whose circumstances do not trigger immediate alarm. Where engagement is episodic, crisis-driven, or narrowly task-focused, children's voices are less likely to shape decision-making, and emerging concerns may go unnoticed until they escalate.

Families and carers experience related impacts. When professional judgement is exercised within a compliance-heavy and defensive culture, relational trust is more difficult to establish and maintain. The Commission heard that carers and families often experience decision-making as opaque, predetermined or insufficiently responsive to their knowledge of the child. This undermines collaboration, increases conflict and weakens the legitimacy of decisions made in children's best interests.

These dynamics also affect practitioners. Where systems reward procedural adherence more clearly than thoughtful judgement, practitioners are incentivised to narrow their focus to what is defensible rather that what is relationally or developmentally optimal for the child. Over time, this contributes to moral distress, constrains professional confidence, and erodes the conditions required for reflective practice and learning with flow-on effects for workforce stability and continuity of care.[66]

At a system level, the most significant consequence is a loss of learning capacity. In environments where compliance and defensibility dominate, information about what is not working, particularly information that challenges existing assumptions, struggles to surface or be acted on.[67]

The cultural dynamics described in this section have direct implications for how authority is exercised, how professional judgement is supported, how accountability operates, and how learning occurs within the child safety system. These issues are examined in greater detail in later chapters that address governance, workforce capability, information systems, and accountability mechanisms.

Understanding culture as a product of system design is, therefore, essential to meaningful reform. Without changes to the structures, incentives, and authorising environments that shape everyday behaviour, reform efforts risk reinforcing compliance and defensiveness rather than enabling the relational, child-centred practice the system aspires to.

[66] Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123, 125-126.
[67] Ron Westrum, 'A Typology of Organisational Cultures' (2024) 13 *BMJ Quality & Safety* ii23, ii25; Eileen Munro, 'Decision-making under Uncertainty in Child Protection: Creating a Just and Learning Culture' (2019) 24 *Child & Family Social Work* 123, 126.

This section does not seek to resolve cultural challenges in isolation. Nor does it propose culture change as a matter of individual behaviour or attitude. Rather, it establishes why later analysis of system design, leadership, workforce capability, funding, information flows, and accountability must attend to the cultural effects of those arrangements if reform is to be sustained.

Why the Munro Review still matters in 2026

The Munro Review of Child Protection (2011) is highlighted throughout this report as a particularly influential example of systems-based analysis, rather than as the sole or primary reference point for the Commission's conclusions. The Munro Review remains highly relevant because it addressed how child protection systems behave under pressure, rather than focusing narrowly on policy settings or organisational structures specific to its time. More than a decade on, the core system dynamics it identified continue to shape outcomes for children, families, and the workforce.

Some enduring insights from the Munro Review include:

Child protection remains inherently uncertain – Munro demonstrated that child protection is a domain of irreducible uncertainty. Decisions are always made with incomplete information and involve weighing competing risks and potential harms. This reality has not changed, in that systems that attempt to eliminate uncertainty through tighter rules, timeframes, or procedural compliance continue to struggle to improve safety or outcomes.

Compliance-driven accountability distorts learning – Munro identified how performance regimes focused on process measures and timeliness can draw attention away from whether children and families are, in fact, receiving the help they need. Many contemporary systems continue to collect large volumes of data that provide organisational assurance but offer limited insight into children's actual experience or long-term outcomes.

Feedback loops are essential but often misaligned – Munro emphasised that effective systems depend on feedback loops that support learning and adaptation and do not lay blame. Where information is used primarily for audit, risk management, or external assurance, opportunities for reflective learning and improvement are reduced. This remains a central challenge for our child protection system (and others).

Professional judgement must be supported, not constrained – Munro highlighted the impact of managerial and audit cultures on professional confidence and decision-making. Ongoing workforce stress, defensive practice, and turnover indicate that many systems still struggle to create conditions in which skilled professional judgement can flourish.

Late intervention remains a systemic pattern – Munro's critique of crisis-driven systems continues to resonate. Despite repeated reform efforts, investment and attention remain concentrated at the statutory end of the system, while earlier, relational, and preventative responses are comparatively under-resourced. This limits the system's capacity to reduce harm over time.

The continuing relevance of the Munro Review lies in its systems-based analysis. It reinforces that sustainable improvement depends on designing systems that:

- value professional expertise
- align accountability with what matters to children
- use feedback to support learning and improvement
- acknowledge uncertainty rather than attempting to eliminate it through prescriptive measures.

3.7 Shared responsibility across the child protection system

Child protection is not delivered by a single agency or service, nor can responsibility for children's safety and wellbeing be meaningfully located within just one part of the child protection system. Consistent with systems thinking and the public health approach outlined earlier in this chapter, outcomes for children are produced through the interaction of multiple actors operating across universal, targeted, and statutory domains.[68]

These actors include government agencies with responsibilities for child safety, health, education, housing, youth justice and community services; non-government and ATSICCOs delivering prevention, early help and care services; and families, carers, and communities themselves. Each plays a distinct role in shaping children's experiences and trajectories, both before and after statutory intervention.

[68] Brian Head and John Alford, 'Wicked Problems: Implications for Public Policy and Management' (2015) 47(6) *Administration & Society* 711.

The concept of shared responsibility reflects this reality. It recognises that protecting children from harm, supporting families, and promoting safety, stability, and wellbeing require coordinated effort across the whole child protection system. Importantly, shared responsibility does not imply diluted responsibility. Rather, it underscores the need for clarity about who is responsible for what, how responsibilities connect across system boundaries, and how collective effort is stewarded in the interests of children.

3.7.1 The risks of fragmentation in shared systems

While shared responsibility is a necessary feature of a successful child protection system, it also introduces predictable risks. In complex systems involving multiple actors, fragmentation can arise where roles are unclear, incentives are misaligned, or accountability is dispersed across organisational and jurisdictional boundaries.

Evidence before the Commission indicates that such fragmentation may manifest as gaps at service interfaces, inconsistent decision-making, delays in response, and uncertainty about ownership of risk. Children and families may experience these system effects as repeated assessments, hand-offs between services, or a lack of continuity in relationships and planning. Practitioners, in turn, may experience confusion about authority, competing priorities or pressure to manage risk within narrow organisational silos.

These patterns are not primarily the result of individual or organisational failure. They are characteristic of shared systems that lack strong mechanisms for coordination, learning, and accountability. Without deliberate design, shared responsibility can unintentionally become diffused responsibility, where no single part of the system is positioned to see or respond to the whole of a child's experience.

3.7.2 Implications for system stewardship

Recognising child protection as a shared system endeavour has important implications for how the system is governed and stewarded. Shared responsibility requires more than goodwill or collaboration at the frontline. It depends on system-level arrangements that provide clarity, alignment, and support across organisational boundaries.

Most of all, shared responsibility requires clear articulation of roles and expectations across agencies and service sectors; alignment between policy intent, commissioning, funding and accountability arrangements; mechanisms for information-sharing, feedback and learning that enable the system to adapt over time; and visible stewardship by the State consistent with its role as system steward and corporate parent for children in care.

These requirements reinform themes developed earlier in this chapter. The effectiveness of shared responsibility is shaped by how authority is exercised, how professional judgement is supported, how culture influences behaviour, and how information is used to learn and improve. Where these conditions are weak or misaligned, shared responsibility becomes fragile; however, where they are coherent and sustained, it can enable coordinated action in the interests of children.

3.8 Why these foundations matter for reform

This chapter has established the foundational conditions that shape how Queensland's child safety system behaves, regardless of the specific programs, policies, or reforms in place at any point in time. These conditions determine not only how decisions are made, but how responsibility is understood, how authority is exercised, how risk is managed, and how children and families experience the system over time.

The evidence before the Commission demonstrates that many of the system's most persistent challenges do not arise from a lack of goodwill, commitment, or reform effort. Rather, they reflect deeper issues of system design and alignment. Where foundational elements such as authority, accountability, culture, information use, and shared responsibility are misaligned, reform efforts tend to produce limited or uneven impact, and in some cases generate new pressures or unintended consequences.

Meaningful reform relies on understanding these foundations. Without clarity about where authority sits, how it is delegated, and how decision-making operates across time, initiatives intended to strengthen participation, collaboration, or early intervention risk becoming procedural overlays rather than drivers of change. Similarly, without attention to organisational culture and the conditions that support professional judgement and learning, reforms may reinforce compliance and defensiveness rather than enable thoughtful, child-centred practice.

This chapter has also highlighted the importance of distinguishing between intent and effect. National frameworks, public health models, and legislative reforms provide important direction and aspiration. However, their effectiveness depends on whether the system is capable of translating intent into practice. This requires coherence between a range of elements: policy, governance, workforce capability, commissioning, information systems, and accountability arrangements. Where these elements pull in different directions, the system struggles to deliver consistent outcomes for children.

The Commission's approach to reform is, therefore, grounded in the view that no single intervention or structural change will, on its own, resolve the challenges facing the child safety

system. Sustainable improvement requires disciplined attention to how the whole system is designed, stewarded, and supported. It requires recognising that authority, culture, information, and shared responsibility are not abstract concepts but practical forces that shape everyday decisions and long-term outcomes.

The chapters that follow apply these foundational insights to a detailed examination of how different parts of the system operate across prevention and early help, statutory intervention, care and permanency, workforce capability, governance, funding, and information systems. In doing so, the Commission assesses not only what the child protection system is doing, but whether it is structurally equipped to do what is required of it—namely, to protect children from harm, support families early, and act as a responsible and accountable corporate parent when the State intervenes in children's lives.

Chapter 4

The Overrepresentation of Aboriginal and Torres Strait Islander Children

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 4: The Overrepresentation of Aboriginal and Torres Strait Islander Children

4.1 Introduction

The over-representation of Aboriginal and Torres Strait Islander children in the child safety system has been lamented for several decades. Since the Carmody inquiry, over-representation has continued unabated on an upward trajectory. The submissions referred to below detail some of the relevant data, which is both instructive and alarming. The headline figure is that Aboriginal and Torres Strait Islander children represent approximately half of the children in state care.[69]

4.2 Impediments to reform, the paralysis of analysis and who should decide

At the heart of the debate about how best to address the ongoing problem of over-representation of Aboriginal and Torres Strait Islander children in the child safety system are two core propositions which, on one view at least, are in tension with each other.

The first proposition is that the state's responsibility for child protection is non-residual – that is, it is pervasive and continuous. In this context, non-residual means that state intervention is not conditional upon a manifest risk of harm to a particular child, but rather a broad duty to intervene and control conditions which are known contributors to child harm. This contention posits that because government decisions form the environment in which families raise their children, the state has a duty to act to keep them safe, particularly from known causes of harm such as alcohol abuse.

On this premise, it is argued that the state is responsible for all of the socio-economic conditions that directly or indirectly cause social, cultural or economic vulnerability. Some, like the Cape Yorke Institute (CYI), argue that the state should not be reluctant to intervene to exercise non-consensual control over known causes of harm when necessary. This non-residual concept of the state's duty is accepted by the bodies representing Aboriginal and Torres Strait Islander peoples' interests which have recently made submissions to the Commission, as shall be

[69] QATSICPP, *Submission to Child Safety Commission of Inquiry* (August 2025)10,11; QATSICPP, *Submission to Child Safety Commission of Inquiry* (February 2026) 3; ATSILS, *Submission to Child Safety Commission of Inquiry* (August 2025)14-15; PeakCare *Submission to Child Safety Commission of Inquiry* (March 2026) 7; OATSICC, *Submission to Child Safety Commission of Inquiry* (January 2026) 12, 13.

discussed below. The difference between them lies not in whether the state has a pervasive duty to prevent harm to Aboriginal and Torres Strait Islander children, but as to the content of that duty, and particularly as to what non-consensual state interventions are justified to prevent harm to Aboriginal and Torres Strait Islander children. To put it another way, the issue between the contending positions is: what means are justified by the end and where should the line be drawn as to the scope of non-consensual intervention?

The second proposition is that for any state intervention and allied programs to be effective in preventing harm to Aboriginal and Torres Strait Islander families and children, they must be designed and operated by local community-based organisations such as Aboriginal and Torres Strait Islander community-controlled organisations (ATSICCOs). This contention is proffered on the basis that it is only those bodies which possess cultural authority and legitimacy. An important feature of this contention is that cultural legitimacy and authority is local and cannot be extrapolated statewide, or at the least, it should not be assumed that it is capable of being extrapolated, assigned to other locations, or imposed from outside the local area. This limitation applies even if a particular suite of measures has proved to be successful in a particular regional area. In other words, the model of governance, including its legitimacy and efficacy, is indispensably local.

As a matter of principle, there may be no tension between the above two propositions. But the tension becomes quite apparent at the point of design and implementation of the solutions. Fundamentally, this tension arises because the posited responsibility for child protection lies with the state and the solution with disparate locally based bodies. The suggested solution to this tension is for local bodies to exercise self-determination aided by delegated authority, or shared responsibility. In practical terms, this means numerous locally situated bodies finding their own solutions for the protection of children, implementing their own protective programs and, importantly, making their own decisions about the extent to which non-consensual measures should be imposed, though necessarily requiring government sanction at the state and/or federal levels.

There is broad agreement about some solutions – early intervention and family support programs for example. However, as the contending submissions referred to below demonstrate, there is substantive disagreement about specific priorities and the extent to which non-consensual interventions should be supported.

It is not necessary for the Commission to consider purely as a matter of principle the desirability of the second proposition, namely that reform must be founded upon local community-led

solutions, though it is relevant to note that it is not a condition applicable to the exercise of state power generally. Neither is it applicable to the exercise of state power in relation to child protection in respect of non-Aboriginal and Torres Strait Islander children.

It would be convenient, and uncontroversial among the commentators in the field of child protection, for the Commission to embrace each of the above propositions and thus join with the plurality of contenders who agree they are both morally and practically imperative. However, for the reasons developed below, the second proposition, in particular, elevates the level of complexity involved in reforming the child protection system in relation to Aboriginal and Torres Strait Islander children to a degree that the solution may have become one of the greatest obstacles to its own success. To borrow a series of observations from a submission made by the CYI: 'Queensland has become a serial inquirer while remaining a reluctant reformer'; 'The result is "death by 1000 consultations"'; and 'Governments repeatedly seek levels of consensus that are rarely achievable in any community, particularly where it is clear the reforms needed challenge entrenched interests, alcohol availability, passive welfare settings or longstanding dysfunction.'[70]

The following observations by the Queensland Indigenous Family Violence Legal Service (QIFVLS) in its submission in response to the CYI's submission reflect the alternative view: 'A causal framework derived primarily from one regional and community experience should be applied to statewide reform recommendations with appropriate and serious care.'[71] Further, 'The assumption that a model with proven legitimacy in one community can be applied elsewhere without that foundational work [community-led institution-building] risks reproducing, in a new institutional form, precisely the top-down imposition that both organisations [CYI and QIFVLS] agree has failed Aboriginal and Torres Strait Islander families.' [72]

The Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICCP), in its recent submission in response to the CYI submission, expresses similar reservations: 'Any consideration of extending [Family Responsibilities Commission]-style models, Alcohol Management Plans or income linked compliance mechanisms should be determined by communities, through locally led processes involving Elders, Traditional Owners …' [73]

As is to be expected, there are many diverging opinions and emphases in the submissions from bodies representing Aboriginal and Torres Strait Islander interests, concerning the solutions to

[70] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (May 2026) 6.
[71] QIFVLS, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 3.
[72] QIFVLS, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 3.
[73] QATSICPP, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 2.

the child protection system. That is natural in any informed discourse about matters which concern the child protection system and its impact on Aboriginal and Torres Strait Islander communities within the broad socio-economic and cultural context within Queensland and more widely in Australia.

However, the combination of widely differing views about many matters, including the extent to which non-consensual interventions should be imposed, combined with an agreed imperative that the design and implementation of programs be fashioned at a local level, creates a very real obstacle to determining what should be done, where, and by whom. It clearly contributes, as the CYI put it, to 'death by 1000 consultations.' Another way of putting it, is that it leads to 'the paralysis of analysis.'

Throughout the Inquiry, the Commission has tried to understand the impediments to reforming the child protection system and any that apply in particular to Aboriginal and Torres Strait Islander communities. Why is it, despite serial inquiries into the child protection system, together with wider initiatives that touch upon it, such as the *National Framework*, that Aboriginal and Torres Strait Islander children remain grossly over-represented in the child protection system? What is it that we do not understand about the barriers to reform which are revealed in earlier failed attempts to reform the child protection system? Is the failure one of design or implementation, or both?

In relation to those questions, the Commission offers the following observations. The first and second will be discussed below in the context of contending aspects of the submissions produced to the Commission.

The first observation is that actions to address over-representation of Aboriginal and Torres Strait Islander children in the child protection system have not been sufficiently focused on the proximate causes of harm.

The second observation is that the posited solutions have become entangled in assertive contentions based upon inscrutable assumptions. An example of this is the assumptions underpinning delegated authority, which are discussed in section 4.5 of this chapter.

The third observation is that there is a tension between the second proposition referred to above, which demands fragmented local decision making, and constitutional government authority at the state and national levels.

4.2.1. The tension between state-wide government duty and local authority

It is convenient to commence with the third observation because it relates to competing decision-making structures as distinct from contestable causal theories and remedies. The Commission considers that this tension sets up a contest of decision-making power at the expense of achieving coherent reform objectives. This observation is not intended as a criticism of self-determination. That is a matter for broader political debate about which the Commission has no remit. Rather, it is to observe that the demands for localised decision making have unintended consequences which need to be recognised and addressed if the pattern of excessive and continuous consultation is to come to an end and lasting reform is to be achieved.

At the risk of proposing too many more unending consultations, both government and Aboriginal and Torres Strait Islander organisations must resolve this impasse, one way or another. The Commission appreciates that, apart from DWATSIPM,[74] there is no generic statewide Aboriginal and Torres Strait Islander authority. This point has been made pellucidly clear throughout the Inquiry and is confirmed by the recent contending submissions. The question becomes one of structure for decision making. What structure would satisfy the posited imperative of local decision making, and/or shared decision making, while not creating an unmanageable competition between constitutional government responsibility and local cultural authority? What structure would facilitate a mediated compromise between shared local decision making and coordinated state-wide remedial responses to child protection which could not be reasonably opposed as 'precisely the top-down imposition' that has failed Aboriginal and Torres Strait Islander communities?

Regrettably these are questions that the Commission is not able to venture a tutored opinion about. Fundamentally, they are political questions. They are questions which extend beyond the scope of the Terms of Reference but more importantly require deep analysis and, dare it be said, wide consultation. Plainly, there is an important role to be played by ATSICCOs and peak bodies, working together with government to create a decision-making structure which would mediate the tensions discussed above. It is also plain that such attempts as have been made to date have not achieved that objective. The reasons why that has not occurred is also a matter about which the Commission is not able to express an opinion. Hence, regrettably, the Commission can but contemplate a problem for which it is not able to offer any solution, save to say that it is one that should be further investigated and grappled with. The tension is not resolved by simply expanding the incidence of delegated authority as it is presently applied for the reasons discussed in the

[74] Part of the Department of Women, Aboriginal and Torres Strait Islander Partnerships and Multiculturism, is focused on policy, programs and services for Aboriginal and Torres Strait Islander communities.

Executive Summary in Chapter 1. That is all the Commission is able to say about the third observation referred to above.

4.3 The causes of over-representation of Aboriginal and Torres Strait Islander children in the child protection system

The balance of this chapter considers opinions and evidence concerning the causes of over-representation of Aboriginal and Torres Strait Islander children in the child protection system. The chapter addresses differing opinions about the proximate and wider causes and how best to address those causes.

4.3.1 Recent submissions from the Cape York Institute and responsive submissions by QATSICPP, QIFVLS and PeakCare

No topic has been given more attention throughout the course of the Inquiry than the over-representation of Aboriginal and Torres Strait Islander children. Unfortunately, it was only in April 2026 that the Commission received a submission from the CYI. Despite the lateness of this submission, the Commission was able to confer with the CYI in within a few weeks of receiving the submission. Following receipt of the CYI submission, the Commission invited QATSICPP, QIFVLS, PeakCare, Aboriginal and Torres Strait Islander Legal Service (ATSILS), and the Queensland Family and Child Commission (QFCC) to respond to the CYI submission. The Commission received, only very recently, responsive submissions[75] as well as a supplementary submission from the CYI.[76]

The lateness of these submissions is unfortunate, particularly as the Commission has sought to grapple with the issue of over-representation from the outset of the Inquiry. This is not intended as a criticism of CYI or any other body, but rather a lament that the Commission has not had more time to digest and examine the many nuanced issues these submissions raise.

Nevertheless, these submissions have been received against a background where throughout the Inquiry, the Commission has engaged closely with QATSCIPP, including by representatives from the Commission attending several direct engagements. QATSCIPP has been an active participant in the Inquiry and has provided ten submissions. In addition to QATSCIPP, the Commission has benefited from the representation at the Commission's hearings on behalf of QIFVLS and ATSILS. The Commission has heard evidence from Aboriginal and Torres Strait Islander children in care,

[75] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (8 May 2026); Peak Care, *Submission to Child Safety Commission of Inquiry* (11 May 2026); QATSICPP, *Submission to Child Safety Commission of Inquiry* (11 May 2026); QIFVLS, *Submission to Child Safety Commission of Inquiry* (11 May 2026).
[76] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (May 2026).

or previously in care. In addition, it has heard from Aboriginal and Torres Strait Islander children during youth engagement sessions. The Commission has heard from kinship carers, frontline Aboriginal and Torres Strait Islander workers from various ATSICCOs, cultural practice advisers from within the Department, and Department officers with policy and operational responsibility for engaging with Aboriginal and Torres Strait Islander communities.

The Commission is by no means naïve to the fact that any causal analysis must be understood in the broader socio-economic and cultural context in which Aboriginal and Torres Strait Islander Australians live. Neither is the Commission naïve to the fact that multiple concurrent causes transcend the geographic boundaries of the State of Queensland and transcend the direct remit of the child safety system. The Commission recognises that actions by the Department alone cannot address all of these causes and that a whole of government approach is required within Queensland in alliance with the Commonwealth government and other state and territory governments. The Commission further recognises that there is an important historical context to the manifest over-representation of Aboriginal and Torres Strait Islander children in care. This includes historical actions and inactions by government, as well as actions by non-government institutions, which have wounded confidence among Aboriginal and Torres Strait Islander communities in the instrumentalities of the state and in other institutions outside their communities.

The Commission recognises the express desire for self-determination on the part of Aboriginal and Torres Strait Islander communities. The principle of self-determination is enshrined in the *Child Protection Act 1999* (Qld) (Act) and in other legislation, in the *United Nations Declaration on the Rights of Indigenous Peoples* and in other international and State instruments, and in the *National Framework*. In the context of the child protection system, the desire for self-determination is given practical expression in the provisions of the Act which allow for delegated authority to ATSICCOs.[77]

4.3.2 The Cape York Institute Submission: the proximate causes of Aboriginal and Torres Strait Islander over-representation in the child safety system

The Commission was grateful to receive the submission from the CYI for several reasons, most significantly because it is the only submission received from an Indigenous body which directly addresses in terms, and gives emphasis to, the proximate causes of the disproportionate representation of Aboriginal and Torres Strait Islander children in the child safety system. The submission is available on the Commission's website, along with the other submissions

[77] *Child Protection Act 1999* (Qld), s 148BB.

presently under discussion. For convenience, set out below are selected extracts from the CYI submission dated 13 April 2026, omitting headings and footnotes.

> *'The proximate causes of this crisis are not mysterious. In Cape York they are visible and well documented: alcohol, cannabis and methamphetamine epidemics, violence that has become routine. Passive welfare that has hollowed out work, responsibility and social norms. These conditions drive children into Child Safety, youth detention and prison. Yet policy has been governed by what we call the 'symptom theory'—the idea that addiction and violence are mere by-products of deeper historical wrongs, and that governments need only multiply services at the margins while tolerating epidemics at the centre of children's lives.*[78] *...*
>
> *The proximate cause of this crisis is not a lack of programs or services, and not mysterious cultural issues in Aboriginal and Torres Strait Islander families. The proximate cause is the substance-abuse epidemics that have taken hold in Indigenous communities, and the deeper structural cause is the passive-welfare environment that has entrenched them.*[79] *...*
>
> *The misdiagnosis underpinned by 'symptom theory' has dominated policy thinking ... On that view, the State can continue to proliferate programs at the margins while tolerating epidemics of grog and drugs in the centre of these children's lives.*[80]
>
> *...*
>
> *The implication is clear: the Commission must insist on a different ordering of responsibility.*
>
> *Firstly, Aboriginal and Torres Strait Islander families must accept, and be enabled to exercise, their responsibilities to care for, protect and raise their children free from violence, neglect and abuse. Those responsibilities are not optional, and they are not excused by history.*
>
> *Secondly, the State must accept its full responsibility for the environment in which those families live. It cannot plausibly claim to be a residual actor when its laws and policies have suppl[ied] essential conditions for substance-abuse epidemics—passive income, idle time, availability, and a permissive ideology—around Indigenous children. Nor can it*

[78] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 6-7.
[79] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 7.
[80] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 7.

maintain a posture of helplessness in the face of a tertiary child-protection industry it finances and designs. [81]

In policy terms, this means three things.

1. *Queensland must hold the line and go further on Alcohol Management Plans and related supply-reduction measures, treating alcohol and drugs as the central proximate drivers of the child-protection disaster rather than as peripheral 'risk factors.' The perceived right to drink cannot continue to trump the right of Indigenous children to safety, sleep, food, education and mental health.*
2. *The State must move beyond a purely voluntary, referral-based model of family support. Parents must be offered structured support and, where necessary, required to participate in it—attendance at parenting programs, engagement with alcohol and drug treatment, and cooperation with school attendance plans cannot remain optional extras at the very point children's safety is at stake.*

This is where a properly empowered Family Responsibilities Commission model in the child-protection space becomes essential. Notifications from child safety, police, schools and housing should operate as triggers to bring parents before respected Local Commissioners, who can put in place binding Family Responsibility Agreements and orders, backed by case management, income-management powers and clear consequences if parents refuse to engage.

The principle must be responsibilities-plus-opportunities: the State undertakes to provide intensive, practical support, but parents are not permitted to stand aside from their own obligations while the system raises their children.

3. *These expectations must be underpinned by concrete options for families to stabilise and rebuild their lives in their own communities. That requires the development of in-community, on-Country residential care options where parents and children can live together for defined periods in a structured, supportive environment. Such facilities would combine safe accommodation, daily routines, therapeutic and disability support, alcohol and drug treatment, and hands-on parenting coaching, with a clear pathway back into ordinary community life. They must not be warehouses for children, or another layer of the tertiary industry, but temporary, intensive platforms for parents who are willing—or can be compelled—to step up.* [82]

[81] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 8.
[82] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 8-9.

> ...
>
> *The Commission stands at a familiar fork in the road. It can produce another report that faithfully recites the history of trauma, recommends more programs, invokes 'partnership' in the abstract, and leaves intact the policy settings that have grown this crisis over 30 years. Or it can confront the hard questions about the primacy of substance-abuse epidemics and passive welfare in driving Indigenous child protection crisis [sic], about the real distribution of responsibility between families and the State, and about the structural reforms needed to give local Indigenous authority and Queensland's own institutions the tools to change behaviour and change the environment. The Cape York Institute urges the Commission to choose the harder path.*[83]
>
> ...
>
> *Aboriginal and Torres Strait Islander children are bearing the greatest weight. Across Queensland, Indigenous children are about 9 per cent of the child population—but they make up around a quarter of all children notified to child safety, and just over half of all children in care. FNQ dramatically intensifies that over-representation: departmental breakdowns show that FNQ is responsible for roughly one-third of all Indigenous notifications in Queensland, about 20 per cent of all Indigenous children in care, and around 20 per cent of Indigenous children where harm has been substantiated.'*[84]

It is unnecessary to further summarise the submission as the above extracts convey the essence of the causal thesis advanced by the CYI and the measures it advances to address them. In the passage quoted above in italics, the submission characterises the Commission as standing '*at a familiar fork in the road'* and poses a choice: one familiar and characterised by abstract notions and the invocation of the history of trauma, and the other, a more difficult path, of confronting the proximate causes of over-representation. In their own words, 'The Cape York Institute urges the Commission to choose the harder path.' As will become clear from the discussion which follows, the Commission chooses the latter.

4.3.3 Is the 'Stolen Generation' being repeated?

Before turning to the proximate causes of Aboriginal and Torres Strait Islander children being removed identified by the CYI, it is convenient to consider another potential cause of gross Aboriginal and Torres Strait Islander over-representation. This cause, if true, would be an

[83] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 9.
[84] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 10.

appalling indictment on the child protection system with corrosive consequences impossible to overstate.

Throughout the course of the Inquiry, the Commission raised questions in hearings and in discussions about the proximate causes of the rates of Aboriginal and Torres Strait Islander children being removed into care. In the early stages of the Inquiry, during the hearings in Cairns, evidence was given broadly to the effect that Aboriginal and Torres Strait Islander children continued to be removed without good cause.[85]

Perceptions of unwarranted removal of Aboriginal and Torres Strait Islander children, if accurate, would be extremely serious as they would indicate continuing injustice being visited upon Aboriginal and Torres Strait Islander children and families redolent of the historical practices that have maligned the child safety system. If accurate, they would constitute a serious indictment not only on the Department but also upon the court system. It would also mean that any critique of the child safety system would have to be adjusted to take account for an unknown number of children who should not have been removed from their families. Last, but not least, if accurate, it would mean that the public generally, and Aboriginal and Torres Strait Islander communities in particular, could not have confidence in the assumption underlying the tertiary system, namely that children are only removed when they are in need protection.

Consequently, the Commission investigated the bases of these claims as detailed in Companion Report 1: Functions of System, Chapter 3: Supporting pregnant women and new mothers. For the reasons explained in the Companion Report, the Commission is satisfied that the cases it investigated did not reveal an unwarranted removal of the children concerned.[86]

While it may be impossible to say that mistakes in relation to decisions to remove children are never made, the evidence before the Commission concerning the practices and processes of the Department, as well as the present litigation model, indicate that the relevant risk assessment and decision making processes are at least sufficiently robust and cautious to ensure that children are not removed without a rational basis for a reasonable apprehension that the child is in need of protection. That is not to say that further efforts should not be made to enhance the opportunities for children to be protected at home or cared for within community, nor that the court process should not be improved in various ways to avoid removal wherever possible and to facilitate the earliest possible return of children to family and community. These matters are the

[85] Transcript, Evidence of Alana Mitchell (16 September 2025) 901:32-901:38; Transcript, Evidence of Emily Hapea and Rachel Ham (17 September 2025) 1007:5-1007:19, 1015:39-1015:46; Transcript, Evidence of Rachael Ham (17 September 2025) 1110:7-1110:16; Transcript, Evidence of Thelma Schwartz (22 September 2025) 1498:20-1498:26, 1500:13-1500:42; Transcript, Evidence of Michelle O'Connor (23 September 2025) 1558:33-1562:47.
[86] See, case study of Baby Nathan.

subject of a Companion Report 2: Child Protection Litigation and are the subject of several recommendations by the CYI referred to below.

The above discussion digressed from the proximate causes identified by the CYI submission to address a cause, or causes, on which it does not place weight in its submissions to this Inquiry. The Commission does not suggest that the CYI, if asked, would rule out racism as a factor, but its focus is on proximate causes rather than attributing overarching racial characteristics to the causes of over-representation.

Other organisations representing Aboriginal and Torres Strait Islander communities and interests in the child protection system continue to place racial explanations at the forefront of their causal theories. For example, QATSICPP submitted: '[t]he over-representation of Aboriginal and Torres Strait Islander children, and the unequal impacts they face, point to a system that is discriminatory – whether by design or through application. Cultural bias and lack of competency within mainstream child protection services can lead to mislabelling Aboriginal and Torres Strait Islander families as neglectful.' [87] QIFVLS similarly submitted: 'overrepresentation springs from a variety of factors…[including] systemic racism deeply embedded in departmental practices and culture.'[88] Submissions from other groups representing Aboriginal and Torres Strait Islander interests were to similar effect.[89]

As discussed above, the Commission's examination of a sample of specific cases identified by QIFVLS did not sustain a criticism that the children concerned were removed without a sufficient rational reason.

This is not an inquiry into racism in the child protection system or otherwise, including the distributed meanings that should be given to that species of prejudice. That is presently the work of a separate of Inquiry, the *Royal Commission on Antisemitism and Social Cohesion*, in relation to a different target group. However, in this Inquiry, the issue of racism arises as a necessary incident of understanding whether it contributes to over-representation of Aboriginal and Torres Strait Islander children with the dire consequences referred to above.

It is very difficult to interrogate accusations of racism framed at the assertive level put by QATSCIPP, QIVLS and in other similar submissions. Theses submissions enlist the passive voice,

[87] QATSICPP, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Far North Queensland* (August 2025), 25.
[88] QIFVLS, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Far North Queensland* (25 August 2025), 7.
[89] ATSILS, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Far North Queensland* (28 August 2025) 15; Institute for Urban and Indigenous Health, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System* (November 2025) 11; SNAICC, *Submission to Child Safety Commission of Inquiry* (March 2026) 9.

impliedly conflating malevolent motivation, or unspecified structural bias, as inferences to be drawn from over-representation. There is a circularity to this contention, which attributes racism as a cause to be inferred from the fact of over-representation of Aboriginal and Torres Strait Islander children compared to non-Aboriginal and Torres Strait Islander children. This is a path of reasoning which should be approached with great caution. It has an *in terrorem* quality to it that may segue to a hunt for malevolent forces and wrongdoers aptly depicted in Arthur Miller's play *The Crucible*. The assertion of racism as the cause to be deduced from the empirical data about over-representation provides the false logic for the extrapolated conclusion that only racists, consciously or unconsciously, could deny the truth revealed by the data. Such reasoning also has the tendency to discourage honest debate about proximate causes of the nature identified by the CYI and fortifies entrenched narratives of ongoing inter-generational harm caused by racial discrimination.

The conditions described by the CYI from which Aboriginal and Torres Strait Islander children are removed cannot be characterised as a mislabelling of neglect due to cultural bias or lack of cultural competency. Neither could the removal of children living in such conditions be explained because of deeply embedded racism within the Department. While it may be said that these observations are but to set up a 'straw man', that is not entirely so. The counterpoint is that failing to directly identify and focus upon proximate causes is to try to ignore the proverbial 'elephant in the room'.

The absence of an intangible force such as racism is extremely difficult to prove, certainly far more difficult than making the accusation that it does. As said above, it is not the burden or function of this Inquiry to make findings about the existence or absence of racism within the Department or more widely. The relevant question is whether there is evidence that racism is a motivating or causal factor in decisions to remove Aboriginal and Torres Strait Islander children from their families, and in relation to other relevant respects in which the Department acts towards Aboriginal and Torres Strait Islander communities.

As indicated above, the Commission has not found evidence to support such a conclusion. On the contrary, the Department's policies and processes indicate that it is acutely conscious not to repeat the culturally ill-informed mistakes of the past. These policies and processes include the widespread involvement of cultural practice advisers, the increased funding for ATSICCOs under the *Safer Children, Safer Communities* plan, and the introduction of the *Our Way Strategy* aimed

at eliminating the over-representation of Aboriginal and Torres Strait Islander children in the child protection system in Queensland.[90]

In the historical context of Aboriginal and Torres Strait Islander children being removed for misconceived and misunderstood reasons, it is unsurprising that Aboriginal and Torres Strait Islander communities' trust in government, including the court system, has been eroded. The Commission considers that the best way to remedy concerns about racism is to ensure that the decision-making process, including the court process, is so robust that it defies rational criticism on the grounds of racism.

The decision to remove any child should be a decision for the Childrens Court, based on cogent and compelling evidentiary material. The Commission has given in depth consideration to the legal process and to the anterior risk assessment and decision-making processes. These matters are discussed in other parts of this Report and in the Companion Reports.[91]

The legal process must include the practical ability for participation in that process by the children and families directly affected. If Aboriginal and Torres Strait Islander families, indeed all families, are to have confidence in legal process, they must be provided with practical access to legal representation. In the case of Aboriginal and Torres Strait Islander children there is a strong case for ATSICCOs such as QIFVLS being supported to provide that representation. The broader benefits of legal representation are both direct and consequential. The direct benefits include helping to fulfill the legal obligation in section 5C(d) of the Act – the 'participation principle'. There are many consequential benefits, including enhancing the efficiency of the court process. The broadest consequential benefit will be enhancing confidence in the child safety system for all children, families and communities. The greater the confidence in the system, the more likely it will be that Aboriginal and Torres Strait Islander communities, and other communities, will participate in programs and interventions aimed at prevention, early reunification or long-term placement.

4.3.4 Proximate causes of removal of Aboriginal and Torres Strait Islander children identified by the Cape York Institute

Returning now to the proximate causes identified by the CYI, the Commission makes the following observations. First, identification of the proximate causes is the first step toward devising means to address the problem. Throughout the Inquiry, other submitters in relation to

[90] Family Matters, Queensland Supporting Families Changing Futures, *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families: 2017-2037* (Report, 2017).
[91] See, Chapter 6: The Child Protection Litigation Model and the Court Process and Companion Report 2: Child Protection Litigation.

this topic, including the Department, have not given emphasis to those proximate causes to the degree of detail and careful analysis exposed in the submission by the CYI.[92]

The Department identified the principal causes of harm to children to be alcohol and drug abuse, domestic and family violence and mental health issues. Those causes encompass, in a general way the causes more specifically identified and explained in the Cape York submission, but do not include 'passive welfare'. QATSICPP's recent submission in response to the CYI submission says:

> Across urban, regional and remote Queensland, our members consistently identify alcohol and other drug use, domestic and family violence, intergenerational trauma, poverty, housing stress and limited access to timely, culturally safe supports as key contributors to statutory involvement. They also emphasise system responses occur too late, after risks have escalated, rather than investing early to stabilise families and prevent harm.[93]

QIFVLS's recent responsive submission contends that domestic and family violence is a principal 'upstream mechanism by which Aboriginal and Torres Strait Islander mothers and children come to the attention of the child protection system.'[94] It further contends that this does not reduce neatly to a proximate cause model, noting 'substance use/abuse, housing instability, neurodevelopmental need, trauma, and the structural consequences of historical dispossession are not competing variables to be ranked and assigned priority.'[95] The causal analysis by QATSICPP and QIFVLS are essentially aligned. Each focus on the broader historical and contextualising factors. They essentially dispute the veracity of a causal analysis which gives priority or greater weight to the proximate causes upon which CYI focuses.

Before proceeding further with the discussion of the contending theories of causation, it is worth noting that the submissions from bodies representing Aboriginal and Torres Strait Islanders communities do not give focus to the prevalence of Foetal Alcohol Spectrum Disorder (FASD) or its consequences. The reference to 'neurodevelopmental need' in QIFVLS's submission may, however, be a reference to it. It is important to note that the prevalence of FASD, even in cases of children with observable physical or behavioural characteristics consistent with FASD, are not routinely tested and diagnosed.[96] The Commission was left with the impression that discussion of FASD is a taboo.

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[92] See the Companion Report 1: Functions of Systems, Chapter 1.8: *Implications for Reform*, where the Commission advocates a dedicated focus for ATSICCOs in supporting families and addressing the proximate causes of harm and proposes how the Department might be structured to achieve this.
[93] QATSICPP, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 1.
[94] QIFVLS, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 2.
[95] QIFVLS, *Submission to Child Safety Commission of Inquiry* (11 May 2026) 2.
[96] Transcript, Evidence of Marnie Fraser (26 September 2025) 1949-1950, 1973:8-1973:34; Statement of Marnie Fraser (18 November 2025) [59]; Queensland Health, *Submission to Child Safety Commission of Inquiry* (28 March 2026) 16-17.

The Commission sought FASD data from Queensland Health and learned that there is very little reliable statewide data concerning the incidence of FASD.[97] FASD causes lifelong cognitive impairment and behavioural issues. For all children, including children in care, it is plainly necessary to understand the child's medical condition in order to provide treatment and support.[98] The Commission infers that one reason for the paucity of data concerning the incidence of FASD is because it is a condition which carries with it shame and opprobrium from the mother's perspective in particular. That is, of course, understandable and not to be underestimated. However, it is not a good reason not to recognise and address it. There is a clearly a higher legal and moral duty to treat the child for the consequences of FASD to the extent possible. The failure where appropriate to routinely investigate, test and treat FASD is a systemic failing. FASD can produce acute symptoms and lasting consequences. This is an uncomfortable truth but the consequences of FASD, like the other direct consequences described in the Cape York submission, must be confronted, not elided. It is a further example, should any be required, which confirms that plain speaking identification of the proximate causes of harm is the indispensable foundation of any measures aimed at prevention.

The Commission does not accept the contention advanced by QIFVLS and QATSICPP that proximate causes cannot be disaggregated from the broader historical and contextual factors which they identify. There is no inconsistency as a matter of causal analysis based on cognate legal theory between recognising all concurrent causes and characterising them by reference to their proximity to the result. If anything, the debate within the jurisprudence concerning the recognition and content of legal duties is the opposite. The controversy generally concerns whether broader causative factors might be included; not the exclusion of, or weight to be given, to known proximate causes. In this sense the causal contentions of QFVILS and QATSICPP invert the jurisprudential debate.[99] In any case, the distinction between proximate and wider causes is of importance to determining the steps that may be taken to address them at the differing levels at which they each contribute to harm.

The CYI submission openly and explicitly describes the fission between alcohol, marijuana, and now ice, mixed with passive welfare, often exacerbated by gambling. In combination, these forces combine to increase the frequency and severity of violence between Aboriginal and Torres Strait Islander people, inside and outside the home. Of course, the children suffer. The CYI submission

[97] Queensland Health, *Submission to Child Safety Commission of Inquiry* (28 March 2026) 16.
[98] Queensland Health, *Submission to Child Safety Commission of Inquiry* (28 March 2026) 16.
99 *Jaensch v Coffey* (1984) 155 CLR 549 at 584 per Deane J; *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 498 per Deane J. See also *McCann v Switzerland Insurance Australia Ltd* (2000) 203 CLR 579 at 639-640 per Callinan J, citing *Chappel v Hart* (1998) 195 CLR 232 at 269 [93] per Kirby J.

speaks truth not to power but to outcomes. It speaks to dependency and the powerlessness it contributes to. It alone among the submitters speaks to an overlooked restorative factor – individual agency and responsibility.

The fact of disadvantage in Aboriginal and Torres Strait Islander communities has been much studied and widely acknowledged. The ambition of public policy has been encapsulated by the metaphor of 'closing the gap'. The Commission ventures that the better metaphor might be the warning broadcast on the London underground railway network, which says: 'mind the gap'. In other words, step over the gap. This metaphor may be more apt because it conveys that it is possible for an individual to do something about the gap, not wait until the gap disappears. That is not to suggest that the gap should not also be closed. As the CYI submission makes clear, the government must do all that it can to set conditions which make it possible for communities to have real and practical opportunities for meaningful employment and provide services which help to build strong communities.

The underlying contention of the CYI is that the policies which turn the tide are a combination of those which prevent the tide from ebbing, such as alcohol management plans, and those which help it to flood, such as family responsibility supported by real and practical opportunities for employment, together with community designed intervention and support programs and in situ services such as locally available residential care.

The reason that these causal integers and their consequences resonate with authenticity is because they are the widely observable. The consequences in essence are the same whenever and wherever the conditions of degradation are found. They are not unique to Aboriginal and Torres Strait Islander communities though they are more prevalent. The Commission agrees that the proximate causes must be tackled head on if the self-perpetuating consequences are to be prevented from continuing from this generation to the next, and beyond. To be absolutely clear, that is not to suggest that the complete answer is to be found in only addressing the cocktail of proximate causes. That is not what is suggested by the CYI. As discussed in Chapter 5, Targeted Intervention and Family Support, the Commission strongly supports the importance of early help and support, before, during and after a child enters the tertiary child safety system. However, those strategies alone will not suffice.

A further distinguishing feature of the CYI position is that welfare programs alone will not abate the known consequences, and that passive welfare helps create a purposelessness which has pervasive self-perpetuating effects. The CYI solution involves a range of measures including

alcohol management plans and compulsory income management under the local authority of a Family Responsibility Commission. These features of the CYI model are discussed below.

4.3.5 Cape York Institute Supplementary Submission

At the end of April 2026, the Commission was able to meet with the Cape York Institute. The Commission requested the Institute provide a supplementary submission addressing certain matters in greater detail. The supplementary submission is now also available on the Commission's website. In its covering letter the Institute made the following tragic observation:

> The day of our meeting came the unbearable news that the body of Kumanjayi Little Baby, taken from a family home at Old Timer's Town Camp near Alice Springs, had been found in a dry creek bed. Little Baby had been exposed to extremely unsafe, alcohol-fuelled circumstances when she was at her most vulnerable. Despite enormous public expenditure directed towards additional services in Alice Springs, the conditions that placed her at risk remained unchanged. We refer to this tragedy not to prejudge matters properly reserved for other processes, but because the pattern is tragically familiar.

For the same reason, and subject to the same qualification, the Commission has quoted what was said by the Institute.

Cape York Institute's supplementary submission builds upon the themes and analysis of its original submission. It argues for an expansion of the family and responsibility commission to be allied with a government obligation to provide real opportunities, suggesting that the commission be redesignated as the Family Responsibilities and **Opportunities** Commission. It would be unfair and incomplete to attempt to summarise either the CYI's original or supplementary submissions. Both submissions contain detailed reference to the direct experience of the CYI, to the evidence in support of its analysis and recommendations and to the challenges that must be overcome to achieve a real and genuine improvement in the life trajectory of Aboriginal and Torres Strait Islander children. The CYI unpacks the many critical elements to any lasting solution, not least being access to educational opportunities. All of these factors are synthesised in the Institute's submissions. The Commission acknowledges that, while the CYI contemplates the approach that it advocates as being scalable, it is based upon its success in the discrete remote communities that it represents in the Cape York Peninsula.

That said, as a matter of policy intent and in terms of the implementation of a strategic approach which has a practical likelihood to turn the tide, the Commission respectfully adopts in principle each of the recommendations made by the Institute in the original and supplementary submissions in relation to the Cape York region, subject to one important qualification. That

qualification relates to the third proposition discussed above, namely the insistence upon local decision making. Unless and until there is a body able to mediate between different local views about priorities in terms of programs and actions, and whether compulsory income management and alcohol management plans are necessary and appropriate, there is little prospect of the CYI model being extrapolated or applied more widely. Its application to other areas within the vast geographic area of Cape York will require local agreements and will likely not be achievable without first establishing a body with the confidence and authority of many different communities within the Cape York region, but it is certainly worth trying. As noted in CYI's original submission, FNQ is at the epicentre of Aboriginal and Torres Strait Islander over-representation.[100] For these reasons, the Commission recommends that government engage with the CYI and the Aboriginal and Torres Strait Islander communities in the Cape York region to assess the feasibility of, and means by which, the recommendations made by CYI may be implemented and or adapted more widely in that region. If successful it may, with modification, be tested more widely.

4.4 Delegated authority – and predetermined assumptions

Delegated authority is heavily relied upon as a factor which will make a material difference to over-representation and, in particular, enhance opportunities for reunification. Indeed, delegated authority is vociferously pressed as the solution to much which is said to be wrong with the system, and as a meaningful expression of self-determination. It is also the topic which illuminates the observations of the Commission concerning obstacles to reform, namely that solutions to reform have become entangled in assertive contentions based on inscrutable assumptions. The Commission has already discussed some other fundamental limitations to delegated authority as presently conceived.[101]

The Commission has also discussed the adverse effects of making predetermined inscrutable assumptions when making decisions affecting children.[102] Plainly, delegated authority to make the decision does not fix the environment described in the CYI submission, nor of itself alter the proximate causes of child harm. That does not mean it does not have a role, rather the question is where it is best used.

The Commission considers that delegated authority would be better directed to actions aimed at changing the conditions which combine to require removal in the first place. An ATSICCO's capacity to effect positive change through its trusted position, community involvement and

[100] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 13.
[101] See above 4.2 in this chapter, and the discussion in the Executive Summary. Chapter 1.3.1 and Chapter 3.5.
[102] See the discussion of the paramount principle in in the Executive Summary, Chapter 1, and in Chapter 6.2.

connections would be better deployed where there is a potential for those advantages to assist in driving change at the outset, at the stage when prevention has the potential to prevent the removal of a child. If delegated authority was to be deployed in that context its effectiveness could be properly put to the test.

QATSICPP contends that delegated authority must continue, and that it is unquestionable that delegated authority can deliver clear benefits for children and families. These contentions have been vigorously pressed throughout the Inquiry, effectively presenting delegated authority as a broad-spectrum panacea.

The gravamen of QATSICPP's submissions in support of delegated authority is essentially that Aboriginal and Torres Strait Islander communities know what is best for Aboriginal and Torres Strait Islander children and how best to care for and nurture them. As a general proposition, it is unnecessary to debate this contention. However, it is not a persuasive answer once the state has been required to intervene to protect a child. It is even less persuasive when the answer is shrouded by the mystery of cultural knowledge that can neither be understood, nor questioned, by non-Aboriginal and Torres Strait Islander people. At that point the answer becomes an impediment in its own right to implementing reform.

4.5 Delegated authority and the lack of evaluation

The inscrutability of delegated authority's effectiveness is compounded by the absence of reliable evaluations.

The Commission called for submissions into delegated authority in late July 2025. No submissions were received which called into question the wisdom, efficacy, efficiency or outcomes of Delegated Authority. All were universally positive and expressed a desire for delegated authority to be expanded. This was consistent with what the Commission consistently heard from ATSICCOs during direct engagement sessions.

Nonetheless, the evidence in support of these strongly held views is not convincing. The Commission notes that, in 2024, the QFCC conducted its annual survey of the child protection, youth justice and family support workforces, and found that 58% of respondents agreed that Delegated Authority 'will result in better outcomes for Aboriginal and Torres Strait Islander children and young people'. Two things may be said about that. First, it is not clear how quantitative support for the effectiveness of delegated authority should be equated, if at all, to qualitative assessment of its effectiveness. Second, to the extent that conclusions may be drawn

from the poll, it is notable that slightly less than half the surveyed population – professionals working in child protection or adjacent fields – agreed that delegated authority would benefit the targeted children. No commentary was provided in the annual report around this finding.

The fact remains that the effectiveness of delegated authority has not been seriously evaluated, either by the Department or any independent third party. There are many assertions as to the success of delegated authority – one ATSICCO with delegated authority claimed that it had reunified 17 children directly back to their parents, and that none of those children would have been reunified without the delegated authority process in place.[103] However, the basis for this claim was not disclosed and remains unclear.

It appears the Department has no current plans to have Delegated Authority independently assessed. As the Department's delegated authority team sits within the Office of the Chief Practitioner, the Commission questioned the Acting Chief Practitioner about evaluation of Delegated Authority during public hearings. The Acting Chief Practitioner told the Commission that the Department will 'largely rely upon the evaluation of QATSICPP'.[104] This was a reference to the evaluation that is currently being conducted by QATSICPP pursuant the Delegated Authority Learning and Adaption Framework published by QATSCIPP (DA Evaluation Framework)[105], which outlined a three-year plan for the evaluation of the implementation and outcomes of Delegated Authority across Queensland.

It is of concern to this Commission that the evaluation of Delegated Authority outcomes rests on QATSICCPP's evaluation alone because — it must be noted — QATSICPP cannot approach the evaluation from an unbiased, independent perspective. It starts from a position of an unambiguous advocate for Delegated Authority and as the peak body for its ATSICCO members who will benefit from the granting of delegated authority to its CEOs.

4.5.1 The current status of QATSICIPP's evaluation

Pursuant the DA Evaluation Framework, an interim evaluation report was due to be provided to the Department by December 2025. It was not so delivered — due to what the Department told the Commission were unspecified 'delays'.[106] On numerous occasions between December 2025 and May 2026, the Commission sought updates from the Department on the delivery of this interim evaluation report. Based on communications from the Department's lawyers, the Commission understands that the Department met with QATSICPP on 30 January 2026 during

[103] SNAICC, *Family Matters* (Report, 2023) 98 "REFOCUS and Delegated Authority".
[104] Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3084.
[105] Published in June 2024.
[106] Letter from Crown Law to the Commission of Inquiry dated 19 December 2025.

which 'the limitations of the data able to be drawn from service provider quarterly reporting was discussed.' [107] A further briefing was scheduled for 1 April 2026 to discuss progress and an anticipated date of completion. According to the Department, that meeting was then postponed until 16 April 2026 – and then to 11 May 2026 – at the request of QATSICPP.[108] Assuming the 11 May meeting went ahead, no further update was provided to the Commission.

These delays have deprived the Commission of relevant information about a topic that: affects the lives of numerous Aboriginal and Torres Strait Islander children in the child safety system; is of high priority to QATSICPP's members; and in respect of a legislative scheme which QATSICPP has contended to this Commission ought to be expanded as a method of reducing over-representation of Aboriginal and Torres Strait Islander children in the Child Safety system. That is unfortunate to say the least.

It is unclear what, if any, ramifications the delay in this interim evaluation report will have on the further funding of the Delegated Authority scheme. The Commission was notified by Crown Law (on behalf of the State) on 11 May 2026 that 'the Director-General has approved the engagement of Queensland Government Consulting Services to undertake a project that will consider options for future costing models for delegated authority, having regard to benefits and outcomes.'[109]

4.5.2 QATSICPP's submissions

In a submission to the Commission in March 2026, QATSICPP stated that its evaluation 'has been drafted and is progressing through review'.[110] The data limitations referred to in the Department's communication to the Commission were not mentioned, nor did QATSICPP explain why it did not deliver the evaluation on time, what has caused the delay, and why — more than four months later — it is still outstanding.

Despite the outstanding evaluation, QATSICPP nonetheless submitted that 'delegated authority must continue'[111] and that 'it is unquestionable that DA can deliver clear benefits for children and families.'[112] This Commission has been at pains to point out that — based on the evidence it has seen and heard over the course of its remit — the assertion that certain reform agendas within the child safety system are unassailable or not open to question creates systemic problems which distort and distract from the paramount principal. QATSICPP had the opportunity to put

[107] Letter from Crown Law to the Commission of Inquiry dated 26 March 2026.
[108] Email from Crown Law to the Commission of Inquiry dated 8 April 2026. Email from Crown Law to the Commission of Inquiry dated 11 May 2026.
[109] Email from Crown Law to the Commission of Inquiry dated 11 May 2026.
[110] QATSICPP, 'Community-led, Reform-ready: Community controlled leadership. Shared Responsibility. Early Action. Better outcomes, p 17.
[111] QATSICPP, Submission to Child Safety Commission of Inquiry (March 2026) 17.
[112] Ibid.

before this Commission objective, measurable evidence of delegated authority outcomes. It has not done so, nor has it explained its failure to do so.

4.6 Conceptual and legal constrains relevant to delegated authority

Delegated authority is often framed as an expression of self-determination. Yet the removal of a child into State care for protective purposes necessarily deprives parents and families, Aboriginal and Torres Strait Islander and non-Indigenous alike, of fundamental parental rights. That consequence is inherently inconsistent with self-determination understood at either an individual or collective level. In the Commission's view, this requires a careful and honest examination of what self-determination can, and cannot, mean in the context of statutory child protection.

Public confidence in the child safety system also depends on decisions to remove a child being made by an independent judicial authority. It was not seriously contended during this Inquiry that such decisions should be removed from the jurisdiction of the courts in relation to Aboriginal and Torres Strait Islander children. This creates a principled constraint on the scope of delegated authority at the critical decision point at which a child is placed into State care.

The Commission gave particular consideration to whether delegated authority should extend to decisions about reunification or long-term placement. These decisions are as consequential as the initial decision to remove a child. An unsound decision may expose a child to serious harm. Consequently, all decisions must be subject to an impartial evaluation of the child's best interests in accordance with the paramount principle.

While the Aboriginal and Torres Strait Islander Child Placement Principle is important, it must remain genuinely subordinate to the paramount principle when the State is acting as corporate parent. Decisions must be made on the basis of the individual child's circumstances in a way that is capable of being shown to be reasonably objective. Broader macro-objectives and system-level goals, such as reducing the number or proportion of Aboriginal and Torres Strait Islander children in State care, cannot, of themselves, influence the evaluation of the best interest of the individual child, nor be used to justify decisions made about that child.

The evidence before the Commission included examples of reunification decisions that were difficult to explain by reference to a rational evaluation of the child's best interests, and more readily explained by an aspirational pursuit of broader, cultural or socio-political goals. These examples emphasise the risk to public confidence when entities with a strong interest in

producing particular outcomes — including the Department itself — are left to make such decisions without judicial oversight and scrutiny.

For these reasons, the Commission does not support the use of delegated authority in relation to coercive decisions, including decisions that cannot properly be disaggregated from the exercise of coercive power involved in taking a child into care. Decisions concerning reunification or long-term placement are preceded by the exercise of coercive power. In the Commission's view, the Court should decide, or assent to, arrangements which, at a practical level, bring the exercise of that power to an end, or render it spent.

4.7 Legal consequences of delegated authority

If delegated authority is to be implemented more broadly as the ATSICCO sector advocates it must be, it is important to understand the legal effect of the delegation of authority in the context of child protection. Before turning to that question, it is relevant to note that the incidence of delegated authority having been conferred on ATSICCOs has to date been limited as demonstrated in the table below.[113]

Region	Number of Children
Far North Queensland	27
North Queensland	29
Sunshine Coast and Central	284
Brisbane and Moreton Bay	37
South West	28
South East	34
Total	**439**

Table 2: Delegated Authority Register Summary

The following analysis of the legal constraints which pertain to delegated authority under the Act, and the effect of delegation in relation to the legal responsibility for the exercise of delegated authority, is of significance to the framing of accountability mechanisms and to the need to ensure appropriate capability on the part of the ATSICCO.

[113] This table shows the number of delegations made to ATSICCOs by different child safety regions as at 10 December 2025. It is based on the latest data that was available in a Register of Delegated Authority provided to the Commission and has not been separately verified with the Department.

4.7.1 The power to delegate functions to an ATSICCO

The power by which the state may delegate authority to ATSICCOs is contained in Part 2A of Chapter 4 of the Act, which provides for a policy of 'prescribed delegates' in respect of Aboriginal and Torres Strait Islander children.

In particular, section 148BB of the Act specifies that the chief executive (i.e. the Director-General) of the Department may delegate any of his or her functions or powers under the Act in relation to an Aboriginal or Torres Strait Islander child who is: (a) in need of protection or (b) likely to become a child in need of protection.

The delegation of a function or power is to a specified person (s 148BB(2)(a)), in respect of a particular child (s 148BB(2)(b)), and must be limited to specific functions or powers (s 148BB(2)(c)). There are specified requirements that must be satisfied (as to the eligibility, suitability and qualifications of the individual in question) before a delegation can be made: s 148BB(3). Those include that the person to whom the delegation is made is an Aboriginal or Torres Strait Islander person and holds a working with children authority.

Before delegating a function or power to an ATSICCO, the chief executive must (to the extent it is safe, possible and practical to do so) seek the views of the child and the parents of the child, and have regard to those views (s 148BB(4)). In practice, the Acting Chief Practitioner, Victoria Van Houdt, gave evidence that there will ordinarily be a step of obtaining the parents' consent for delegation of authority for particular decisions, before that delegation is made.[114]

A delegation under section 148BB cannot be sub-delegated. A further constraint upon the exercise of delegated authority is that in all cases, the chief executive retains power to make decisions in respect of the delegated power. Section 148BC provides that the performance of a function or exercise of a power by the chief executive prevails to the extent of any inconsistency with a decision made by a delegate pursuant to s148BB.

4.7.2 Non-delegable nature of delegated authority under the Act

Having identified the statutory power to delegate functions, a question relevant to accountability and capability is whether the State remains liable for the discharge of the delegated obligation or duty, once delegated.

This question invites consideration as to whether the duty imposed by the Act is a non-delegable duty. A non-delegable duty of care is: 'a duty … of a special and "more stringent" kind and not

114 Transcript, Evidence of Victoria Van Houdt (27 November 2025) 2965:32-2965:36.

merely a duty to take care, but a "duty to ensure that reasonable care is taken"; to "ensure that the duty is carried out"; or to "procur[e] the careful performance of work [assigned] to others".'[115]

The duty is owed directly by the putative defendant (here, the State) because of an antecedent relationship between it and the plaintiff (or, in this case, a child to whom the duty is owed). The putative defendant — the State — is thereby exposed to a direct liability as opposed to a vicarious one.[116]

Such a duty cannot be discharged by entrusting the performance of the duty of the State to another. It is breached when the person engaged (or entrusted as a delegate) by the State fails to exercise reasonable care.[117]

Owing to the special and more stringent nature of non-delegable duties, their imposition is limited to specific, policy driven circumstances which include (among other categories) the protection of vulnerable parties.[118] To the extent non-delegable duties have been recognised, the critical indicia are high levels of: (1) assumption of responsibility; and (2) vulnerability of the plaintiff.[119]

The touchstone in respect of both indicia is ***control***. In *Kondis*, Mason J observed[120] that a non-delegable duty would arise: 'because the person on whom it is imposed has undertaken the care, supervision or control of the person … or is so placed in relation to that person … as to assume a particular responsibility for [their] safety, in circumstances where the person affected might reasonably expect that due care will be exercised.'

Under the Act, the State ***assumes responsibility*** for children and young people in its care. Such children and young people are in a position of ***unique vulnerability***. Moreover, the State exercises ***control*** over the child or young person by determining their placement and care arrangements. Taken collectively, these factors suggest that even where functions are delegated to ATSICCOs under section 148BB of the Act, the State remains liable for the exercise of those functions because the duty is non-delegable.

Lest there be any confusion, it is important to recognise that even if the State owes a non-delegable duty, that does ***not*** mean the duty cannot be delegated pursuant to the Act. Rather, it

115 *Willmot v Queensland* (2024) 98 ALJR 1407 at [49] per Gageler CJ, Gordon, Jagot and Beech-Jones JJ.
116 *Bird v DP* (2024) 98 ALJR 1349 at [36] per Gageler CJ, Gordon, Edelman, Steward and Beech-Jones JJ.
117 *Kondis v State Transport Authority* (1984) 154 CLR 672 at 694 per Deane J (*Kondis*).
118 *Kondis* at 681 per Mason J.
119 *Bird v DP* (2024) 98 ALJR 1349 at [37] per Gageler CJ, Gordon, Edelman, Steward and Beech-Jones JJ; *Burnie Port Authority* (1994) 179 CLR 520 at 551 per Mason CJ, Deane, Dawson, Toohey and Gaudron JJ; *Kondis* (1984) 154 CLR 672 at 687 per Mason J.
120 *Kondis* (1984) 154 CLR 672 at 687 per Mason J.

means that the State remains responsible for ensuring the duty is carried out by the person to whom it has delegated the obligation or duty. The content of such a duty is essentially:

1. to guard against a foreseeable risk of a particular kind or class, not all risks that might manifest;[121]
2. in respect of risks that arise in relation to a sphere of activity which sufficiently implicates the person or entity that owes the duty, and the aspect of its duty which has been delegated;[122] and
3. while the duty can be expressed positively, the duty is still one to take reasonable care; it is not a duty to guarantee an outcome.[123]

In the Commission's view, the duty of care owed by the State to children within its care is very likely to be found to be non-delegable (if tested). This view is further supported when regard is had to the Queensland Government Indemnity Guidelines.[124] The guidelines apply to 'public officers' acting within the scope of their duties and functions. The term 'officers' is defined to include (among other things) any person who acts under the direction and supervision of the State.[125]

Once delegated a function by the chief executive, it therefore appears that a delegate under section 148BB of the Act is entitled to a Crown indemnity under the guidelines. Crown indemnity covers civil proceedings, inquiries or investigations or criminal proceeding, arising from or relating to the public officer's duties and functions.

If required, the indemnity can be called upon to cover any combination of:

1. an undertaking to pay any damages or costs awarded against the public officer or agreed to as part of a negotiated settlement;
2. the payment of reasonable legal costs incurred by the public officer before an indemnity arrangement is in place; and/or
3. the provision, at the cost of the state, of legal representation and advice by the crown solicitor or another approved legal representative.[126]

121 *New South Wales v Lepore* (2003) 212 CLR 511at 552 [102]-[103] per Gaudron J (*Lepore*).
122 *Bazley v Curry* [1999] 2 SCR 534 at [22], [36]–[40] per McLachlin J.
123 *Lepore* (2003) 212 CLR 511 at [104] per Gaudron J.
124 See, Queensland Government Indemnity Guidelines (DFS.0225.0004.0006).
125 See, Queensland Government Indemnity Guidelines (DFS.0225.0004.0006) 3.
126 See, Queensland Government Indemnity Guidelines (DFS.0225.0004.0006) 1.

The existence and extended reach of this indemnity supports the conclusion that the duty in question is non-delegable, such that the State would remain liable for a breach by an ATSICCO of its duty of care to a child while exercising delegated authority.

The above legal consequences do not mean that authority should not be delegated. However, they do mean that when delegating authority to an ATSICCO, the Department must have a high degree of assurance that the delegated power is capable of being exercised consistent with the State's duty of care to the child, which regardless of the legal effect of the delegation (whether non-delegable or not), the State should ensure remains the paramount consideration.

It is for the reasons expressed above that the Commission recommends a degree of caution and careful consideration before the Department hastily adopts the proposition that state intervention and allied programs directed towards Aboriginal and Torres Strait Islander children should be designed and operated by ATSICCOs.

Chapter 5

System Functions

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 5: System Functions

5.1 Introduction

This chapter distils the Companion Report 1: System Functions on some of the key functions of Queensland's child safety system. It examines three key functions: (a) targeted intervention and family support; (b) intake and assessment; and (c) placement and casework decisions once children are in State care. The chapter also examines the way in which some of those functions interact with a significant group: pregnant women. A fourth function, litigation, is the subject of the next chapter and a separate Companion Report.

The Commission regards those functions as sitting within a continuum, running from primary prevention, through to early intervention, diversion and targeted intervention, to statutory involvement and tertiary prevention.

To some extent, the *Child Protection Act 1999* (Qld) reflects this. Its purposes and the chief executive's functions are far broader than investigation and coercive intervention. They include providing preventive support, helping families to protect children who are at identified risk, supporting Aboriginal and Torres Strait Islander community programs, and cooperating with other agencies and non-government providers.[127]

The next parts address the three key functions in turn.

5.2 Targeted Intervention and Family Support

5.2.1 Definitions

'Targeted intervention' means support provided once families are known to the child safety system. It encompasses two related functions:

- **Intervention and diversion**: time-limited support activated before statutory escalation. The purpose is to stabilise families, address emerging concerns, and prevent unnecessary progression to coercive action where it is safe to do so.
- **Ongoing family support**: support provided once statutory involvement occurs, during investigation, court processes and, ultimately, reunification. The purpose is to address the concerns that brought the family into the system and, if possible, to enable safe reunification.

[127] *Child Protection Act 1999* (Qld) ss 4, 5B(a)–(e), 7, 14, 22, 159H.

5.2.2 When and how families enter targeted intervention

There are indications that targeted intervention could come earlier than it presently does. Organisations that deliver targeted assistance services described receiving referrals *after* risk had crystallised or removal was already contemplated. As at 30 September 2025, the Department was the largest single referral source to Family and Child Connect (5,826 of 24,175 referrals) and to the Aboriginal and Torres Strait Islander Family Wellbeing Service (2,245 of 5,576 referrals).[128]

Relatedly, the Commission heard that targeted intervention is sometimes presented to parents less as a source of support, than as a condition or a compliance activity. Even so, the Department regards a parent's engagement with support services as a necessary but not a sufficient condition to ensuring child safety. As one Child Safety Service Centre Manager put it, 'a program or a certificate never kept a child safe. It's actually the actions of protection of the parent that keep a child safe.'[129] In one case examined by the Commission, a parent completed 13 family and parenting programs without progressing towards reunification.

5.2.3 How families experience early system involvement

Families' experience of targeted intervention is shaped by how support is offered, framed and connected to statutory decision-making. Obviously, many families enter the child safety system at points of stress. They are often uncertain about the purpose of the engagement with support services, and the consequences of any disclosures. In many cases, they are concerned that participation will be read as an admission of risk or of wrongdoing, rather than of need.

One witness told the Commission that families 'will often refuse to engage with Child Safety and its officers' but are more willing to talk to community workers when they are present. Another witness referred to a 'distrust to actually say anything', because that 'could result in … involvement from places such as [Child Safety] which then means there could be a removal … or an intervention of some sort.'

5.2.4 What effective targeted intervention requires

Ideally, targeted intervention should have a prophylactic effect — that is, it should prevent unnecessary escalation toward more coercive statutory interventions. Targeted intervention that has that effect tends to have all, or most of, the following features:

- It is activated as soon as possible after concerns emerge, rather than after the Department's position has hardened.

[128] Department of Families, Seniors, Disability Services and Child Safety, 'Supporting Queensland families' *Our Performance* (Web Page, n.d.) <https://performance.dcssds.qld.gov.au/supporting-queensland-families>
[129] Transcript, Evidence of Witness W (18 November 2025) 2229:19–2229:22; See case study of Melanie.

- It involves continuity of support workers and teams over time, so trust can be built with the family.
- It involves transparent communication of the Department's expectations.
- There is some integration with statutory decision-making, in that supported outcomes are properly considered and weighed before matters are escalated.
- It is accompanied by early access to independent legal advice for families once more coercive interventions are contemplated.
- It involved early family mapping and mobilisation of kin, led by those with relational and cultural knowledge.

5.2.5 Aboriginal and Torres Strait Islander families and ATSICCOs

As discussed elsewhere, the over-representation of Aboriginal and Torres Strait Islander children in the system is neither inevitable nor culturally determined. It reflects system design choices and under-investment in prevention. Aboriginal and Torres Strait Islander Community-Controlled Organisations (ATSICCOs) play a role in addressing this issue, and have the potential to add the greatest value early, in the prevention and early and targeted intervention phases, before statutory escalation occurs. The Commission heard, however, that ATSICCO involvement in those phases is frequently delayed, constrained by referral thresholds, or limited to discrete program functions. This reduces ATSICCOs' ability to influence outcomes at the points at which that influence can have most effect.

5.3 Supporting Pregnant Women

Pregnancy is a critical window from the standpoint of prevention and early intervention. Section 22 of the Act empowers the Department to act before a child is born where it reasonably suspects the child may be in need of protection after birth. The action must be appropriate, and may include investigations, assessment, and the offer of help and support. The statutory purpose of this power is to reduce the likelihood of protection being necessary after birth — not to interfere with the rights or liberties of a pregnant woman. The Department's *Child Safety Practice Manual* aligns with the purpose of the power, and emphasises maximising opportunities for engagement, assessment and support.

5.3.1 Why pregnancy matters

During pregnancy, many women are motivated to engage with support and to make behavioural changes that improve the safety of their unborn child. The same period can also be experienced as one of heightened scrutiny for women with prior involvement with the child safety system. Women who have prior contact with the system may experience antenatal engagement as a

pathway to removal of their child at birth rather than a form of support. Disengagement in that context can be the product of fear or self-preservation – it is not necessarily evidence of unwillingness to care for a child. In short, there is a paradox at the heart of the system's response to unborn children: the same period that is most effective for early help is often experienced as the most threatening.

5.3.2 Decision-making during pregnancy

The Commission heard that risk judgements about an unborn child are often formed early in pregnancy and not meaningfully revisited as circumstances change. Determinations are commonly anchored to concerns relating to other children removed from the same mother at an earlier stage. In one Child Safety region, 66 applications for emergent and other orders for newborns occurred between 2021 and 2025. Of the 63 mothers involved in those 66 applications, 58 already had at least one child subject to a child protection order at the time of birth.[130]

Reliance on historical concerns is rational, especially where those same concerns have not been resolved. But these concerns must be tested against current circumstances – protective acts during pregnancy, the availability of supportive kin, and the mother's engagement with services. Put simply, historical concerns can inform but should not substitute for a genuine assessment of present and evolving risk. Concerningly, in some cases reviewed by the Commission, decisions to seek a temporary custody or assessment order at birth were effectively made months in advance and not meaningfully revisited.

5.3.3 Delay and the absence of early support

Unborn notifications are commonly responded to outside of prescribed timeframes. Support Service Cases – the principal mechanism for working with a pregnant woman where an unborn child is assessed as likely to be at risk – are frequently opened late or not at all. The Newborn Project examined 66 newborn applications. Twenty Support Service Cases were opened. Seventeen support plans were provided to the mother before birth. Of those 17, 12 children were removed within seven days of birth.[131]

Where there is no antenatal engagement, decision-making is pushed to the immediate post-birth period. That period is one of compressed timeframes, emotional distress and limited room for proportionate responses. Crisis-driven assessments at birth are more likely to result in removal,

[130]Newborn Project case file review (Notice 116), aggregated data on newborn removals in one Child Safety region (FY 2020-21 to 2024-25). See, Newborn Project at Appendix D.
[131]See, Newborn Project at Appendix D.

not because removal is the only option, but because it is the most readily available course under pressure.

A separate issue arose in 12 cases in the Newborn Project where a newborn was removed under a Temporary Custody Order without a current Safety Assessment for the newborn. The assessments relied upon were for siblings, sometimes years old, or copies of the pre-birth unborn assessment.[132]

5.3.4 Arrangements following removal

The period immediately after birth is very important for a child's development and their future health. The opportunity for bonding, breastfeeding and skin-to-skin contact in this window cannot be recovered once missed. The *Child Safety Practice Manual* provides no guidance on the frequency, type or method of family contact between a parent and a newborn after removal. The Commission's review of departmental case files disclosed inconsistent arrangements: one breastfed newborn was permitted contact three times a week for one hour; several newborns had no contact provisions specified in the emergent order application, contrary to the legislative requirement; and, in one case, custody of a newborn was withheld for five days with no contact arrangements in place at the time of a further emergent application, despite the newborn being breastfed.[133]

5.3.5 ATSICCOs and health-led models

Aboriginal and Torres Strait Islander women and babies are disproportionately affected by unborn notifications and newborn removals. Queensland records the second-highest number of unborn reports involving Aboriginal and Torres Strait Islander children in Australia.[134]

ATSICCOs are well placed to play an important role in engaging and supporting pregnant women, particularly where mistrust of statutory services would otherwise drive disengagement. Engagement is more likely where a trusted community-controlled organisation makes the offer of support directly, rather than through statutory processes. Health-led models — specialist midwifery, perinatal mental health, and integrated maternity and family wellbeing services — also work effectively when integrated with child protection responses.

Referrals to ATSICCOs and specialist services during pregnancy are inconsistent. Services are sometimes at capacity at the critical time. In other cases, referrals occur only after birth, limiting any preventive effect.

[132] See, Newborn Project at Appendix D.
[133] See, Newborn Project at Appendix D.
[134] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (6 August 2025) 6.

5.4 Intake and Assessment

Intake is the formal entry point to the statutory child safety system. The Regional Intake Service receives information and applies the statutory threshold (that is, whether there is a reasonable suspicion that a child or an unborn child may be in need of protection). If the threshold is met, a concern becomes a Child Protection Notification (CPN), which requires assessment and an appropriate statutory response. Where concerns do not meet the statutory threshold, they are simply recorded as a Child Concern Report (CCR).

5.4.1 Intake – the evidence

There is a narrative that overreporting of concerns, compounded by mandatory reporting obligations, has been causing system failure. That narrative is not supported by the evidence.

The Department's Intake Reform Project (June 2021) drew on more than 4,000 case records. It found no clear evidence that mandatory reporters were reporting outside scope. To the contrary, it found that serious allegations — including chronic neglect, domestic violence and sexual abuse — were being recorded as Child Concern Reports rather than Child Protection Notifications. It found that cumulative concerns were assessed episodically rather than as patterns. It also found that families were diverted to voluntary services in cases where statutory assessment and oversight were in fact warranted.[135]

5.4.2 Assessment – the evidence

Notifications must be assessed. Assessment is critical to understanding the extent and nature of the risk. The Department performs assessment through dedicated assessment teams. The assessment stage is important because it is often the Department's first direct, face-to-face engagement with a child and their family, and an opportunity to build a trusting and productive relationship.

Assessment should be timely. The Commission obtained Departmental data on the proportion of investigations commenced within statutory timeframes. Compliance with this requirement has *declined* each year and has fallen sharply since April 2025, as follows:[136]

- 24-hour priority response: 96% in time (2021-22) → 91% (Jul 2024 to Mar 2025) → 44% (Apr 2025 to Mar 2026).

[135] Department of Families, Seniors, Disability Services and Child Safety, *Intake Reform Project — Final Report* (Report, June 2021); Department of Families, Seniors, Disability Services and Child Safety, *Investigation and Assessment End of Project Report* (Report, April 2020).
[136] See, spreadsheets produced in response to Notice No 353 (3 March 2026).

- 72-hour priority response: 38% (2021-22) → 30% (Jul 2024 to Mar 2025) → 13% (Apr 2025 to Mar 2026), with a median of 41 days to commence.
- 7-day standard response: 30% (2021-22) → 26% (Jul 2024 to Mar 2025) → 6% (Apr 2025 to Mar 2026), with a median of 63 days to commence.

The post-April 2025 fall coincides with the rollout of Unify and the full implementation of the Enhanced Intake and Assessment Approach (EIAA). The 2025-26 figures therefore warrant caution. The trend in earlier years, however, is not attributable to Unify.

The Department's 2020 Investigation and Assessment Project found that 63% of investigations were not commenced within statutory timeframes. Curiously, 27% of cases reviewed with an 'unsubstantiated' outcome were ultimately considered appropriate for an alternative response. The Project found inaccurate outcomes resulting from the use of limited or unreliable information, or under-analysis of parental capacity.

In response to backlogs, the Department has at various times relied on administrative strategies such as the 'Review and Complete' and 'Review and Close' processes to authorise officers to close investigations without an outcome. A 2022 internal review found that a significant proportion of matters closed in this way attracted further or repeated concerns. This is concerning. As the New South Wales Ombudsman has observed in another context, routine closure of reports without investigation is incompatible with statutory child protection obligations.[137]

5.4.3 The Enhanced Intake and Assessment Approach

The EIAA was introduced in April 2025 to differentiate between levels of risk and need. Among other things, it introduced an additional, alternative response pathway. Under the 'Safety and Support Response', a notification is referred to a non-government Assessment Service Connect (ASC) provider. The provider then engages the family, assesses support needs and connects services. The notification closes after a defined period unless concerns escalate or the family fails to engage within ten days, in which case a Standard Response is initiated.[138]

The EIAA has only been in existence for a short time and is currently the subject of other separate evaluations. Without seeking to pre-empt that evaluation, some preliminary concerns about the EIAA may be mentioned.

[137] NSW Ombudsman, *Report on the practice of closing reports without assessment in NSW child protection* (Report, 2023).
[138] Department of Families, Seniors, Disability Services and Child Safety, *Enhanced Intake and Assessment Approach (EIAA) operational guidance* (April 2025); *Child Protection Act 1999* (Qld) s 14(1)(b).

The Safety and Support Response is available only where concerns have crossed the notification threshold. The Department's statutory function — to assess risk and determine whether the child is in need of protection — is therefore triggered. Section 14(1)(b) of the Act permits non-government delivery of action where appropriate, but the statutory response must still demonstrate how risk has been assessed and addressed before the Department disengages. On the material before the Commission, it is unclear how the Department satisfies that requirement when an ASC provider only conducts a support-needs assessment. That is not to doubt that ASC providers can deliver effective support. It is question of governance —that is, whether the Department is fully discharging its statutory authority and responsibilities at the point at which they arise.

However, these are preliminary views which the Commission did not have time to test in dedicated hearings. Nonetheless, the concerns raised here warrant further consideration, regardless of the outcomes of the separate evaluations of EIAA that are currently in train.

5.5 Placement and Casework Decisions

5.5.1 From court orders to everyday decisions

Once a court order is made, and the State assumes responsibility for a child's care, responsibility shifts from the court to the child safety system. Placement and casework decisions are the means by which State authority is exercised on an ongoing basis. Presently, placement and casework decisions are largely operational or administrative, with limited judicial oversight. These decisions profoundly shape the child's experience of State care. They determine where a child lives, who cares for them, how often they move, whether siblings are kept together, how contact with family is managed, and whether reunification is pursued. Placement decisions that are often made in moments of urgency frequently set trajectories for the placed child that are potentially harmful and difficult to reverse.

5.5.2 Placement instability and cumulative harm

Placement decisions are commonly made under conditions of urgency, scarcity and constraint. In these conditions, availability can displace suitability as the primary determinant of placement. The question shifts from 'what does this child need?' to 'where can this child go right now?'

As the Commission has learned, in an unsatisfactorily large number of cases, the answer to that question is residential care, irrespective of whether that is a form of care to which the child is suited. This is the subject of Chapter 7 in this report and Companion Report 3: Models of Care.

Each placement change involves loss for the child — of carers, routines, schooling, friendships and cultural connection. For children who have already experienced trauma, repeated moves may compound harm and reduce the capacity to form trusting relationships with adults. As children become more distressed, the options become narrower.

Disruption of the child's education is one of the most immediate consequences. Changes of placement often involve changes of school, long travel distances, disrupted routines and gaps in attendance. In crisis placements, some children miss schooling altogether. Over time, education disengagement contributes to exclusions and loss of access to consistent supports. The evidence concerning crossover and dual-order cohorts identifies exclusion from education as a recurring mechanic that interacts with placement instability and contributes to escalation into police and youth justice responses.

5.6 Summary of Principal Recommendations

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 1: Functions of System and in the Compendium of Recommendations.

- **Recommendation 1:** Respond to the proximate causes of harm
- **Recommendation 2:** The role of ATSICCOs in intervention and family support
- **Recommendation 3:** "Safety and Support Response" pathway within the Enhanced Intake and Assessment Approach
- **Recommendation 4:** Reorienting unborn notifications
- **Recommendation 5:** The role of ATSICCOs in supporting pregnant women
- **Recommendation 6:** Ensure casework decisions made in the best interests of the child
- **Recommendation 7:** Providing meaningful transition to adulthood

5.7 Conclusion

The system functions examined in this chapter are important. These functions shape whether risks to children are promptly and adequately addressed, whether parents engage positively with the system, whether unnecessary escalation can be avoided, and whether the child's best interests are adequately promoted over time. The evidence indicates that, across all three functions discussed in this chapter, some present settings are misfiring and causing unintended harm. The reforms suggested here are directed to recalibrating those settings.

Chapter 6

The Child Protection Litigation Model and the Court Process

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 6: The Child Protection Litigation Model and the Court Process

6.1 Introduction

The removal of a child from family into State care is among the most consequential exercises of public power. If the State does not get the decision right, the child and family may suffer irreparable harm. Where the State is compelled to intervene, it must do so scrupulously and at all times in the best interests of the child.[139]

This chapter distils the Commission's detailed examination, presented in the accompanying Companion Report 2: Child Protection Litigation, of the child protection litigation (CPL) model and the court processes that govern the removal of children into the State's care. The examination drew on a public hearing program in Brisbane between December 2025 and February 2026, evidence from senior officers of the Department,[140] the Office of the Child and Family Official Solicitor (OCFOS), the Director of Child Protection Litigation (DCPL), and a wide body of stakeholder submissions.[141]

The Terms of Reference require the Commission to examine investigation, assessment and decision-making practices, tertiary interventions, frontline resourcing pressures and court processes, and the governance and accountability of State entities exercising child protection powers. The CPL model and associated processes have also contributed to the growth of, and reliance on, the residential care sector. The recommendations in this chapter are directed to legislative, structural and procedural reform to simplify litigation pathways, strengthen judicial oversight and ensure that State intervention is proportionate, accountable and reviewable.[142]

6.1.1 Themes

The Commission's inquiries brought to the surface the following recurring themes:

- There is uncertainty around the paramount principle, particularly its relationship with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).

[139] *Child Protection Act 1999* (Qld) s 5A.
[140] As in other chapters, 'The Department' refers to the Department of Families, Seniors, Disability Services and Child Safety and its predecessor departments.
[141] Child Safety Commission of Inquiry, 'Call for submissions — child protection litigation model' (Media release, 13 November 2025); Public hearings, Brisbane (8 December 2025-5 February 2026).
[142] Commission of Inquiry into the Child Safety System, Terms of Reference (Commissions of Inquiry Order (No 1) 2025), cls3a(i), 3b(i)–(ix), 3(c), 3(e)–(f), 5(b), 5(g)–(f).

- Under the current model, CSOs are diverted to preparing court material at the expense of direct work with children, families and carers.
- Child protection proceedings are long, complex and inefficient. In particular, the framework for child protection orders (including emergent orders) is highly complex and results in protracted, serial litigation.
- There is fragmentation and poor coordination between the Department, OCFOS and the DCPL.
- There are procedural fairness concerns arising from the use of untested allegations, the absence of a contradictor, and the prevalence of *ex parte* applications. These concerns undermine public confidence in the system.
- There are barriers to meaningful participation by parents and other significant people in a child's life — limited legal advice and representation, restricted standing, and few opportunities to participate in decision-making.
- Alternative dispute resolution and case planning arise too late in the process.
- There is a need for greater court oversight of the ongoing intervention, not just the removal of children.

6.2 The Paramount Principle

Section 5A of the *Child Protection Act 1999* (Qld) (the Act) provides that the 'safety, wellbeing and best interests of a child, both through childhood and for the rest of the child's life, are paramount.' The principle is to guide all action by the Department, the courts and non-state actors engaged in child safety.[143]

6.2.1 A balance of harm analysis

A child can only be removed from their family if they are exposed to harm that meets the threshold set out in the Act. The statutory test in section 10 of the Act is, on its face, one-sided: a child must have suffered, be suffering, or be at unacceptable risk of significant harm *and* have no parent able and willing to protect them from harm.[144] The test contains an unstated assumption that children removed into State care will be safe and properly cared for. Where, in a given case, that assumption is unsound, the test may misfire.

The evidence before the Commission is that placement in residential care, particularly, involves exposure to harm: it is associated with significantly worse outcomes, including elevated rates of trauma, self-harm, suicide attempts, unmet mental health needs, placement instability, children

[143] *Child Protection Act 1999* (Qld) s 5A.
[144] *Child Protection Act 1999* (Qld) s 10.

going missing from care, and exposure to further abuse.[145] In cases where the State cannot demonstrate it is able, or likely to be able, to provide reasonable and less harmful care, interventions less intrusive than removal warrant consideration. The Commission recommends that section 5A be amended to provide expressly for a ***balance of harm*** evaluation, involving the consideration of any relative harm posed to the child by removal from family or removal from a current placement, and the circumstances of any proposed new placement.

6.2.2 The paramount principle is not static

In other litigious contexts, interim orders preserve the status quo. That is not possible when a child is removed: the child's life is altered materially from the moment of removal, and continues to be altered. As the child settles into a new environment, forms attachments to carers and develops connections at school and in the community, the calculus of 'best interests' evolves. These dynamic effects must inform later reunification and placement decisions and cannot be ignored.

Relatedly, the words 'both through childhood and for the rest of the child's life' in section 5A invite speculation about future matters that, at the time of decision, are not knowable. The Commission recommends that those words be removed. Sufficient ascertainable matters — the present harm or risk, the availability and quality of placement options, and the child's expressed views (where age-appropriate) — bear on the evaluation without requiring untestable long-range predictions.

6.2.3 Corporate parent and broader preventive objectives

The State acts in two capacities. As the notional corporate parent for an individual child, the State must evaluate that child's wellbeing and best interests in the actual circumstances in which the child is found, 'as is where is'. In a different capacity, the State pursues broader preventive objectives — reducing the need for corporate parenting and the time children must remain in care. These capacities frequently align but will not always do so. The State, when acting as corporate parent, cannot assume their congruence; otherwise, the child risks becoming a non-consenting participant in a policy experiment.

6.2.4 The relationship between the paramount principle and the ATSICPP

The gross over-representation of Aboriginal and Torres Strait Islander children in the child protection system is a matter of grave concern. The ATSICPP is an interdependent set of

[145] Transcript, Evidence of Daniel Short (10 April 2026) 5138:35–5139:9; Transcript, Evidence of Leanne Linard (16 April 2026) 546:5–546:10.

principles aimed at redressing the deracination of those children and at promoting partnership, participation, placement and connection.[146]

The Commission identifies, however, real uncertainty as to how the paramount principle and the ATSICPP relate. Some stakeholder submissions and identifiable Departmental decisions suggest the principles are sometimes applied so as to give paramount priority to one or more elements of the ATSICPP — particularly the placement and connection principles — without separately evaluating whether the action or decision is in the best interests of the particular child. Unless and until the legislature provides otherwise, the ATSICPP must remain genuinely subordinate to the paramount principle. The two principles are not in opposition but that depends upon the genuine evaluation of the child's best interests and application of the paramount principle in clear priority to any other principle. As QATSICPP put it:

> The ATSICPP does not propose that children can be placed in unsafe environments or that reunification or reconnection with family should occur in all circumstances, regardless of the risk to the children. The paramount priority of QATSICPP and our members is the safety and wellbeing of our children and whilst we support our children's rights to grow with family and community, we support careful and considered implementation of the ATSICPP to ensure decision making to best ensure its application is in alignment with s 5A of the Act.[147]

The Commission respectfully adopts that statement. The ATSICPP, properly applied, requires real and genuine implementation of *each* of its connected elements — partnership, participation and connection — and not a 'jump' to the placement principle. The concept of 'active efforts' under section 5F is integral to this work.[148]

6.3 The Current Child Protection Litigation Model

On 1 July 2016, following the Carmody Inquiry, Queensland introduced a 'bifurcated' CPL model. OCFOS, established within the Department, took responsibility for emergent order applications. The DCPL, established by the *Director of Child Protection Litigation Act 2016* (Qld) as an independent statutory office in the Department of Justice, took exclusive jurisdiction to make applications for child protection orders (CPOs).[149] Queensland is the only Australian jurisdiction

[146] *Child Protection Act 1999* (Qld) ss 5C(2)(a)–(e), 5F.
[147] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) p 33.
[148] *Child Protection Act 1999* (Qld) s 5F.
[149] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 476-483, recs 13.16-13.18; Queensland Government, *Queensland Government Response to the Queensland Child Protection Commission of Inquiry final report: Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, December 2013) 29; Explanatory Memorandum, *Director of Child Protection Litigation Bill 2016* (Qld).

in which responsibility for litigation sits outside the department with responsibility for child safety.[150]

The Carmody reforms were intended to address widespread mistrust of departmental conduct of proceedings, the use of hearsay-laden materials, and the absence of appropriate legal representation for children, families and departmental officers. However, those well-intentioned reforms have caused further difficulties, which must now be addressed.

6.4 Should the Bifurcated Model be Maintained?

6.4.1 OCFOS

When established, OCFOS was delegated decision-making in respect of emergent orders and referrals to the DCPL. However, between 2018 and mid-2020, OCFOS transitioned to an 'instructional model' under which decisions to apply for an emergent order rest with the Senior Team Leader (STL) or Manager. OCFOS is expected to act on those instructions, escalating where significant legal issues arise.[151] The Department's current guidance is that OCFOS *must* act on the Department's instructions where those instructions are based on legal advice. Final decision-making in the event of disagreement rests with the Regional Director.[152] In practice, decisions with which OCFOS disagrees are often simply put before the Court.

The Commission heard compelling evidence that the instructional model has eroded independence: decisions as to emergent orders are shaped by departmental perspectives and operational constraints.[153] In *VD and WD v Department of Child Safety, Seniors and Disability Services*, Holliday DCJ observed that 'the clear and obvious need to protect the interests of children cannot override an obligation to ensure that an application is not made unless there are sufficient grounds to do so.'[154] That points to why the instructional model is misconceived. Whether there is a proper basis for an application is a legal and forensic question: the decision to file an application for an emergent order should rest with a lawyer, not with a CSO or STL.

[150] *Director of Child Protection Litigation Act 2016* (Qld) ss 9–10, 13.
[151] Office of the Child and Family Official Solicitor, Operating Guidelines (27 June 2016) 5; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3181:19-3181:21; Transcript, Evidence of Clair Martin (12 December 2025) 3770:33-3770:39.
[152] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3180-3181; Department of Families, Seniors, Disability Services and Child Safety, Escalation Process for Emergent Orders (20 February 2025).
[153] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3185:21–3185:30; Transcript, Evidence of Clair Martin (12 December 2025) 3631:36-3631:45, 3645:5-3645:14.
[154] *VD and WD v Department of Child Safety, Seniors and Disability Services* [2025] QChC 2, [33] (Holliday DCJ). The Department conceded on appeal that the application material was incapable of satisfying the Magistrate that the TAOs ought to have been made.

6.4.2 The DCPL

Although the Carmody Inquiry envisaged a regional presence, the DCPL was established only in Brisbane, with three chamber groups servicing the State; in practice, the DCPL appears in most regional courts by telephone.[155] The geographic distance from frontline practice impedes awareness of regional child protection needs.

Data tendered by the Director discloses sustained increases in duration and procedural intensity of CPO proceedings. Across the preceding three financial years, there has been an increase of approximately 67 days in the average time to finalisation of a CPO application, and approximately 75 days in matters involving applications for long-term guardianship to the Chief Executive — taking the average time to finalisation of long-term guardianship determinations to approximately 14 months.[156]

Information sharing between the DCPL and the Department was a major cause of delay. The DCPL has no direct access to the Department's case management system and depends on the Department to identify, collate and provide records. In the financial year 2024-25, the DCPL sought further evidence or information from the Department in 73.2% of referred matters (up from 61.8% in financial year 2022-23). The Department's 'Unify' rollout presented an opportunity to integrate information systems with the DCPL; but that did not occur.[157]

The Department and the DCPL also assess matters differently. In financial year 2024-25, in 18.8% of referred matters, the DCPL dealt with the matter differently to the Department's initial assessment (including 4.4% without departmental agreement). Since the DCPL's commencement to 30 June 2025, 693 matters have been referred back to the Department; 62.5% of those ultimately have required the filing of a CPO application at a later date.[158]

6.4.3 The bifurcated model should be abandoned

The Department (including OCFOS) and the DCPL agree that the bifurcated model has not worked in practice. The Commission shares that view, for six principal reasons:

- **First,** OCFOS is not, in substance, independent of the Department; the co-mingling creates structural conditions for actual and perceived conflicts.

[155] CA-51, *Statement of Nigel Miller* (7 November 2025) [41]–[46], [109], [130]–[131], [171], [183], [205], [217]; Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry* (2 September 2025) 3.
[156] CA-51, *Statement of Nigel Miller* (7 November 2025) [59], [61].
[157] Transcript, Evidence of Nigel Miller (11 December 2025) 3561:3; Together Union, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 48–50; Child Protection Practitioners Association Queensland, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 15, 44.
[158] CA-51, *Statement of Nigel Miller* (7 November 2025), tendered 9 December 2025, [205].

- **Secondly**, bifurcation has produced duplication across all stages of proceedings, delay and procedural complexity.[159]
- **Thirdly**, dual ministerial portfolios have diffused accountability. It is also inefficient, with workforce costs in OCFOS and the DCPL rising each year since establishment.
- **Fourthly**, serial transfer of responsibility between legal entities fractures forensic stewardship, producing unexplained changes in the State's case, different risk thresholds and re-litigation of issues that might have been settled earlier. This sits uneasily with the model litigant obligation.[160]
- **Fifthly**, stakeholders, including families, perceive the relationship between OCFOS, the DCPL and the Department as competitive and uncollaborative.
- **Sixthly**, the suite of different orders available under the Act has produced an unnecessarily complex legal process involving serial proceedings and duplication.

6.4.4 Unified responsibility

Sole responsibility for all child protection applications should rest with a single, statutorily independent litigation body. The DCPL — which already possesses statutory independence — is the appropriate body. The Commission therefore recommends that the DCPL be conferred with unified responsibility for the full life cycle of child protection proceedings: initiation, conduct, amendment, permanency decision-making and review. This should be accompanied by direct access to relevant departmental information systems, appropriate co-location with, or access to, Child Safety Service Centres, governance arrangements that locate accountability for litigation coherence and timeliness, and periodic independent evaluation of outcomes, particularly for Aboriginal and Torres Strait Islander children.[161]

6.5 Pre-Court Statutory Intervention

Many of the most consequential decisions in the child protection continuum are made before any court is involved, often under conditions of urgency, and frequently without contemporaneous legal advice to parents or to departmental officers. The Department characterises these decisions as matters of 'practice' rather than 'law'; the Commission considers that characterisation unsound. The decisions in question — whether a child remains at home, who

[159] Transcript, Evidence of Nigel Miller (10 December 2025) 3475:24; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3211:26-3213:44.
[160] Queensland Government, *Model Litigant Principles* (Web Page, 26 January 2023) <https://www.justice.qld.gov.au/about-us/services/general-counsel/legal-services-coordination-unit/legal-service-directions-and-guidelines/model-litigant-principles>
[161] Director of Child Protection Litigation, *Submission to Child Safety Commission of Inquiry* (23 March 2026).

may care for the child, and whether separation can be avoided — involve substantial exercises of power, often statutory power.[162]

6.5.1 Voluntary mechanisms — safety plans and care agreements

Safety plans are not provided for in the Act. They are administrative tools, developed and regulated entirely through departmental policy. In practice, safety plans can do much of what a court order does — move a child out of the home, supervise contact, impose conditions on a household, set milestones for reunification. There is no statutory framework governing their duration, review, variation or termination, and no express safeguard concerning consent or legal advice.

Care agreements are provided for in the Act and are constrained by an important condition: they may only be entered into where the Chief Executive is satisfied that, on withdrawal of parental consent, the child would not be at immediate risk of harm. Child protection care agreements require a determination that the child is a child in need of protection within section 10 — the same threshold that would justify court-based intervention — but operate as 'voluntary' arrangements occupying an anomalous position within the statutory scheme.

Arrangements described as 'voluntary', in the circumstances in which they are negotiated, frequently operate as mechanisms for the de facto removal of a child. Consent obtained in conditions of urgency, power imbalance, or implicit threat of involuntary removal cannot be assumed to be fully informed or freely given. The Commission recommends statutory recognition and regulation of safety plans, with a maximum initial duration of 14 days (extendable once by consent to a total of 28 days) and a requirement that parents be informed, orally and in writing, of their right to obtain independent legal advice and to withdraw consent.

6.5.2 Administrative removal under section 18

Section 18 of the Act authorises an authorised officer or police officer to take a child into the custody of the Chief Executive on a reasonable belief that the child is at risk of harm and likely to suffer harm if not immediately taken into custody. Custody under section 18 may be maintained for up to eight hours, during which time the officer must, as soon as practicable, apply for a Temporary Assessment Order (TAO) or, alternatively, a Temporary Custody Order (TCO). Section

[162] *Child Protection Act 1999* (Qld) ss 18, 25, 27, 28; pt 4 div 2 (ss 51Z–51ZI); Department of Child Safety, Youth and Women (Qld), *Structured Decision Making in Child Protective Services: Policy and Procedures Manual* (Version 4.3, May 2019), 6-32; Transcript, Evidence of Clair Martin (12 December 2025) 4009:14-4009:35; Transcript, Evidence of Nigel Miller (10 December 2025) 3475:25-3476:2.

18 is, by statutory design, a bridging power: it operates only until urgent court involvement can be obtained.

The Commission recommends that section 18 be amended to provide that the power may only be exercised where: the risk has arisen suddenly or escalated unexpectedly; the harm cannot reasonably be prevented through voluntary or less intrusive measures, including the timely filing of a court application with notice; and delay for judicial consideration would itself materially increase the risk. The exercise of the power should be accompanied by a written statement of reasons addressing each precondition. The maximum duration of section 18 custody should be extended to five business days *only* where the child is to be safely placed with a family member or other trusted adult, with the existing eight-hour limit otherwise retained. The Department should be required to publish annual data in relation to section 18 removals, including the number, the prior involvement of the family, the placement type following removal, and the duration of separation prior to any judicial determination.

6.6 The Court Process

6.6.1 The orders the Court may make

Under section 61 of the Act, the Court may make directive, supervision, custody and guardianship orders. Only guardianship may be long-term. The current modular framework imposes a binary distinction between 'custody' and 'guardianship' that often fails to reflect the nuanced reality of children's care arrangements. The Court is limited to creating the conditions for protection rather than ensuring that the protective purposes are realised, and CPOs cannot bind the Chief Executive to particular arrangements.[163]

The Commission recommends adoption of the concept of 'parental responsibility', consistent with the *Family Law Act 1975* (Cth), in place of 'custody' and 'guardianship'. That change — also recommended by the Carmody Inquiry — would permit a court to fashion orders that allocate components of parental responsibility flexibly, including by shared allocation (for example, with cultural decisions reserved to the child's parents). The Commission further recommends that the current suite of short-term and long-term orders be replaced with two purpose-defined orders:

- **Reunification Orders** — addressed to whom has parental responsibility, whom the child lives with, contact arrangements (with a staged increase where appropriate), and

[163] *Child Protection Act 1999* (Qld) ss 61, 62, 67, 77–78; *Department of Communities v LE & Ors* [2011] QChC 4 [30], [35]; *DCPL v Starling (a pseudonym)* [2025] QChCM 4, 25.

duration (not exceeding twelve months), with the child's care plan annexed; supervised through a Reunification Court List with periodic mention.

- **Permanency Orders** — addressed to whom has parental responsibility, residence, contact, and duration as the court sees fit, with the care plan annexed; orders granting parental responsibility to the Department should be limited to 12 months initially and reviewed prior to expiry.

6.6.2 Emergent orders, *ex parte* applications and procedural fairness

Across financial years 2022-23 to 2024-25, the Department brought 14,142 applications for emergent orders. Of those:

- 97% were granted;
- 1% were dismissed or not granted; and
- 2% were withdrawn.[164]

The very high endorsement rate, combined with stakeholder evidence of routine *ex parte* applications — often heard after hours and decided 'in a vacuum' without the Department's broader court material being before the magistrate or served on the respondent parents — warrants close consideration.[165]

Although section 28 of the Act permits applications for TAOs to be decided without notice, in *urgent or other special circumstances*, the Commission heard that *ex parte* determinations have become routine, including in matters where parents are on notice and able to be contacted. The Department was unable to produce data on the incidence of *ex parte* applications. The Commission considers this lack of visibility, in respect of so drastic a dispensation with procedural fairness, to be of serious concern for public confidence in the administration of justice.

Section 99(2) of the Act, intended to ensure that there is no gap in protective custody between an emergent order and the determination of a CPO application, is overused. Across financial years 2022-23 to 2024-25, the average period between the stated end-date of emergent orders and the first mention of the CPO application was 28 days, rising from 23 days in 2022 to 31 days in 2025.

[164] See, spreadsheet provided by the Department on emergent order applications finalised in Queensland 1 July 2023 to 31 March 2025 (DFS.0081.0001.0001); spreadsheet provided by the Department on emergent order applications finalised in Queensland 1 April 2025 to 30 June 2025 (DFS.0081.0001.0001).

[165] *Child Protection Act 1999* (Qld) ss 25(1), 28; Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (1 December 2025) 9; Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry* (12 December 2025) 8; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3171:45, 3277:8; Transcript, Evidence of Clair Martin (12 December 2025) 3676:45.

In one case examined by the Commission, three months elapsed before a respondent mother was first heard on the removal of her children. Such delays — compounded for regional and remote families — erode accountability and require the Court, at the first opportunity, to consider the child's circumstances in a status quo materially different from the day of removal.[166]

6.6.3 Substantive CPO proceedings

Access to legal representation

The Act requires that all parties be afforded every reasonable opportunity to obtain legal representation.[167] DCPL data for the period 1 July 2022 to 30 June 2025 nevertheless shows that only 37% of respondent parents were legally represented during proceedings, only 10% were represented at first mention, and the average period from filing to representation was 145 days. Fathers were represented less often (26%) than mothers (47%) and at a later stage. Legal Aid Queensland reports growing pressure on services and a decline in preferred providers; child protection duty lawyers operate from only 19 locations on specified days. The Commission recommends that all parties in child protection proceedings be legally represented from the commencement of proceedings, including any contested hearing, under a duty lawyer or equivalent model.

Case planning and Family Group Meetings

The case plan is central to the statutory scheme. Family Group Meetings (FGMs) generally remain a constructive, family-led process. There are, however, significant problems with timeliness and quality. The most common reason for adjournment of a CPO application is to allow time for the Department to hold a FGM. In 2019, an initial case plan took on average 70 days to approve; in 2024, most case plans took at least 90 days to approve, with more than a third taking between 120 and 200 days. Reviews of departmental case plans identified a 'deficit-focus', vague or absent placement and contact arrangements, and revisions in which earlier content had been copied and pasted without acknowledgement of family progress. Carers were not consulted in 71% of FGMs in one external review in 2019.

The Commission recommends that the court process be redesigned so that mandatory early court-facilitated conciliation occurs as soon as possible after the Director files an application. The conciliation would identify agreed and disputed concerns, clarify the order sought, develop

[166] *Child Protection Act 1999* (Qld) ss 99(1)–(2); Explanatory Memorandum, *Child Protection Bill 1998* (Qld) 37; See, spreadsheet showing matters referred to the DCPL with an existing order (whether emergent order or CPO) provided by DCPL under Notice 144 (21 October 2025).

[167] *Child Protection Act 1999* (Qld) s 109; *Childrens Court Rules 2016* (Qld) r 68; Women's Legal Service (WLS) Qld, *Submission to Child Safety Commission of Inquiry* (28 November 2025) 13, 18, 25; Family Inclusion Network, *Submission to Child Safety Commission of Inquiry* (21 January 2026) 4.

the case plan with actions and timeframes, and determine whether the matter will be contested. The agreed plan should be annexed to the resulting order and subject to review.

Children's views

Despite legislative recognition of the right of a child to express views in proceedings, the Commission heard that those views continue to be marginalised. Further inquiry is warranted into the proportion of children represented in proceedings, the uptake of the Child Advocate program, and current practices for obtaining and presenting children's views to the courts.

6.6.4 Exit from the litigation system — reunification and revocation

The most significant element of the child protection continuum without current court oversight is the decision to reunify a child with a parent. Reunification, which is not given a statutory definition, most commonly proceeds under section 82(2) of the Act, with the child placed in the parent's care while a CPO granting custody or guardianship to the Chief Executive remains on foot. The order then expires with the passage of time. Placement under section 82(2) is not a reviewable decision, and there is no independent judicial determination that the child is no longer in need of protection.[168]

The court is heavily engaged at the removal end and largely absent at the reunification end of the continuum. That asymmetry is, in the Commission's view:

- ***logically unsound*** because the decision to reunify is at least as consequential as the decision to remove;
- ***anomalous*** because, unlike many other orders, the CPO may end on the Department's assessment that the underlying concerns that prompted it being made are resolved; and
- ***structurally problematic*** because the Department, as notional parent, is in actual and apparent conflict in deciding whether to relinquish its rights and obligations, with reputational risks creating a further tension of duty and interest.

Across financial years 2021-22 to 2024-25 only a small proportion of children in out-of-home care were reunified (generally less than 5%). Revocation applications are infrequent compared to the volume of reunification through section 82(2) or 'self-placement'. The Commission recommends that reunification decisions and long-term placement decisions be subject to court supervision.

[168] *Child Protection Act 1999* (Qld) ss 82(1)–(2); Statement of Nigel Miller (7 November 2025) [274]; See, spreadsheet provided by the Department of reunification data (FY 2021-22 – 2024-25, partial year) (DFS.0048.0001.0001).

6.6.5 Suitability, kinship placement and the Blue Card

To be approved by the Department as a carer, a person must hold a working with children authority ('Blue Card').[169] The Court's power under sections 61(d)(i), 61(f)(i) and 67(1)(a)(ii) to grant custody or long-term guardianship to a 'suitable person' is not fettered by that requirement. The powers are sometimes used even where the Department has not presented family-based placement options, resulting in the only placement option being non-family based residential care.[170]

The Commission applauds these efforts and recommends that magistrates be encouraged, with the active support of the Department, to exercise the existing discretion as an immediate interim step pending other reform.[171] The Commission further recommends that section 67 of the Act be amended to broaden the scope of persons in whose care the Court may place a child, on an interim basis, with a 'suitable person' with whom the child has a relationship of trust (for example, a family friend, neighbour or teacher), and that section 159 be amended to clarify that any person granted care of a child pursuant to a CPO — including on an interim basis — is eligible for the carer allowance.[172]

6.6.6 The QCAT review jurisdiction

Persons aggrieved by departmental decisions may seek merits review in the Queensland Civil and Administrative Tribunal (QCAT). The Tribunal's primary jurisdiction in child protection is a list of approximately 14 reviewable decisions and, separately, to Blue Card matters. Stakeholders reported long delays in obtaining contact reviews and dismissals of applications on technical jurisdictional grounds. The list of reviewable decisions excludes — among others — schooling, health and medical care, and NDIS-related decisions, exclusion from case planning and gender-affirming care. The Commission notes that the Honourable David Thomas is conducting a review of the *Queensland Civil and Administrative Tribunal Act 2009* (Qld), in which these issues may be considered.[173] The Commission recommends, in any event, that review of family contact and placement decisions be removed from QCAT and vested solely in the Childrens Court, and that a child's carer have standing to appear before the Court and make submissions on family contact and placement, whether or not joined as a party under section 113 of the Act.

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[169] *Child Protection Act 1999* (Qld) s 135.
[170] *Child Protection Act 1999* (Qld) ss 61(d)(i), 61(f)(i), 67(1)(a)(ii); *Working with Children (Risk Management and Screening) Act* 2000 (Qld) (and uncommenced amendments); Department of Families, Seniors, Disability Services and Child Safety, *Expenses - Fortnightly caring allowance and interstate foster payments*, Policy No 365-17.
[171] *Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024* (Qld) s 4.
[172] *Child Protection Act 1999* (Qld) s 159.
[173] *Child Protection Act 1999* (Qld) ch 7 Pt 1; *Queensland Civil and Administrative Tribunal Act* 2009 (Qld) ss 17–20; *Judicial Review Act 1991* (Qld).

6.7 A Streamlined Court Process — the Way Forward

The Commission proposes a single, child-centred court process underpinned by active judicial case management, a simplified and transparent architecture for CPOs, and defined jurisdictional pathways. The proposed process has the following features:

- A single court proceeding in relation to the child, not multiple serial applications.
- Parental responsibility as the organising legal concept underpinning the care of the child.
- Early, independent legal oversight of child protection applications by the unified DCPL.
- Mandatory court-facilitated conciliation at the earliest possible opportunity, formalising arrangements for the child's care.
- Active judicial case management and oversight, particularly with respect to care arrangements and progress toward reunification.
- Greater integration with related jurisdictions, particularly the federal family law jurisdiction, where appropriate.
- Ongoing judicial oversight whenever the State holds parental responsibility, with continued active efforts toward family-based placement, kinship placement and reunification.
- The architecture of 'short-term' and 'long-term', 'custody' and 'guardianship' orders to be replaced with 'Reunification orders' and 'Permanency orders.'

All child protection proceedings would be commenced by a single Form 10 application, distinguishing between matters on notice and those brought on an urgent basis after administrative removal under section 18. Urgent applications would be filed and heard the day after removal, with evidence addressing why the section 18 power was enacted, why voluntary or less intrusive arrangements were not viable, and whether the child can safely return with conditions or whether continued separation is necessary and proportionate.

6.8 Summary of Principal Recommendations

The Commission's principal recommendations are summarised here. The full text appears in the accompanying Companion Report 2: Child Protection Litigation and in the Compendium of Recommendations.

- **Recommendation 8:** 'Balance of harm' analysis to the paramount principle
- **Recommendation 9:** Amending the paramount principle
- **Recommendation 10:** Abolish the bifurcated model (OCFOS & DCPL)
- **Recommendation 11:** Amend section 18 of the Child Protection Act
- **Recommendation 12:** Replace 'custody' and 'guardianship' with 'parental responsibility'
- **Recommendation 13:** Enlarge definitions of 'suitable persons'
- **Recommendation 14:** Positive obligation to provide court with 'suitable persons'
- **Recommendation 15:** Suitable persons to receive financial assistance
- **Recommendation 16:** Childrens Court to replace QCAT review
- **Recommendation 17:** Simplify child protection orders
- **Recommendation 18:** Legal representation for all parties
- **Recommendation 19:** Consolidate emergent orders
- **Recommendation 20:** Contact arrangements as part of child protection orders
- **Recommendation 21:** Early Court-facilitated conciliation
- **Recommendation 22:** Improve case management framework

6.9 Conclusion

The Commission's inquiries have revealed that the child protection litigation model and court process are not delivering the timely, fair and child-centred outcomes that the legislative scheme contemplates, and that Queensland deserves. The bifurcated structure has diffused accountability, led to conflict between the State bodies, and increased the duration of proceedings. Pre-court interventions operate outside any clear legal framework. Emergent orders are too routinely used and become the basis for long periods of removal before any court review. Substantive proceedings are too long, with most parents unrepresented at first mention and one of the most consequential decisions in the continuum — reunification — falling outside court oversight.

The reforms outlined in this chapter are directed to resolving those problems: to creating a single, streamlined, child-centred process under unified statutory responsibility, with active judicial oversight, expanded family-based placement options and improved access to representation. The Companion Report 2: Child Protection Litigation sets out the detailed evidence and analysis upon which these conclusions are based.

Chapter 7

Models of Care and Residential Care Financials

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 7: Models of Care and Reforming the Residential Care System

7.1 Introduction

Out-of-home care is the point at which the State's responsibility for a child, as his or her corporate parent, becomes practical and immediate, bringing with it profound obligations. Once a child cannot safely live with their parents, the system must decide how that child will be cared for, by whom, in what setting, with what support and towards what future. These decisions must always be guided by the child's safety, wellbeing and best interests as the paramount consideration.[174] This chapter distils the Commission's detailed examination of Queensland's out-of-home care system, which is contained in the accompanying Companion Report 3: Models of Care and Companion Report 4: Understanding and Reforming the Residential Care System. It focuses on different models of care, the state of the residential care market, and the financial and governance conditions that have shaped both. The examination draws on evidence from public hearings in Cairns, Toowoomba and Brisbane which occurred between September 2025 and April 2026,[175] in addition to the significant volume of submissions received by the Commission and a bespoke analysis prepared for the Commission by KPMG entitled 'Financial Review of Non-Family Based Residential Care'.[176] The analysis across both Companion Reports reveals a singular system problem: The Department's approach to out-of-home care is dominated by placement scarcity, crisis purchasing and service availability rather than by a child's assessed needs or best interests, the support required by carers and providers, and the State's responsibilities as corporate parent.

The Terms of Reference require the Commission to examine tertiary interventions, placement arrangements, frontline resourcing pressures, service availability, funding and contracting models, and the governance and accountability of State entities exercising child protection powers. The recommendations in this chapter are directed to structural, operational and legislative reform to strengthen family-based care, define and improve non-family-based care, establish a lawful and therapeutic secure care pathway, and ensure that public expenditure is directed to safe, relational, therapeutic and accountable care for children.

[174] *Child Protection Act 1999* (Qld) s 5A.
[175] Public hearings, Cairns [8 September 2025] – [26 September 2025], Brisbane [17 November 2025] – [5 February 2026], Toowoomba [16 February 2026] – [25 February 2026] and Brisbane [7 April 2026] – [17 April 2026].
[176] KPMG, *Financial Review of Non-Family Based Care* (Report, 2 April 2026). See Appendix E.

7.2 Themes

The Commission's inquiries revealed the following recurring themes:

- **Family-based care must remain the foundation of the out-of-home care system and is to be preferred over non-family based care (including residential care).** It provides children with the best available opportunity for stable relationships, healthy attachment, belonging and an ordinary family life – outcomes that residential care, by its shift-based structure, cannot readily replicate. Family-based care is also in the order of 10-15 times less expensive than residential care.[177]
- **Departmental operational failures are undermining family-based care, and carers and children pay the price.** Carers are poorly informed, excluded from critical decisions, unable to obtain timely approvals for medical care, uncertain about the scope of their parenting authority, and exposed to unclear and disproportionate safeguarding processes. Those failures demoralise and disincentivise carers, destabilise placements and compound scarcity issues.
- **The strain on family-based care has consequences across the whole out-of-home care system.** When family-based placements are underfunded, unsupported or break down, children move into non-family-based care. Non-family-based care has a legitimate role, but its legitimacy depends on having a defined purpose, therapeutic quality and a clear pathway out — not on being the placement that is available when others are not.
- **Residential care itself provides the clearest evidence of system imbalance.** Residential care has expanded from a specialist, time-limited intervention into a core response to pressure elsewhere in the system. The State has purchased residential care capacity to meet unplanned demand without sufficient regard to quality, pathway or outcome, and the market has shaped itself accordingly.
- **The financial and market evidence reveals that Queensland missed an earlier opportunity to correct course.** The Department had cogent and compelling information that the following trends would coalesce in the years following 2020: increasing demand for out-of-home care; insufficient supply of family-based care placements; increasing reliance on short-term, high-cost residential care arrangements; and rising costs within the residential care system generally. The nature

[177] Transcript, Evidence of Danny Short (10 April 2026) 5138:37-5138:42; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5314:10-5314:20.

of these issues and their consequences had been identified by the Department in the Care Systems Investment Plan (CSIP), published in January 2020, and by the Queensland Treasury Corporation (QTC) in its Phase I and Phase II Reports (published in April and August 2020, respectively). In the outcome, the investment in family-based care required to quell or reverse the projected growth in residential care was not made at the necessary scale or in a sufficiently timely manner. The cost – to children in care and to the public at large – has been substantial.

- **Where the care system has no lawful therapeutic response for the highest-risk cohort, youth detention becomes the de facto containment mechanism.** Children whose behaviour reflects trauma, disability, exploitation or unmet therapeutic need are being managed through the justice system because the child safety system lacks the lawful pathway to manage them safely. That is a child safety failure expressed as a youth justice problem.

- **Queensland needs secure care.** There is a clear gap for a narrow cohort of children whose immediate risk of serious harm cannot be safely managed in existing family-based or non-family-based arrangements. Absent a lawful therapeutic alternative, risk is displaced into residential care, police responses, hospital presentations and youth detention. The system is not stronger without secure care: it is weaker. Secure care must be court-authorised, therapeutic, time-limited and connected from the outset to an intended pathway back to less restrictive care.

7.3 Family-based care

7.3.1 The preferred foundation

Family-based care sits at the foundation of Queensland's out-of-home care system. It includes foster care, kinship care and other household arrangements in which a child who cannot safely live with their parents is cared for in a family setting. That position remains conceptually sound and developmentally grounded. Children need safety, stability, attachment, belonging and ordinary relationships with adults who know them, remain with them and provide the daily rhythms of family life. These are not incidental features of care. They are central to children's development, identity and recovery from trauma.[178]

[178] John Bowlby, A *Secure Base: Clinical Applications of Attachment Theory* (Routledge, 1988); National Scientific Council on the Developing Child, *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain* (Working Paper No 12, May 2012).

Children told the Commission what good care means in simple and concrete terms. Care was described as 'being part of a family and being loved' and success as 'being loved … cared for … being safe.'[179] That evidence identifies what the system must preserve: not a placement category, but the capacity of children to be cared for by people who know them, remain with them and help them experience safety and belonging.

Family-based care is also the most cost-effective option. In 2020, QTC identified that transitioning children from residential care into family-based care would produce both significant cost savings and improved outcomes for children across safety, health and education.[180] The then-Minister described this as 'a fortunate coincidence' — the most affordable option was also in the child's best interests.[181] The Commission has concluded that this transition did not occur at the necessary scale or with sufficient urgency.

7.3.2 Why family-based care is under strain

Family-based care in Queensland is under strain for structural and demographic reasons that cannot be reduced to a recruitment problem. Contemporary households are more diverse, more likely to involve dual workforce participation, more exposed to housing and cost-of-living pressures, and more likely to be balancing overlapping caring responsibilities for children, older relatives and family members with disability or illness.[182] At the same time, many children entering care have substantial and overlapping needs arising from trauma, neglect, family violence, developmental concerns, disability, mental health issues, school disengagement and multiple prior placements. The model still relies heavily on goodwill, but the work increasingly requires skill, time, therapeutic support, clear decision-making authority and sustained practical scaffolding.

As at 18 February 2026, 19.7% of children in Queensland's out-of-home care were in residential care[183] — the highest proportion in the country. By comparison, the proportion in New South Wales is approximately 7%, in Victoria 5% and in Western Australia 8%.[184] Queensland accounts for nearly half of Australia's total residential care population, despite having approximately 20%

[179] Youth Voices Survey response No 39 from former child in care (March 2026); Youth Voices Survey response No 80 from former child in care (March 2026).
[180] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) 70–71; Queensland Treasury Corporation, Child Safety Phase II Report (Report, August 2020) 70–73.
[181] Transcript, Evidence of Leanne Linard (16 April 2026) 5463:12-5463:25.
[182] PeakCare and Queensland Family and Child Commission, Preserving *a Vital System: The Future of Foster Care, Queensland Foster Carer Demographic Insights Report* (Report, June 2024) 12–13, 17–30; UNSW Social Policy Research Centre and Uniting NSW.ACT, *Insights into the diversity of families raising children and young people* (Report, 2024) 3, 59; The Demographics Group, *Demographic Outlook: why the sector faces systemic change* (Report, April 2025) 4.
[183] Department of Families, Seniors, Disability Services and Child Safety, 'Operational data: Care arrangements', *Our Performance* (Web Page, 18 February 2026) <https://performance.dcssds.qld.gov.au/our-performance/operational-data/care-arrangements>
[184] KPMG, Financial Review of Non-Family Based Residential Care (Report, 2 April 2026) Figure A.22; Australian Institute of Health and Welfare, *Child Protection Australia 2023–24* (Report, 2024).

of the nation's children in out-of-home care. That disproportion is not explained by the relative complexity of Queensland children. It reflects the relative weakness of family-based care supply.

Kinship care carries particular importance. It can preserve family, cultural and community connection more readily than most other care arrangements and is rightly prioritised under the *Child Protection Act 1999* (Qld).[185] However, kinship care is not self-sustaining simply because it is relationally preferred. Kinship carers are often older, on fixed incomes, living in crowded or insecure housing, caring for other family members, and navigating complex relationships with the child's parents and extended family. Some Aboriginal and Torres Strait Islander potential kinship carers are deterred by distrust of the child safety system, previous involvement with child protection, or concern that engagement with the Department may expose their own household to scrutiny.[186] A system that seeks to increase kinship placements for Aboriginal and Torres Strait Islander children must meet these challenges head on.

When family-based care is not adequately supported, placements break down. When placements break down, children move into non-family-based care. When residential care grows, the system becomes more expensive and more reactive, and less connected to the relational conditions children need. The strain on family-based care is therefore not a discrete service issue. It is one of the key functional problems in Queensland's child safety system.

7.3.3 The partnership gap and its consequences

The relationship between foster and kinship carers and the Department is one of the clearest indicators of whether family-based care is functioning as intended. Carers provide daily parenting care on behalf of the State. That role enters every part of household life – employment, finances, other children and adults in the home, daily routines, medical appointments, school, relationships and crisis response.

The evidence before the Commission shows that this practical reality is not consistently reflected in how carers are treated. Through the course of its inquiries, the Commission received substantial evidence from carers through public hearings, private sessions, written submissions and survey material. That evidence included a finding that 80% of foster carers surveyed in a 2024–25 exit survey said they would not recommend the role to a friend.[187] That figure speaks to the sustainability of family-based care as a system, not only to individual carer satisfaction.

[185] *Child Protection Act 1999* (Qld) ss 5B(g), 5C.
[186] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to call for submissions regarding Far North Queensland* (August 2025) 30, 37, 39.
[187] Queensland Foster and Kinship Care, *Carer Exit Survey 2024–2025: Voices of Queensland's Exited Foster and Kinship Carers* (Report, 2025) 5.

The Commission's evidence identified a consistent and consequential partnership gap. Carers described being treated as peripheral to decision-making, even where they held direct and daily knowledge of the child's needs, routines, distress and development. Witness H described foster carers as being treated as 'afterthoughts' despite carrying out the day-to-day responsibility of caring for children.[188] Witness AB, a foster carer and registered nurse, described the tension between being expected to act as a volunteer and having relevant professional judgment: 'I'm happy to be the volunteer and not be the professional. But I want to be listened to, and I think that's the problem.'[189]

This partnership gap has direct consequences for children. Carers described being given incomplete information about children's health, trauma, disability, behavioural or family contact needs. Some were excluded from decisions they were then required to implement. Others described delays in health, dental, therapeutic, disability or education approvals that left children without necessary assessment or treatment. One carer gave evidence of a young person waiting approximately 12 months for a paediatric medication review; before that review occurred, the young person experienced a psychotic episode, the placement broke down, and the medication review eventually occurred in youth detention.[190] Information, timely approval and practical support are not administrative courtesies. They are safeguarding tools.

Carers are expected to provide children with routines, boundaries and guidance – ordinary aspects of parenting that are particularly important for children who have experienced trauma. Yet the evidence discloses widespread uncertainty about the scope of carers' parenting authority: whether they can restrict mobile phone use, manage online safety, limit movement at night, intervene physically in an emergency, or maintain reasonable household boundaries without those decisions later being characterised as restrictive practices or Standards of Care concerns. That uncertainty can leave carers hesitant or defensive and can leave children without the predictable structure that supports regulation and safety.

Standards of Care reviews and Harm Reports are essential safeguards to ensure children in out-of-home care are be protected from poor care, neglect and abuse. The evidence does not cast any doubt on this proposition. However, the evidence does suggest that those processes do not consistently operate to provide carers with the clarity, proportionality and procedural fairness they require. Some carers described processes that were unclear in threshold or consequence, that appeared triggered by advocacy on behalf of children, or that were experienced as

[188] Transcript, Evidence of Witness H (8 September 2025) 118:33–118:35.
[189] Transcript, Evidence of Witness AB (12 September 2025) 606:12–606:14.
[190] Transcript, Evidence of Witness C (9 September 2025) 49:45-50:5.

unnecessarily combative rather than protective. Complaint handling raises similar issues. Carer complaints are often about children's needs: delay in approvals, lack of information, unsafe contact arrangements, service access, placement stress or poor communication. They are therefore a source of system intelligence. If those complaints remain local, informal, unrecorded or unresolved, the Department misses patterns that may reveal wider weaknesses in corporate parenting, practice culture and placement support.

The Commission does not need to resolve every disputed account to identify the system risks. It is sufficient to identify just two such risks. ***First***, where carers fear that raising concerns will attract scrutiny, the Department loses the information it needs to identify problems before they escalate. ***Secondly***, where carers are unfairly treated during safeguarding processes, they can be disincentivised from remaining as carers and exit the system.

The Commission's concern is practical. Family-based care depends on carers being trusted, informed, supported, treated fairly and able to speak candidly. A system that treats carers as peripheral to decision-making weakens the care arrangement it (rightly) says it prefers.

7.4 Non-Family-Based Care: Purpose, Quality and Pathway

Non-family-based care has a legitimate role in Queensland's out-of-home care system. Among the various alternatives, residential care, Supported Independent Living and Safe Houses each serve different purposes. Each may be necessary for some children at particular points in time. The Commission's concern is not that non-family-based care exists, though it does say that family-based care must be preferred. The Commission's concern is that Queensland's non-family-based care system is used to cover a shortfall in family-based care placements and that it does not consistently operate as a purposeful, therapeutic and pathway-oriented response to assessed need.

7.4.1 Residential care: from specialist intervention to system response

Residential care was historically understood as a specialist, time-limited placement for a limited cohort of children whose safety or therapeutic needs could not, at a particular time, be met within a family-based setting. In more recent times, at least in Queensland, it has become a major component of the out-of-home care system. From March 2015 to March 2025, the number of children and young people in residential care increased by 229%.[191] As at 31 March 2025, there were 2,258 children in residential care in Queensland, including 78 children under the age of five

[191] Statement of Belinda Drew (3 September 2025) [30]; Statement of Bernadette Harvey (3 September 2025) [126]–[130].

and 472 children under 10 years of age.[192] Residential care was not designed for young children. Early childhood is the developmental period in which attachment, relational consistency, emotional regulation and foundational identity are formed. The presence of 550 children under 10 in shift-based residential care is one of the most acute indicators of system failure in the evidence before the Commission.

The evidence also indicates that many children are in residential care not because it is the right placement for them, but because no suitable alternative exists. As at 27 March 2026, the material produced by the Department indicated that 1,555 of approximately 2,800 children placed in residential care were assessed as suitable for family-based care with intensive supports — if such placements were available.[193] That figure speaks for itself. More than half of Queensland's residential care population is in that setting because the system has been unable to provide the arrangement assessed as appropriate for their needs.

That pattern reflects upstream system failure. Residential care absorbs the consequences of weaknesses elsewhere: insufficient supply of family-based care placements, unmet disability and mental health needs that prevent placements from being sustained, inadequate early intervention, educational disengagement, placement instability, and the absence of intermediate care options between foster care and residential care. The Department's own evidence was that family-based care is preferred for all children because it enables them to experience predictability and stability with a consistent caregiver, supporting the development of a secure bond with a trusted adult.[194] The fact of there being 1,555 children in residential care, none of whom should be there in a properly commissioned out-of-home-care system, demonstrates the distance between that principle and the operational reality.

7.4.2 What children experience

Children do not experience the out-of-home care system as placement types. They experience adults, homes, rosters, routines, rules, school, family contact, culture and decisions made about them.

Aimee, speaking from both lived experience and frontline practice, described residential care as carrying an 'unnatural and cold' quality. She said she had been 'raised by policies and procedures and checklists', with terms and conditions attached to relationships rather than the unconditional protection and care expected of a parent or family member.[195] Witness X described

[192] Statement of Belinda Drew (3 September 2025) [30]; Statement of Bernadette Harvey (3 September 2025) [126]–[130].
[193] Department of Families, Seniors, Disability Services and Child Safety, Children placed in residential care by region and whether suitable for family-based care as at 27 March 2026 (Spreadsheet, 2 April 2026) (DFS.0392.0002.0001).
[194] Statement of Victoria Van Houdt (5 September 2025) [153]–[158]; Statement of Bernadette Harvey (3 September 2025) [34].
[195] Transcript, Evidence of Aimee (16 February 2026) 4125:5–4126:1, 4150:29–4150:46.

the cumulative effect of repeated placement moves: there was, he said, 'no point getting emotionally attached to anyone if you're just going to move the next day.'[196]

The evidence also identifies a significant and under-acknowledged problem: the misidentification of disability-related need as challenging behaviour. Children with trauma histories, Foetal Alcohol Spectrum Disorder, neurodevelopmental vulnerability, cognitive impairment or unmet mental health needs are often described through their behaviour — they abscond, assault, refuse school, self-harm or disengage. Those descriptions may be accurate, but they are insufficient. They do not explain what is driving the behaviour, what disability or developmental needs may be present, or what response would reduce the risk.[197] A care system that responds to disability as behaviour will cycle children through placements without addressing the child's underlying needs and may escalate toward a residential care placement that is not clinically equipped to respond.

7.4.3 Quality, minimum standards and pathway discipline

Effective non-family-based care requires five core features. It must be **purposeful** — each type of placement should have a defined role and cohort, not serve as a default response to scarcity. It must be **relational** — residential workers must be oriented toward consistency and genuine engagement with children, not merely occupancy and shift completion. It must be **therapeutic** — children in residential care in Queensland have almost universally experienced significant complex trauma, and any model not designed to respond to that will at best provide accommodation and at worst compound existing harm. It must be **culturally attuned** — for Aboriginal and Torres Strait Islander children, cultural connection is a dimension of safety, not an ancillary service. And it must be **connected to a pathway** — residential care should not become a static destination.

Each residential care placement should be understood by reference to its purpose and trajectory, not by occupancy alone. Practitioners in the system should know why the child is there, what the placement is intended to achieve, what therapeutic work is planned, and who owns responsibility for progressing the child's pathway out. The evidence indicates that this pathway discipline is not consistently present. Children remain in residential care not because it is the right placement, but because nothing better is available and no one is accountable for progressing the next step.

Quality in residential care cannot be measured by bed nights, occupancy or placement availability. Those metrics say nothing about whether a child is safe, known, supported at school,

[196] Transcript, Evidence of Witness X (22 September 2025) 1403:3–1403:8, 1416:4–1416:8, 1420:25–1420:34.
[197] NOFASD Australia, *Submission to Child Safety Commission of Inquiry* (March 2026); Well Life Services, *Submission to Child Safety Commission of Inquiry* (March 2026).

connected to culture, cared for by consistent adults, or moving toward a stable future. They are measures of throughput, not of care.

7.5 The Financial and Market Evidence

7.5.1 The cost trajectory

The financial evidence described in Companion Report 4: Understanding and Reforming the Residential Care System explains how Queensland reached this point. In 2019–20, the average annual cost of residential care was approximately $300,000 per child. By 2024–25, it had reached approximately $500,000 per child.[198] KPMG identified that by 2024–25, the median Individualised Placement Support (IPS) agreement was 39% more expensive than the median Outsourced Service Delivery (OSD) contract.[199]

The problem is not that higher-cost care is never justified. Some children require intensive, specialist, regionally located or disability-informed support. The problem is whether the State can identify what the additional price purchases in each case. KPMG found no discernible relationship between the average price charged by providers per placement day and the level of staff training or model of care provided.[200] The Queensland government is paying more for care of undemonstrated quality. That is simultaneously a value-for-money failure and a child safety failure.

The market structure compounds this. Residential care is a State-created and State-funded market. The Department is simultaneously the purchaser, funder, regulator and corporate parent. Children cannot choose a provider, assess quality or leave a poor placement through any mechanism available to an ordinary consumer. In that setting, robust and strategic commissioning is the only available mechanism for aligning cost, quality and outcomes. The evidence indicates that commissioning has too often operated as a response to immediate placement pressure, leaving the Department exposed as a price taker in a market it should have been actively stewarding.

7.5.2 The commissioning and governance failure

The Commission observed systemic failures in the Department's approach to commissioning, procurement, contracting and licensing of residential care. Those failures are not simply

[198] Department of Children, Youth Justice and Multicultural Affairs, Pre-budget brief to Minister with residential care placement data as at 9 December 2020 (DFS.0397.0004.0511); PeakCare, *The future residential care workforce: Demographic analysis* (Draft Consultation Report, September 2025).
[199] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 21.
[200] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services Internal Audit Report* (Internal Audit Report, September 2025) (DFS.0271.0001.0025); KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) ES.14.

operational inefficiencies. They represent a sustained governance failure in one of the State's most consequential service markets.

From at least 2019, children entering residential care were commonly placed with providers on expensive short-term IPS agreements, because the supply of funded long-term placements under OSD contracts was insufficient. Reliance on those short-term agreements incentivised crisis response and high cost purchasing. It also created conditions in which for-profit and unlicensed providers could enter and grow within the market with limited barriers, inconsistent oversight and no demonstrated link between revenue and care quality.

The Commission observed significant regional variation in procurement and contracting practices, reliance on inconsistent and outdated documents, unclear standards, and delays in inviting providers to become licensed. The administrative burden created by high-volume short-term purchasing consumed departmental resources and capacity that should have been directed to market stewardship, supply planning and quality improvement. Regional staff described being occupied with high-volume, high-frequency and highly manual processes — extending placements, reconciling invoices — rather than with redesigning the conditions that produced the demand.[201]

7.5.3 The missed window

The governance failures in commissioning and procurement cannot be separated from a more fundamental accountability question. The early warning signals were widely known within the Department. In 2020, the CSIP and QTC, in both the Phases I and II reports, identified difficulties recruiting, training and retaining family-based carers and increasing reliance on high-cost residential care arrangements. The only antidote for forecasted overspending in child safety was a decisive, upfront and sustained early investment in family-based care.[202] The Department therefore well understood that transitioning children from residential care into family-based care would produce both significant cost savings and improved outcomes. That analysis was shared among senior executives within the Department and summarised for the then-Minister.

Despite these clear warning signs, the Department did not invest in family-based care at the necessary scale or with sufficient urgency. The system, under pressure, continued to purchase residential care capacity. The market developed around crisis demand. Costs escalated. By the time additional funding arrived, the opportunity to arrest the trajectory at lower cost had passed.

[201] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5207:31–5208:19.
[202] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 70–71; Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 70–73; Transcript, Evidence of Leanne Linard (16 April 2026) 5486:11-5486:26.

And even when the funding did arrive, it was only barely sufficient to cover historical and projected deficits in the child safety budget.

This is a governance and accountability failure, not simply a market development challenge. Government had the information. It identified the window. The decision not to act carries consequences that are now visible in the cost data, in the residential care population, and in the 1,555 children assessed as suitable for family-based care who remain in residential care placements because the preferred care arrangement does not exist.

7.6 Secure Care

7.6.1 The gap and the need

Queensland has a clear gap for a narrow cohort of children who pose an immediate risk of serious harm to themselves or to others, and who cannot safely be managed in existing family-based or non-family-based care arrangements. That gap was identified by the Carmody Inquiry in 2013, which recommended therapeutic secure care as a last resort, with court oversight.[203] The current Queensland Government has committed to deliver a Secure Care facility by 2028.[204]

The evidence before the Commission confirms the need for a lawful, therapeutic secure care pathway. The Commission heard of children repeatedly absconding and at risk of exploitation, engaging in serious self-harm, behaving violently toward peers, carers and workers, cycling between residential care, police, hospital and youth justice, and presenting with overlapping trauma, disability, neurodevelopmental vulnerability, substance use and mental health needs.[205] Where there is no lawful therapeutic pathway for this cohort, risk does not disappear. It is displaced — into residential care settings not designed to contain it, into police responses, hospital presentations, emergency relocations, informal restriction and, for some children, youth detention.

The absence of secure care does not make the system or children safer. It makes them less safe. Youth detention is a youth justice intervention. It should not become the practical containment response for children whose behaviour reflects unmet therapeutic need, trauma, disability or exploitation — but that is the consequence when the child safety system has no lawful alternative.

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[203] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013) xxxiii.
[204] Queensland Parliament, Question on Notice No 1, Education, Arts and Communities Committee, 31 July 2025; Queensland Government, *Budget to help deliver safer children, safer communities* (Joint Ministerial Statement, 24 June 2025) https://statements.qld.gov.au/statements/102869.
[205] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026); Transcript, Evidence of Corinne Porta (24 November 2025) 2618–2619; Transcript, Evidence of Luke Twyford (25 February 2026) 4743–4754.

7.6.2 Design requirements

The Commission's position is that **legislation must come before infrastructure.** If implementation proceeds through facility design, procurement and operational planning before the legal model is settled, secure care risks becoming custodial in function even if therapeutic in intention. The Queensland Government has committed to a facility by 2028. That timeline must not be allowed to compress the legislative and design work that must precede it. The legislation should define the purpose of secure care, the target cohort, the threshold for admission, the authorisation pathway, maximum duration, review obligations, legal representation and advocacy rights, the regulation of restrictive practices, independent oversight, data reporting and transition obligations.

Admission threshold. Admission should be authorised only where the child presents an imminent serious risk of harm to themselves or others, no less restrictive arrangement can safely manage that risk, and the proposed placement is therapeutic, necessary and proportionate. Complex need, placement breakdown, disability-related distress, difficult behaviour or the absence of a suitable alternative placement must not be considered to be sufficient. The threshold for admission must not be based on the system's demonstrated tendency to treat scarce placement options as justifications for admission.

Court authorisation. Because secure care involves deprivation of liberty, the decision to admit a child must not rest with the Department alone. The Commission recommends that admission to secure care be authorised by court order. The appropriate court for first-instance jurisdiction is the **Childrens Court** – not the Supreme Court, as the Carmody Inquiry recommended. The nature of the jurisdiction concerns the subject matter of child protection over which the Childrens Court has established expertise and experience. Under the streamlined child protection litigation model proposed in the accompanying litigation chapter, the Childrens Court exercises oversight across the full continuum of a child's contact with the statutory system. Secure care jurisdiction should sit within that continuum. Decisions of the Childrens Court in this jurisdiction should be subject to the usual rights of appeal.

Duration and review. Secure care is a stabilisation pathway, not a placement destination. The initial authorisation should not exceed **21 days**. Any extension should be subject to fresh court evaluation against the admission criteria. Extensions should never be granted merely because a suitable exit placement is unavailable. Duration limits prevent open-ended containment. There should be periodic reviews, to test whether the threshold continues to be met, whether the child is receiving the therapeutic intervention for which admission was authorised, and whether a less

restrictive pathway has become available. Both duration limits and periodic reviews are necessary; neither is sufficient without the other.

Therapeutic model. The daily model within the secure care setting should include structured routines, education, clinical support, cultural connection as appropriate, family and kin engagement where safe, and workers skilled in responding to trauma, disability and distress, and in de-escalation. The measures of success are not occupancy or bed utilisation. They are whether the child has been stabilised, whether the drivers of risk have been better understood, whether therapeutic intervention has occurred, whether restrictive practices have been minimised, and whether the child's exit has been safe and sustained.

Transition and step-down. A child should not enter secure care unless an initial exit pathway has been identified. Step-down options may include specialist family-based care, genuinely therapeutic residential care, intensive kinship support, disability and mental health services, or supported transition to adulthood. Those pathways must be funded and available before the step-down commences. Without them, secure care will drift from stabilisation toward prolonged containment — repeating, in a more restricted setting, the same pathway deficit that has undermined residential care.

7.6.3 Over-representation, rights and cultural matters

Secure care invokes rights of a different order from those in ordinary placement decision-making. It involves deprivation of liberty, limitations on freedom of movement and heightened exposure to restrictive practices. The children most likely to be admitted are among those most vulnerable to harm from coercion, isolation, restraint, seclusion, cultural disconnection and institutional drift.

The Commission has heard concerns about the risk of disproportionately high numbers of Aboriginal and Torres Strait Islander children being admitted to secure care. Those concerns must be addressed through the design of the model: a narrow statutory threshold, independent judicial authorisation, strict time limits, mandatory review, cultural safeguards at the transition and step-down phases, and public accountability for who enters secure care, why they enter, how long they remain, and what happens when they leave. The Commission notes that where a child meets the threshold for admission — where the risk of serious harm is imminent and cannot otherwise be safely managed — the overriding legal and ethical obligation is safety and therapeutic treatment. Secure care is inherently a short-term clinical intervention, not a long-term placement or living environment. Cultural considerations, where relevant, belong principally to the transition and step-down phase, not to the acute phase of admission.

7.6.4 Restrictive practices

Queensland presently has no statutory framework governing restrictive practices for children in out-of-home care. In the context of secure care, that gap is untenable. Secure care necessarily authorises containment, and consequently other restrictive practices might be used. A legislative framework governing restrictive practices must be enacted before secure care commences. It should define each form of legitimate restrictive practice, prohibit practices that are punitive or degrading, set authorisation requirements, require positive behaviour support planning as the default, mandate recording and review, provide for independent oversight, and have as its overriding objective the reduction and elimination of restrictive practices over time.[206]

The establishment of a secure care restrictive practices framework should also prompt broader consideration of restrictive practices across out-of-home care. The same children most likely to be considered for secure care will move between residential care, secure care, family-based arrangements and community settings. If the law provides clarity inside secure care but leaves uncertainty elsewhere, children will be exposed to unacceptable risk of harm in settings where carers and workers lack legal and practice guidance. The principles should be consistent across the continuum: children must be protected from unnecessary restriction; carers and workers must know what is permitted; restrictive practices must be reduced and eliminated wherever possible; and any use must be lawful, necessary, proportionate, recorded and subject to review.

7.7 Summary of principal recommendations

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 3: Models of Care, Companion Report 4: Understanding and Reforming the Residential Care System and in the Compendium of Recommendations.

- **Recommendation 23:** Reform out-of-home care as a coherent system
- **Recommendation 24:** Carers as genuine partners in the care team
- **Recommendation 25:** Revise model of family-based care
- **Recommendation 26:** Therapeutic baseline for non-family based care
- **Recommendation 27:** Legislated therapeutic secure care
- **Recommendation 28:** Sufficient funding to support Department's placement strategy
- **Recommendation 29:** Demand and Cost Modelling

[206] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026); Office of the Aboriginal and Torres Strait Islander Children's Commissioner, *Submission to Child Safety Commission of Inquiry* (March 2026).

- **Recommendation 30:** Revised procurement documentation
- **Recommendation 31:** Feasibility of direct service delivery
- **Recommendation 32:** Risk-based monitoring of funded services
- **Recommendation 33:** Minimum role-specific training for procurement and contract staff
- **Recommendation 34:** Pre-Qualification Framework
- **Recommendation 35:** Review of Licensing Framework
- **Recommendation 36:** Minimum Qualification Standards

7.8 Conclusion

The evidence before the Commission reveals an out-of-home care system under serious strain at every point. Each part of Companion Reports 3 and 4 speaks to a common story: a system that has drifted from its foundational commitments, accumulated structural imbalances, and absorbed the consequences in cost, complexity and harm to children.

Family-based care remains the system's foundation. It provides the best available opportunity for children to experience stable relationships, attachment, belonging and ordinary family life. Yet it is being asked to carry a load for which the model was not designed. Carers are expected to absorb increasing complexity within households affected by contemporary workforce, housing, financial and caring pressures, often without the information, authority, practical support or collaborative engagement required. The result is that carers leave and are not replaced, placements break down, and children move into residential care — not because that is the right arrangement for them, but because nothing else is available.

Non-family-based care has grown not because it is a better model of care, but because the rest of the system has been unable to hold children within it. Residential care is the clearest expression of that dynamic. There are currently as many as 1,555 children in residential care who have been assessed as suitable for family-based care. Those children would be in family-based care placements if such placements had been funded, generated and maintained in a timely manner. Residential care, as a placement that provides accommodation without stable and continuous relationships, therapeutic quality, cultural connection and a planned pathway forward, is not an adequate substitute for those children.

The financial evidence shows how this trajectory of overreliance on residential care and perpetual overspending became embedded and normalised within the Department, notwithstanding overwhelming evidence about the lack of family-based care supply, rising demand for residential care services and escalating costs in the system. Notwithstanding this,

the investment required to arrest the trajectory was not made at the necessary scale. The system continued to purchase residential care capacity under pressure. Costs nearly doubled. The market adapted to crisis purchasing. That is a governance failure, and its consequences — financial and human — are now visible in the data.

Secure care addresses a genuine and urgent gap. A narrow cohort of children present immediate and serious risks that existing family-based and non-family-based care cannot safely manage. Queensland is less safe without a lawful therapeutic pathway for those children. But Queensland will also be less safe if secure care is designed poorly — if it becomes the place where the system contains the consequences of its own underinvestment in earlier, less restrictive care. Secure care must be established by legislation before infrastructure is built. It must be court-authorised, narrow, therapeutic, time-limited and independently overseen, and must be connected from the outset to a pathway back to less restrictive care.

The reform task is to build a coherent out-of-home care system: one that preserves and strengthens family-based care; defines and improves non-family-based care; constrains residential care to its proper specialist function; establishes secure care with strict legal safeguards; and ensures that funding, commissioning, procurement, licensing and quality assurance are directed to children's safety, relationships, development and outcomes.

Queensland cannot continue to purchase its way through placement pressure and call that care. The State's responsibility as corporate parent requires more.

Chapter 8

Corporate Parenting and the Youth Justice Interface

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 8: Corporate Parenting and the Youth Justice Interface

8.1 Introduction

The State's responsibility as corporate parent requires it to do more than keep a child safe in the immediate sense. It requires the State to pursue the legal and relational arrangements that give a child a permanent, stable foundation for life. For children who cannot live safely with their parents, this means finding people who will love and care for that child on a permanent basis and to give that care a legal foundation that endures. Where the State fails to do this, the consequences for the child and the community can be dire.

This chapter distils the Commission's examination of three interconnected dimensions of corporate parenting, each addressed in detail in the accompanying Companion Report 5: Corporate Parenting and the Youth Justice Interface. Firstly, whether Queensland's permanency framework is being given practical effect. Secondly, whether adoption is being considered and pursued as a vital part of that permanency framework for children who cannot return to their families. Thirdly, whether the corporate parent's failures are contributing to childrens' involvement in the youth justice system, and whether the State is accountable when they do. The evidence on each question reaches the same conclusion: the system is not discharging its obligations, to the detriment of children in care and the wider community.

The Commission's examination was informed by the Commission's public hearing program, particularly the hearings related to the Child Protection Litigation Model and the Toowoomba hearings on the Child Safety / Youth Justice interface,[207] submissions from the public, as well as the voices of children in care, an analysis of data on long-term guardianship applications and section 51VAA reviews, and the detailed exploration of two case studies (Aimee and YP) that demonstrate, in concrete and documented terms, what failures of corporate parenting mean for individual children and the community.

The recommendations in this chapter are directed at legislative, structural and accountability reform: to give the permanency hierarchy practical effect; to restore adoption as a genuine permanency option and increase the numbers of children being adopted from care; to prevent

[207] Brisbane [8 December 2025]-[12 December 2025], [2 February 2026]-[5 February 2026], and Toowoomba [16 February 2026]-[25 February 2026].

children in care from entering the justice system; and to better hold the State accountable for failures of corporate parenting that have serious consequences for community safety.

8.2 Themes

The Commission's examination of the issues uncovered the following themes:

- **The permanency hierarchy is systematically inverted.** Long-term guardianship to the Chief Executive, the least preferred form of long-term order under the *Child Protection Act 1999* (Qld) (the Act), is sought in over 80% of cases for four consecutive years. The permanency hierarchy legislated in section 5BA of the Act is not a matter of aspiration. It is a mandatory framework. Its consistent subversion is a systemic breach of the Department's statutory obligations.
- **Guardianship assessments are resisted, and the mandated section 51VAA review is not being conducted.** Carers who are found suitable to provide daily care for a child, sometimes for years, are not being considered or assessed for the guardianship that would give that care a permanent foundation, including for reasons associated with culture and race. In a sample of 100 children, fewer than 10% received the section 51VAA review required by law. Of those in long-term family-based placements who did not receive a review, the majority had been in that placement for more than three years.
- **Children are telling the system what they need. The system is not listening.** Children in care told the Commission, directly and consistently, that they want permanency with their carers, reduced Departmental involvement, and the normalcy of belonging to a family. The data shows that the opposite is being delivered. The distance between what children want and what the system provides is sizeable and reflects settled features of Departmental practice.
- **Adoption has been effectively mothballed.** No child has been adopted from State care in Queensland since 2019. This has occurred despite a decade of legislative mandates, inquiry and coronial recommendations, and the Department's own assertions, now exposed as unfounded, that adoption was being routinely considered and pursued. Adoption exists in statute but not in practice.
- **One group of children faces compounded impermanence.** Aboriginal and Torres Strait Islander children are approximately half as likely as other children to achieve permanency via guardianship. Adoption is functionally unavailable to them, regardless of individual circumstances. The combined effect is that the children most overrepresented in out-of-

home care are also the most likely to remain under the State's guardianship, its least stable and most institutional form of care, for the duration of childhood.

- **The care-to-custody pipeline is foreseeable and preventable.** The pathway from State care to youth justice involvement is not random. Placement instability, residential care environments that criminalise rather than contain behaviour, disability left undiagnosed until detention, self-placing without financial support or sustained outreach, and motel placements that expose already high-risk children to even greater risk, all expose children to conditions directly associated with further offending. Each of these conditions is identifiable and amenable to reform.
- **There is no accountability when care fails with serious consequences for the community.** The existing policy trigger for a Departmental review requires a child death or serious injury to a child. Where a child in State care causes serious injury or death to a member of the public, no review is triggered. That gap is both illogical and indefensible. It must be closed.

8.3 Permanency

8.3.1 What permanency requires

Children who cannot safely return to their families need permanency — the experience of having stable, enduring relationships with people of significance, settled living arrangements, and legal security that supports a coherent sense of self and belonging. The *Child Protection Act 1999* (the Act) gives that concept legislative expression. Section 5BA defines permanency across three dimensions: relational, physical and legal.[208] It establishes a hierarchy of preferences for achieving those outcomes, in order of priority: care by the child's family; guardianship to a family member or other suitable person; adoption (for non-Aboriginal and Torres Strait Islander children); guardianship to the Chief Executive; and, as a last preference for Aboriginal and Torres Strait Islander children, adoption.[209]

The hierarchy is not aspirational. It is the operative legal framework for long-term guardianship decision-making. The Childrens Court must not grant guardianship to the Chief Executive if it can properly grant guardianship to another suitable person.[210] The Department's section 51VAA obligation requires, within six months of the second anniversary of a Long-Term Guardianship to the Chief Executive (LTG-CE) order, a review specifically considering whether permanency can be

[208] *Child Protection Act 1999* (Qld) s 5BA(4).
[209] *Child Protection Act 1999* (Qld) s 5BA(4)(a)–(e).
[210] *Child Protection Act 1999* (Qld) s 59(7)(b).

better achieved through alternative arrangements.[211] These provisions are not procedural suggestions. They are mandatory obligations.

The Commission heard from children what permanency means in practice. Their responses were direct and consistent:

> I want mum [carer] to have permanent care order I don't want the government to be my parent.
>
> PCO so I don't have to stress about child safety and just be normal.
>
> We should always be listened to if we don't want to go back to birth families and want to go PCO or LTGO — doesn't matter if we Indigenous, our safety and happiness comes first, the government needs to stop controlling us.

Those responses reveal that children understand, in concrete and immediate terms, what guardianship would mean for their daily lives, and are acutely aware that they do not have it.[212]

8.3.2 The permanency hierarchy in practice — a system inverted

The data does not demonstrate that the Department, as a corporate parent, is actively working towards making available the least-restrictive long-term order appropriate for its children. It discloses the opposite. In financial year 2024–25, the Department sought LTG-CE in 81.5% of referrals to the Director of Child Protection Litigation. Guardianship to a suitable family member or other suitable person was sought in 10% of referrals combined. Permanent care orders accounted for 8.5%.[213] The pattern is not new, and it is not improving. Across four consecutive financial years of data, LTG-CE accounted for between 82% and 84% of applications.[214]

The Court, it should be noted, departs slightly from that pattern: across the same four years, LTG-CE accounted for between 73% and 79% of final orders made. That modest difference does not remedy the systemic problem. The 80% rate reflects a practice failure that occurs before the matter reaches the Childrens Court.

Based on evidence from senior Departmental officers, and an examination of the data, it is evident that the Department does not, in practice, follow the permanency hierarchy required by the Act. Instead, the Department has developed a practice of skipping over long-term guardianship to a suitable carer or family member, as well as adoption, and seeks LTG-CE orders

[211] *Child Protection Act 1999* (Qld) s 51VAA.
[212] Youth survey response No 25 from child in care (2 October 2025); Youth survey response No 69 from child in care (6 October 2025); various Youth survey responses from children in care (October 2025 to February 2026).
[213] Office of the Director of Child Protection Litigation (Qld), Annual Report (Report, 2024–2025) 112; Statement of Nigel Miller (7 November 2025) [220].
[214] Office of the Director of Child Protection Litigation (Qld), Annual Report (Report, 2024–2025) 112.

when a child requires a long-term order.[215] Fundamentally, the Department has decided upon its own set of priorities that are not consistent with the prescription in section 5BA of the Act. Furthermore, the Commission is entitled to infer, and does infer, that this practice is approved at the highest level within the Department.[216]

The consequences for children are illustrated in the data concerning 144 children whose short-term orders were expiring. In 39 cases, carers had been identified as potentially suitable for guardianship, but no assessment had commenced. In 39 further cases, the recorded barrier to guardianship for the carer was concern about the carer's ability to maintain family contact — a matter that, where a child has been in stable long-term placement, the Department must be taken to know was being managed, and was not sufficient to justify the denial of a superior form of permanency to the child. These are not legitimate reasons to defer assessment. They are reasons to conduct it.[217]

8.3.3 Section 51VAA and the failure of mandatory review

The section 51VAA review is designed as a structural check on indefinite LTG-CE arrangements. In theory, this is the legislative mechanism that prevents children from remaining on LTG-CE indefinitely without the question of a better permanency option being revisited.

In practice, the mechanism is rarely operationalised. Of a sample of 100 children whose section 51VAA review fell due in 2025, only nine reviews were conducted.[218] Of the 61 children in foster or kinship care who did not receive the mandated review, 57% had been in their placement for more than three years, and 85% had been in placement for more than one year.[219] These are precisely the children for whom a review might have produced a better permanency outcome. The failure to conduct those reviews is a failure to comply with existing law. No accountability mechanism currently applies.

The design of section 51VAA compounds the compliance failure. The provision requires only one mandatory review, at the two-year mark. If that review does not produce an alternative outcome, the question of whether a better option is available need never be revisited, even if a child remains on LTG-CE for a further decade. A child's circumstances, placement stability and relationships evolve over time. The legislative obligation should require periodic review every two

[215] Transcript, Evidence of Corinne Porta (21 November 2025) 2482:11- 2482:26.
[216] Transcript, Evidence of Corinne Porta (21 November 2025) 2482:11- 2482:26.
[217] Department of Families, Seniors, Disability Services and Child Safety, Short term order expiry spreadsheet (1 July 2025 to 31 December 2025) (DFS.0394.0006.0001).
[218] Department of Families, Seniors, Disability Services and Child Safety, Spreadsheet of s.51VAA reviews (4 August 2026) (DFS.0394.0002.0001).
[219] Department of Families, Seniors, Disability Services and Child Safety, Spreadsheet of s.51VAA reviews (4 August 2026) (DFS.0394.0002.0001).

years for as long as a child remains on LTG-CE, not a once-only assessment that, in practice, is rarely conducted at all.

8.3.4 Aboriginal and Torres Strait Islander children and the guardianship gap

The evidence demonstrates a specific and troubling pattern: carers across different regions and circumstances reported being told they were ineligible to seek guardianship for their Aboriginal and Torres Strait Islander foster children because they themselves were non-Indigenous, even where the carer had been the primary caregiver for many years.[220] Practice panel notes reviewed by the Commission confirmed that assumptions of this kind have been made explicitly and applied as near-determinative factors.[221] Witness A confirmed that the Department is more proactive in pursuing guardianship options for non-Indigenous children than for Aboriginal and Torres Strait Islander children.[222]

There is no legislative basis for that position. The paramount principle applies to all children. Cultural connection and the Aboriginal and Torres Strait Islander Child Placement Principles are relevant considerations in the assessment of any permanency option; they are not a presumption against guardianship to a non-Indigenous carer regardless of the circumstances. The evidence discloses that these factors are being applied as decisive obstacles to the assessment itself, before any assessment has been undertaken. That is both legally incorrect and harmful to the children affected.

Murphy's case illustrates the consequences. Murphy is an Aboriginal child who spent eight years in the care of an experienced and committed foster carer. Within weeks of the LTG-CE order being made, the Department committed to assessing the carer as a prospective permanent guardian. No assessment was ever commenced. A practice panel convened before the assessment began declined to support it on the ground that kin had not yet been explored, a failure entirely of the Department's own making. At a later meeting, a Departmental manager stated on the record that she did not agree with permanent care orders for Aboriginal children being made to non-Aboriginal carers, and that this would not occur under her oversight. A Regional Director giving evidence to the Commission agreed that this raised serious concerns that privately held views were impermissibly influencing permanency decisions. At the time of hearing, eight years after Murphy came into the carer's care, no guardianship assessment had been undertaken.

[220] Department of Families, Seniors, Disability Services and Child Safety, Practice Panel Notes, s.51VAA review (1 August 2025) (DFS.0394.0001.0001) 2; Transcript, Evidence of Witness O (11 September 2025) 496:10-496:15.
[221] Department of Families, Seniors, Disability Services and Child Safety, Practice Panel Notes, s.51VAA review (28 February 2025) (DFS.0394.0001.0030) 1–7; Practice Panel Notes, s.51VAA review (13 August 2025) (DFS.0394.0001.0038) 1–13.

8.4 Adoption

8.4.1 A legislated option effectively mothballed

Adoption is the only permanency option that removes a child entirely from the child safety system. It is the only permanency option that results in an order that legally endures after the child turns 18 years of age. It provides lifelong and intergenerational belonging that no guardianship order can replicate.

In Queensland, no child has been adopted from State care since 2019. This is despite a decade of legislative mandates and repeated recommendations designed to boost adoption numbers from State care. The Carmody Inquiry recommended in 2013 that adoption be routinely considered and pursued, particularly for children under three years of age.[223] The then government accepted that recommendation. The recommendation was closed out in 2019 with an assertion by Government that it had been implemented. There had been, at that point, nine adoptions in the intervening five years. The Department's own principal legal officer accepted in evidence that the Department had not in fact done what was asserted, and that the Department 'could do better for all children.'[224] The Deputy State Coroner, in her 2020 findings into the death of Mason Jet Lee, found that the recommendation had not been implemented 'in any real sense' and made further recommendations. Legislative amendments followed. No adoptions have occurred since.[225]

The Director of Child Protection Litigation gave evidence that he had never been engaged to provide advice on adoption or to represent the Department in an adoption matter.[226] He reviewed case plans and legal submissions and was unable to find any reference to adoption in applications for LTG-CE orders. A statutory pro forma question on whether a parent had considered adoption had, in each case reviewed, been answered in the negative. There was no evidence that the question was being explored by the Department with the parents in any meaningful way.

For the Department to make an adoption application in respect of a child subject to a child protection order, the Chief Executive must be satisfied that adoption is an appropriate way of meeting the child's need for long-term stable care.[227] That precondition is not being reached because adoption has not been entering the conversation at all. The Adoption Practice Manual

[223] Queensland Child Protection Commission of Inquiry, Taking Responsibility: A Roadmap for Queensland Child Protection (Final Report, June 2013) 221–227.
[224] Transcript, Evidence of Clair Martin (4 February 2026) 3977:4–3980:10.
[225] Findings of the Inquest into the death of Mason Jet Lee (Coroners Court of Queensland, Deputy State Coroner Bentley, 2 June 2020) [945]–[946], [953].
[226] Transcript, Evidence of Nigel Miller (10 December 2025) 3490:3–3491:40.
[227] *Adoptions Act 2009* (Qld) s 178.

sits outside the Child Safety Practice Manual, meaning that its contents are not routinely known by Child Safety Officers in their day-to-day role. Adoption has been, in effect, institutionally invisible.

8.4.2 The legacy of forced adoption

The frank evidence of the Department's own principal legal officer was that there is, within the Department, reluctance to considering adoption unless 'deemed appropriate' by a practitioner, or unless it is directed or supported by the family; and that the reason for this was to be reflective about Queensland's historical forced adoption practices and the 2012 apology.[228] The Commission does not minimise the gravity of any historical wrongs. However, an institutional disposition against future adoption, even where adoption would genuinely serve the best interests of a particular child, is not a consequence that the apology was intended to produce. Permanency planning is not an opportunity for the Department to demonstrate institutional contrition about historical wrongs. It is the legal and practical mechanism by which the State discharges its obligation to a particular child in front of it, and whose best interests are paramount. Allowing historical wrong to foreclose present obligation substitutes one form of harm for another.

Contemporary adoption in Queensland operates within a fundamentally different legal and ethical framework: it is characterised by openness, judicial oversight, and a focus on the child's lifelong best interests. That distinction must be clearly understood by practitioners. Without it, historical harms will continue to foreclose consideration of adoption in circumstances where prolonged impermanence may itself cause lasting harm to children who cannot go home.

8.4.3 Simple adoption and integrated birth certificates

The only form of adoption available under the *Adoptions Act 2009* (Qld) is plenary adoption: it severs the legal relationship between the child and their birth parents, creates a new legal relationship with the adoptive family, and replaces the child's original birth certificate. The Commission received submissions from people with experience of forced adoption for whom that legal excision has had lasting consequences. It received evidence from practitioners and carers for whom this is an ethical barrier to pursuing adoption. It received evidence from birth parents for whom the prospect of permanent legal severance is the reason they will not consent.[229]

[228] Transcript, Evidence of Clair Martin (4 February 2026) 3979:43–3980:10.
[229] Kathleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 5–8; Jigsaw Australia, *Submission to Child Safety Commission of Inquiry* (25 March 2026) 3–11.

Professor Kathleen Gribble's 2018 'Belonging in Two Families Study', the first Australian research to canvas the views of people with lived experience of out-of-home care and adoption as legal frameworks for permanency, found broad agreement across groups that the creation of an enduring legal membership in the caregiving family was valued, but the permanent legal severance from the birth family was not.[230] Simple adoption, available in many international jurisdictions and contemplated to a limited extent within the *Adoptions Act 2009* (Qld) itself, addresses both concerns simultaneously: it creates full legal parenthood in the adoptive family while preserving the child's legal relatedness to the birth family. The child loses nothing; and gains a permanent legal family. The Commission considers that the feasibility of simple adoption, and of integrated birth certificates that reflect the practical reality of children who belong in two families, warrants serious and urgent examination.

8.4.4 Adoption and Aboriginal and Torres Strait Islander children

The permanency hierarchy in section 5BA places adoption as the last preference for Aboriginal and Torres Strait Islander children.[231] The Child Safety Practice Manual states that adoption is unlikely to uphold the rights of Aboriginal and Torres Strait Islander children and their families or to enable the Department to fulfil its ATSICPP obligations. The evidence before the Commission indicates that adoption is, in practice, never considered for Aboriginal and Torres Strait Islander children regardless of individual circumstances and the operation of the paramount principle.

The Commission acknowledges the significant concerns held by Aboriginal and Torres Strait Islander community organisations about adoption, grounded in the history of forced removal and the importance of identity and cultural connection. However, the current effect of the permanency hierarchy and its practical application is that Aboriginal and Torres Strait Islander children are, on the basis of race, denied the opportunity for the most permanent legal and relational connection available under Queensland law, without any individualised assessment of whether that option might serve their best interests.[232] That position sits in tension with the paramount principle. Due to overrepresentation, Aboriginal and Torres Strait children are more exposed to the instabilities of the child safety system over longer periods, with fewer legal tools to interrupt that trajectory. Reform in this area requires great care, consultation and sensitivity. It also requires honesty about the current consequences of inaction.

[230] Kathleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 6–8.
[231] *Child Protection Act 1999* (Qld) s 5BA(4)(e); Department of Child Safety, Seniors and Disability Services, Child Safety Practice Manual – Permanency (Practice Guide, 18 June 2025) 37.
[232] Kathleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 4.

8.5 Corporate Parenting and the Youth Justice Interface

8.5.1 The dual order cohort

A dual order youth is a child who is simultaneously the subject of a youth justice supervision order and an active child protection order. On any given day, this cohort comprises between 24% and 28% of Queensland's total youth justice client load.[233] When expanded to include all young people under youth justice supervision who had any prior contact with the child safety system in the preceding ten years, that figure rises to 72.9%, the highest number nationally and the second highest proportion in any Australian jurisdiction.[234]

Of 388 serious repeat offenders aged 10 to 17 in Queensland, as at September 2024, 111 were subject to a child protection order.[235] The 2024 Child in Care Census data makes the demographic picture stark. Dual order youth are at least twice as likely as other children in care to have experienced every significant negative indicator: 91% have self-placed at least once, compared to 29% of other children in care; 77% have had four or more placements, compared to 37%; 72% have been excluded from an educational facility, compared to 25%; and 61% have limited to severely limited intellectual functioning or developmental delay, compared to 31%.[236] Acting Director-General Michael Drane confirmed that, in many cases, the first time a dual order youth with a typical disability profile receives a comprehensive health assessment, diagnosis and support services is upon entering youth detention, at an average age of approximately 16.[237] He described that as 'a sad indictment'. The Commission concurs.

8.5.2 The care-to-custody pipeline

The entry of children in care into the youth justice system is not random. The evidence before the Commission identifies a set of systemic conditions, each recurring and in most cases amenable to reform, that create and sustain the dual order and cross-over cohorts.

Placement instability and permanency failure. Placement stability is one of the strongest and most consistent predictors of youth justice involvement for children in out-of-home care. Instability disrupts attachment and trust; each placement move reinforces feelings of rejection and abandonment; and children in unstable placements are more likely to enter residential care,

[233] Queensland Family and Child Commission, *Crossover Cohort: Young People under youth justice supervision and their interactions with the child protection system* (Fact Sheet, November 2024) 2.
[234] Australian Institute of Health and Welfare, *Young people under youth justice supervision and their interaction with the child protection system 2022–23* (Report, 25 October 2024).
[235] Department of Children, Youth Justice and Multicultural Affairs, 'Queensland's most serious young criminals housed in Labor's broken State care system' (Media Statement, 19 May 2025) <https://statements.qld.gov.au/statements/102584>
[236] Department of Families, Seniors, Disability Services and Child Safety, Child in Care Census (2024) (dual order cohort data).
[237] Transcript, Evidence of Michael Drane (23 February 2026) 4448:36–4449:36.

where the criminalisation of behaviour is well-documented. YP's case illustrates the direct trajectory from care to criminal offending. He cycled through 20 foster carers by age nine. A Departmental assessment recorded his acute need for permanency and stability. The LTG-CE order was not made until close to a decade after he entered care, and there is no evidence that his foster carers were ever assessed as potential long-term guardians. By the time his final foster placement broke down following an unsubstantiated harm report at age 13, he never again experienced stability. He soon spiralled into self-placing and criminal offending.

Residential care and the criminalisation of behaviour. Previous inquiries, in Queensland and across comparable jurisdictions, have consistently identified residential care as a major driver of the dual order cohort. The children in residential care are criminalised through police call-outs for behaviour that would, in a family home, be managed by a parent: verbal aggression, property damage, emotional dysregulation linked to trauma, and refusal to comply with house rules. Between 1 July and 30 September 2025, there were 228 calls for service to residential care facilities in a single district.[238] Luke Twyford, Principal Commissioner of the Queensland Family and Child Commission gave evidence that children with trauma backgrounds who do not receive appropriate therapeutic intervention in childhood are likely to exit the care system as angry, confused young adults whose behaviour is frequently associated with mental health problems, addictions and criminal activity.[239]

Disability undiagnosed and unmet. Neurodevelopmental disability, including FASD, ADHD, autism spectrum disorder, intellectual disability, acquired brain injury and complex trauma-related neurocognitive impairment, is one of the strongest predictors of a child in care entering the dual order cohort. The care system's failure to identify and respond to these needs means that the behaviour driven by disability is managed as a conduct or placement problem rather than a clinical need. By the time a diagnosis is made, often, as Mr Drane noted, at first entry into detention, the opportunity to alter the trajectory has narrowed or closed.[240]

8.5.3 Self-placing, survival crime and financial abandonment

When a child disengages from placement and begins self-placing, the corporate parent's practical capacity to discharge its obligations is severely diminished. The July 2025 census of children in out-of-home care, ordered by this Government following media reports that 780 children were missing from placements, found that 594 children had no current placement open

[238] Transcript, Evidence of Witness D (19 September 2025) 1285:9-1285:14; Statement of Luke Twyford (28 November 2025) [3.72]; Transcript, Evidence of Aimee (16 February 2026) 4128:43-4128:45.
[239] Statement of Luke Twyford (28 November 2025) [3.72].
[240] Transcript, Evidence of Michael Drane (23 February 2026) 4449:31-4449:36.

and that the location of 93 children was unknown. The youngest child with no current placement open was eight years old.[241]

Financial supports that flow through an authorised placement cease when a child self-places. The only alternative mechanisms are discretionary Departmental assistance and Centrelink youth allowance, the latter of which has an age threshold many self-placing children do not meet.[242] The Commission's examination of YP's case showed that during periods of self-placing, a prescribed home visit resulted in a $50 Woolworths voucher and a sports equipment voucher. His request for clothes was deferred for approval because he had received clothes the previous month. The predictable consequence, that a child below Centrelink age, in (nominal) State care, with no financial means while self-placing, faces a survival-driven imperative to offend, is a foreseeable product of a system that has abandoned a child it remains legally responsible for.

Aimee's evidence illustrates how self-placing and financial abandonment create conditions of sexual exploitation and survival crime.[243] Effectively homeless from age 12, Aimee couch-surfed and, on at least one occasion, slept in a skip bin for warmth. A Child Safety assessment at age 15 described her as 'at risk of harm due to her own deceitful and transient behaviour' and capable of self-protecting, while simultaneously acknowledging her family's extensive child protection history. Because she was subject to a child protection order, she was ineligible for funded homelessness services. The order that was meant to protect her barred her from the safety nets available to other homeless young people. She was sexually exploited within a licensed residential care placement and outside it. She was charged with trespass for sleeping in locked public spaces, possession of methamphetamine for handing her drugs to a residential care manager, and offences arising from survival in conditions the system had placed her in. She pleaded guilty to every charge because, she said, no one had ever told her she was allowed to plead not guilty. In her words: 'I was criminalised for the State's failure to intervene and provide me with a safe placement with access to food and basic amenities.'[244]

The Commission also notes the enduring lesson of Tiahleigh Palmer's disappearance and death in 2015 and the QFCC's subsequent systems review, *When a Child is Missing*.[245] The absence of a child from their placement is a child safety issue, not a compliance issue. It requires urgent, coordinated, multi-agency response. The Acting Chief Practitioner acknowledged that attempts to locate YP during periods of self-placing were sporadic, that enduring attempts to locate him

[241] Data provided pursuant to NTP 28 (July 2025 census).
[242] Statement of Bernadette Harvey (27 March 2026) [52]–[53]; Department of Families, Seniors, Disability Services and Child Safety, *Child Related Costs – Child and Young Person Support* (Child Safety Procedure 645.4-2, 24 June 2021).
[243] Transcript, Evidence of Aimee (16 February 2026) 4127:10 – 4128:41, Transcript, Evidence of Aimee 4124:2–4124:4.
[244] Transcript, Evidence of Aimee (16 February 2026) 4124:2-4.
[245] Queensland Family and Child Commission, *When a child is missing – Remembering Tiahleigh* (Systems Review, 2016).

were not made, and that only one missing person report was recorded across the entire relevant period, contrary to procedural requirements.[246] That pattern is not consistent with the obligations of a corporate parent.

8.5.4 Motel and emergency placements

In the absence of appropriate regulated placements, the Department uses commercial hotels, motels, caravan parks and Airbnbs to house children in care. It relies on section 82(1)(f) of the Act to authorise this practice. The legislative provision was introduced in 2005 for a narrow purpose: to enable placement in a facility regulated by another government agency where a child's particular needs could not be met by the range of approved care options. The Explanatory Notes expressly provided that the provision was not intended to be used as a means of circumventing the regulatory framework for approval of carers.[247] The Department treats commercial motel accommodation as a default emergency option.

Motel placements are characterised by isolation, lack of supervision, limited access to support services, and the absence of the relational care that children require. The risks they create are not theoretical. Data obtained by the Commission from the South West region recorded that 48 children entering care were initially placed in emergency placements, and that 17 children were placed in emergency placements on release from watch houses or youth detention centres.[248] The direct link between motel placement and re-offending is illustrated by YP's case: after his first detention centre stay at age 15, he was released to a commercial motel placement; and Queensland Police Service records show he was committing burglaries during that period. The use of commercial accommodation as an emergency placement reflects a failure of system capacity and planning, not a safe or appropriate care response. Its use must be the exception, not the rule, and must be eliminated entirely for young people exiting detention.[249]

8.5.5 Transition from detention to the community

The transition from detention back to the community is a critical risk point for dual order youth. Approximately 90% of young people in youth detention on any given day are held on remand. Bail applications can arise without notice. Once in custody, a young person is not prioritised for a placement until after the court decides to release them. When they are released, the urgency of the court's decision leaves no time for considered placement planning. The placements available, if any, may include commercial motel accommodation that, as discussed above,

[246] Statement of Victoria Van Houdt (13 March 2026) [66]–[68].
[247] Child Safety Legislation Amendment Bill 2005, Explanatory Notes, s 20; Statement of Victoria Van Houdt (20 February 2026) [5].
[248] Data obtained pursuant to NTP 296 (South West Region, 1 July 2024 to 6 February 2026); Department of Families, Seniors, Disability Services and Child Safety, Notice to Produce 9 on a Critical Incident Report (24 July 2025) (DFS.0296.0001.2002).
[249] Transcript, Evidence of Michael Drane (23 February 2026) 4457:21–26, 4460, 4463–4464.

exposes the young person to conditions directly associated with further offending.[250] That is a circular and dysfunctional result. It is also a known and recurring one. The system's continued inability to respond to the predictable discharge of young people from detention is a structural failure of basic corporate parenting responsibility. Transition planning must occur before release, not after.

8.5.6 Girls in care: sexual exploitation

Girls in the cross-over cohort are particularly vulnerable to sexual exploitation. Commission analysis of critical incident reports found that approximately 67% of reported incidents of sexual abuse of children in care involve children placed in residential care, and approximately 40% of all reported instances occurred while the child was absent from placement. One incident report records the rape of a child by a youth worker while placed in emergency accommodation.[251] Aimee's case demonstrates the multi-layered nature of this exploitation and the absence of any coordinated agency response. She was sexually abused by a youth worker at a licensed residential care placement; there was no information-sharing mechanism between providers, Blue Card Services and the National Redress Scheme, and this failing allowed the perpetrator to remain employed in the sector despite disciplinary findings. When she called her residential care service from a motel where she was being sexually exploited, the request to be collected was refused on the basis that doing so would amount to 'enabling child prostitution.'

The Commission considers that a targeted, gender-responsive strategy for girls in out-of-home care at risk of sexual exploitation is both necessary and overdue. The system continues to respond to this cohort with generic placement and casework models that are plainly inadequate.

8.5.7 The accountability gap

Where a child under the guardianship of the State causes serious injury or death to a member of the public, the question of what the State as corporate parent knew, did, and failed to do is directly relevant. In YP's case, no review of the Department's processes or conduct followed the significant offending event which had tragic results for a member of the public. The reason given in Regional Executive Director Leanne Black's statement, and confirmed in evidence, was that the qualifying trigger for a review, the death of or serious injury to a child, had not been met.[252]

The Commission regards the current trigger as inadequate. An internal review of the Department's conduct in caring for a child does not impinge on and cannot prejudice criminal

[250] Statement of Kate Connors (1 September 2025) [30], [53]; Statement of Michael Drane (12 February 2026) [31(b)].
[251] Department of Families, Seniors, Disability Services and Child Safety, Notice to Produce 9 on a Critical Incident Report (24 July 2025) (DFS.0296.0001.2002).
[252] Transcript, Evidence of Leanne Black (19 February 2026) 4386; Statement of Leanne Black (13 January 2026) [20].

proceedings, which concern entirely different questions. Ms Black ultimately accepted that there would be value in reviewing any significant outcome involving a child in care. The Commission agrees, and considers that such a review should be mandatory and without threshold. A system that does not review its conduct when it has the most direct reason to do so is a system that cannot learn from its failures.

8.6 Summary of Principal Recommendations

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 5: Corporate Parenting and the Youth Justice Interface and in the Compendium of Recommendations.

- **Recommendation 37:** Feasibility of simple adoption and ways to boost adoption
- **Recommendation 38:** Amend permanency hierarchy
- **Recommendation 39:** Full consideration of permanency options for all children
- **Recommendation 40:** Improving permanency through guardianship
- **Recommendation 41:** Reviews incidents harming community members
- **Recommendation 42:** Using hotels and motels as emergency accommodation
- **Recommendation 43:** Strategy to prevent exploitation of girls in residential care

8.7 Conclusion

The State's responsibilities as corporate parent are discharged — or they are not — through every decision made about that child from that point forward: about where they live, who cares for them, whether a suitable guardian is sought, whether adoption is considered, whether disability is diagnosed, whether there is a plan when they leave detention, and whether the system reviews its own conduct when care fails with catastrophic consequences.

The evidence on permanency is unambiguous. Over 80% of long-term guardianship orders are sought to the Chief Executive, the last resort in the statutory hierarchy, in a pattern so consistent and so persistent that it cannot be attributed to individual error or workforce pressure alone. It is a settled feature of practice. Children who are in stable, long-term family-based placements are not being considered for the guardianship that would give that care a permanent foundation. The section 51VAA review mechanism, which exists precisely to prevent children from remaining on LTG-CE indefinitely, is not being used. Fewer than 10% of children in the Commission's sample received the review the law requires. The legislation has not been sufficient to change practice.

Structural compulsion is required, and the reforms recommended in this chapter are designed to provide it.

The evidence on adoption is equally clear, and more troubling for what it reveals about institutional culture. No child has been adopted from State care in Queensland since 2019. This is not a consequence of legal barriers or individual case complexity. It is the consequence of a department that has, over a decade and in defiance of its own legislation, its own repeated commitments and multiple external recommendations, allowed adoption to become institutionally invisible. The fear of repeating historical wrongs is a legitimate concern. It is not a licence to deny children who cannot go home the opportunity of lifelong legal belonging. The Commission recommends a fundamental reorientation of practice, and the examination of simple adoption and integrated birth certificates as legal models better suited to contemporary understandings of identity, openness and relational permanence.

The evidence on the youth justice interface discloses a care-to-custody pipeline that is foreseeable, documented and preventable. The pathway runs through placement instability, residential care without therapeutic capacity, self-placing without financial support, motel placements that expose children to conditions directly associated with criminal offending, and a transition from detention that occurs without a plan. Each of these conditions is identifiable. Each is amenable to reform. YP's case and Aimee's case are not outliers. They are illustrations of what the data describes: a system that has failed to provide the nurturing, stable and lawful care that children in its guardianship deserve, and that has not been required to account for the consequences.

That accountability gap must be closed. A corporate parent that is not required to review its conduct when a child in its care causes serious injury or death to a member of the public is a corporate parent that cannot learn from its failures. That is not an acceptable position for the State.

The reform task in this chapter is straightforward in conception, even if challenging in execution: give the permanency hierarchy practical effect; restore adoption to its lawful place; address the structural conditions that drive children from care into custody; and ensure the State is held to account when it falls short. The children whose evidence the Commission received have been clear about what they need. It is imperative that we keep faith with these children and deliver the change they need and deserve.

Chapter 9

Complaints

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 9: Complaints

9.1 Introduction

This chapter distils Companion Report 6: Complaints Systems, on complaints within Queensland's child safety system. It examines the role of complaints as a core element of the safeguarding and accountability architecture and considers whether the current framework enables concerns to be heard, assessed and acted upon in a way that protects children and supports improvement.

The Commission approaches complaints on the basis that they are not merely administrative processes. Within a system that exercises significant authority over the lives of children and families, complaints are one of the primary mechanisms through which concerns can be raised, decisions can be reconsidered, and risks can be identified and addressed.

The importance of complaints was recognised from the commencement of the Commission, with a specific call for submissions on complaints within the child safety system yielding 20 specific submissions. Notably, however, of the 1193 total submissions received by the Commission, dissatisfaction with how the Department receives, assesses and responds to complaints was a recurring theme.

9.2 Why complaints matter in child protection systems

Complaints are a standard feature of public administration. However, in the context of child protection, they perform a broader and more critical role. A complaint may reveal that a decision has had unintended consequences, that a service is not meeting a child's needs, or that a response to known risk has been inadequate. In some cases, it may be the first indication that a child's circumstances are deteriorating. For that reason, complaints operate not only as a mechanism for resolving individual concerns, but as part of the system's safeguarding infrastructure.

Complaints serve two interrelated purposes.

First, they provide a means of individual review and resolution. Children, families and carers may use complaints processes to question decisions, seek clarification, or request action where they believe a child's needs are not being met.

Second, they function as a signal to the system. Patterns of complaints may reveal recurring issues that are not visible through other monitoring mechanisms. They may include delays in

accessing services, placement instability, communication failures or gaps in support. When systematically captured and analysed, complaints can inform policy reform, practice development and resource allocation.

The effectiveness of this dual function depends on whether people feel able and safe to raise concerns, and whether the system is capable of hearing and responding to them.

9.3 Historical and legislative context

Concerns about the operation of the child safety complaints system are not new. Over more than two decades, successive inquiries and reviews, including the Forde Inquiry, the Crime and Misconduct Commission Report, the Child Protection Commission of Inquiry and investigations by the Queensland Ombudsman, have identified recurring issues in the way complaints are recognised recorded, escalated and resolved.[253]

These reviews have led to incremental reform, including changes to oversight arrangements and internal processes. However, the persistence of similar concerns over time suggests that the issues are not simply procedural. They reflect deeper challenges in the design of the complaint's framework itself.

This context is significant. It demonstrates that the current system is the product of successive adaptions, rather than a purpose-designed complaints architecture aligned to the specific demands of child protection.

9.4 Understanding the current complaints system

The present complaints framework broadly follows a conventional model of internal resolution with external oversight. Complaints are initially managed within the Department. Where concerns are unresolved, they may proceed through internal review processes and, ultimately, to external oversight bodies such as the Queensland Ombudsman or other integrity agencies.

Within this structure, a large proportion of concerns are addressed through local resolution mechanisms, particularly the First Attempt at Resolution (FAAR) process.

At a structural level, this framework appears consistent with standard administrative practice. However, the child safety system is characterised by multiple decision-makers, funded service

[253] Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry) 1999, Protecting children: an inquiry into abuse of children in foster care (Crime and Misconduct Commission) 2004, Queensland Child Protection Commission of Inquiry (Carmody Inquiry) 2013, Management of Child Safety Complaints Report (Queensland Ombudsman) 2016, Management of Child Safety Complaints – Second Report (Queensland Ombudsman) 2020.

providers and overlapping oversight bodies. As a result, complaint pathways are not singular or linear. They vary depending on the nature of the concern and the entity involved. The Commission concluded that in practice the complaints system is fragmented. Individuals raising concerns must often navigate:

- different complaint processes for the Department and service providers
- multiple internal stages before reaching external review
- uncertainty about whether their concerns qualify as a complaint, or how it will be classified.

This complexity places responsibility on complainants to understand and move through the system, rather than on the system to respond clearly and coherently to the concern. For many individuals, particularly those experiencing vulnerability, trauma or power imbalance, these barriers are significant.

9.4.1 Complaint pathways and local resolution

The FAAR process is central to the current system, and is intended to support early, local resolution of concerns, often by referring the matter back to the operational area responsible for the decision or service. While early resolution can in many cases be appropriate, its operation within the current framework raises important issues. The Commission heard that a substantial proportion of concerns are managed through FAAR and are not recorded as formal complaints. Matters may be considered 'resolved' where they do not proceed further, rather than on the basis that the underlying concern has been substantively addressed.[254]

This approach limits visibility of concerns at a system level and reduces the system's ability to identify patterns or recurring issues.

9.4.2 Flaws in the current approach

A consistent theme in the evidence is the perceived lack of independence within the complaints process. Complaints are frequently referred back to the same operational teams responsible for the original decision. Even where this reflects established process, it can undermine confidence in the neutrality of the outcome and discourage further escalation.

The current framework places a significant burden on individuals raising concerns. Complainants may be required to raise concerns repeatedly, navigate multiple stages of internal

[254] Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3094.

review or persist over extended periods to achieve a response. For children in care, families and carers, this burden can be difficult to sustain, particularly where they remain dependent on the system for ongoing support or decision-making.

The Commission also heard that fear of negative consequences may deter individuals from raising complaints. Given the imbalance of power within the system, parents, carers and staff may perceive risks in challenging decisions or raising concerns. These dynamics can suppress complaints and limit the flow of information necessary for effective safeguarding.

The current system does not consistently function as a mechanism for learning. Concerns may be inconsistently classified or recorded, resolved without central visibility or separated across multiple reporting systems. As a result, opportunities to identify recurring themes and improve practice are diminished.

Finally, a central weakness in the current framework is the absence of a clear and credible pathway for independent escalation of complex concerns. Courts and tribunals review only a limited subset of decisions. External oversight bodies focus on administrative fairness or systemic issues, rather than case-specific merits. Many day-to-day case management decisions, with significant consequences for children, are therefore reviewed only through internal processes. This creates an accountability gap within the broader system.

9.4.3 Conclusions about the current system

The Commission is satisfied that the current complaints framework is not functioning effectively as a safeguarding or accountability mechanism. It does not consistently provide an accessible and navigable pathway for raising concerns, timely and proportionate responses, independence in the review of serious matters, system-wide visibility of issues or a reliable basis for learning and improvement. The persistence and consistency of these issues across submissions and the evidence before the Commission indicate that the shortcomings are systemic rather than isolated.

9.5 The future for complaints management

The evidence before the Commission points to the need for a fundamental shift in how complaints are understood within the child safety system. Complaints must be recognised as a core system function, integral to safeguarding, accountability and system learning, rather than as a peripheral administrative process.

9.5.1 Design principles for reform

A redesigned complaints system must be capable of responding to the realities of child protection practice. This requires alignment with a set of underlying design principles.

- It must be accessible and safe to use, ensuring that children, families and carers can raise concerns without undue burden or fear of consequence
- It must provide credible independence where required, so that serious or unresolved matters can be assessed outside the structure responsible for the original decision
- It must be timely and responsive, recognising that delay may allow risk to escalate
- It must be child-centred, ensuring that the voices of children and those advocating for them are heard and taken seriously
- It must support learning and transparency, so that complaints contribute to improved practice and system performance over time.

These principles are not abstract. They reflect the fundamental functions that a complaints system must perform if it is to operate effectively as part of the child safety system's safeguarding infrastructure.

9.6 Summary of the Recommendation

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 6: Complaint System and in the Compendium of Recommendations.

- **Recommendation 44:** Independent child safety complaints and escalation framework

9.7 Conclusion

Complaints are one of the primary ways in which the child safety system hears from those it is intended to protect. The current framework does not consistently enable those voices to be heard, nor does it provide a clear and credible pathway for concerns to be assessed and acted upon.

Reform is therefore required to ensure that the complaints system can fulfill its role as both a safeguard and a source of system learning. A redesigned framework, grounded in the principles identified in this Report, would strengthen accountability, improve responsiveness and enhance the system's capacity to protect children and support families.

Chapter 10

Enablers of an Effective Child Protection System

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 10: Enablers of an Effective Child Protection System

10.1 Introduction

> 'Queensland cannot reform its way out of this crisis by doing more of the same, even if trying to do it better.'[255]

As noted in Chapters 1 and 2, Queensland's child safety system has been repeatedly examined, reviewed and reformed. Many of the issues now before the Commission are not new. Their persistence points to a deeper problem: the system has not been configured to implement reform, sustain it over time, and adjust its course when the evidence reveals unintended consequences or shows that children and families are not being well served.

This chapter distils the Commission's examination – presented in Companion Report 7: System Enablers – of the conditions that sit beneath, and affect, the visible operation of Queensland's child safety system. The Companion Report examines five categories of system enablers: (i) system design, structure and the operating model; (ii) leadership, governance and accountability; (iii) workforce, culture and practice capability; (iv) funding, commissioning and market design; and (v) information, technology, feedback and learning systems.

The purpose of this chapter is to identify the principal matters from the Companion Report that inform the Commission's findings and recommendations.

The Commission uses the term 'enablers' to describe the underlying factors and conditions that determine whether the child safety system can perform its functions coherently and consistently. These factors and conditions influence and shape how authority is exercised, how responsibility is allocated, how services are commissioned, how information is used, and how reform is implemented. They affect the experiences of children, families, carers, workers and providers within the system.

The evidence before the Commission indicates that in Queensland many of the current enabling conditions are poorly aligned with the intended outcomes of the system. Functions are distributed across roles, regions, providers and other human service systems. Accountability is dispersed. Frontline workers are expected to perform complex relational, statutory and legal work in conditions shaped by high workload pressure, turnover and compliance demands. Funding

[255] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026).

and commissioning arrangements have too often been focused on securing immediate capacity in response to placement pressure. Data is collected in substantial quantities, but is not consistently converted into intelligence information, learning and corrective action.

Earlier inquiries, reviews and oversight reports have identified similar concerns about fragmentation, variable practice, workforce pressure, the growth of residential care, weak and purposeless information flows, insufficient outcome measurement and the uneven implementation of reform.[256] The recurrence of those concerns suggests that the problem is not only that particular reforms were incomplete, delayed or insufficiently effective; it also suggests that the system's underlying architecture has not been strong enough to support effective reforms.

The recommendations arising from this analysis in this chapter are summarised near the end of the chapter. They address whole-of-system outcomes and accountability; ministerial and cross-government responsibility; the redesign of the department, including the roles of its officers; disciplined reinvestment and commissioning; and consideration of a proactive child protection inspectorate. Collectively, the recommendations are directed to the factors and conditions that will determine whether reform to the child safety system can be implemented and sustained.

10.2 Why enabling conditions are central to reform

The Commission's focus on enabling factors and conditions arises from the pattern of the failed reform disclosed in the evidence. There has been no shortage of reports, reviews, strategies, frameworks or reform programs in Queensland: The more difficult question is why known problems have persisted despite repeated attempts to address them.

The evidence suggests that previous reform efforts have too often addressed the visible signs of system failure, without sufficiently changing the factors and conditions that have produced and reproduced it. Child safety reform in the past has usually been aimed at practical objectives: earlier help and support for families, safer decisions, more stable family-based care, better residential care, stronger cultural connection, more effective transition from care, and improved responses for children with complex needs. Each objective depends on the factors and conditions required to deliver it in practice.

[256] See, for example, Leneen Forde, *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (Report, May 1999); Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013); Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026); Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025); Queensland Family and Child Commission, *Too little, too late: The progress made against the Queensland residential care roadmap* (Report, December 2024).

For example, family-based care depends on available and supported carers, suitable services, timely therapeutic and disability supports, effective family engagement, clear responsibility for ensuring stable placements, and reliable information about emerging stress. Residential care reform depends on commissioning that shapes the market toward required care models, contracts that specify quality and outcome expectations, oversight that tests and ensures the care children actually receive, workforce settings that enable and support relational care, and information that shows whether children are safe, stable and supported. Transition from care depends on the availability of housing, health services, disability services, education, employment pathways and ongoing adult relationships, many of which sit outside the child safety portfolio.

Implementation is therefore a crucial part of reform design. A recommendation must be capable of being carried out through reform of the structures, roles, funding arrangements, governance mechanisms, information systems and workforce conditions that determine whether it changes practice. Misalignment at any of those points most likely will result in reform activity that does not improve children's experiences of care or transition from care.

This is especially important in child safety, where the consequences of system failures often accumulate over time. These may arise from delayed responses, incomplete records, unresolved concerns, poor communication between systems, unstable placements, workforce turnover, weak supervision, unclear authority, or unavailable services. A system that focuses only on the final point of failure will not reliably identify the factors and conditions that allowed the failure to develop.

The five enabling domains examined in Companion Report 7: System Enablers are therefore central to the Commission's analysis and proposals for reform. Structure determines how responsibility is held as children move across functions, regions, providers and other systems. Leadership, governance and accountability determine who must act when risks emerge and whether reform is properly implemented. Workforce, culture and practice capability determine whether practitioners can exercise judgement, build relationships and sustain effective practice. Funding, commissioning and market design determine which services exist and how providers behave. Information, technology, feedback and learning systems determine whether the State can see what is happening and correct course.

These domains operate together. The State's task is to create the conditions in which change can be implemented, tested and sustained. Without those conditions, Queensland will remain

vulnerable to the cycle that has led to this Commission of Inquiry: known problems, partial reform, renewed pressure, and further evidence that the system has not changed enough.

10.3 Structural design and the continuity of responsibility

Chapter 1 of Companion Report 7 provides a detailed analysis of the organisational design, structure and operating model of the child safety system. The issue examined in this chapter of the Executive Report is narrower: the present structure does not consistently maintain clear responsibility for children as they move through the system, across regions, between providers, and into other human service systems.

The core functions of Queensland's child safety system are widely distributed – these functions include intake, assessment, ongoing intervention, litigation, placement coordination, carer engagement, permanency, transition from care, commissioning and provider oversight. Services are delivered through regional structures across a geographically large and diverse State. Non-government organisations provide a substantial proportion of direct support and care, including family support, foster and kinship care support, and residential care. The system also depends on other systems to meet the needs of children, including the health, mental health, disability, education, housing, policing and youth justice systems.

Each of those arrangements has a clear rationale. Functional distribution can support specialisation. Regional delivery draws on local knowledge and is more responsive to local circumstances. Non-government providers can bring community connection, cultural capability and additional service capacity. Other human service systems provide expertise and take statutory responsibility for matters outside the Department's direct control. The major challenges arise at the points where those arrangements must join together around the life of one child.

Children and families experience the system across those joins. A child may move from investigation to ongoing intervention, from one team to another, from one placement to another, from family-based care to residential care, from a regional service centre to a provider, and from the child safety system into health, education, disability or youth justice processes. At each point, information must be transferred, decisions must be understood, relationships must be rebuilt, and responsibility must remain clear. The evidence before the Commission indicates that this continuity is not consistently maintained.[257]

[257] See Companion Report 7: System Enablers, Chapter 1. See also evidence of children and carers describing repeated transitions, changes in workers and loss of relational continuity.

The Child Safety Officer (CSO) role illustrates the structural problem. CSOs are expected to assess risk, support families, engage with children and carers, prepare or contribute to court material, coordinate services, respond to issues about unstable placements, document decisions and work across other service systems. These functions require different forms of professional engagement including relationship building, investigation and evidence, coordination, and rapid response to crisis. The manner in which these functions are aggregated in one key frontline role illustrates how the complexities of the broader system are concentrated at the point of practice.

The litigation interface is another point at which structure has an impact on processes within the child safety system. The current model separates responsibilities for legal advice, litigation decision-making and casework across different entities and professional frameworks. Those issues are considered in greater detail in the next section and in Companion Report 7. For present purposes, they illustrate how structural separation can affect the child's pathway, family participation and timely decision-making.

The way in which services are delivered at regional level creates a different structural tension. Queensland's geography requires local responsiveness. The circumstances of children and families in metropolitan, regional and remote communities differ materially. Local relationships with Aboriginal and Torres Strait Islander communities, service providers and carers are important. At the same time, regionalisation can result in differences in the services that are available, the stability of the workforce, and the nature and quality of decision-making and implementation of policy. Some variation is appropriate and necessary, but it becomes unacceptable where it affects children's access to support, the quality of decision-making or the stability of outcomes.[258]

The practice of outsourcing the delivery of services to the non-government sector creates another point of structural risk. The Department retains statutory responsibility for children, while providers deliver much of the day-to-day support and care. This requires commissioning, contracting and oversight arrangements that align provider conduct with the Department's responsibilities as corporate parent. The evidence indicates that this alignment is uneven. In residential care, for example, regional officers may carry responsibility for placement decisions while contract, licensing and service agreement oversight sits elsewhere in the system.[259] That

[258] Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 30; Transcript, Evidence of Corinne Porta (20 November 2025) 2475:4-2475:14; Transcript, Evidence of Witness AB (12 September 2025) 581:18-581:19.
[259] Transcript, Evidence of Corinne Porta (20 November 2025) 2598:4-2598:11.

separation limits the ability of those responsible for children's day-to-day outcomes to control the levers that shape the quality and availability of care.

The involvement of many human service systems compounds the problem. Children and families involved with child safety often require support from the mental health, disability, education, housing, policing and/or youth justice systems. These systems have separate thresholds, mandates, funding arrangements and accountabilities. The evidence shows that coordination often depends on local relationships, persistence and goodwill. Former PeakCare CEO, Tom Allsop, described the difficulty of assigning accountability for prevention and early intervention when multiple systems are involved, noting that the Department is often required to be responsible for outcomes it cannot control.[260] Witness H's evidence provided a practical illustration: a family-based placement broke down because the supports required to sustain it were not available when needed by the child and carer.[261]

The principal structural issue is continuity: The system must be able to maintain a clear line of responsibility for a child across functions, regions, providers and other agencies. It must also ensure that those responsible for outcomes have sufficient authority, information and access to services to act.

10.4 Leadership, governance and accountability

Chapter 2 of Companion Report 7 examines issues of leadership, governance and accountability across ministers, departments, regions, courts, statutory bodies, providers and other human service systems. The key issue for this Report is that Queensland has many accountability mechanisms, but they do not consistently operate together as a coherent framework for direction, assurance and corrective action.

The child safety system vests key institutions with significant coercive authority, including altering parental responsibility, determining where children live, regulating family relationships and shaping the support provided to children into adulthood. That authority requires accountability arrangements that are clear, active and capable of operating before a crisis occurs.

The evidence before the Commission indicates that responsibility is widely distributed, while accountability for outcomes is often harder to locate. Those responsible for a child's pathway do

[260] Transcript, Evidence of Tom Allsop (15 September 2025) 715:8-715:12, 715:24-715:25.
[261] Transcript, Evidence of Witness H (8 September 2025) 132:28-132:33.

not always control the settings required to improve that pathway. Those controlling important system levers may be remote from the child's day-to-day experience.

The evidence of the way in which residential care services are provided illustrates these points. Regional leaders were responsible for placement and practice decisions, while staff with investment and partnership functions elsewhere in the structure were responsible for contracts, licensing and service agreements.[262] Placement decisions were constrained by the available supply of residential care services. In those circumstances, leaders were focused on managing constrained options, rather than directing a planned response to assessed need. This is a governance problem as well as an operational one, because staff with authority over decisions did not have authority over the conditions required to implement them.

The litigation model provides another example. The creation of independent legal scrutiny of the litigation process was a response to legitimate concerns about the quality of evidence and the way the Department conducts proceedings.[263] The evidence before the Commission indicated that the present model also presents challenges for families and practitioners. Angela Schifilliti described the model as difficult for families to navigate, because of uncertainty about the relevant decision-makers.[264] Clair Martin identified the tension created where a legal team sits within statewide operations, while its core purpose remains the provision of independent legal advice.[265] The issue is how governance arrangements can preserve independence while maintaining clarity, timeliness and coherence in a child's pathway.

The Commission also received evidence that system leadership often operates in a reactive environment. Leaders at regional and frontline levels are required to respond to urgent placement shortages, workforce pressure, service gaps and barriers between agencies. Tom Allsop described the system as under sustained tension, with significant demand pressures and finite resources.[266] These conditions place heavy reliance on the judgement, persistence and local relationships of individual leaders. Where those leaders are experienced and stable, they may mitigate the effects of misalignment. Where leadership capacity is constrained, the same structural pressures are more likely to produce delay, inconsistency and drift.

Accountability is also weakened by the way the system defines and reports on its performance. The Commission heard that performance information remains heavily weighted toward measures of activity, compliance and process. Those measures are necessary in a statutory

[262] Transcript, Evidence of Corinne Porta (20 November 2025) 2598:4-2598:11.
[263] See Companion Report 2: Child Protection Litigation.
[264] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3298:10-3298:14.
[265] Transcript, Evidence of Clair Martin (12 December 2025) 3737:17-3737:28.
[266] Transcript, Evidence of Tom Allsop (16 September 2025) 961:33-961:36.

system, but they do not report on whether children are safe, stable, connected, heard and supported. The QFCC and PeakCare each identified limitations in current reporting arrangements, particularly in relation to children's experiences and longer-term outcomes.[267] A system that counts activity more readily than it assesses impact will struggle to hold itself accountable for whether intervention has improved a child's life.

This limitation affects public and ministerial accountability. Ministerial responsibility in child protection is not for ordinary individual case decisions; rather it is for the performance, architecture and reform discipline of the system within which those decisions are made. Where reviews, complaints, oversight reports and evidence of childrens' and families' experiences with the system repeatedly identify the same risks, ministerial accountability should be focused on the adequacy, urgency and durability of the system's response.

The evidence indicates that Queensland's current accountability arrangements do not reliably convert scrutiny into regular and sustained correction processes. Complaints, case reviews, child death reviews, audits, oversight reports and inquiries generate substantial information about the weaknesses of the system, but the pathway from finding to action, and from action to verified change, remains underdeveloped.

For this Report, the governance analysis supports recommendations of clearer ministerial responsibility for children in care and for care leavers, formal cross-government accountability for child protection outcomes, a whole-of-system outcomes and accountability framework, and departmental redesign.

10.5 Workforce, culture and practice capability

Chapter 3 of Companion Report 7 examines the conditions in which the child safety workforce performs statutory child safety work. The chapter is concerned with the practical capacity of the workforce to deliver the work required of it, including risk assessment, engagement with children and families, support for carers, case planning, court preparation, cultural practice, service coordination and decision-making in circumstances of uncertainty.

The evidence points away from any simple explanation based on lack of practitioner commitment. Instead, it shows a system that places complex statutory, relational and administrative expectations on practitioners without consistently providing the role design, time,

[267] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026).

supervision, training, support functions and organisational culture that are required to perform that work well.

The current environment within which the Department's staff operate constrains that form of practice. A defining feature of that environment is a heavy workload. Together's submission informed the Commission that team leaders consistently reported 225 or more staff above the trigger (16 cases) for a review of their caseloads across consecutive reporting periods in 2024-25.[268] Evidence from departmental staff in Far North Queensland identified concerns about heavy workload, supervision and training, including limited structured opportunities for in-field learning.[269] Practitioners described substantial administrative, documentation and court-related tasks, including affidavit preparation, that take time away from direct engagement with children and families.[270]

The effect of this pressure, often resulting in the turnover of CSOs, is felt by children and carers. One young person described frequent changes in CSOs, saying they were repeatedly given a new card or told the person they were looking for was no longer their CSO.[271] A foster carer reported more than 25 CSOs being assigned across six years, including five changes since January 2025.[272] These accounts illustrate the practical consequence of turnover and workload pressure. Relationships are interrupted. Knowledge is lost. Children and carers are required to repeat histories that should already be held and understood by the system.

The role of the CSO is central to this analysis. Over time, the role has accumulated responsibility for statutory decision-making, case management, administration, service coordination and legal preparation.[273] Each activity is necessary within the broader system, but their allocation to a single frontline role requires CSOs to prioritise certain tasks at the expense of others. Tasks that are urgent, time-bound, legally required or externally scrutinised tend to take priority. Engaging with carers and children, reflective assessment and follow-up work are more vulnerable to compression because they are less visible in the formal accountability system.[274]

Training and supervision are also uneven. Mandatory qualifications provide a foundation in relevant disciplines, and departmental training provides legislative and procedural knowledge. The evidence indicates gaps in applied preparation for the realities of statutory practice,

[268] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 64.
[269] Exhibit CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland*, tendered 17 November 2025, 1 [3], 3 [18], [21]-[23].
[270] Exhibit CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland*, tendered 17 November 2025, 4 [30]; Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 68-69.
[271] Youth survey response No 114 from former child in care (24 October 2025).
[272] Submission No 225 to Child Safety Commission of Inquiry (15 August 2025).
[273] Department of Child Safety, Seniors and Disability Services, *CSO Functional Analysis Project Phase 1 Summary Report* (Report, March 2024) 9-10.
[274] Eileen Munro, *The Munro Review of Child Protection: Final Report: A Child-Centred System* (Report, May 2011).

particularly in ongoing intervention work and complex case management.[275] In-field learning, mentoring and observation depend heavily on local capacity and workload. One CSO explained that once a new worker receives their own case allocation, opportunities to observe, and be mentored by, experienced practitioners can stop quickly because the workload takes over.[276]

Supervision has particular significance in this context. It is one of the mechanisms through which professional judgement is developed, tested and supported. In a high-risk statutory environment, supervision should provide more than task monitoring: It should support analysis, reflection, emotional containment, cultural safety practices, risk assessment and decision-making. The evidence indicates that supervision frameworks exist, but their consistent application is affected by the same workload and capacity pressures that affect frontline practice.[277]

Organisational culture shapes how these conditions are experienced. The Commission received evidence of a practice environment strongly oriented toward compliance, documentation and risk containment.[278] Those matters have an important place in a statutory system. The difficulty arises when they dominate the way performance is understood and the way practitioners allocate their time. A compliance-oriented environment can narrow practice, encourage defensiveness, and reduce the space for relational engagement with children and carers, and reflective judgement.

The Commission's concern is therefore whether the statutory task and the conditions of practice are aligned. The system expects practitioners to be relational, analytical, culturally capable, legally literate, administratively compliant and responsive to crisis. That expectation can only be met if the workforce model is deliberately designed around the work required. This includes clearer role design, better use of support roles, structured in-field learning, consistent supervision, manageable workloads, cultural capability, and a practice culture that supports judgement and learning.

There is evidence that alternative configurations of the CSO role are feasible. Trials involving paralegal and case support roles have shown potential to reduce administrative burden and allow CSOs to focus more directly on assessment, engagement and decision-making.[279] The issue is

[275] Bright People, CSO Recruitment & Retention Findings & Recommendations, Rockhampton Service Centre (June 2019) 13-17; CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland*, tendered 17 November 2025, 1-3.
[276] Quote from interview with CSO, cited in Companion Report 7: System Enablers, Chapter 3.
[277] Exhibit CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland*, tendered 17 November 2025, 1 [3].
[278] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026); Ron Westrum, 'A typology of organisational cultures' (2004) 13 *BMJ Quality & Safety* ii22; Eileen Munro, 'Decision-making under uncertainty in child protection: Creating a just and learning culture' (2019) 24 *Child & Family Social Work* 123.
[279] Department of Child Safety, Seniors and Disability Services, *FNQ regional trial of paralegal officer positions* (Final Review, February 2024) 10; Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 56.

scale and permanence. Isolated or temporary initiatives cannot address a system-wide workforce design problem.

For this Report, the workforce analysis supports recommendations concerning departmental redesign, reform pacing, outcome accountability and reinvestment. Reform cannot be delivered sustainably unless the workforce is configured and supported to perform the work the reform requires.

10.6 Funding, commissioning and market stewardship

Companion Report 7 examines funding, commissioning and market design as the economic architecture of Queensland's child safety system. The significance for this Report is that the way government allocates money, purchases services and shapes provider markets has become a central driver of system behaviour.

The Department's 2025-26 Service Delivery Statements identify controlled income of $3.617 billion.[280] A substantial proportion of that expenditure is directed to out-of-home care and outsourced supports for vulnerable children and families. The Queensland Family and Child Commission's Buyer Beware report recorded that out-of-home care expenditure increased from 58 per cent of the child protection budget in 2020 to 73 per cent in 2024.[281] The same report stated that more than $1.1 billion, or approximately 51% of total child protection expenditure, was spent on residential care services for around 2,000 of the approximately 12,000 children in out-of-home care.[282]

Those figures reveal the direction in which the system is being pulled. The evidence before the Commission indicates that Queensland's funding profile is weighted toward statutory intervention and out-of-home care, rather than earlier support, reunification, family-based care and the conditions that may reduce later demand. Residential care provides the clearest illustration. It has grown from a more limited placement option for children whose needs could not be met in family-based care, into a major component of the tertiary system. KPMG's analysis found that most children in residential care were placed there because suitable family-based care was unavailable[283] and that residential care costs reflected dependence on short-term,

[280] Queensland Government, *Service Delivery Statements: Department of Families, Seniors, Disability Services and Child Safety* (State Budget Paper, 2025) 11.
[281] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 32.
[282] Queensland Family and Child Commission, Buyer Beware: *How economic forces are shaping Queensland's residential care market* (Report, June 2025) 1.
[283] KPMG, Financial Review of Non-Family Based Residential Care (Report, 2 April 2026) 34.

high-cost contracting arrangements, used to address a continuing shortfall in contracted long-term placements alongside the decline of family-based care.[284]

The Commission's concern is the system behaviour created by these settings. Government has repeatedly purchased high-cost emergency residential care capacity. The market has responded by supplying high-cost emergency capacity. Government has paid for availability in conditions of urgency, often without sufficient information about quality or outcomes. Providers have responded to the incentives created by those purchasing decisions. Over time, the Department has become increasingly exposed to price-taking behaviour in a market it created, funds, regulates and depends upon.

The residential care market has distinct features. Children do not choose providers, compare quality, negotiate price or easily exit unsafe or unsuitable care. The Department purchases the service; the child experiences it. The State's market stewardship obligations therefore extend to entry controls, pricing, licensing, quality assurance, financial transparency, provider capability and outcome expectations.

Market conditions across Queensland also differ. Thin markets in regional and remote areas involve workforce shortages, housing constraints, higher operating costs and fewer placement options. KPMG observed variations in costs as between providers and regions, including premiums in regional, rural and remote placements.[285] Those conditions make strategic commissioning more important. Where demand is inelastic and the State must secure a placement, late purchasing leaves government exposed to price escalation and weak bargaining power.

The evidence indicates that commissioning has too often operated as a mechanism for securing immediate capacity, rather than as a disciplined system-design function. Proper commissioning requires demand modelling, regional planning, service design, pricing, market development, clear quality expectations, provider selection, performance monitoring and adjustment over time. Michelle McNamara's evidence to the Commission described commissioning activity in a way that responded to immediate placement pressures rather than as implementing a fully planned supply strategy.[286] KPMG similarly emphasised the importance of modelling and data as the first step in a commissioning model.[287]

[284] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 33, 49.
[285] KPMG, *Financial Review of Non-Family Based Residential* Care (Report, 2 April 2026) 24.
[286] Transcript, Evidence of Michelle McNamara (9 April 2026) 5090:28-5090:43.
[287] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 44.

The quality and value-for-money problem is equally significant. The State can track expenditure, placement nights and contractual activity more readily than it can assess whether children are receiving safe, stable, therapeutic and culturally responsive care. KPMG found that the information available to the Department did not allow a robust assessment of provider performance against care outcomes.[288]

The Commission accepts that proper residential care is expensive. Safe and effective care requires suitable housing, trained staff, supervision, therapeutic capability, cultural knowledge, transport, education support, family contact and after-hours responsiveness. The issue is whether the State can determine what a higher price is purchasing, and whether the additional expenditure is producing better care and better outcomes. On the evidence before the Commission, that assurance is presently weak.

For this Report, the funding and commissioning analysis supports the recommendation for a structured reinvestment and reform framework. It also informs the broader recommendations concerning outcomes, accountability, departmental redesign and system learning.

10.7 Information, technology, feedback and learning

Chapter 5 of Companion Report 7 examines the information architecture through which Queensland's child safety system records, interprets and acts on what is happening to children and families. The chapter considers case records, data, technology, information sharing, complaints, child voice, reviews, audits, outcome measures (indicators), feedback loops and learning cycles. The significance for this Report is that information and technology are part of the safeguarding infrastructure. They determine whether the system can see risk, understand children's experience, measure outcomes and correct course.

At a system level, Queensland collects substantial information about demand, statutory activity, service usage, expenditure and placement movement. The limitation is the way much of that information is presently used. The system remains stronger at counting activity than at assessing impact. The Queensland Family and Child Commission has previously identified the need to measure outcomes achieved through child protection reform.[289] Together Union similarly commented that the system measures quantity more readily than quality.[290] KPMG reached a comparable conclusion in residential care, finding that available contract, quality and

[288] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27.
[289] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment* (2014–2020) (Report, 2021).
[290] Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 37–38, 77.

performance information did not allow a robust assessment of provider performance against outcomes for children.[291]

Case records have particular importance. They preserve risk history, family context, cultural identity, placement movement, professional judgement, reasons for decisions, unresolved concerns and actions required. When workers, supervisors, providers or placements change, the record may be the only continuous source of the child's story held by the system. Poor record quality can obscure chronology, weaken supervision, affect legal decision-making and make emerging risk appear as isolated events.[292]

The Office of the Information Commissioner's submission also emphasised the importance of records for children and care leavers seeking to understand their own lives.[293] Information governance must therefore serve two purposes: protecting sensitive personal information and allowing lawful access to information required for safe decisions, meaningful participation and personal identity.

Information sharing across agencies and providers is equally important. Children involved with child safety often need coordinated support from health, disability, education, housing, police, youth justice, community organisations and funded providers. Where information is incomplete, inaccessible or delayed, those responsible for decisions may act on a partial picture of the child's circumstances.

Complaints, child voice, reviews and audits are also sources of system intelligence. Complaints can identify delay, poor communication, unsafe care, cultural unsafety, weak support, or decisions that have not been properly explained. Their value extends beyond individual resolution. A mature system should be able to track what was raised, what was found, what action was taken, who was responsible, what changed, and whether the change reduced risk. Acceptance of a recommendation is an early step. The more important question is whether practice, resourcing, commissioning, oversight or outcomes changed as a result.

Chapter 5 of Companion Report 7 therefore advances the argument for a more disciplined learning system that uses information from records, children, families, carers, workers, providers, complaints, reviews, audits and performance data to identify risk and test whether intervention is working. It links information to decisions about practice, policy, workforce, commissioning, investment and oversight. The central task for the Department is to develop

[291] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27.
[292] Eileen Munro, *The Munro Review of Child Protection: Part One: A Systems Analysis (*Report, 2010) 16–18; Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022) 221.
[293] Office of the Information Commissioner, *Submission to Child Safety Commission of Inquiry* (19 December 2025).

specific, meaningful, observable and measurable indicators, and then gather and use information to track progress against the indicators by embedding feedback loops which enable practitioners and carers to engage in conversations to redress malfunctioning parts of the system.

For this Report, the information, feedback and learning analysis supports recommendations for a whole-of-system outcomes and accountability framework and a design review of a child protection inspectorate. In principle, the inspectorate could be preventive, proactive and system-focused, and could check whether children and families are experiencing the system as intended, and whether concerns are being rectified before harm occurs. It also supports the broader recommendations concerning accountability, departmental redesign and reform assurance, because reform cannot be tested or sustained unless the system can see whether children's lives are improving.

The recommendations that follow draw these categories of system enablers together. They are directed to the architecture required to align responsibility, authority, resources, information and assurance across the child protection system.

10.8 Summary of Principal Recommendations

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 7: System Enablers and in the Compendium of Recommendations.

- **Recommendation 45:** Redesign and restructure of the Department
- **Recommendation 45A:** Creation of a function focused on intervention and family support
- **Recommendation 45B:** Creation of a function focused on coercive statutory powers
- **Recommendation 45C:** Creation of a 'Child Guardian' function
- **Recommendation 45D:** Creation of an Associate Director-General or similar position
- **Recommendation 46:** Permanent reform implementation office
- **Recommendation 47:** Ministerial-level accountability for broad child protection system
- **Recommendation 48:** A whole-of-system outcomes and accountability framework
- **Recommendation 49:** Design and feasibility review for a child protection inspectorate
- **Recommendation 50:** Structured reinvestment and reform framework

10.9 Conclusion

The analysis in this chapter, and in Companion Report 7, identifies a common feature across the five enabling domains: Queensland's child safety system contains many necessary parts, but they are not sufficiently aligned around the pathway, experience and outcomes of the child.

Structural distribution makes continuity of responsibility harder to sustain. Dispersed governance makes it harder to identify who must act when outcomes deteriorate. Workforce pressure limits the time and stability required for relational and reflective practice. Reactive commissioning reduces the availability of suitable care options and reinforces crisis purchasing. Information systems generate substantial data, but do not yet provide a mature architecture for learning, accountability and correction.

The Commission's recommendations are directed to the architecture required for reform to hold. They seek to make responsibility clearer, align authority with accountability, direct investment toward the stated reform direction, make children's outcomes visible, and strengthen the system's capacity to identify and correct failure before harm becomes entrenched.

The State's responsibility as corporate parent requires a system capable of seeing children clearly, hearing their views, maintaining their histories, supporting the people who care for them, commissioning services that meet their needs, and measuring whether its involvement has improved their lives. Unless the enabling conditions beneath the system are deliberately strengthened, Queensland risks repeating the cycle that has brought it again to inquiry: known problems, partial reform, renewed pressure and further evidence that children and families have not experienced the change intended for them.

Chapter 11

The Way Forward

From Pressure to Purpose:
Reforming Child Protection in Queensland

Chapter 11: The Way Forward

11.1 Introduction

The matters examined in this Inquiry are not, in most respects, novel. Over more than two decades, successive inquiries, reviews, oversight bodies, peak bodies, service providers, workers, carers, families and young people have identified recurring pressures within Queensland's child safety system. These include high and growing demand, placement instability, over-reliance on residential care, workforce pressure, variability in practice, insufficient integration with the health, disability, education and housing systems, the overrepresentation of Aboriginal and Torres Strait Islander children, and poor transitions between parts of the system, particularly at points of escalation or exit.[294]

These themes were reflected across the 1193 submissions to the Inquiry, including those from peak bodies, service providers and individuals with direct experience of the system. While submissions differed in emphasis and proposed solutions, there was a high degree of consistency in the identification of system pressures and in the description of their effects on children, families, carers and workers.[295]

The persistence of these themes is not the result of a lack of knowledge. In many instances, the Department, and allied participants and commentators, have correctly diagnosed the system's own challenges. In some cases, the elements of an effective response have also been identified. The evidence presented during the residential care hearing block provides a clear illustration of this pattern. The extraordinary growth in residential care did not occur unexpectedly. The associated risks were well understood, and this demonstrated a failure of government to respond to a known problem with sufficient timeliness, scale and coordination. In many respects, the burgeoning growth and expense of residential care in Queensland provides a practical example of how known system pressures, when not addressed early and decisively, can become embedded features of the system itself.[296]

The questions which have been a thread throughout this Inquiry are not simply what the system should do, but why it has been unable to do it consistently and sustainably, and how future reform

[294] Crime and Misconduct Commission (Qld), *Protecting Children: An Inquiry into Abuse of Children in Foster Care* (Report, January 2004) 136, 143; Queensland Family and Child Commission, *Measuring What Matters: Evaluating Outcomes Achieved through the Queensland Child Protection Reform Environment (2014–2020)* (Report, 2021); Queensland Family and Child Commission, *'A System that Cares': Queensland Family and Child Commission Response to Child Safety's 'A Roadmap for Residential Care in Queensland'* (Report, April 2024); QFCC, *Submission to Child Safety Commission of Inquiry* (31 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026); QATSICPP, *Submission to Child Safety Commission of Inquiry* (March 2026).
[295] QFCC, *Submission to Child Safety Commission of Inquiry* (31 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026); QATSICPP, *Submission to Child Safety Commission of Inquiry* (March 2026).
[296] See Appendix D to Companion Report 4: Understanding and Reforming the Residential Care System (KPMG Financial Review of Non-Family-Based Residential Care) ES.9–ES.14, A.1–A.11 and A.32–A.50.

can be safeguarded against drift, dilution, passive resistance and repeated failure. Those questions are also not new. As early as 2004, the Crime and Misconduct Commission found that incremental reform would be insufficient, that transformational change would be required to achieve real gains, but that the departmental structure, culture and work practices were not conducive to sustained improvement.[297]

This Inquiry therefore raises a fundamental question of public administration: How can a system subject to sustained scrutiny, with repeated access to evidence, expertise and recommendations for reform, continue to exhibit the same structural issues over time?

That question is not directed at individual practitioners. Nor is it resolved by identifying isolated instances of poor decision-making. This Report recognises the extraordinary work and dedication of frontline staff, many of whom continue to support children and families in conditions of high risk, high demand and limited capacity. The question is one of system design and system accountability.

In a system where risks are well known, solutions are broadly understood, and reform has been repeatedly recommended and attempted, accountability cannot be confined to examining whether individual decisions were reasonable at the time they were made. It must extend to whether the system itself is capable of identifying failure early, correcting course, sustaining reform, and delivering consistent outcomes over time.

The evidence considered throughout this Report suggests that Queensland's child protection system does not fail because it lacks intent or effort. It struggles because it operates under conditions that make sustained reform difficult to achieve. Three interrelated dynamics are particularly significant.

11.1.1 Chronic demand and operational saturation

The system operates under persistent and, at times, acute demand pressure. This has several consequences. The decisions that are made are increasingly reactive. Management directs it attention and effort to immediate risk management rather than longer-term stabilisation. The workforce responds to crises, and reform activity competes with operational survival.

In this environment, the immediate and pressing exigencies of daily practice invariably demand priority ahead of sustainable and orderly implementation of reform. Even well-designed reforms risk becoming diluted, deferred or inconsistently applied, as the system is required to change

[297] Crime and Misconduct Commission (Qld), *Protecting Children: An Inquiry into Abuse of Children in Foster Care* (Report, January 2004) 130-131.

while continuing to absorb high levels risk as well as immediate and often critical tasks. This appears to have significantly limited the Department's capacity to implement and sustain necessary reform over the last two decades.

11.1.2 Fragmented governance and diffused accountability

Although the Department bears primary statutory and corporate parenting responsibility, many of the outcomes that determine a child's safety and wellbeing depend on systems beyond its direct control. Child protection intersects with youth justice, health, disability, education, housing, family support, domestic and family violence, mental health and community-controlled services.

This creates a structural condition in which problems are often recognised, but not sufficiently owned, across government. Funding can be siloed. Interventions can be incomplete or uncoordinated. Escalation pathways can be unclear or ineffective. Accountability can dissipate across systems. The result is not necessarily inaction, it is fragmentation. The various systems involved may respond, but not always in a way that produces consistent or durable outcomes for the child.

These same issues are observed in fractured structures, unclear reporting lines, and limited clarity of focus within the Department.

11.1.3 Absence of a binding implementation, learning and accountability architecture

Reform recommendations arising from the numerous reviews and reports into child safety are typically adopted and implemented through a combination of policy change, program development and administrative adjustment. Those steps are necessary, but they have not been sufficient. The evidence considered by the Commission suggests that implementation is often not anchored in enforceable duties or standards, monitoring frequently focuses on activity rather than outcomes, and that there are too few mechanisms to intervene when reform stalls or drifts. Additionally, as shown during the public hearings held in April 2026 regarding the financing arrangements for residential care, adequate funding for the Department to deliver reform work internally is weighted against broader government priorities.

In effect, reform is expected to occur within the same system conditions that produced the initial problem, often with limited additional funding, and it relies heavily on local leadership and workforce capacity in an environment of immense and competing operational pressures. Even should best intentions exist, this leads to variability in practice, a gradual erosion of reform intent over time and reform fatigue.

These dynamics are not limited to external pressures such as demand or complexity. They also include how the Department is internally organised and governed. The evidence before the Commission suggests that the organisational concerns identified by the Crime and Misconduct Commission in 2004 remain relevant. Current arrangements do not consistently support clear lines of responsibility, effective escalation of concerns, independent challenge, or sustained oversight of outcomes across the breadth of the child safety system.[298]

This is reflected in several features identified throughout the report, including:

- key decisions about children's lives are often made by individuals who do not have a sustained relationship with the child, while responsibility for the longer-term consequences of those decisions sits elsewhere;
- functions intended to review, scrutinise or challenge decision-making are frequently located within the same operational structures responsible for delivering services, limiting both the independence and effectiveness of oversight;
- the system is fractured into regions with substantively different approaches, without sufficient impetus or mechanism to align practice where consistency is required;
- system performance is commonly measured and managed through indicators such as placements, compliance with bureaucratic requirements, and throughput, rather than through the stability, relationships and developmental progress of children; and,
- concerns raised by children, carers, families and frontline workers are not always escalated beyond the point at which they are raised and are not consistently used to identify patterns of risk or inform system-level response.

These structural features affect the system's capacity to identify and respond to failure early and, in turn, limit its capacity for self-correction.

Reform must therefore establish the structural and organisational conditions required for the system to implement and sustain change.

If the system is to change meaningfully, it will not be because it has identified new problems. It will be because it has created the conditions necessary to act on what it already knows. The Commission has aspired throughout its inquiries, and in writing this Report, to assist those charged with the task of redesigning the parts of the system most central to delivering outcomes for children.

[298] Crime and Misconduct Commission (Qld), *Protecting Children: An Inquiry into Abuse of Children in Foster Care* (Report, January 2004) 130-131, 156.

Respectfully, the onus now rests on the government to take steps to create these conditions. It is abundantly clear is that the Department will not be able to create this change alone.

11.2 Core Principles to Guide the Implementation of Recommendations

The recommendations in this Report should not be read as a list of disconnected policy, administrative or legislative actions. They are directed to the underlying causes of systemic failure and to the reasons Queensland's child safety system has resisted earlier attempts at reform. The Commission has grappled with the multiple and concurrent causes of systemic failure. It has been guided in this analysis by identifying the critical principles which should guide the child safety system and has identified the places where the system has most notably strayed from those principles.

This task concerns a 'wicked problem'. The child safety system is required to respond to complex human need, risk, family relationships, trauma, poverty, disability, violence, substance misuse and institutional responsibility, often at the same time. Action in one part of the system may have consequences elsewhere. Nevertheless, the Commission has sought to distil the causes of systemic failure from their manifest effects and to identify the core principles that should guide government in responding to this Report.

The Commission recognises that there are potentially many policy choices and actions which might be deployed to meet the immediate and long-term difficulties which confront the system. That is inevitable in a system concerned with children, families, risk and State responsibility. The recommendations are therefore specific where specificity is required, but they are also guided by broader principles against which reform must be tested.

Four guiding principles should guide the implementation of the recommendations.

11.2.1 The safety, wellbeing and best interests of the child must remain the organising principle

The child protection system must test all policies and actions against the paramount principle of the safety, wellbeing and best interests of the child.

This principle is foundational. It must operate as an individual evaluation of the child's needs, circumstances, rights and interests. The Commission has found that the principle has, at times, been eroded or confused in practice. Where that occurs, decision-making can become driven by the availability of placements, organisational risk, compliance with processes, system pressure or unresolved tension between competing policy objectives, rather than by a disciplined

assessment of what is required for the particular child. Importantly, there is no substitute of bona fide impartial evaluation of the child's best interests or pre-determined assumptions about how a child's best interests are invariably satisfied.

The recommendations in this Report should be implemented in a way that restores clarity to the paramount principle. This requires the Department and other agencies to test decisions against the needs and interests of the individual child, not against administrative convenience and not against pre-determined values which may be achievable in the individual case.

This is particularly important where decision-making involves Aboriginal and Torres Strait Islander children. The Aboriginal and Torres Strait Islander Child Placement Principle remains a statutory and practice obligation. It must be applied carefully based upon evaluation of the circumstances of the child as and where found. The paramount principle must not become obscured. The task is to make decisions that properly evaluate the child's best interests and whether, and how, the Aboriginal and Torres Strait Islander Placement Principle aligns with that paramount principle.

11.2.2 Family-based care should be accorded priority and disincentives to family-based care must be addressed

Family-based care should be accorded priority over non-family-based care, except where a child's particular needs require a different response.

There is little contest to the proposition that family-based care is preferable for most children. Yet the Commission has heard evidence that there has been insufficient investment in promoting, sustaining and expanding family-based care. There are also material disincentives to family-based care caused by policies, operational practice and attitudes towards carers, including the exclusion of carers from decisions, slow approvals, inadequate support, unclear authority and processes that can make an already demanding role more burdensome.

This Report's recommendations concerning family-based care, kinship care, foster care, specialist family-based care, carer authority, carer support, non-family-based care and step-down pathways should be understood collectively. They are directed to rebuilding family-based care as core infrastructure of the child safety system.

Implementation should therefore test whether reform is making family-based care more viable, better supported and more capable of meeting children's needs. It should also test whether investment and operational practice are reducing unnecessary reliance on residential care and other non-family-based responses, rather than reinforcing them.

11.2.3 The proximate causes of harm to children must be acknowledged and targeted

The proximate causes of harm to children must be acknowledged and targeted. This proposition applies to all children, irrespective of ethnic or cultural background. A system that concentrates its effort at the point of removal, placement or crisis will continue to reproduce demand if it does not also address the conditions that bring children and families into contact with the statutory system.

The Commission has heard about the role of alcohol and drug misuse, domestic and family violence, and related companion causes, such as mental health issues, that are usually present. However, there are other wider contributing causes which also contribute to harm and cannot be ignored. The failure to explicitly recognise and target the proximate causes of harm will continue to work against sustained improvement, including efforts to reduce the overrepresentation of Aboriginal and Torres Strait Islander children in the system.

This means that reforms must be accompanied by direct, practical and coordinated responses to the causes of harm that place children at risk. Implementation of the recommendations should therefore be tested against whether government action is reducing the drivers of statutory intervention, not only improving the system's response after intervention has occurred.

11.2.4 There is an unresolved structural tension between government statewide responsibility for child protection and the unrealised goal of local decision making by Aboriginal and Torres Strait Islander communities

The Commission is not able to make any recommendations about how this tension might be resolved but rather notes its existence as a significant factor which works against reducing the over representation of Aboriginal and Torres Strait Islander children and improving their care. The question of how this tension might be addressed is fundamentally a political question. It is beyond the scope of the Terms of Reference and raises foundational questions concerning authority and accountability which the Commission is not in a position to address.

This tension should at a minimum be recognised as a manifest constant which has a direct bearing upon the implementation of reform for so long as it continues unresolved.

11.3 Independent reform architecture in the form of an implementation entity

The Commission's review of past reform indicates that implementation has often been uneven, difficult to monitor and vulnerable to erosion over time.

A central implementation and reform assurance function, in the form of an independent entity, taskforce or authority, is required to translate accepted recommendations into structured, time-bound and publicly visible action. This function must have authority to monitor progress across government, report publicly on delivery, identify dependencies, assess implementation quality, and escalate where reform stalls, drifts or is diluted.

The entity, taskforce or authority should not merely monitor whether recommendations have been accepted, commenced or administratively closed. It should test whether implementation remains faithful to the reform disciplines identified above, whether the intended change has reached practice, and whether government action is improving the safety, stability, relationships, cultural connection and life chances of children and young people.

For the body to make a real difference, its remit must include the power to initiate, and to the extent required, compel action to be taken by the Department and other government agencies to implement the reform accepted by the government. It should not be cast as a commentator or monitor, but as the body with responsibility, and practical power and authority to implement the reforms and co-ordinate action across government agencies to achieve implementation of the interdependent suite of reforms. It should be characterised in similar terms to a body charged with the responsibility and co-coordinating authority commonly conferred upon establishment for the purpose of delivering major complex infrastructure projects. The roles of such authorities are not dissimilar, though the nuances of reform in the child protection system are makes measurement against key milestones less tangible. The analogy is nevertheless apposite, both in terms of the vast sums of public monies involved, and in terms of the criticality of co-coordination across government agencies and the indispensability of identifiable, inescapable direct responsibility. The suggested reforms entail a level of complexity which may in fact be greater than delivering a complex infrastructure project. The planning for implementation requires the development of a 'critical path' of likely greater complexity and nuance than required for an infrastructure project. The sums of money at stake are just as significant, as is the objective.

The case for such a function is also strengthened by the knowledge that reform implementation in child protection is unusually vulnerable to displacement by operational pressure, fiscal constraint, portfolio boundaries and changes in leadership. Without an architecture (and the corresponding leadership) that preserves reform intent over time, accepted recommendations can become fragmented into separate work programs, narrowed through implementation, delayed by competing priorities, or reported as complete before they have produced meaningful change in practice. In that environment, implementation assurance is not an additional layer of

bureaucracy. It is the mechanism by which government protects its own reform commitment from the pressures that have historically weakened reform.

Independence is essential, but it should not be understood as distance from delivery. The assurance function should function as a taskforce or Authority that works in close and shared responsibility with the agencies required to implement reform, particularly Child Safety, Justice, Queensland Treasury and the Department of the Premier and Cabinet. Its role should be to provide discipline, visibility and escalation, not to substitute for agency ownership. Line agencies must remain responsible for delivery. The assurance function must ensure that delivery is coherent, sequenced, adequately supported, tested against outcomes and not allowed to drift from the purpose of the recommendations accepted by government.

This requires a partnership model with authority. The function should have sufficient independence to report candidly on progress and risk, but sufficient connection to government to understand operational constraints, resolve dependencies and assist agencies to sequence reform realistically. It should identify where reform requires cross-agency action, where funding or legislative decisions are blocking progress, where implementation is producing unintended consequences, and where frontline practice has not changed despite formal completion of a task.

Implementation assurance should not be limited to whether a recommendation has been administratively closed. It should test whether the intended change has occurred, whether it has reached frontline practice, whether it is being implemented consistently, and whether it is producing the intended effect. Completion is not the same as consolidation.

The purpose of this final chapter is to ensure that this Report does not meet the same fate as others that have preceded it. Queensland does not need another cycle in which known problems are identified, recommendations are accepted, activity is commenced, and the system gradually returns to familiar patterns. It needs the conditions necessary to act on what it already knows, the courage to redesign the parts of the system that no longer meet contemporary need, and the discipline to ensure that reform is implemented, tested, corrected and sustained.

11.4. Summary of Principal Recommendations

The Commission's principal recommendations are summarised here. The detailed recommendations and supporting analysis appear in Companion Report 7: System Enablers and in the Compendium of Recommendations.

- **Recommendation 50:** Structured reinvestment and reform framework

- **Recommendation 51:** Independent implementation and reform assurance function
- **Recommendation 52:** Government response to this Report



From Pressure to Purpose:

Reforming Child Protection in Queensland



Compendium of Recommendations

Child Safety

Commission of Inquiry

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Recommendation 1: Respond to the proximate causes of harm	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 1)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, ensure collaboration between relevant agencies to commission, fund, support and develop evaluation frameworks for intervention responses capable of directly addressing the proximate causes of harm in children's lives. The framework for the evaluation of outcomes must critically examine whether funded activities reduce escalation into more intrusive statutory responses, support family preservation and reunification, and achieve better outcomes than downstream statutory intervention alone.	
CONTEXT: The Commission notes the relevance of evidence describing the needs for sustained, multi-system approaches to address the proximate causes of harm. The Commission considers that targeted intervention will only function as a genuine alternative to escalation if it is designed to engage directly with the drivers of harm and is supported by system settings that enable early, coordinated, and sustained action.	
IMPLEMENTATION NOTES: The Queensland Government should treat this reform as a Tier 1 system reform and assign responsibility for its design, implementation and oversight to the independent implementation and reform assurance function established in response to this Report (see Recommendation 51).	

Recommendation 2: The role of ATSICCOs in intervention and family support	
Executive Report (Chapter 5)	Companion Report 1 (Chapter 1)

RECOMMENDATION:

That the Queensland Government, through the Targeted Intervention and Family Support business function established in Recommendation 45A and within 12 months of the Government's response to this report, commence the process of repositioning and resourcing ATSICCOs to deliver targeted intervention and family support services for Aboriginal and Torres Strait Islander children and families. This should include:

(a) Early and consistent ATSICCO involvement once families become known to the child safety system, including involvement in diversion, family mapping, and support planning.

(b) Clear role definition and authority at system interfaces, including how ATSICCO input is considered in decision-making prior to escalation, while maintaining appropriate boundaries between support and statutory investigation.

(c) Timely information-sharing and participation in planning processes, so ATSICCOs can support families effectively and reduce fragmentation across services, legal processes, and decision-making.

(d) Resourcing models that recognise relational, culturally grounded practice, including outreach, trust-building, cultural brokerage, and coordination across services, rather than narrowly defined service outputs.

(e) Shared accountability for outcomes, with ATSICCOs recognised as accountable for the delivery and effectiveness of culturally led, targeted intervention functions within their role, and government retaining accountability for statutory thresholds, coercive interventions, and legal decisions.

CONTEXT:

Evidence before the Commission highlights the importance of targeted intervention responses that can combine clear expectations, culturally legitimate authority, practical support pathways, and sustained follow-up, particularly in communities experiencing entrenched disadvantage and concentrated drivers of harm. The Commission notes the relevance of evidence describing the needs for sustained, multi-system approaches that enable capability and address the harms produced by the alcohol and drug economy, violence, and institutional settings around children.

The Commission considers that strengthening ATSICCO roles in targeted intervention is a matter of system design and reform, not program expansion, and is central to improving engagement, preventing escalation, and supporting preservation and reunification for Aboriginal and Torres Strait Islander children and families.

The Commission considers that targeted intervention will only function as a genuine alternative to escalation if it is designed to engage directly with the drivers of harm and is supported by system settings that enable early, coordinated, and sustained action.

IMPLEMENTATION NOTES:

In implementing this recommendation, the development and commissioning of targeted intervention and family support responses should be guided by the following features:

(a) early activation and intervention pathways in response to visible indicators of escalating risk, such as chronic truancy, substance-related harm, family violence, housing instability, and untreated disability;

(b) Integrated whole-of-family responses that combine clear expectations with practical support across relevant systems (including health, housing, education, disability, justice, and alcohol and drug

services), so that intervention is organised around what is driving harm rather than procedural compliance;

(c) Community-led and culturally legitimate models, including conferencing or monitored-agreement approaches where appropriate, that can combine responsibility, authority, and opportunity without defaulting immediately to statutory escalation;

(d) Early family mapping and mobilisation of kin and community supports as a core stabilisation and diversion function.

Recommendation 3: Review of intake 'Safety and Support Response' pathway	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government, within two months of the Government's response to this report, undertake a review and realignment of intake, assessment and family support functions that, in view of this Commission's provisional observations:

(a) restores functional clarity for these functions within the Department
(b) clarifies and maintains the integrity of intake thresholds
(c) clarifies roles, authority and accountability for decision-making within the statutory system
(d) ensures intake and assessment processes are not driven by demand-management tools or resourcing constraints, but are sufficiently resourced to carry out their critical statutory task
(e) specifically considers whether the Department is complying with section 14 of the *Child Protection Act 1999* in its Enhanced Intake and Assessment Approach.

CONTEXT:

While the Commission recognises the aim of reducing intrusive intervention and strengthening early support, it is concerned that the current design of the 'Safety and Support Response' pathway does not clearly demonstrate how the Department meets its statutory responsibilities once the notification threshold is reached. In particular, the pathway appears to rely on non-government providers to undertake functions central to assessing risk, safety and harm, without clear evidence that the Department has undertaken, directed or retained accountability for these assessments.

In the absence of clarity regarding how risk and safety are assessed and acquitted within this pathway, the Commission considers that Department review this approach as part of the broader realignment of the intake and assessment functions. This will ensure that any future model maintains alignment with legislative requirements, community expectations and the paramount objective of protecting children from harm.

IMPLEMENTATION NOTES:

The Commission notes that the Department is presently seeking an external evaluation of the Enhanced Intake and Assessment Approach. The extent to which these evaluations will address the Commission's concerns is unclear. Therefore, while these evaluations may inform the Government's consideration, they should not be determinative of the action taken in response to this recommendation.

Recommendation 4: Reorienting unborn notifications	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 3)**

RECOMMENDATION:

That the Queensland Government, within two months of the Government's response to this report and as a part of the Government's redesign of intake processes and pathways, reorient unborn notifications as a time critical early help pathway by establishing a specialised intake response for concerns raised during pregnancy in line with the preventative intent of section 22 of the *Child Protection Act 1999*.

CONTEXT:

Pregnancy is widely acknowledged as a time in which early help can be most effective, yet current system settings often promote uncertainty, fear and scrutiny through delay, secrecy and crisis-driven intervention. These approaches increase the likelihood of intrusive action at birth, undermine procedural fairness and compromise the preventive purpose of the legislation.

Reform in this area therefore requires more than incremental practice change, it requires a deliberate re-orientation of the system toward early help during pregnancy.

IMPLEMENTATION NOTES:

This response should be designed to:

(a) prioritise timely contact and assessment during pregnancy

(b) facilitate early, practical support planning

(c) embed culturally appropriate and community-led engagement, particularly for Aboriginal and Torres Strait Islander families

(d) ensure that decisions about removal are approached as a last possible option, informed by current circumstances and the availability of less intrusive supports.

Recommendation 5: The role of ATSICCOs in supporting pregnant women	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 3)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, embed and resource community-led engagement models, including ATSICCO co-response approaches as the default pathway for responding to unborn notifications for Aboriginal and Torres Strait Islander families.

CONTEXT:

ATSICCOs are well placed to play an important role in supporting pregnant women and mitigating risk to unborn children. The Queensland Aboriginal and Torres Strait Islander Child Protection Peak submitted the likelihood of a pregnant woman accepting offers of help may be improved where a trusted support service or community-controlled organisation is able to make that offer directly, rather than through statutory processes.

Where prevention and early engagement are the primary aims, initiation of contact by ATSICCOs may be more effective, noting that some Aboriginal and Torres Strait Islander families may be remain reluctant to engage for a variety of reasons, including shame at needing help and a desire to keep this hidden. Nonetheless, the Commission considers there is merit in the principle of initial contact with pregnant Aboriginal and Torres Strait Islander women to discuss concerns for an unborn child coming from an ATSICCO.

IMPLEMENTATION NOTES:

This approach is intended to include:

(a) earlier involvement of Aboriginal and Torres Strait Islander community-controlled organisations during pregnancy;

(b) use of collective, culturally informed decision-making models (such as HALT or EIRC-style approaches); and

(c) stronger collaboration with health services as universal antenatal providers.

Recommendation 6: Casework decisions in best interests of the child	
Executive Report (Chapter 5)	**Companion Report (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, commencing immediately as part of its cycle of case planning reviews and in all future decision-making, ensure that all decisions relating to the placement and casework for children in care are made with the best interests of the child in mind, in accordance with the paramount principle in section 5A of the *Child Protection Act 1999* (and as amended in response to this report).

CONTEXT:

The *Child Protection Act 1999* already requires all decisions to be made in the best interests of the child.

However, the evidence before the Commission suggests that other considerations may impact on this singular focus. In particular, the caseloads and roles of the Child Safety Officers in undertaking multiple functions, including supporting parents to work towards reunification, may be impacting on both their assessment of the best interests of the child, and also their capacity to focus on the true best interests of the children in their care.

IMPLEMENTATION NOTES:

The Department's existing cycle of case planning reviews enables this recommendation to be commenced immediately, given the existing statutory obligation to apply the paramount principle in all matters. The recommendation obviously relies on the Department undertaking the casework and planning required under the *Child Protection Act 1999*.

It will not be sufficient to merely report that this has been implemented. Identifiable changes will need to be shown to Department practices, policies, processes, and training to overcome current workload and organisational culture barriers and deliver on the intent of this recommendation.

Recommendation 7: Providing meaningful transition to adulthood	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, amend all necessary policies, processes and practices and identifies a single, responsible officer within the Department (most appropriately the 'Child Guardian' as described in Recommendation 45C) to ensure the Department meets the following obligations:

(a) that all children in care commence a 'transition from care' plan within 14 days of their fifteenth birthday;
(b) that this plan is regularly revised, every six months at a minimum, until their eighteenth birthday;
(c) that there is central coordination, monitoring and reporting on measures including the timeliness of transition plans being commenced and reviewed, a review of the quality of the plans, and the effectiveness of achieving the required needs of the care leaver.

The transition from care plan, at a minimum, should require:

(a) enforceable, equitable, transition arrangements;
(b) early and collaborative planning;
(c) whole-of-government responsibility for outcomes; and
(d) robust tracking of post-care pathways.

CONTEXT:

The Commission heard evidence that transition to adulthood planning is often delayed, inconsistent or absent. Where planning does occur, it is frequently inaccessible to young people, developed too late to be useful, or dependent on the young person being able to advocate for supports they may not know exist.

The Commission's view is clear that legal independence does not equate to readiness for adult life, and the Department's responsibilities as a corporate parent should not end, any more than a natural parent's responsibilities end, on the young person's eighteenth birthday.

This reform will support young people in experience continuity, stability and a safer and smoother transition into adulthood.

IMPLEMENTATION NOTES:

At a minimum, the Commission supports the inclusion of T2A aggregated aged-based milestone data by State and region in Departmental annual reporting.

Recommendation 8: 'Balance of harm' analysis to the paramount principle	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government, within 12 months of Government's response to this report, amend the Paramount Principle in section 5A of the *Child Protection Act 1999* to introduce a 'balance of harm' analysis. An indicative example is set out below:

> **5A Paramount Principle**
> ...
> (2) In evaluating the wellbeing and best interests of the child, regard must be had to any consequences for the child of:
> (a) removal of the child from the child's family; or
> (b) removal of the child from the child's current placement, including all:
> i. circumstances relevant to the child's proposed new placement; and
> ii. any other matters relevant to the effect of the proposed action upon the child's wellbeing and best interests.

CONTEXT:

There is no removal of a child from their family that does not cause harm and trauma to that child, at least to some degree. The unavoidable harm caused by removal is justified by satisfaction of the twofold test in section 10 of the Child Protection Act — namely, that the child has suffered or is suffering harm, or is at unacceptable risk of harm *and* does not have a parent able and willing to protect them from harm.

The legal test in section 10 is one-sided, in that it does not expressly mandate any analysis of the counterfactual, that is the relative safety and wellbeing of the child *if* removed into State care. On one view, there is an unstated assumption that children removed into the care of the State will be safe from harm and cared for in accordance with the paramount principle. If in any given case that unstated assumption is unsound, the test in section 10 may misfire.

In other legal contexts, such as where injunctive relief is sought, courts are commonly required to engage in a balancing analysis, weighing any harm in making an order against the harm of not doing so. This is referred to as the 'balance of convenience'.

The possibility that the making of an order may involve some, and even greater relative harm, should also be allowed for, and analysed, in any decision to remove a child into State care. If, for example, the evidence suggests that the State will be unable to find the child a placement that will provide that child reasonable care, and that reduces the child's overall risk of harm of some kind, this factor ought to be considered in deciding whether a removal order should be made.

A balance of harm analysis in these terms would inform not only removal decisions but also reunification and placement decisions where there are similar competing harm considerations as between the status quo (the child remaining in his or her current placement) and the counterfactual (being reunified with his or her family or being placed with a different carer, including a kin carer). The need to consider and balance relative harm again in that context is necessary because the best interests of the child are not static but evolve dynamically.

Recommendation 9: Amending the paramount principle	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 2)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, further amend the Paramount Principle in section 5A of the *Child Protection Act 1999* to remove the words 'both through childhood and for the rest of the child's life'.	
CONTEXT: For reasons explained in the Companion Report, the words which the Commission recommends excising are undesirable because they give a licence to make unspecified and unreasoned assumptions and untestable predictions concerning the long-term best interests of the child. They introduce uncertainty as to the meaning and effect to be given to the paramount principle. Further, this phrase does not provide any practical guidance in relation to the proper application of the principle in any given case.	

Recommendation 10: Abolish the bifurcated model (OCFOS & DCPL)	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, confer the Director of Child Protection Litigation with responsibility, including decision-making responsibility, in relation to all child protection proceedings, from the commencement of court involvement to the conclusion of proceedings. The Government should, including by relevant amendments to *Child Protection Act 1999* (Qld) and the *Director of Child Protection Litigation Act 2016* (Qld) and any other relevant instrument:

(a) place sole responsibility on the DCPL as the applicant and litigant on behalf of the State in all child protection proceedings;
(b) place appropriate obligations on the DCPL to:
    (i) engage systemically with families, children, ATSICCOs and specialist advocacy stakeholders;
    (ii) ensure DCPL lawyers complete relevant training with respect to cultural competence and trauma-informed practice; and
    (iii) litigate in a way which promotes meaningful participation by parents and children from the earliest stage of proceedings;
(c) provide suitable arrangements for the DCPL to access all relevant Departmental databases, information and systems, to the extent necessary to discharge its unified responsibility;
(d) provide suitable arrangements to facilitate an appropriate degree of co-location of DCPL lawyers with Child Safety Service Centres, to balance the need to preserve DCPL's statutory and practical independence while also facilitating engagement with frontline practitioners and families;
(e) promote clear governance arrangements identifying DCPL's accountability for litigation coherence, timeliness and proportionality across proceedings;
(f) require monthly public-facing reporting on trends in litigation duration, interim order length, reunification outcomes and permanency timeframes; and
(g) ensure there be an independent evaluation of outcomes of the unified model for children and families, particularly Aboriginal and Torres Strait Islander children.

CONTEXT:

The context to this recommendation is the subject of Chapter 3 of the Companion Report. In short, the bifurcated model fails because: OCFOS lacks substantive independence from the Department, and the 'instructional model' conflates the operational child protection function with the distinct legal and forensic evaluation that ought to be undertaken by an independent lawyer. Bifurcation also produces duplication, delay, diffused accountability across two ministerial portfolios, and a serial transfer of responsibility between OCFOS and the DCPL that fractures legal stewardship, undermines the State's model litigant obligations, and generates an unnecessarily complex process of serial proceedings under the CP Act.

IMPLEMENTATION NOTES:

This recommendation should be understood as being directed entirely to the analysis of the present bifurcated model, set out in the Companion Report, and not otherwise.

Recommendation 11: Amend section 18 of the Child Protection Act	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 5)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, amend section 18 of the *Child Protection Act 1999* (Qld) in order to:

1. Provide that the administrative power to remove a child without prior judicial authorisation may only be exercised where:
   (a) the risk of harm has arisen suddenly or escalated in an unexpected manner;
   (b) the harm is such that it cannot reasonably be prevented through voluntary measures or other measures less intrusive than removal of the child into State care, including safety planning, supervision, placement with family or kin, or the timely filing of a court application with notice; and
   (c) delay for judicial consideration would itself create, or materially increase, the risk of harm to the child.
2. Allow for an extended maximum duration of care to five business days, where the child is to be safely placed with a family member or another person with whom the child has an existing trusting relationship, and otherwise a maximum duration of eight hours.

CONTEXT:

The context is set out in detail in Chapter 5 of the Companion Report. The intention of this amendment is to incentivise engagement with family members and consideration of voluntary care options before a child is removed, and to acknowledge that where a safe placement is arranged with family or a trusted person, there is likely to be less need for immediate adjudication of the removal by the Court.

IMPLEMENTATION NOTES:

Making such legislative changes will require a broad review of the *Child Protection Act 1999* for consequential amendments.

Recommendation 12: Replace 'custody' and 'guardianship' with 'parental responsibility'	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* to remove the concepts of 'custody' and 'guardianship', and instead adopt the meaning of 'parental responsibility' as set out in section 61B of the *Family Law Act 1975* (Cth).	
CONTEXT: For reasons explored in section 6.1.2 of the Companion Report, the Commission considers that the present distinction between 'custody' and 'guardianship' of a child imposes a binary that often fails to reflect the nuanced reality of children's care arrangements. The concept of parental responsibility as it applies to all families in Australia is preferable because it is flexible and adaptable, and may be shared between different persons.	
IMPLEMENTATION NOTES: The Commissioner intends that the *Child Protection Act 1999* adopt the meaning of 'parental responsibility' as set out in section 61B of the *Family Law Act 1975* (Cth), such that any future amendment of section 61B definition of parent responsibility will apply to the Child Protection Act.	

Recommendation 13: Enlarge definitions of 'suitable persons'	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend section 67 of the *Child Protection Act 1999* to broaden the scope of persons in whose care the Court may place a child on an interim basis, to include a 'suitable person' with whom the child has a relationship of trust, including for example a family friend, neighbour or teacher.	
CONTEXT: For reasons explored in section 6.5.1 of the Companion Report, the Commission considers it desirable to expand the Court's existing ability to place a child with a suitable person, whether or not that person is a Departmentally approved carer, and whether or not the child is a family member. The Commission considers it desirable to provide the Court the option, where appropriate, to place the child with a person with whom there is an existing relation of trust. By enlarging the pool of potentially appropriate family-based placements, it is intended to reduce the placement of children suited to families in residential care.	

Recommendation 14: Positive obligation to provide court with 'suitable persons'	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* to: (a) introduce a positive obligation on the DCPL to furnish the Court with all the information it requires to undertake the evaluation of who may be a suitable person, from the earliest possible stage in proceedings, and including persons who are not already approved as carers; (b) clarify that the child (where practical), and the family of the child, are to be afforded the opportunity to put forward and nominate kinship or other carers whom they believe should be considered by the Court.	
CONTEXT: This recommendation complements Recommendation 13 and is designed to encourage and facilitate the Court's use of its powers to place a child with a suitable person, whether or not that suitable person is a Departmentally approved carer. It does so by ensuring that the Court is, through the DCPL and interested family members, made of aware of potentially suitable persons with whom it may consider, where appropriate, placing the child.	

Recommendation 15: Suitable persons to receive financial assistance	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend section 159 of the *Child Protection Act 1999* to clarify that any person who is granted care of a child pursuant to a Child Protection Order, including on an interim basis, is eligible to receive payments for care and maintenance from the Department.	
CONTEXT: This recommendation complements the previous two recommendations and is designed to remove the financial disincentive to accepting care of a child which presently applies to a suitable person who is not a carer approved by the Department. It is intended that this will facilitate the Court's use of the power to place with suitable persons who are not Departmentally approved carers.	

Recommendation 16: Childrens Court to replace QCAT review	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, will amend the *Child Protection Act 1999* to: (a) remove the power to review family contact and placement decisions from the QCAT and vest this power with the Childrens Court; and (b) provide that a carer for a child has standing to appear and make submissions with respect to family contact and placement of the child.	
CONTEXT: The context for this recommendation is explained in detail in section 6.5 of the Companion Report. In short, QCAT's existing review function is too limited, and the Commission considers that judicial oversight of decision-making across the child protection decision is best situated with the Childrens Court. The enlargement of standing is designed to ensure that all relevant parties have the opportunity to be heard on decision-making affecting the child's welfare.	
IMPLEMENTATION: The Commission notes the *Queensland Civil and Administrative Tribunal Act 2009* is presently under review.	

Recommendation 17: Simplify child protection orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the government remove the current suite of child protection orders contained in section 61 of the *Child Protection Act 1999*, and replace them with two new types of child protection orders:

(a) A **Reunification Order**, being a short-term order designed to achieve reunification and establishing the necessary arrangements to ensure the care and protection of the child;

(b) A **Permanency Order**, being a long-term order designed to achieve ongoing permanency for the child where reunification is not possible, achievable, or in the child's best interests. A Permanency order should confer parental responsibility on a suitable person; or if there is no suitable person, on the Department.

Each child protection order should address:

(i) who is granted parental responsibility for the child, including any adjustments such as shared parental responsibility with respect to certain matters;

(ii) who the child will live with for the duration of the order;

(iii) family contact arrangements for the child;

(iv) an annexure, which is the care plan for the child.

The duration of any child protection order should be for the period as the court sees fit, and:

(i) for a Reunification Order – no longer than twelve months, subject to regular review by the court;

(ii) for a Permanency Order granting parental responsibility to a suitable person – for the period the court sees fit to ensure ongoing permanency for the child (up to age 18);

(iii) for a Permanency Order granting parental responsibility to the Department – no longer than twelve months, to be extended subject to annual review by the court.

CONTEXT:

For reasons more fully explored in section 6.6.1 of the Companion Report, the Commission considers that simplifying and streamlining the current process will reduce the duplication, inefficiency, and delay it has identified in the present system.

The Commission considers it highly desirable that there be active judicial supervision across the child protection, and that this recommendation would reduce the likelihood that children who are placed in the custody of the Department but are suitable for family-based placements remain in unsuitable residential care placements on an ongoing basis.

IMPLEMENTATION:

The Commission notes that this amendment would result in the removal or Directive orders and Supervision orders currently contained in section 61 of the CP Act. In the Commission's view, the proposed reforms – particularly with respect to parental responsibility, the 'balance of harm' analysis, and reforms to section 18 of the Act – would likely remove the need for special 'directive' or 'supervision orders'. For example, a child protection order may establish that a parent maintains parental responsibility subject to directions or alterations as the court sees fit.

Recommendation 18: Legal representation for all parties	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, seek to ensure all parties in child protection proceeding be afforded the practical opportunity to be legally represented from the commencement of proceeding, including at any contested hearing or conciliation model, whether under a duty lawyer model or some other suitable model which achieves that objective.	
CONTEXT: The context for this recommendation is explained in section 6.3.2 of the Companion Report. The Commission knows that rates of legal representation remain concerningly low, despite this also being a recommendation made in the Carmody Report. Legal representation of the parties is beneficial not only for the parties but also assists the Court, including by assisting the Court in identifying suitable persons with whom the child may be placed, if necessary. Significant court costs and time can be avoided by providing early and adequate legal representation. The desirable goal of making the legal process more agile, and intervening earlier to resolve the length of time a child may remain in care, is dependent on legal representation being available.	
IMPLEMENTATION NOTES: In relation to this recommendation, see the discussion in section 6.3.2 of the Companion Report. Implementation of this recommendation may involve taking steps to: (a) explore the costs and benefits of different models of providing legal advice, support, and advocacy for all parties in child protection proceedings, including at contested hearings, whether under a duty lawyer model or some other suitable model; and (b) conduct a pilot program over at least 12 months (with independent evaluation of the return on investment) for the preferred model. In addition, the Commission notes there may be a place for non-government organisations to assist with providing advocacy and support throughout the court processes.	

Recommendation 19: Consolidate emergent orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* to abolish the current framework for emergent orders (TAOs, CAOs and TCOs) and replace those orders with a single *Interim Care Order*, to be made (on application by the Director) on terms as the Court sees fit to ensure the child's care and protection during the interim phase of proceedings.	
CONTEXT: The current architecture for ensuring the child's care and protection during the interim phase(s) of proceedings is complex, fractured and incomplete. This recommendation complements other recommendations designed to streamline and simplify the current litigation and court process, so as to reduce duplication, inefficient, and delay.	
IMPLEMENTATION NOTES: Under the proposed model, proceedings may commence and progress using single originating application in which the Director: (a) outlines any Interim Care Order sought for the care of the child; (b) outlines any procedural orders sought to progress the matter; (c) files a supporting affidavit with relevant material, including the matters that are yet to be assessed and the proposed plan and timeframes for the assessment; and (d) identifies the final orders sought, if known, otherwise the application to seek in the alternative (such as a Reunification or Permanency order). If, as is likely in many instances, it is unknown at the commencement whether reunification can be achieved, the Director will nominate either a Reunification or Permanency Order as soon as practicable.	

Recommendation 20: Contact arrangements as part of child protection orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, ensure that where necessary or appropriate, family contact arrangements should be specified as part of all child protection orders (including both interim and final orders).

In particular, the court should be expressly empowered to determine, in the best interests of the child:

(a) How often family contact is to occur between the child and their parents;
(b) How often family contact is to occur between the child and their siblings (if any);
(c) How often family contact is to occur between the child and other family members (if any);
(d) What restrictions or conditions, if any, are necessary to ensure the best interests of the child in having family contact; and,
(e) Whether increased family contact could safely occur, including any supports required.

CONTEXT:

The Court is currently empowered to make orders in relation to contact including permitting, restricting, or placing conditions on the child's contact. However, in the current framework contact arrangements are generally decided by the person with custody or guardianship of the child without court input or oversight. This jurisdictional cross-over has contributed to duplication between the court and QCAT with respect to jurisdiction.

Family contact is an essential component of the child protection system. Contact arrangements made in the early interim phases of the court process tend to continue over a long period. The amount, quality and progress of family contact is a focus of case plans, review reports, and strength and needs assessments. Most importantly, many children and young people identify limited family contact as one of the most impactful elements of their experience in state care.

Given the centrality of family contact as an essential element of ensuring the child's protection, family contact arrangements should be established at the earliest possible opportunity following removal and expressly contained in any Interim Care Order (either within the order or as an annexure).

IMPLEMENTATION NOTES:

The intent of this recommendation is not to prevent any family contact prior to the court hearing an application or making an *Interim Care Order*. Such arrangements should be made in the child's best interests and would be subject to review by the court at the earliest opportunity.

By way of guidance as to how family contact arrangements should be determined, the Commission notes the considerable family law jurisprudence with respect to interim contact arrangements that may be applied. The Commission envisions this will be made easier with the adoption of parental responsibility as an element of all child protection orders.

Recommendation 21: Early Court-facilitated conciliation	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* and other relevant instruments to require early court-facilitated conciliation as a mandatory step occurring as soon as possible upon the Director filing a child protection application, replacing the need for parents to attend both a Family Group Meeting and a Court Ordered Conference.

CONTEXT:

The Commission heard that very few child protection applications proceed to contested hearing, with most resolved by agreement, at various stages, or by withdrawal of the application.

In the current framework, the separation of case planning and dispute resolution within the court process creates duplication, confusion, and extensive delays in resolving matters. The Commission is aware of cases where the length of proceedings is longer than the duration of the order sought, even where the parents were not opposed to the application. Two amendments are required to address this impediment to resolution:

(a) Dispute resolution must occur at the earliest possible stage of litigation, not merely as a precursor to trial; and
(b) Case planning in relation to the child should form part of the dispute resolution process, being an essential element of the grounds for any CPO.

Further, the court process be redesigned so that court-facilitated conciliation is mandatory at the soonest possible opportunity following the litigation director bringing an application. On conclusion, the Court should be furnished with a report detailing the agreed outcomes of the meeting including the proposed care plan/s with respect to the child.

The purpose of the conciliation is to promote early resolution of the application, by:

(a) identifying agreed and disputed child protection concerns;
(b) clarifying the type of final order sought;
(c) developing a case plan with actions and timeframes; and
(d) determining whether the matter will be contested.

IMPLEMENTATION NOTES:

This recommendation does not deride the value of the FGM process or of family-led decision-making generally. As noted in the report, many stakeholders spoke positively of FGMs as a valuable opportunity to build rapport with families, establish trust, and take action. The main goal of this recommendation is to remove unnecessary delay from the court process – which fundamentally undermines case planning as it currently operates – by decoupling the FGM process from the court process. For example, the Department may continue to utilise the FLDM framework for engaging with families in the course of ongoing intervention.

Nor does this recommendation preclude the Department from holding a FGM.

The terms of the care plan developed in the course of proceedings should be contained in the order or as an annexure. It is envisioned this will promote a level of independence by which the Department can focus its efforts on supporting and engaging with families.

Recommendation 22: Improve case management framework	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, consult with the Childrens Court to review the current *Childrens Court Rules 2016 (Qld)* with a view to establishing an improved court case management framework for child protection proceedings, having regard to the observations and other recommendations made by this Commission as to judicial oversight, case management, and timely dispute resolution.	
CONTEXT: The proposed court process introduces a clear, structured and child focused approach to the commencement and management of child protection proceedings in Queensland, with the court to have oversight of the intervention until a suitable ongoing permanency arrangement for the child is achieved. If the Commission's recommendations with respect to the legislative framework and the court process are adopted, the significant burden of duplication and inefficiency currently present in the system as a result of the bifurcated model would be removed. The Commission intends that the proposed reforms would result in a significant reduction in time, effort and resources, particularly in the earliest stages of the court process. Currently, the *Childrens Court Rules 2016* (Qld) provide the case management framework for child protection proceedings. If the Commission's recommendations with respect to the litigation model and legal framework are implemented, the Rules should be revised to reflect the streamlined model. This will also assist in identifying what additional resources will be required to enable the court to take on an expanded role, providing greater oversight, rigorous case management and early dispute resolution.	
IMPLEMENTATION NOTES: This Commission notes that the recommendations relating to the litigation model will necessarily involve an appropriate increase in resourcing for the court commensurate with the additional responsibilities conferred on the court. The Commission notes the proposed streamlined system would benefit from additional specialist Magistrates and, potentially, from the introduction of child protection Registrars capable of assisting the court with mentions, conciliation conferences, directions hearings,	

and general case management. The Commission notes similar reforms have been recently implemented in the Family Court.

Recommendation 23: Reform out-of-home care as a coherent system	
Executive Report (Chapter 7)	

RECOMMENDATION:

That the Queensland Government immediately commence, and finalise within 12 months of Government's response to this Report, an out-of-home care system framework that treats family-based care, non-family based care and therapeutic secure care as connected parts of one system, rather than as discrete placement types. The framework should recognise:

(a) that family-based care and non-family-based care are the two primary care models within the out-of-home care system;

(b) secure care as a time-limited stabilisation pathway for a narrow cohort of children presenting with imminent serious risk of harm;

(c) that children may move between care types over time according to their support needs, rather than there being an established 'continuum' of care; and

(d) that the Department remains responsible for the quality, safety and relational integrity of care wherever a child lives, for as long as they are in the care of the Department.

CONTEXT:

The Commission has heard that out-of-home care can operate as a set of placement types rather than as a coherent system with shared expectations, defined pathways and clear accountability for progression. This can leave children moving between care types without consistent principles, stable relationships or a clear plan for where their care is heading.

The intended outcome is to create a single system framework that defines the purpose of each care type, the principles that apply across all care settings and the Department's responsibility for quality and progression. For children, the expected impact is more consistent care, stronger relationships, better transitions and reduced drift in unsuitable or unnecessarily restrictive settings.

IMPLEMENTATION NOTES:

The framework should be embedded in departmental policy, commissioning, provider contracts and practice guidance.

The framework should establish a common set of care principles that apply across all out-of-home care settings, including:

(a) relational continuity and enduring trusted adults

(b) physical, emotional and psychological safety

(c) developmentally appropriate care and support

(d) connection to family, community and culture as appropriate

(e) integration with disability, health, mental health and education systems

(f) active pathway planning and accountability for progression

(g) clear expectations for transition, step-down and permanency planning.

Implementation should include:

(i) clear definitions of family-based care, non-family-based care and secure care;

(ii) a statement of purpose for each care type;

(iii) pathway criteria for entry, review, transition and exit from each care type;

(iv) shared care principles applying across all settings;

(v) minimum expectations for pathway planning and progression;

(vi) alignment with the outcomes and accountability framework recommended elsewhere in this Report;

(vii) reporting on children's movement between care types, time in each care type, placement stability and progression to less restrictive or more relationally stable arrangements.

Recommendation 24: Carers as genuine partners in the care team	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government should, within 12 months of Government's response to this report, implement operational reforms across the Department and funded carer support services to ensure that foster and kinship carers are treated as genuine partners in the care team surrounding a child in care.

The reforms should include:

(a) the Standards of Care being refreshed so they are contemporary, fit for purpose, and recognise foster and kinship carers as integral members of the child's care team;

(b) expectations for timely and appropriate information sharing with carers and how issues can be escalated;

(c) carer participation in case planning, family contact, reunification, transition and permanency decision-making where relevant to the child;

(d) a decision-making authority framework identifying what decisions carers can make, what requires approval, who can approve it, and what escalation occurs when delay places a child's needs at risk;

(e) improved approval pathways for health, dental, therapeutic, disability, education, travel and other ordinary caregiving matters;

(f) clear guidance on ordinary care (including discipline, household boundaries) as opposed to emergency intervention and restrictive practices;

(g) reform of Standards of Care review and Harm Report processes to ensure clear thresholds, front-end triage, proportionality, procedural fairness, access to support, timely resolution and record-keeping that distinguishes substantiated, unsubstantiated and resolved matters;

(h) education for carers about a trusted complaint pathways, with complaint themes aggregated and reported for system learning; and

(i) routine measurement and reporting of carer experience, responsiveness, retention and the effect of these reforms on placement stability.

CONTEXT:

The Commission has heard that foster and kinship carers can experience inconsistent information sharing, unclear decision-making authority, slow approvals, variable support and processes that leave them feeling scrutinised rather than supported. These operational failures weaken family-based care and contribute to carer dissatisfaction, placement stress and avoidable instability. They also act as disincentives to carers.

The intended outcome is to reset the Department's operational relationship with foster and kinship carers so they are treated as active caregiving partners, not peripheral parties. For children, the expected impact is more stable caregiving, faster responses to ordinary needs, stronger care planning and fewer avoidable placement pressures. For carers, the expected impact is more stable caregiving and carer retention, potentially increased carers and more satisfied carers.

IMPLEMENTATION NOTES:

Implementation should include:

(a) revised Standards of Care and supporting practice guidance

(b) updated departmental procedures for information sharing, approvals and carer participation

(c) a statewide decision-making authority framework for carers

(d) revised Standards of Care review and Harm Report processes

(e) education about carer complaints pathways, separate from ordinary casework escalation; and

(f) baseline and annual reporting on carer experience, approval timeframes, complaints, retention and placement stability.

The reforms should be embedded in contracts, practice guidance, staff training and carer support service expectations.

This recommendation is premised upon the current legal framework. If recommendations relating to legislation and the litigation model are implemented, any system reform will need to align with a new legal framework.

Recommendation 25: Revise model of family-based care	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, within 12 months of Government's response to this Report, design and commence the implementation of a revised approach to family-based care organised around children's needs, relationships and developmental interests, rather than around placement type.

The model should:

(a) recognise family-based care as the primary service delivery infrastructure of the child safety system;

(b) begin with the child's relational world, including parents, siblings, kin, carers, cultural connections, community and other significant adults;

(c) support safe and appropriate shared caregiving arrangements involving foster carers, kinship carers, parents, siblings, extended family and other trusted adults;

(d) provide flexible practical, therapeutic, cultural and financial support matched to the child's needs and the demands placed on the caregiving household or network;

(e) include clear arrangements for carer authority, respite, crisis response, health and disability navigation, therapeutic advice, training, professional support and placement stability;

(f) enable intensive and specialist family-based arrangements for children who would otherwise enter, remain in, or be unable to step down from non-family-based care;

(g) include case-by-case financial arrangements, including enhanced subsidies, stipends, salaried or professionalised caregiving models where required to support the child and sustain the caregiving household; and

(h) measure outcomes relating to stability, relational continuity, cultural connection, wellbeing, carer retention, reduced placement breakdown and reduced unnecessary reliance on non-family-based care and linked to guardian KPIs.

CONTEXT:

The Commission has heard that family-based care remains the preferred form of care for most children, but current arrangements are often organised around placement categories rather than the child's relationships, needs and developmental trajectory. Existing models do not always provide the level of practical, therapeutic, cultural or financial support required to sustain complex caregiving arrangements in the contemporary environment.

The intended outcome is to establish family-based care as a flexible, supported and structured model capable of meeting a broader range of children's needs and suitable to the current demographic and social context. For children, the expected impact is greater relational continuity, stronger connection to family and culture, fewer placement breakdowns and reduced unnecessary entry into residential or other non-family-based settings. For carers, the expected impact is more stable caregiving and carer retention, potentially increased carers and more satisfied carers.

IMPLEMENTATION NOTES:

The Queensland Government should treat this reform as a Tier 1 system reform and assign responsibility for its design, implementation and oversight to the independent implementation and reform assurance taskforce established in response to this Report (see Recommendation 51).

Implementation should include development of:

(a) a statewide model of family-based care, including ordinary, enhanced, intensive and specialist family-based arrangements;

(b) eligibility and support criteria based on the child's needs and the demands placed on the caregiving household or network;

(c) funding models that allow flexible financial support, including stipends or professionalised arrangements where justified;

(d) clear pathways for children to step down from non-family-based care into supported family-based arrangements;

(e) shared caregiving models that preserve safe and appropriate relationships with parents, kin, siblings and other significant adults; and

(f) outcome measures and public reporting on stability, carer retention, relational continuity, cultural connection and reduced reliance on non-family-based care.

Recommendation 26: Therapeutic baseline for non-family based care	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government should, within 12 months of Government's response to this Report, establish mandatory requirements for therapeutic and quality care that:

(a) is to be delivered in all non-family-based care environments; and

(b) is consistent with the care principles to be applied to the out-of-home care system as a whole.

The baseline should apply to Residential Care, Supported Independent Living and Safe Houses, along with any other setting types of non-family-based care, with model-specific requirements for each care setting. At a minimum, the baseline must require:

(i) a clear statement of purpose, target cohort and expected duration for each model;

(ii) genuine, individualised care planning linked to the child's needs, risks, strengths, relationships and pathway plan;

(iii) therapeutic practice requirements that deliver trauma-informed care, behaviour support, de-escalation and access to clinical advice;

(iv) active support for connection to family, community and culture;

(v) integration with education, health, mental health, disability and therapeutic services;

(vi) minimum workforce capability, supervision, induction and training requirements;

(vii) priority to be given to the continuity of relationships between children and staff wherever possible;

(viii) clear rules for incident response, restrictive practices, complaints and escalation;

(ix) active transition planning from the point of entry;

(x) regular review of whether the child remains in the right care setting; and

(i) routine reporting on quality, safety, stability, incidents, restrictive practices, education engagement, health needs and progression.

CONTEXT:

The Commission has heard that non-family-based care is relied upon for children with significant needs, but quality, therapeutic intent and pathway planning can vary across models and providers. Without a mandatory baseline, non-family-based care risks becoming a holding environment rather than a purposeful care response.

The intended outcome is to establish minimum, enforceable expectations for every non-family-based care setting. For children, the expected impact is safer and more consistent care, stronger therapeutic support, better integration with specialist services and clearer pathways towards family-based care, independence or another appropriate long-term arrangement.

IMPLEMENTATION NOTES:

This recommendation should be implemented in consultation with relevant organisations, providers, carers, young people with direct experience and relevant oversight bodies.

Implementation should include:

(a) model-specific standards for Residential Care, Supported Independent Living and Safe Houses

(b) contractual requirements requiring provider compliance

(c) revised monitoring, audit and quality assurance processes

(d) workforce capability requirements linked to the needs of the cohort

(e) reporting on placement stability, education engagement, health access and transition outcomes

(f) mechanisms to identify and respond to providers or services that do not meet the baseline.

The baseline should be used to inform commissioning, provider oversight and investment decisions.

Recommendation 27: Legislated therapeutic secure care	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 3)**

RECOMMENDATION:

The Queensland Government should, within 24 months of its response to this Report, establish by legislation a therapeutic secure care capability as a narrow, time-limited stabilisation pathway for children and young people presenting with imminent serious risk of harm to themselves or others.

The legislation should provide that therapeutic secure care is not to be used as an emergency placement option, a behavioural management tool, a punitive response, or as a substitute for investment in family-based care, therapeutic residential care or integrated service responses.

The legislation should require that no child or young person may be admitted to therapeutic secure care unless:

(a) the placement is authorised by the Childrens Court;

(b) the child or young person has access to independent legal assistance;

(c) the admission is supported by an independent multi-disciplinary assessment;

(d) the child or young person presents an imminent serious risk of harm to themselves or others;

(e) no less restrictive placement or support option can safely manage that risk;

(f) the purpose of admission is therapeutic stabilisation; and

(g) the admission is necessary, proportionate and time-limited.

The legislation should prescribe:

(a) the purpose, cohort, admission threshold, authorisation process, duration, review and exit requirements;

(i) a maximum initial period of 21 days before court review;

(ii) ongoing, mandatory review points;

(iii) appeal or review rights;

(iv) transition planning from the point of admission;

(v) independent oversight and inspection;

(vi) approval recording, review and reporting of restrictive practices; and

(vii) a step-down pathway back to less restrictive care.

In addition to the required stipulated above, implementation should include development of a clinical governance framework, management of medication, use of restrictive practices, and qualified therapeutic oversight.

The model should include evidence-based therapeutic supports matched to each child's needs, qualified clinical oversight, a skilled workforce, and cross-sector involvement including from agencies responsible for health, disability, and education.

CONTEXT:

The Commission has heard evidence of a small cohort of children and young people whose immediate risks cannot safely be managed in family-based care or open residential settings. In the absence of a lawful and tightly governed therapeutic secure option, responses can include informal containment, repeated placement breakdown, crisis-driven relocation and youth justice detention being used as a de facto containment response.

The intended outcome is to create a lawful, therapeutic and accountable stabilisation pathway for the small number of children whose risks cannot be safely managed in a less restrictive setting. For children, the expected impact is safer containment where absolutely necessary, intensive therapeutic assessment and support, reduced drift into youth justice, and a planned pathway back to less restrictive care.

IMPLEMENTATION NOTES:

The Queensland Government should not commence therapeutic secure care until the legislative framework, restrictive practices framework, oversight arrangements and step-down pathways are in place.

Recommendation 28: Sufficient funding to support Department's placement strategy	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 3)**
RECOMMENDATION: That the Queensland Government, within its MYFER 2026/27 budget cycle, ensure that sufficient ongoing funding is provided to the Department in its annual budget and across the forward-estimates to meet anticipated demand for out-of-home care placements, with additional funding available as necessary to build an appropriate 'buffer' or 'surge' capacity of additional family-based care placements and OSD-funded residential care placements.	
CONTEXT: Adequate funding and a buffer of family-based care placements to meet unexpected demand will enable the Department to implement initiatives that promote family-based care and support financial delegates to primarily use long-term and cost-effective Outsourced Service Delivery-funded contracts with confidence, rather than being limited to high-cost Individual Placement and Support agreements.	
IMPLEMENTATION NOTES: The government should not restrict itself to an arbitrary target for residential care capacity, but rather should ensure the use of placement types is responsive to the confirmed and projected needs of the children in out-of-home care, and is governed with rigour.	

Recommendation 29: Demand and Cost Modelling	
Executive Report (Chapter 7)	**Companion Report 4 (Chapters 4 and 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the government's response to this report, design and implement a funding model suitable to enable the Department to deliver its services and implement system reforms.

CONTEXT:

The Commission endorses, without limitation, the following aspects of KPMG's Report.

The SAM should be adapted or expanded to:

(a) include a driver-based intake module that links intake volumes to observable drivers, reducing the reliance on trend-only inflows;

(b) include a supply/capacity module to make placement mix and substitution dynamics explicit within the model (such as carer recruitment, retention or burnout);

(c) include a standard set of sensitivity ranges for materially significant parameters that affect the demand for child safety services; and

(d) establish formal governance over probability distributions to ensure pathways within the SAM remain representative of system behaviour.

The PBFM should be adapted or expanded to:

(a) accommodate two standard reporting outputs: a 'base case', reflecting approved target-driven parameter settings; and a 'reference case' used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model; and

(b) establish formal governance over cost escalation assumptions to ensure cost parameters remain reflective of reality.

These reforms to the PBFM will enable the Department to seek appropriations from the Cabinet Budget Review Committee properly informed by both actual and aspirational projections.

IMPLEMENTATION NOTES:

The Commission suggests that a working group be established to consider the findings in KPMG's Report in relation to the SAM and PBFM to ensure that the Department has a model that is fit-for-purpose in terms of enabling the Department to implement critical reforms with confidence.

Recommendation 30: Revised procurement documentation	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 5)**
RECOMMENDATION: That the Queensland Government, within three months of the Government's response to this report, revise and update standard form contracts and procurement documentation for all service delivery types (with a particular focus on the Individualised Placement and Support (IPS) standard form agreement and IPS Business Rules) and include a mechanism for periodic review.	
CONTEXT: The Commission heard evidence that the current standard form contracts used by the Department are out of date and inadequate for their intended purpose. The Department has been intending to review these for some time.	
IMPLEMENTATION NOTES: First, the standard form contract for IPS agreements should be revised to promote visibility over the services provided by residential care providers, measure and improve quality of service delivery, and align boilerplate clauses in IPS agreements with protections in Outsourced Service Delivery contracts, to the extent practical (or permissible) under the *Child Protection Act 1999*. Second, the Department should embed periodic review practices in respect of its critical procurement documentation (both internal and external facing), including the benchmark pricing in the IPS Business Rules and IPS Supplier Guidelines.	

Recommendation 31: Feasibility of direct service delivery	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, and as part of the out-of-home care system review, should undertake a feasibility review to explore the prospect of the Department entering the non-family based care market as a service provider.	
CONTEXT: The purpose of undertaking this feasibility study is to consider whether there would be benefits of the Department entering the market, especially in regional, remote and other thin markets where competition is limited or non-existent.	
IMPLEMENTATION NOTES: The feasibility study report should be considered in conjunction with the out-of-home care system redesign.	

Recommendation 32: Risk-based monitoring of funded services	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within six months of the Government's response to this report, develop a system for appropriate, risk-based financial monitoring of all services funded by the Department, including residential care providers, regardless of funding type. Those providers receiving above a determined threshold level of funding should be required to produce to the Department, on an annual basis: (a) audited statements at the funded organisation level; (b) audited acquittal statements for each service or contract; and (c) a signed statement confirming compliance with any contract conditions.	
CONTEXT: The Department requires service providers funded under outsourced service delivery (OSD) agreements to disclose certain financial documentation annually. However, there are no similar requirements for service providers funded under other arrangements, including Individual Placement and Support (IPS) agreements, despite these agreements being widely used by the Department. Further, even where submitted, not all of that financial documentation is reviewed on an annual basis.	
IMPLEMENTATION NOTES: All financial statements lodged with the Department, whether at the organisation level or service level, should be subject to an independent review by a qualified accountant employed by the Department each year, with appropriate pathways and processes for escalation where financial risks are identified.	

Recommendation 33: Minimum role-specific training for procurement and contract staff	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within six months of the Government's response to this report, should develop mandatory minimum, role-specific training to be required for all staff involved in procurement, contract management and/or regulatory activities including licensing.	
CONTEXT: The Commission observed there was a lack of training for key Department staff involved in procuring and managing contracts, creating a significant risk for the Department. However, training itself will not be sufficient. The Commission recommends that a Department-wide costing tool that can be deployed to assist those in the regions responsible for negotiating with suppliers.	
IMPLEMENTATION NOTES: The Department should also explore opportunities for professional development and formal accreditation in relation to these same roles, as ongoing learning opportunities.	

Recommendation 34: Pre-Qualification Framework	
Executive Report (Chapter 7)	**Companion Report 4**
RECOMMENDATION: That the Queensland Government, within three months of the Government's response to this report, develop a pre-qualification framework and associated criteria for residential care providers. This framework and criteria should include, at a minimum: (a) preliminary financial assessments; (b) incentives for providers to become licensed ; (c) pre-contracting with the Department with improved instruments; and (d) any other criteria that would be necessary to ensure the Department is procuring value for money.	
CONTEXT: The Department has foreshadowed that it intends to develop a pre-qualification framework and associated criteria, but that has not been implemented to date and there is no commitment to a date by which that would be operational. The Commission recommends that this be given high-order priority, and that elements be built into the framework that align with other recommendations.	
IMPLEMENTATION NOTES: The pre-qualification framework should include, at a minimum, preliminary financial assessments, incentives for providers to become licensed and pre-contracting with the Department with improved instruments. In this context, the Department should also give consideration to requiring suppliers to provide additional supporting documentation to justify their pricing schedule (in the context of Individual Placement and Support agreements) such as payroll information, rental lease contracts and energy or utility bills.	

Recommendation 35: Review of Licensing Framework	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 7)**

RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this report, review its licensing framework and associated policies and procedures for non-family based care providers to ensure the delivery of at least the following:

(a) Repository of providers: The Department should maintain a central repository of licensed and unlicensed providers to monitor the number of active placements and their value, the outcomes of initial site assessments and visits, and concerns in relation to compliance with standards of care

(b) Monitoring and oversight of providers: The Government should ensure the delivery of quarterly inspections (announced and unannounced) for all providers, regardless of whether they are licensed or unlicensed. The Government should also develop and maintain a central repository of information about licensed and unlicensed providers.

(c) Mapping of providers and regulatory regimes: The Department should undertake a mapping exercise to determine which other regulatory regimes apply to licensed and unlicensed providers and explore opportunities for cross-accreditation or streamlining of processes to encourage providers to become licensed.

(d) CSPH Screening: The Department should introduce mandatory Child Safety and Personal History (CSPH) Screening for all persons delivering direct care services at non-family based residential care services. Allied to this, the Department should consider what reforms are required so that CSPH Screening decisions are communicated to affected persons and so that there are avenues of revenue or appeal.

(e) Delays in licensing process: The Department should seek to minimise delays in the licensing process by undertaking activities relevant to licensing prior to engaging providers and during the pre-licensing phase.

(f) Primary function requirement: The Department should explore the utility or otherwise of limiting the licensing process to those providers who have the care of children as their primary function and consider avenues for legislative reform if required.

CONTEXT:

The Department's current licensing framework was implemented in 2013 and has not undergone a full review since that time. Evidence before the Commission indicates that the Department's licensing regime is operating in a manner which does not allow sufficient oversight, expediency, and may be inconsistent with its policy intent.

IMPLEMENTATION NOTES:

Licensing reform should be implemented as a collaborative exercise involving the Child Safety Licensing team, the regional Investment & Partnerships team, the State-wide Licensing Panel and the Department's Licensing Delegate.

Recommendation 36: Minimum Qualification Standards	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 7)**

RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this report, should:

(a) undertake a review to determine whether the Minimum Qualification Standards (MQS) remain fit for purpose and, if necessary, revise those standards; and

(b) expand the application of the MQS to all residential care workers, regardless of whether employed by a licensed or unlicensed provider.

CONTEXT:

The MQS impose requirements on employees of licensed residential care providers, which do not apply to employees of unlicensed providers. Further, even where they do apply, the MQS have not been updated since implemented. The MQS should be revisited given the Commission has repeatedly heard evidence about an increasingly complex cohort of children entering residential care, who require the care of workers with the necessary skills and qualifications.

IMPLEMENTATION NOTES:

In considering the suitability of the MQS, the Department should specifically interrogate whether the following training should be mandatory for residential care staff:

(e) water safety assessment training;

(f) safe sleeping for infants training;

(g) non-violent crisis intervention training;

(h) first aid qualifications and medication management; and

(i) child protection training.

The requirement for safe sleeping for infants training has been included due to the current number of children under the age of 5 placed in residential care, and the Department's stated intention to continue to place sibling groups within residential care facilities (noting the Commission has not endorsed this approach).

Recommendation 37: Full consideration of permanency options for all children	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, review and address the policies, practices and organisational culture of the Department to ensure that the priority order for considering permanency options as required under section 5BA of the *Child Protection Act 1999* is met in all cases, including consideration of adoption for all children.

CONTEXT:

The evidence before the Commission shows that the Department has significant shortfalls in delivering on its responsibilities as a corporate parent under the paramount principle to prioritise the best interests of the child, and more specifically, to effectively provide permanency for children in care in accordance with the permanency hierarchy in section 5BA of the Child Protection Act.

Despite previous recommendations and the Government's acceptance of those recommendations, the Department has systemically failed to consider the full range of permanency options for children in care as required by the Child Protection Act. In particular, the Department has failed to consider and pursue adoption for children for whom reunification is no longer a possibility, despite:

(a) on more than one occasion being recommended to do so; and
(b) the Department continuing to assert or claim that it was in fact doing so.

This reform addresses the urgent need of children in care to experience belonging to a family, in order to have the best possible chance of reaching their full and best potential.

IMPLEMENTATION NOTES:

It will not be sufficient to merely report that this has been implemented. Identifiable changes will need to be shown to Department practices, policies, processes, and training to overcome current personal and organisational culture barriers and deliver on the intent of this recommendation, as required by the Child Protection Act.

Recommendation 38: Improving permanency through guardianship	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, introduce measures to improve permanency for children in care through improved assessment of guardian, including at a minimum:

a) amend the *Child Protection Act 1999* to confer a right on carers to seek assessment as guardians after two years of continuous care for a child.
b) amend section 51VAA(3) of the *Child Protection Act 1999* to require a permanency review to be undertaken every two years for as long as a child remains on an LTG-CE order.
c) amend the *Child Protection Act 1999* to confer power on the DCPL and the Court to direct the assessment of prospective guardians.

CONTEXT:

Evidence before the Commission demonstrated the assessment of carers as suitable guardians was not being prioritised, leading to extraordinary delays in assessments of many years, or assessments not being conducted. Further evidence demonstrated that only 10% of section 51VAA reviews were being conducted.

Legislative amendment is required to ensure assessments are conducted in a timely manner in the best interests of s child who has a prospective guardian willing to care for them, and that children on LTG-CE orders have the benefit of having this arrangement periodically reviewed to determine if their permanency needs would be better met under an alternative arrangement.

Recommendation 39: Feasibility of simple adoption and ways to boost adoption	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this report, commence a feasibility study to assess how the concept of simple adoption could be incorporated into the *Adoption Act 2009*.

Relevantly, the availability of adoption should not be limited by cultural background or ethnicity.

This feasibility study will include obtaining advice on:

(a) how best to introduce a framework to deliver 'simple open adoption' for appropriate children in Out-of-Home Care;
(b) how this framework can be best aligned with the *Child Protection Act 1999* and Department processes;
(c) how the framework can best permit suitably competent child to request or consent to their own adoption;
(d) the feasibility of introducing integrated birth certificates;
(e) the appropriate oversight and safeguards for the function; and
(f) any other appropriate changes to the *Adoption Act 2009*.

CONTEXT:

Contemporary adoption operates within a fundamentally different legal and ethical framework that past adopted practices, now characterised by openness, judicial oversight, and a focus on the child's best interests. Allowing historical wrongs to foreclose consideration of adoption entirely risks substituting one form or harm for another, and risks prolonged impermanence for children who cannot return home.

The Commission notes the strong submissions from First Nations stakeholders against adoption, however, considers it would be inappropriate to exclude one cohort of children in out-of-home care from this option.

Recommendation 40: Amend permanency hierarchy	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 2)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend section 5BA(4) of the *Child Protection Act 1999* to entrench adoption as the third permanency option for all children regardless of cultural background.	
CONTEXT: The position of adoption within the permanency hierarchy for Aboriginal and Torres Strait Islander children operates as a direct barrier to the Court ultimately granting adoption orders for Aboriginal and Torres Strait Islander children as a result. The evidence suggests that in practice, adoption is rarely if ever considered for Aboriginal and Torres Strait Islander children, even where it may be culturally appropriate, supported by the child and/or their parents, or consistent with the child's long-term wellbeing. Consequently, there is a risk that the current operation of the permanency hierarchy results in adoption being functionally unavailable to Aboriginal and Torres Strait Islander children and not assessed on an individual, child-centred basis. To ensure the CP Act is operationalised with the true intent of applying the paramount principle in s 5A without racial distinction, an amendment is required to s 5BA to allow for adoption to be considered as the third preference in the permanency principles for Aboriginal and Torres Strait Islander children as well as non-indigenous children. Without such an amendment, the place of adoption in the hierarchy for Aboriginal and Torres Strait Islander children de facto subordinates the paramount principle for Aboriginal and Torres Strait Islander children for whom adoption might best give effect to the paramount principle.	

Recommendation 41: Reviews incidents harming community members	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 3)**
RECOMMENDATION: That the Queensland Government within three months to the Government's response to this report, expand the terms of reference for the Department's system and practice reviews to include reviewing incidents causing serious injury or death to members of the community where such incidents materially involved a child in care.	
CONTEXT: The Commission considers that the State as a corporate parent should review all incidents of children in the State's care who are materially involved in the serious injury or death of community members. The Commission is not of the view that conducting reviews would prejudice criminal proceedings as those proceedings are concerned with different matters, that is, whether the relevant conduct is the conduct of the child, any issues of criminal responsibility and whether the child is guilty of serious offence.	
IMPLEMENTATION NOTES: Reviews should support: (a) examination of the connection between 'self-placement' and youth justice involvement prior to an incident occurring (b) embedding a proactive continuous improvement and learning culture that supports improved child and community safety outcomes	

Recommendation 42: Using hotels and motels as emergency accommodation	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 3)**

RECOMMENDATION:

That the Queensland Government immediately suspend the practice of placing children in out-of-home care in care arrangements that require the use of hotels or motels, or other emergency accommodation, except in tightly defined emergency circumstances. These permissible emergency circumstances should not include youths exiting detention.

Where emergency accommodation is used, this use must be subject to prior approval from a senior Department officer (such as the 'Child Guardian' as described in Recommendation 44C), and there should be strict time limits on use accompanied by the immediate commencement of transition planning.

CONTEXT:

The Commission heard evidence that the Department has a practice of allowing service providers to use commercial hotels, motels and caravan parks to accommodate children who cannot be placed a regulated placement (utilising sections 82(1)(a)-(e) of the *Child Protection Act 1999*). Such placements are understood to contribute to the opportunities or drivers for offending behaviour.

The Commission considers that the use of emergency accommodation of this nature reflects a failure of system capacity and planning, rather than a safe or appropriate care response, and its use must therefore be justifiably limited. Removing this as a regular system option will strengthen safeguards and decision making oversight at the point where placement options narrow.

IMPLEMENTATION NOTES:

The Department should immediately commence monitoring and reviewing, at a senior level, the use of emergency accommodation across the different regions to ensure this use diminishes over time.

Recommendation 43: Strategy to prevent exploitation of girls in residential care	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 3)**
RECOMMENDATION: That the Queensland Government, within 6 months of the Government's response to this report, establish a working group to coordinate across relevant agencies, and to develop and implement a targeted, gender-responsive strategy to address the risks of sexual exploitation of girls in out-of-home care.	
CONTEXT: The Commission heard evidence and received submissions indicating that girls in out-of-home care, and particularly in residential care, are at increased risk of sexual exploitation. This vulnerability is compounded by circumstances of self-placing, residential care instability, inadequate financial support, and the absence of targeted gender-responsive services. Girls in the cross-over cohort characteristically live with complex, acute, and chronic trauma, making engagement in change-oriented programs highly challenging. As the corporate parent for these children, the Department both knows of these risks and has a clear obligation to manage and reduce this risk. The absence of a targeted, gender-responsive strategy for girls in out-of-home care at risk of sexual exploitation means that the system continues to respond to this cohort with generic placement and casework models that are plainly inadequate. The Commission considers that such a strategy, incorporating specialised placements and assertive outreach, and clear contractual and practice requirements for funded services to minimise this risk to children, is both necessary and overdue.	
IMPLEMENTATION NOTES: This recommendation requires the Department to work closely with Queensland Police Service, Queensland Health, Department of Youth Justice and Victim Support, and any other relevant agencies. The agencies should identify the appropriate lead agency for the working group.	

Recommendation 44: Independent child safety complaints and escalation framework	
Executive Report (Chapter 9)	**Companion Report 6 (Chapter 10)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, progress legislation to establish an independent, child-centred complaints and escalation framework for the child safety system.

This framework should:

(a) provide a clear, accessible and trusted pathway for children, families, carers and professionals to raise concerns about decisions and services affecting children, and to have those concerns independently assessed and resolved;

(b) be supported by appropriate governance arrangements and structural safeguards to ensure independence, clarity of role and public confidence; and

(c) if located within an existing statutory body, include clear separation from other functions, and dedicated leadership and accountability.

CONTEXT:

Complaints are a critical component of safeguarding within child protection systems. The evidence before the Commission demonstrates that complaints are not merely expressions of dissatisfaction, but often represent early indicators of risk, system failure or deteriorating circumstances in a child's life.

The Commission considers that an effective child safety system requires a coherent and independent complaints architecture that complements existing oversight, regulatory and review mechanisms. Its purpose is to ensure that concerns about children's safety and wellbeing are heard, assessed and acted upon in a timely and credible way, while also contributing to broader system learning and improvement.

The Commission's analysis indicates that multiple institutional models are capable of supporting this function. The question of where the function sits is therefore not determinative in itself but instead reflects a broader policy judgement about the structure and integration of Queensland's accountability framework.

The reform is intended to complement, not duplicate existing judicial review, regulatory, and system-level oversight mechanisms. It is additional to complimentary recommendations concerning the expanded role of the children's court in crucial decisions such as reunification and long-term placement, which if also implemented are expected to avoid complaints from persons directly involved in the system about such crucial matters.

IMPLEMENTATION NOTES:

In determining the appropriate institutional model for this function, the Queensland Government should consider the options outlined in this Report and select the model that best reflects its preferred balance for independence, integration, implementation timeframe and reform ambition. Implementing this recommendation will require careful legislative and operational design, regardless of the institutional model adopted.

At a minimum, the framework should be established with clear statutory authority to receive complaints directly, obtain relevant information, make findings and recommendations, and refer matters where appropriate. It should operate independently from service delivery and departmental decision-making, and be accessible to children, families and carers.

The success of the reform will depend on the establishment of appropriate capability, including a skilled workforce, effective case management systems and the ability to respond in a timely way. It will also require strong mechanisms for analysing complaint information and translating this into system-level insight and improvement.

Where the function is established within an existing statutory body, particular attention should be given to managing potential conflicts of interest and maintaining public confidence. This will require clear legislative delineation of roles, structural separation between functions and dedicated leadership arrangements to preserve the independence and integrity of the complaints function.

Implementation will also require a structured transition, including detailed design of the complaints pathway, engagement with children, families, carers and the sector, and arrangements to ensure continuity of access during the transition period.

In conjunction with the Commission's recommendations for reform to the Childrens Court processes and role, in establishing the complaints framework, the Government should consider the impacts on appeal rights to QCAT within Schedule 2 of the Child Protection Act.

Recommendation 45: Redesign and restructure of the Department	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government should, within six months of Government's response to this Report, redesign and restructure the Department. This redesign and restructure must address, at a minimum, the following matters:

(a) a direct alignment between decision-making authority and executive-level accountability for outcomes;

(b) strengthened independence and visibility of oversight, review and practice-quality functions;

(c) a clearer separation between operational delivery of specific functions, internal assurance, and system oversight;

(d) discrete functional alignment and reporting lines across the Department's functions of intake, investigation, case management, placement, commissioning, provider oversight and reform implementation, rather than based on regions or locations;

(e) clear statewide practice standards and mechanisms to address unacceptable regional variation; and

(f) improved visibility of children's pathways through the system.

This redesign must also deliver against the specific structural changes in Recommendations 45A, 45B, 45C, and 45D.

CONTEXT:

The Commission has heard evidence of fragmented responsibility, variable practice, unclear accountability and difficulty tracking children's pathways through the system. Structural arrangements within the Department affect whether decisions are made at the right level, whether oversight functions have sufficient independence, and whether statewide practice standards are implemented consistently.

The intended outcome is to align the Department's structure with the functions it must perform, and perform well: statutory decision-making, practice quality, placement and pathway management, commissioning, provider oversight, internal assurance and reform implementation. For children, the expected impact is more consistent practice, clearer responsibility for decisions, better pathway oversight and reduced variation in service quality depending on location.

IMPLEMENTATION NOTES:

Planning related to the redesign should include:

(a) a current-state functional map of the Department

(b) identification of functions that require clearer authority, independence or separation

(c) a proposed future-state operating model

(d) a staged implementation timetable

(e) transitional arrangements to manage operational risk

(f) workforce and capability implications

(g) arrangements for strengthening statewide practice leadership

(h) mechanisms for monitoring regional variation

(i) reporting to government and the independent implementation and reform assurance function.

The redesign should not be limited to organisational charts. It should address how decisions are made, how risks are escalated, how practice is supervised, how children's pathways are tracked and how system learning is converted into operational change.

Recommendation 45A: Creation of a function focused on intervention and family support	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on targeted intervention and family support, with responsibility and stewardship for early and targeted intervention services and family support, distinct from statutory child safety functions.

This business function, under dedicated executive leadership and with corresponding accountability, should be responsible for:

(a) the commissioning, procurement, performance oversight and independent evaluation of intervention and support responses for families known to the child safety system;

(b) intervention/diversion responses at or near statutory thresholds; and

(c) supporting the provision of continuing family support during statutory involvement and reunification pathways.

At a minimum, this function will:

(i) provide clear system leadership and accountability for early intervention and family support, including setting intent, activation points, and outcome expectations for services delivery once families are known to the system;

(ii) oversee commissioning and funding arrangements, with models that recognise relational, preventative, and whole-of-family practice as essential system functions, rather than short-term or compliance-focused activities;

(iii) enable early activation of support once concerns first emerge, so that targeted intervention can meaningfully influence decision-making before escalation occurs;

(iv) integrate targeted intervention with statutory child safety functions so that there are clear mechanisms for information-sharing, participation in planning, and consideration of support outcomes prior to escalation, removal, or permanency decisions;

(v) protect targeted intervention capacity from being overwhelmed by crisis-driven statutory demand, including through organisational separation from statutory investigation and case management functions;

(vi) support pathways for Aboriginal and Torres Strait Islander children and families;

(vii) ensure all existing and new interventions delivered or funded by the Department (including place-based activities and programs delivered by ATSICCOs), are subject to an outcome evaluation conducted independently from those delivering, funding or overseeing the program (including independently from peak bodies).

(viii) consistently and publicly report on performance trends and performance outcomes measures over the long-term, with measures focused on family preservation and preventing escalation, reunification, and sustained family stability.

CONTEXT:

The purpose of the function is to ensure that intervention and family support can operate as core system functions capable of stabilising families, preventing unnecessary escalation, and supporting preservation and reunification where safe to do so, rather than as discretionary or ancillary activities subordinated to statutory demand.

The Commission's analysis demonstrates that targeted intervention and family support are among the most consequential, yet least clearly stewarded, functions within the current child safety system. The absence of a dedicated locus of responsibility within the Department has contributed to late activation, fragmented service delivery, and weak integration with decision-making, thereby increasing reliance on intrusive statutory responses. Further, reporting on outcomes at present is largely measured through service throughput, procedural compliance, or short-term outputs.

Establishing a dedicated and clearly stewarded function within the Department is a system design reform intended to correct structural misalignment and is not a service expansion. This function will improve outcomes for children and families and deliver on the benefits identified in previous reviews of enhancing early intervention responses.

IMPLEMENTATION NOTES:

The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources.

Recommendation 45B: Creation of a function focused on coercive statutory powers	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on the Department's use of statutory (coercive) powers, including intake, assessment and investigation functions, court processes, and reunification. This business function must be staffed by specialised suitably qualified staff.

At a minimum, this function should:

(a) Restore clarity for intake, assessment and investigation functions within the Department;

(b) Restore the integrity of intake thresholds, including the purpose and operation of statutory entry point;

(c) Ensure that assessment and investigation processes are not driven or limited by demand-management or resourcing constraints but are sufficiently funded and enabled to carry out their critical statutory and administrative decision-making functions;

(d) Ensure the inclusion of appropriate professional expertise to support investigations and robust administrative decision-making; and

(e) Establish dedicated executive-level accountability for the Child Safety System function, including oversight of intake, assessments, court-related processes and reunification outcomes.

CONTEXT:

The Department's coercive statutory powers cannot be understood, designed or governed as isolated operational processes or teams. They constitute the point at which the State's statutory authority is first exercised, and, in doing so, set the direction for all subsequent legislative decision-making within the child safety system, including court involvement, ongoing statutory intervention and reunification pathways. Decisions made at that stage have enduring consequences for children and families and significantly influence whether harm is addressed early or escalates toward more intrusive intervention.

The exercise of these powers should therefore be carefully delivered by specialised staff with clear lines of oversight.

IMPLEMENTATION NOTES:

The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources.

Recommendation 45C: Creation of a 'Child Guardian' function	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on delivering on the Department's corporate parenting functions to care for children in care, led by a 'Child Guardian' at a senior executive level within the Department.

The role of 'Child Guardian' should be created under the *Child Protection Act 1999* with responsibility to deliver on the Department's statutory obligations to care for children within the child safety system through dedicated, focused and relationship-based care and to prioritise the delivery of individual children's needs. At a minimum, the 'Child Guardian' should:

(a) provide system-level leadership and executive-level accountability for the Department's corporate parenting responsibilities, including oversight of care quality, stability and outcomes for children in care;

(b) work collaboratively with executive colleagues responsible for the child safety system function (including intake, assessment, and litigation) to support coherent statutory decision-making, continuity of information and clear transitions of responsibility relevant to the care of children;

(c) ensure that children in care receive dedicated, consistent and relationship-based support, protected from dilution by competing statutory, investigative or demand-management pressures;

(d) establish and oversee clear performance and outcomes measures, consistently reported over the long-term, focused on the safety, wellbeing, stability and best interests of children in care.

CONTEXT:

The purpose of establishing the Child Guardian (or equivalent) role is to ensure sustained executive-level focus and accountability for the Department's corporate parenting responsibilities to children in the child safety system. While the State assumes full responsibility for children once they enter care, the Commission understands that accountability for corporate parenting is currently diffuse, with decision-making and oversight distributed across multiple functions and levels of seniority.

The Commission heard that, in practice, responsibility for ensuring children's day-to-day care, stability and wellbeing is often delegated to junior staff operating within demanding and competing statutory environments, with limited central oversight of whether children's needs are being consistently met over time. This has resulted in insufficient executive visibility of children's lived experiences in care of the outcomes being achieved for them as corporate parent.

The Commission was also told that there are approximately 1,555 children currently living in residential care environments who are assessed as suitable for family-based care, highlighting the consequences of a system in which corporate parenting responsibilities lack clear ownership and leadership.

The Commission considers that establishing a 'Child Guardian' with statutory authority and executive accountability is necessary to ensure that children in care of the Department receive the focused attention, stability and relational care they require, and that the Department discharges its corporate parent obligations intentionally, transparently and in the best interests of each child.
IMPLEMENTATION NOTES: The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources. Until established under legislation, the role could be administratively created within the Department within the 6 month timeframe. Following administrative establishment of the role, an initial priority of the 'Child Guardian' should be to undertake a systemic review of the circumstances of each child currently in the care of the Department, to assess whether the Department is meeting its corporate parenting obligations and whether each child's living arrangements, supports and planning are appropriately tailored to their needs and best interests. This should include consideration of which children currently living in residential care environments could be supported to transition to family-based care where safe and appropriate.

Recommendation 45D: Creation of an Associate Director-General or similar position	
Executive Report (Chapter 10)	**Companion Report 7**
RECOMMENDATION: The structural redesign in Recommendation 45 must deliver against the following specific structural changes: The creation of an Associate Director-General or other senior position within the Department, reporting directly to the Director-General, with responsibility for overseeing the reform of the Department's child safety functions. The executive-level roles created within recommendation 45A, 45B, and 45C would report to this Associate Director-General position, allowing for the dedicated senior focus on child safety functions.	
CONTEXT: The purpose of establishing this position is to enable the Director-General to provide consistent senior focus on the child safety reform package, without requiring the separation of child safety functions into a new Department to enable such focus.	
IMPLEMENTATION NOTES: While experience within the child safety system will be a benefit for the person filling this role, it will be critical at this stage that an external leader is appointed to support the Director-General to steward the Department through the necessary cultural changes. This role would be an ideal position for the Reform Implementation Office (see Recommendation 46) to report to, as well as the senior point of engagement with the independent implementation and reform assurance function (see Recommendation 51).	

Recommendation 46: Permanent reform implementation office	
Executive Report (Chapter 10)	**Companion Report 7**
RECOMMENDATION: That the Queensland Government, within six months of the Government's response to this Report, establish and resource with appropriately qualified staff a permanent internal function reporting directly to the Board of Management to coordinate and provide oversight of the Department's actions in response to recommendations arising from internal and external audit reports, external consultant reports, inquest findings, external oversight reports, and industry stakeholder reports.	
CONTEXT: The purpose of this body is to ensure that, moving forward, the Department pays adequate attention to opportunities for system learning and improvement arising out of external review and recommendations. It is envisaged such a body would have an ongoing role akin to the functions presently being performed by the temporarily-established Reform Implementation Office, with scope for focusing on both policy and operations.	
IMPLEMENTATION NOTES: The first role for this focused (redesigned) Reform Implementation Office should be to conduct an audit of all existing recommendations being actioned within the Department, to centralise and coordinate the current work. While this body could have a role in coordinating the Department's responses to this Commission, the Commission notes that such a body, being internal to the Department, would not satisfy the Commission's recommendation that there be an independent implementation and reform assurance function in response to this Commission.	

Recommendation 47: Ministerial-level accountability for broad child protection system	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government should, within two months of Government's response to this Report, establish a broad accountability mechanism across multiple Ministerial portfolios for the entirety of the child protection system, including for young adults who have left care or children who have otherwise transitioned from direct child protection involvement.

The mechanism could take the form of:

(a) a designated lead Minister with responsibility for coordinating cross-government action across the child protection system, and escalating barriers affecting outcomes for children in care and care leavers;

(b) the establishment of a new Cabinet Committee; or

(c) another suitable form that will deliver broad Ministerial-level attention to the child protection system as a whole.

The mechanism will not displace the obligations of existing Ministers or departments, including the Minister with responsibility for child safety, but will operate as a lead accountability and escalation function for outcomes that require whole-of-government action.

CONTEXT:

The Commission has heard that children in care and young adults leaving care often require coordinated responses across child protection, health, disability, education, housing, justice and other systems. No single department can meet those needs alone, but fragmented accountability can allow service barriers to persist without clear ministerial ownership or escalation.

The intended outcome is to create a clear mechanism for ministerial accountability where children's needs require whole-of-government action. For children and care leavers, the expected impact is improved access to services, faster resolution of interagency barriers and stronger accountability for outcomes that sit across portfolios.

IMPLEMENTATION NOTES:

The mechanism should include:

(a) Cabinet-level oversight of outcomes for children in care and care leavers

(b) Associated delegated Chief Executive-level obligations across relevant departments

(c) shared outcome measures across relevant portfolios

(d) escalation pathways where a cohort of children's needs cannot be met by one agency acting alone (for example, youth justice care leavers, or young parents who have been in care);

(e) public reporting on cross-government performance (which may be via the outcomes and accountability framework in Recommendation X)

(f) mechanisms for resolving systemic barriers to service access, funding, information sharing or operational responsibility.

It may be feasible for the independent implementation and reform assurance function (see Recommendation 51) to report to this mechanism.

In designing this mechanism, consideration should be given to the model adopted in Scotland (where responsibility for the care and wellbeing of children was placed within a clearly identified Ministerial portfolio, increasing the prominence of and ensuring the ongoing attention to delivering on the reforms).

Recommendation 48: A whole-of-system outcomes and accountability framework	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this Report, work across portfolios to establish a whole-of-system framework for child protection outcomes and accountability with relevant indicators and measures that link directly to these outcomes.

This framework should require Ministers and relevant departments to report at least quarterly, through a public-facing, consolidated reporting mechanism, on defined outcome measures for:

(a) children and families receiving early intervention or family support;

(b) children subject to statutory child protection intervention

(c) children in out-of-home care

(d) Aboriginal and Torres Strait Islander children and families

(e) children in residential care and other non-family-based care

(f) children reunified with family

(g) children supported in foster, kinship or specialist family-based care

(h) young adults who have left care or otherwise transitioned from direct child protection involvement.

The framework should include, at a minimum, measures relating to safety, stability, relational continuity, family connection, health, disability support, education, transition to adulthood, and children's experience of care and support.

The framework should require outcome data to be disaggregated, where appropriate, by region, age, Aboriginal and Torres Strait Islander status, disability, placement type, care experience, and other relevant characteristics.

CONTEXT:

The Commission has heard that Queensland's child protection system does not have a clear whole-of-system accountability framework capable of showing whether children and families are safer, better supported, more stable and better connected over time. Existing reporting does not consistently connect activity, expenditure, placement type, service response and child outcomes.

The intended outcome is to create a single public framework across all agencies that have involvement in the broader child protection system (that is, not just the agency that provides child safety services). The framework will hold Ministers, departments and the system to account for the outcomes that matter across the child protection continuum. For children, the expected impact is for additional transparency to improve government decision-making, investment, commissioning and reform implementation across measures that are meaningful to their lives.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51).

Implementation should include:

(a) establishing the framework and reporting obligations;

(b) a defined set of outcome domains and measures;

(c) allocation of responsibility for each measure to relevant Ministers and departments;

(d) data-sharing arrangements across relevant agencies;

(e) annual public reporting against the framework;

(f) disaggregated reporting to identify regional variation, cohort outcomes and service gaps; and

(g) mechanisms requiring government to respond where reporting shows persistent poor outcomes, unacceptable variation or lack of progress.

The framework can be drawn on to inform government budget decisions, interagency collaboration, and identify areas of high risk that may lead to poor outcomes for children within the child protection system.

Recommendation 49: Design and feasibility review for a child protection inspectorate	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The Queensland Government should, within 12 months of the Government's response to this Report, undertake and publish a design and feasibility review for the establishment of a proactive child protection inspectorate function in Queensland.

The review should consider:

(a) the purpose, scope and powers of an inspectorate within the Queensland child safety system, and any overlap with existing inspection mechanisms;

(b) whether the function should be located within an existing independent statutory body or established separately;

(c) the relationship between the functions of inspection, complaints, child advocacy, departmental assurance, external monitoring, provider regulation and the role of the Ombudsman;

(d) potential stages for the implementation of an inspectorate;

(e) how inspection would examine children's experience, practice conditions, cultural safety, casework quality, decision-making, supervision, workload and implementation of policy in practice;

(f) public reporting arrangements;

(g) escalation and improvement powers; and

(h) legislative, resourcing and implementation requirements.

CONTEXT:

The Commission has heard evidence of a gap between policy intent and frontline practice. Complaints, internal assurance and system monitoring each serve important functions, but they do not provide a regular, proactive and independent mechanism for examining how the system is operating at the level of local service delivery and children's lived experience.

The purpose of the feasibility study would be to test, proactively and independently, whether policies, records, practice conditions and children's experiences align in practice. The intended outcome is to determine whether Queensland should establish a system inspectorate function, similar to the OFSTED model, capable of examining practice conditions, service quality, cultural safety, decision-making and children's experience before serious failure occurs.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51).

The review should proceed on the basis that inspection would not replace existing or anticipated complaints, advocacy, internal assurance or system monitoring.

The review should be independently led and should include consultation with children and young people with direct experience; Aboriginal and Torres Strait Islander organisations; frontline Child Safety staff; funded service providers; carers; oversight bodies, including the QFCC, the Office of the Public Guardian, and the Ombudsman; and relevant departmental assurance, complaints and regulatory functions.

The published review should cover the following matters:

(i) whether an inspectorate should be established;

(ii) the preferred statutory location and governance model;

(iii) inspection powers and limits;

(iv) initial inspection scope;

(v) reporting and escalation mechanisms;

(vi) implementation sequencing;

(vii) resourcing requirements; and

(viii) legislative amendments required to establish such a body.

Recommendation 50: Structured reinvestment and reform framework	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The Queensland Government should, within eight months of Government's response to this Report, establish and publish a structured reinvestment and reform framework for the implementation of significant change across the child protection system over the next three years.

The framework should be developed by the independent implementation and reform assurance function (see Recommendation 51) to guide staged investment, implementation sequencing and fiscal discipline across the reform program. The framework is to include:

(a) a costed investment plan for the reform program, that incorporates the projected savings from residential care investment and commits to the allocation of necessary funds arising from these actual or avoided future costs to the reform package;

(b) protected investment in critical areas of family-based care, early intervention, reunification, carer support and step-down pathways;

(c) explicit investment in workforce capability, supervision, retention and practice quality

(d) linkage between any expansion of non-family-based care and the development of family-based alternatives, step-down pathways and earlier supports

(e) transparent modelling of demand, cost, capacity and implementation risk

(f) monitoring of the effect of investment decisions on placement stability, workforce pressure, provider behaviour and child safety risk

(g) public reporting on whether expenditure is shifting the system towards the stated reform direction or reinforcing crisis response.

CONTEXT:

The Commission has heard that child protection reform requires sustained investment, but investment alone will not shift the system if expenditure continues to follow crisis demand rather than the intended reform direction. Without a structured reinvestment framework, new funding may reinforce existing reliance on late, expensive and less relational responses, including non-family-based care.

The intended outcome is to ensure that reform is staged, funded, sequenced and monitored in a way that builds the capacity of the system inclusive of earlier support, stronger family-based care, better reunification, sustained carers, step-down pathways and reduced unnecessary reliance on residential care. For children, the expected impact is earlier help, more stable care, better supported carers and fewer children entering or remaining in high-cost, crisis-driven placement responses because alternatives were not available.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51). The recommendation will significantly advance the reform work for the child protection system.

Implementation should include:

(a) alignment between reform pace, workforce capacity and implementation risk;

(b) a published reform investment plan;

(c) annual reporting on expenditure by reform priority and care type;

(d) modelling of demand, placement capacity, workforce capacity and cost pressures;

(e) identification of protected investment categories;

(f) staged investment triggers linked to workforce readiness and service capacity;

(g) monitoring of whether new investment is reducing or increasing reliance on non-family-based care;

(h) reporting on the effect of investment decisions on placement stability, carer retention, workforce pressure and provider behaviour; and

(i) review points to redirect funding where expenditure is not producing the intended system shift.

The framework should make clear that expansion of non-family-based care, where required to meet immediate safety needs, must be accompanied by investment in family-based alternatives, earlier support and step-down pathways.

Recommendation 51: Independent implementation and reform assurance function

Executive Report (Chapter 11)

RECOMMENDATION:

The Queensland Government should, within one month of the Government's response to this Report, establish an independent implementation and reform assurance function (in the form of a taskforce or authority) with independence from the Department, for a period of at least 3 years.

The function should work in close partnership with the Director-General (and the Associate Director-General, when appointed); the Department of Families, Seniors, Disability Services and Child Safety; the Department of Justice; the Director of Child Protection Litigation; the Department of the Premier and Cabinet; Queensland Treasury; and other relevant agencies, while retaining sufficient independence to report candidly on implementation progress, implementation risk and reform drift.

The function should report to the Minister for Child Safety and other relevant portfolio Ministers, and should have authority to:

(a) work with relevant Ministers to compel action to be taken by the Department and other government agencies to implement the reform accepted by the government;

(b) coordinate and oversee the design and implementation of all accepted recommendations;

(c) lead and support reform design where cross-government or structural reform is required, including, at a minimum, Tier 1 recommendations;

(d) steward interdependencies across agencies and portfolios;

(e) sequence reform activity and advise on implementation priorities and timing;

(f) monitor progress against agreed milestones and implementation plans;

(g) assess implementation quality and fidelity;

(h) test whether reforms have translated into frontline practice;

(i) publicly report on implementation progress and reform status;

(j) identify implementation drift, dilution, delay or unintended consequences; and

(k) escalate implementation barriers, risks or unresolved dependencies to Cabinet or another appropriate central decision-making forum.

Implementation assurance undertaken by the independent implementation and reform assurance function should not be limited to whether a recommendation has been administratively closed. It should test whether the intended reform has occurred, whether implementation has been consistent across the system, and whether the reform is producing the intended effect for children and families.

CONTEXT:

Taskforces or implementation bodies are a common response by Government to Commissions of Inquiry and would signal the Government's commitment to this critical reform package. Such independent coordination would make it more likely that the reform activities will be implemented and the outcomes embedded to improve the system overall.

Many of the recommendations in this Report are directed to particular parts of the child protection system. However, a core group of recommendations (marked as 'Tier 1') require whole-of-government authority, central

agency involvement, sustained investment, cross-portfolio cooperation, organisational redesign or independent assurance. They should not be treated as ordinary departmental implementation tasks.

Responsibility for delivery should remain with the relevant Ministers, departments and agencies. However, implementation should be led, tested and publicly assured through the independent implementation and reform assurance function.

The Commission considers that implementation assurance must involve more than tracking activity or administrative completion. Reform assurance must examine whether intended changes have occurred in practice, whether implementation has been sustained over time, and whether reforms are improving outcomes for children and families.

IMPLEMENTATION NOTES:

Primary responsibility for delivery should remain with the relevant Ministers, departments and agencies. However, implementation should be led, tested and publicly assured through the independent implementation and reform assurance function.

The purpose of the Tier 1 designation is not to remove responsibility from agencies. It is to ensure that responsibility is visible, shared where necessary, independently monitored and supported by the authority required to resolve implementation barriers. It is also to ensure that cross-agency recommendations appropriately stewarded, and that the burden of reforming the complex child protection system does not fall solely on the Department to manage.

The Commission considers that implementation assurance must involve more than tracking activity or administrative completion. Reform assurance must examine whether intended changes have occurred in practice, whether implementation has been sustained over time, and whether reforms are improving outcomes for children and families.

Recommendation 52: Government response to this Report

Executive Report (Chapter 11)

RECOMMENDATION:

The Queensland Government should, within two months of receipt of this report, publicly respond to the Commission's recommendations.

The Government response should:

(a) identify whether each recommendation is accepted, accepted in principle, accepted in part or not accepted;

(b) provide reasons where recommendations are not accepted, or are accepted only in part;

(c) identify the responsible Minister, department or agency for each accepted recommendation;

(d) identify proposed implementation timeframes and sequencing for accepted recommendations; and

(e) identify which recommendations are designated as Tier 1 reforms to be led by the independent implementation and reform assurance function.

The Queensland Government should publish both this Report and the Government's response to this Report on an accessible public website.

CONTEXT:

The Commission considers that public accountability requires a timely and transparent response to the findings and recommendations of this Report. To achieve this purpose, the Commission has ensured that confidential, sensitive or protected information has not been published within this Report.

IMPLEMENTATION NOTES:

The Government response should be tabled publicly and published in a format that enables recommendations and implementation commitments to be readily identified and tracked over time.

Publication arrangements should ensure that the Report and the Government's response to the Report, as well as the Commission's website, remain accessible for at least 10 years.



Appendix A

Terms of Reference

Queensland Government Gazette

EXTRAORDINARY

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Commissions of Inquiry Act 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2025

Short title

1. This Order in Council may be cited as the *Commissions of Inquiry Order (No. 1) 2025.*

Commencement

2. This Order in Council commences 1 July 2025.

Appointment of the Commission

3. UNDER the provisions of the *Commissions of Inquiry Act 1950*, the Governor in Council hereby appoints Paul Elias Anastassiou KC as Commissioner from 1 July 2025, to make full and careful inquiry in an open and independent manner with respect to:
   a. Reforming the Residential Care System: Investigate models of care and the factors contributing to the growth and reliance on a billion-dollar residential care sector, including:
      i. Analyse residential care in the historical context since the Carmody Inquiry and the increase in the use of Individual Placement Support Services and residential care.
      ii. Investigate contemporary models around the world for the delivery of residential care, with a focus on best practice to support children who are more at risk.
      iii. Consider what constitutes Quality of Care in both licensed and unlicensed providers, including from the perspectives of children and young people.
      iv. Analyse contemporary models for licensing care providers.
      v. Investigate the current state of the market of residential care providers operating under not-for-profit and for-profit models.
      vi. Analyse previous Queensland government procurement and contracting process for residential care providers to identify opportunities to improve efficiency, transparency and accountability.
   b. Fixing a broken system: reviewing the effectiveness of Queensland's child safety system to keep children safe, including:
      i. The practices and procedures of the Department, specifically focussing on investigation, assessment, case work and reunification.
      ii. Tertiary child protection interventions, including adoption, case management, service standards, and decision-making frameworks.
      iii. The management, training, supervision, and ongoing oversight of case work within the Department.
      iv. Departmental delivery structures including organisational culture; management structures and operations of regional service delivery (in each region).
      v. The ability for information sharing across relevant agencies.
      vi. Review Departmental governance, including financial, procurement and contracting delegations; and structures to manage conflict of interest and reporting.
      vii. Whether Departmental frontline staff are resourced and supported to do their work and outline any deficiencies in the level of support, decision-making frameworks, case loads, and court and tribunal processes.
      viii. Investigate the role of the privacy provisions of the *Child Protection Act 1999* and whether the provisions hamper transparency around system failures.
      ix. Consider how to facilitate a culture of transparent reporting in the context of the Coaldrake Review.
      x. Investigate the role of third parties including peak bodies and oversight bodies and their interaction with the Department and Minister in pursuit of system improvement, and any issues related to funding, reporting and their role in the media to ensure integrity and accountability.
      xi. Evaluate Ministerial accountability of the child safety system since the Carmody Inquiry and the role the Minister has played in the performance of the Department.
      xii. Review the effectiveness of the existing Complaints Process.
   c. Safer Children: failures both systemic and policy that have impeded the ability of the Department responsible for the Child Safety portfolio (the Department) to provide support to families and protection to children at risk of harm in Queensland; and in particular to use case studies to:
      i. Identify failures of the Department to intervene or to protect children, with a summary of findings and recommendations of collated coronial inquiries since the Carmody Inquiry and the establishment of the Child Death Review Board.

ii. Review the decline in foster care and treatment of foster carers by the Department and by service providers contracted by the Department.
iii. Review Child Placement breakdowns, with a focus on cases with more than four placements in a child's life.
iv. Investigate the contributing factors for breakdown of placements due to lack of support for kinship carers.

d. Safer Communities: Evaluate the effectiveness of the Department as a corporate parent and whether it is able to meet community expectations around parenting:
i. Investigate through case studies children subject to dual Youth Justice and Child Protection Orders or children under the Guardianship of the Department who have committed crimes and fall within the Making Queensland Safer Laws category and determine the failures of policy, process and practice that contributed to these children choosing a life of crime.

e. Reviewing Queensland legislation about the protection of children, including the *Child Protection Act 1999* and *Adoption Act 2009*.

f. Any other matter relevant to the inquiry.

Commission to report and make recommendations

4. AND directs that the Commissioner make full and faithful report on the aforesaid subject matter of the inquiry, including an executive summary.

5. AND makes recommendations that the Commissioner considers appropriate and feasible on:
a. Reforming the residential care system: which existing models of residential care best support children who have high complex needs (particularly those with a disability) and Aboriginal and Torres Strait Islander children, and appropriate market structures to best deliver those models.
b. Fixing a broken system: the implementation and appropriateness of child safety practices; Departmental structure, governance and culture; the adequacy and effectiveness of current training programs for child safety staff; the extent to which leadership structures support accountability in the protection of children; Ministerial engagement and accountability; appropriate frontline resourcing; and third parties including peak bodies and oversight bodies.
c. Fixing a broken system: design and implementation plan for a new independent complaints escalation review process to escalate serious concerns about complex cases and restore critical support for families and carers.
d. Safer children: system design to support and facilitate foster care, kinship care and adoption in a modern best practice setting.
e. Safer communities: new models of care ensuring children are provided an opportunity for intervention and rehabilitation and that escalating risk or behaviours are managed in line with community safety expectations.
f. Any reforms to ensure that Queensland's child protection system achieves the best possible outcomes to protect children and support families.
g. Any legislative reforms required.

6. AND directs that the report be transmitted to the Honourable Premier and Minister for Veterans, the Honourable the Attorney-General and Minister for Justice and Minister for Integrity, and the Honourable the Minister for Families, Seniors and Disability Services and the Minister for Child Safety and the Prevention of Domestic and Family Violence.

7. AND directs that the final report be provided to Government by 30 November 2026, AND that the Commissioner will determine whether any interim reports are to be provided before that date.

Application of Act

8. Pursuant to section 4(2) of the *Commissions of Inquiry Act 1950*, it is declared that all of the provisions of the *Commissions of Inquiry Act 1950* shall be applicable for the purposes of this inquiry, except for section 19C (Authority to use listening devices).

Conduct of Inquiry

9. The Commission may receive submissions from relevant individuals and entities and hold public and private hearings in such a manner and in such locations as determined by the Commissioner, as appropriate and convenient, in a way that promotes transparency.

ENDNOTES

1. Made by the Governor in Council on 16 May 2025.
2. Notified in the Gazette on 23 May 2025.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of Justice.

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BRISBANE
23 May 2025



Appendix B

Case Studies

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

Appendix B: Case Studies

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Background

These case studies were developed by the Commission staff as part of the Commission's work to understand and examine how Queensland's child safety system operates in practice, and how systemic settings, decision-making processes and resource constraints shape the lived experience of children, families and carers.

The case studies are not intended to be representative in a statistical sense — they have been selected because they each illuminate issues that arise squarely within the Commission's Terms of Reference, including:

- the experiences of children and young people in out-of-home care;
- the operation of permanency planning and placement decision-making;
- interactions between the child safety system and other systems, including youth justice, health and family violence responses;
- the treatment and role of parents, carers and kin; and
- the consequences of system responses over time.

Each case study is used as a lens through which broader systemic themes and patterns can be examined.

The case studies draw on multiple sources of evidence available to the Commission, including:

- oral evidence given during public and private hearings;
- written submissions made to the Commission;
- Departmental records obtained through notices to produce (compulsory notices);
- affidavits and witness statements filed in response to compulsory notices ; and
- coronial inquests and findings.

In several cases, the Department of Families, Seniors, Disability Services and Child Safety (Department) was given notice of the evidence relied upon and an opportunity to respond to, clarify or contest factual matters. Where the Department disputed aspects of the evidence, this is identified in the relevant case study. Where it did not, this is also noted.

The case studies have been prepared by synthesising these materials into a chronological narrative, supported by references to the underlying evidentiary record. They are not advocacy documents; nor do they involve independent fact-finding beyond the evidence before the Commission.

The Commission invites you to read these case studies cumulatively rather than in isolation. While each case is distinct, common patterns emerge across them, including repeated points of system stress, missed opportunities for early intervention and the downstream effects of instability, delay and disconnection.

These case studies do not seek to attribute fault to individual practitioners. Where errors or shortcomings are identified, they are examined within their organisational and systemic context, including workload pressures, policy settings and governance arrangements.

Names and identifying details have been altered where necessary to protect privacy and confidentiality.

Jack, 24 years old[1]

Background

This case study was chosen in line with the Commission's commitment to elevate the voices of children in care (including former children in care), and to hear from them directly where possible.

Jack is a 24-year-old man who spent the majority of his childhood in out-of-home care. He was first placed in foster care as a toddler. Over the years that followed, his time in care was punctuated by two periods of attempted reunification with his mother, both of which broke down due to her drug misuse.

At the time of giving evidence, Jack was living independently in a share house with friends, having moved out of his long-term foster placement at around age 20. He continues to see his former carer, Witness C, most Sundays for dinner.[2] Jack has triumphed over many adversities and is now studying at university.

Evidence

Early placement history

Jack was not fully aware of his early placement history due to his young age. At around age nine or ten, he was placed in a residential care facility, which was staffed by a rotating roster of support workers. He did not know why he was placed in residential care rather than foster care at that time. He said that "it wasn't too bad in my experience".[3] He wasn't very outgoing and enjoyed staying home at the facility: it was generally just him staying there most of the time. He formed really good relationships with the workers and remains friends with one to this day. Other children came and went from the placement, some of whom "smashed up the place",[4] which meant Jack had to stay out of the facility.

Jack went to school whilst he was at this placement, and remembers being driven there. He does not recall being offered any additional support during this time.

First reunification attempt and a return to care

Following his time at the residential care placement, Jack was reunified with his mother for approximately a year at around ten to twelve years of age. When his mother relapsed into severe

[1] Witness X gave evidence at Cairns public hearing on 22 September 2025. His outline of evidence is CA-38, tendered 22 September 2025. His evidence commences at transcript 1396:20.
[2] Transcript, Evidence of Witness X (22 September 2025) 1398:20.
[3] Ibid 1400:15.
[4] Ibid 1400:34.

drug use, it was Jack himself who contacted Child Safety and asked to be placed back into care. The response was prompt: someone came that day and a temporary placement was found. Jack was not aware whether any family members were identified or explored as potential care givers, nor did he recall being in contact with any relatives at this time.

What followed was a period of intense placement instability. Jack estimates he was moved through approximately fifteen to twenty temporary placements in as many days. Jack told the Commission: "You kind of just stop getting attached. There's no point getting emotionally attached to anyone if you're just going to move the next day."[5]

The Beach placement

After the period of rolling temporary placements, Jack was placed in a foster care home in a particular suburb where he remained for approximately two years. He described this placement in stark terms. The carers initially presented as warm and spoke of promising things such as holidays and activities, but according to Jack it was a veneer which didn't last. The reality, which Jack described as "a bit rough",[6] was as follows:

- Jack and the other children in care (approximately six at any one time, sleeping four or five to a room in bunk beds) were given different and lesser food than the carers, who would eat steak while the children had microwave pies.
- The children were not treated like children – like the carer's children – but "more of an annoyance".[7]
- They were subjected to physical intimidation, including having empty soft drink cans thrown at them.
- One carer operated a lawn maintenance business. The children were used to do the physical labour, both maintaining the carers' own extensive property and working on customers' premises, while the carer would smoke and drink. Jack estimates the property maintenance alone occupied two to three hours every second day, generally after school.
- Jack said that the placement was "fear-driven, so you didn't really feel like you could speak up if you wanted to."[8]

[5] Ibid 1403:6.
[6] Ibid 1405.5.
[7] Ibid 1405:17.
[8] Ibid 1427:39.

Jack said he was never paid for this work, not even pocket money: it was implicit was that the labour was the price of being housed and fed.

During this period Jack required significant dental treatment: his teeth were overcrowded and he required braces. Because treatment was not commenced during a particular developmental window, through a combination of inaction by the carers and delays in Departmental approval, that window closed. As a result, the condition progressed to the point where surgery was required: surgeons had to fracture jaw bones to reposition them.

The condition caused Jack significant social and emotional distress. He grew his hair past his shoulders because he "didn't want to have people look at me...at my teeth".[9] He described his self-confidence during this period as "not great."[10] The problem first became apparent at around age nine or ten; the corrective surgery did not occur until he was with Witness C, some six or seven years later.

Apart from an initial settling-in visit, Jack has no recollection of seeing a child safety officer during the approximately two years he was at this placement. He was not given a telephone number to call, and even if he had been, he says he would not have felt comfortable using the telephone at the placement, given the atmosphere of fear in the home.

Jack was told that a particular person would visit and could be told about any problems, and that those concerns would be relayed to the department. He raised concerns with this person about the way the children were treated and the feeling that they did not belong. He discovered only years later that the person was not in fact a community visitor, but a support worker for the foster care agency, effectively a representative of the carers.

Second reunification – and breakdown

At around age thirteen, Jack was told he would be reunified with his mother. Having already moved schools when he was shifted to the beach placement, he was moved again - to a school closer to his mother's home in preparation for reunification. As best as he recalls, he was not consulted about this – or any – school change and had to leave great friends behind. He did not feel that there was anyone he could talk to have his voice heard.

The reunification lasted approximately two years and began well but broke down when his mother relapsed again. Once more, it was Jack himself who contacted Child Safety to seek to be removed and, once more, the response was prompt. Jack said he had, by that point, become guarded

[9] Ibid 1407:24, 34.
[10] Ibid 1407:38.

about his emotional investment in the reunification, having anticipated it might not be sustainable. He says he received no particular support from the Department during either reunification period – although he accepted it was possible he was offered some support, although no support at school. He thought there were some attempts to help his mother but "you can't really help someone who doesn't think they have a problem."[11]

Placement with Witness C

After the second reunification breakdown, Jack went through one or two further temporary placements before being placed with Witness C. He arrived with Witness C at around age fourteen and remained until approximately age twenty, maintaining a close relationship with her to the present day.

Jack describes the difference between Witness C's home and his former foster placement as 'night and day'[12] and that it was 'just miles better'[13] with Witness C. He was 'treated like family and not just another person to feed'.[14] At Witness C's home: everyone ate together and ate the same food; he was included in family decisions and overseas holidays and was supported to pursue activities and goals. The first thing Jack wanted was to have his jaw treated. Getting Departmental approval took approximately a year but Witness C pursued it to completion. Jack also recalled other children in the placement receiving full support for athletic pursuits when they asked for it.

The transition to genuine attachment, however, was not immediate. Despite being in a stable, nurturing placement, Jack said it was not until he was approximately seventeen, that he felt genuinely comfortable and attached to Witness C.

His most valued child safety officer during this period was Witness H. He describes her as direct, effective, knowledgeable, and a very good advocate – someone who'd "just get things done"[15] and spoke to him as an adult. He noted she was herself a foster parent, which he believed helped her understand what children in care actually needed and how to navigate the system efficiently. Whilst he noted that this might be "wishful thinking"[16], he believes that CSOs should have experience as a foster carer to get a better idea of what needs most children will have.

[11] Ibid 1412:7.
[12] Ibid 1415:26.
[13] Ibid 1415:6.
[14] Ibid 1415:8.
[15] Ibid 1416:46.
[16] Ibid 1419:11.

Transition to Adulthood

Jack moved out of Witness C's home at around age twenty, though he remains closely connected to her. He attended university after finishing school but encountered a significant practical obstacle: Centrelink youth allowance is means-tested against the income of the people you live with, and you are not considered independent until age twenty-four. Because he lived with Witness C – who was fostering him – he was ineligible for youth allowance for approximately eighteen months despite living independently and studying.

Jack said was not informed of available entitlements for care-leavers when he turned 18 and only discovered some of them later. His summation of the transition support he received from the department was: "just 'good luck', and that was it."[17]

Jack recommends that care leavers be given clear information, even simply a list, of the entitlements and supports available to them as they exit the system. The current approach leaves young people to discover these things by chance, if at all.

The most important aspect of any care relationship

Jack's evidence was that stability is the single most important feature of any care relationship — not as an end in itself, but as a precondition for everything else, including emotional attachment, trust, and development. The experience of being treated "like cargo"[18] at twenty placements in as many days had lasting effects on his sense of self-worth that he continues to experience as an adult: "when you're at 20 different houses in as many days you start to feel like, okay, well, nobody wants me."[19]

Knowing there is a person and a place you can always return to is key.[20] He noted that even now, several years after formally leaving care and having moved out, he knows there is always a room for him at Witness C's if he ever needs it. That, he said, is what stability looks like.[21]

The importance of having a voice

Children in care are routinely told where they are going without being asked. Jack did not want to change schools before the second reunification, but he was not asked his view and was moved the same day he was told. He learned years later that friends from his previous school thought he

[17] Ibid 1418:21.
[18] Ibid 1420:16.
[19] Ibid 1420:31.
[20] Ibid 1426:20-45.
[21] Ibid.

had abandoned them. Jack recommends that there is meaningful consultation with children about serious changes to their lives, including, where possible, consideration being given to timing transitions like school changes to coincide with school holidays, so friendships are not abruptly severed.

What this case showed

There are many themes of systemic relevance in Jack's story. A key theme is that attachment and permanency are integral and indispensable to a nurturing relationship between a child and the carer(s). Jack's story reveals that children in home-based care are vulnerable to disingenuous motivations of their carers. Jack's first experience with (stable) foster carers was effectively Dickensian. He was treated as live-in help and made to feel he was obliged to his carers.

The risk that a child may be placed with persons motivated by self-interest, or worse, may not be capable of always being detected in advance. However, it should nearly always be discovered within a short period of time. Jack was able to voice his distress and concerns about his treatment by his foster carers. The problem was there was no one from the Department to tell. Jack was in plain sight but there was no one to see him or what was really going on. Again, the criticality of ensuring there is a CSO who has a real and genuine relationship with the child is confirmed. Real and substantive casework with the child, not compliance focused routine monthly visits, is what is required. If there had been a CSO with real knowledge of Jack's situation, the carers' self-interested motivations would have been discovered, presumably resulting in Jack and the other children being removed from the placement. Self-evidently, the critical factors in any process of oversight is knowledge of the true state of affairs. That knowledge cannot be gained by formulaic compliance-focused inspections.

Jack's experience in being unable to access the dental procedures be required speaks for itself, save to say that the Commission has heard of an alarming number of similar examples, Ellen's story, for example.

There is much more that might be said about Jack's story, but the systemic failure requires little explanation. At its core, the system failed Jack because it did not listen to his voice.

Aimee[22]

Background

At the Toowoomba public hearings, the Commission heard evidence from Aimee, now a young mother in her twenties. Aimee had previously made a written submission to the Commission. Aimee gave evidence about her contact with, and experience within the child safety system, the genesis and escalation of her offending from aged 12 and her perspective that she was left homeless and unsupported by the Department and criminalised for survival crimes, whilst also being sexually exploited and abused during her time in care.

The Commission put the Department on notice that if it wished to dispute any of the facts recounted in Aimee's evidence, it would need to do so expressly.[23] The Department did not do so.

Evidence before the Commission

This case study reflects Aimee's evidence to the Inquiry, including her written submissions and oral testimony. It brings her account together into a single narrative to support the Commission in understanding how the child safety system was experienced from her perspective over time.

Early life and removal from parents

Aimee was removed from her family (and accepted that she ought to have been removed) at a young age on the grounds of emotional abuse.[24] Aimee disclosed incidences of sexual abuse by her father – but the allegations were unsubstantiated. Initially placed in foster care, she was sent to her grandmother, who abused her to the point of leaving scars, and allowed both parents unsupervised access to Aimee, continuing the cycle of abuse.

Homeless at age 12

By age 12, Aimee had left her grandmother's house. She began smoking marijuana as a means of escape. She was suspended from school for possessing marijuana (which, according to Aimee her father gave her). This was a catalyst for discussions between Aimee, her school and the Department. Aimee disclosed fears for her safety if sent home to her father, and physical abuse

[22] Aimee gave evidence at the Toowoomba public hearing on 16 February 2026. Her outline of evidence and recommendations is CA-58, tendered 16 February 2026. Her evidence commences at transcript 4121:16.
[23] Transcript (16 February 2026) 4196:23-32.
[24] Transcript, Evidence of Witness S (16 February 2026) 4156:6.

at the hands of her grandmother. However, the child safety officers (erroneously) advised the school that Aimee had no child protection history, and to call the police if Aimee refused to return to her father's house.

To escape the cycle of abuse, Aimee started couch-surfing with extended family and friends, before ultimately becoming homeless. At this time, there was an open assessment in respect of her situation.[25] It is unclear what the outcome of this was. Aimee began living at a bus shelter. The bus shelter was opposite a Child Safety Service Centre (CSSC). Aimee would go to the CSSC to charge her mobile phone and beg for a placement. The CSSC's response was to call the police because Aimee was trespassing because she was in the building after 5pm. At one point, Aimee slept in a skip bin because it was warm from the fried chicken that was thrown into it by the nearby fast-food outlet when it closed.

"Deceitful and transient" and able to "self-protect": Child Safety

At 15 years old, Child Safety assessed Aimee as "at risk of harm" due to her own deceitful and transient behaviour and at an age where she can self-protect and access support if required.[26] During this same assessment, Child Safety acknowledged that Aimee's family had an extensive history with Child Safety spanning 2005 to present [then-2014] involving domestic violence, neglect, Family Law custody arrangements and Aimee having nowhere to stay.

Youth justice offending commenced in the form of "survival crimes"

Aimee described her youth justice offending beginning as "survival crimes": stealing breakfast foods; stealing shoes because she had lost hers and had blisters on her feet; stealing colouring in pencils and books to stave off boredom at the bus shelter; stealing her first bra.[27] She was also charged multiple times with trespass for sleeping in locations such as locked public toilets and fire escape stairwells.[28]

The offer of a placement following a rape at a youth homelessness shelter

Aimee's youth justice caseworker found her a bed at a youth homelessness shelter, despite Aimee being below the minimum age for the shelter. The Department rebuffed the shelter staff's concerns about Aimee, denying her child protection history or that she was a child in need of

[25] Ibid 4166:5.
[26] Ibid 4132:6-31.
[27] Ibid 4123:19-27.
[28] Ibid 4123:38-42.

protection. Only after the involvement of the Office of the Public Guardian was the record corrected and acknowledged by Child Safety.

Whilst living at the shelter, Aimee was raped by another shelter resident, who was subsequently charged. Following this incident, Aimee was placed by Child Safety in a series of placements in residential care, initially with other young persons, but later in two-on-one or one-on-one placements, that is, placements where she is the sole tenant, under the supervision of one or two youth support workers.

Aimee's experiences with residential care placements

Aimee described the residential care environment as "unnatural and cold", "clinical" and "someone else's workplace" and one that was not conducive to providing her what she was seeking, namely love, connection and understanding.[29] She described rotating youth workers on 8 hour-shifts who were prohibited from sharing personal information about themselves or show any physical affection for the children in their care. She described locked kitchens, no privacy, all doors being alarmed, having your behaviour constantly documented, and waking up to find strangers in the "home" almost daily. To use Aimee's own words:

> I think when you've experienced a lot of abuse and harm by strangers, unknown people and men and you wake up to all three of those things wrapped up in one in your home it's awful because what is one person's workplace is another person's home and you're always hypervigilant and you are always on alert because you can't even feel safe when go to bed because you can't lock your door, you can't know for sure who's going to be there in the morning. [30]

Aimee also said she could never feel fully comfortable in using the bathroom or have a shower because the doors didn't lock and she didn't know if someone was going to come in. Aimee spoke of her struggles to attend school whilst in residential care due to changing placements, the distances between placements and school, and lack of resources within placements. At one point, she had to take four to six buses to get to school. At times, there were three to four young persons living in a residential care placement, and only one vehicle to support them all to attend school (often at different schools) as well as family contact and other appointments) and no support workers rostered on during the day. At times, the Department would not support Aimee's enrolment, so she enrolled herself in the local high school. Ultimately, Aimee did not complete her schooling beyond year 9 whilst she was in care. However, she did return to school as an adult and completed year 12.

[29] Ibid 4150:36-38.
[30] Ibid 4152:42.

According to Amy there was no such thing as a sick day, as residential care providers that closed during the day: if she was sick, she would sit in a park or a train station or go to a shopping centre for the air-conditioning. Support to attend a doctor when ill varied dramatically across residential care placements: some providers who arrange for a support worker to take Aimee to the doctor and wait with her; others would provide no support, requiring her to attend the doctor alone, which was difficult because she did not have a copy of her own Medicare card which made it difficult to make an appointment.

On the issue of the differences in quality of care between licensed and unlicensed providers, Aimee's experience was that licensed providers tended to have stable, well-established team of youth workers, with good routines in place and good working relationships, which translated, in her view, to much better day-to-day care of young people. By contrast, unlicensed providers tended to have very high turnover of staff, brand new staff or new teams who have been recruited in a rush for a residential facility had had just opened.

Aimee recalled being heavily medicated at a 'therapeutic' residential care facility in Cairns and told that if she did not take the prescribed sedative medication, an ambulance would be called. Aimee recalled being so heavily sedated one day that she could not physically move her body from the floor of her residential care bedroom to her bed.[31] Aimee referred to the use of other restrictive practices on her within this facility, such as physically restraining her if she sought to leave the placement, if she was angry or looked as if she was going to escalate. Aimee accepted that during periods of acute mental crisis, medication was – for her – "probably needed".[32] What she regarded as problematic was medication being use "almost like a bandaid for behaviour rather than understanding the root cause, medication was just added and added and added".[33]

Aimee ultimately absconded from this placement, describing it as "not care" and "not therapeutic". Aimee's evidence of what she needed at that time was:

> ...a safe adult in my life, and I needed to feel secure in that and know that that adult's involvement in my life was not based on a birthday, turning 18, and leaving care or a placement end date or any other conditions imposed by the State or the organisation...It is impossible to feel connected or safe or secure when you never know when that relationship with that adult will end...So it made all my attachments with adults difficult...because it felt better to be the one to end that relationship rather than the State ending it for you.[34]

[31] Ibid 4126:23.
[32] Ibid 4126:25.
[33] Ibid 4162:6.
[34] Ibid 4159:23.

Aimee disclosed that she was sexually abused by a youth worker in a licensed, well-established residential care placement. This youth worker required sexual acts in exchange for driving to her places, including her youth justice appointments. Aimee ultimately made a successful National Redress application against this worker, who had worked across multiple residential care providers. Aimee's evidence was that there were multiple successful redress applications in respect of that youth workers. She raised a lack of information sharing between the National Redress Scheme, Blue Card Services, residential care providers and the Department as a factor in this youth worker's ability to abuse a number of young people across multiple providers. She also raised a lack of sharing of information between residential providers themselves regarding disciplinary action against workers, which allowed this support workers to remain employed within the residential care industry despite disciplinary findings against him. There simply were no checks within the system to alert potential residential care provider, a situation that Aimee described as "deplorable".[35]

Seeking love and connection led to sexual exploitation and further offending

Aimee's search for love and connection also led her to form relationships with older men outside the residential care system who exploited her, both sexually and for their own criminal purposes. They injected her with methamphetamine, but gently and with clean needles, which Aimee took as displaying love and care towards her.[36] The drugs gave Aimee courage to commit crimes for these men, including stealing cars. She became addicted to methamphetamine, which the men would then provide her in exchange for sex.[37] This escalated to the men injecting her with methamphetamine, then sending her to a local motel to be exploited by strangers where she would earn enough money for grocery items not provided by her residential care placement. When Aimee called the residential care service to pick her up from a motel, her request was refused because it would, in effect, be (in the words of the residential care service) "enabling... child prostitution".[38] This was so even if Aimee offered to walk to the neared CSSC for the pick up. . It was unclear what if any intervention was attempted with Aimee to support her to break away from this conduct and the men procuring it.

When asked if being homeless was the most significant risk in terms of coming into contact with bad actors who engage in the kind of exploitation, Aimee agreed and noted that if you are on a child protection order and homeless, you are unable to access funded homelessness services

[35] Ibid 4144:10.
[36] Ibid 4127:26-31.
[37] Ibid 4127:33-42.
[38] Ibid 4128:6-7.

because it has been determined that you have a guardian who is willing and able to protect you from harm, including by providing you with a safe placement.[39]

Further criminalisation within the system

Aimee was charged with possession of methamphetamine after a residential care manager convinced her to surrender her drugs, then took them to police and named Aimee as the drug's owner. She was charged with armed robbery in company after a physical altercation with a fellow resident over her own stolen shoes. She was charged with assault after throwing a plastic cup of water at a security screen behind which a youth worker stood.

Aimee said she always pleaded guilty to every charge because no-one had ever told her she was allowed to plead not guilty. Child Safety also repeatedly closed her placements — which, at times, had the direct result of placing her in breach of bail conditions.

Motel room placements

Aimee spoke of being placed in motel placements on multiple occasions, sometimes for a night or two, sometimes for weeks, placements she described as "extremely inappropriate".[40] Aimee said that she:

> "...can't ever really see how a placement in a motel would ever be in a child's best interest or would work towards any type of healing or stability for a child."[41]

Aimee was generally placed in motels following a period of hospitalisation or youth detention, because she would not be released or discharged to homelessness, which required the Department to find a placement for her, albeit temporary.

Willing potential carer denied opportunity to become foster carer due to "conflict of interest"

Aimee told of a police officer who used to be called out residential facility to respond to various incidents. This police officer told Aimee that she had sought to become a foster care to take care of Aimee and only Aimee, but that the Department considered that, because Aimee was a child in conflict with the law, that it would be a "conflict of interest" for the police officer to be a foster carer to her.[42]

[39] Ibid 4165:7.
[40] Ibid 4172:23.
[41] Ibid 4172:3.
[42] Ibid 4156:40.

Transition to semi-independent living

Following a period of hospitalisation in an adolescent mental health ward, Aimee was discharged to find that her residential care placement, one at which she had felt safe and settled, had been closed and her care team had placed her in a semi-independent living placement, according to Aimee because it was a cheaper form of placement. Aimee was on crutches and in a moon boot at the time. With no one to support her at her new placement, she had to catch four to six buses to attend school; medical appointments; and comply with her youth justice order conditions.

Refusal of medical treatment

At times, obtaining medical treatment was also unattainable to her. Aimee required braces, but the Department refused her request for such treatment on the grounds of cost. Aimee raised concerns with her care team, and then made a formal complaint, to which she says she did not receive a response. She raised a further complaint after transitioning out of care.

Life after care

After turning 18, Aimee enrolled in a flexi-school and completed Year 12. She became a youth worker and briefly worked in residential care. She is now a mother and is employed in a role that was not publicly disclosed but is known to the Commission. She pursed legal action against the Department, about matters she had previous raised complaints and for its failings in caring for her. She was ultimately awarded compensation.

Additional concern raised by Aimee: Secure care

Aimee expressed the following concerns about secure care:

> My concern is that there will not be adequate independent oversight…I'm concerned that we will see children admitted into secure care facilities that probably don't need to be there, that could be supported better in a different environment, and that these young people may remain there for long periods or experience significant harm in these environments. I'm unsure how an Aboriginal or Torres Strait Islander child could ever be supported to remain connected to culture or be supported with cultural continuity in such a setting like secure care, what their access to education would look like, what their access to community would look like, and who makes the decision and reviews those decisions that is independent from the State.[43]

[43] Ibid 4164:18.

Aimee disagreed that there was a need for a secure care facility as part of a model of care for some children within the system.[44]

What this case showed

Aimee's evidence to the Commission exposed deep and abiding failures across many aspects of the child safety system, and the child protection system more broadly. It is significant to note that the Department did not dispute her account of events and did not seek to question her on any aspect of her evidence.

Although properly removed early, Aimee was placed back with kin who harmed her, both directly and by handing her back to those who originally harmed her. Inadequate record keeping meant that decisions were being made about Aimee's safety and welfare in the dark – and Aimee's voice was consistently either not heard or disbelieved. It took the intervention of an oversight body to correct the record. The pattern of misinformation prevented appropriate responses at critical junctures and left Aimee without the acknowledgment and support her circumstances warranted.

Aimee's homelessness did not trigger an emergency response by a functioning child safety system but a bureaucratic failure of striking proportions. Despite throwing herself on the mercy of the Department by attending the CSSC opposite her bus shelter 'housing' to charge her phone and ask for help, the Departmental response was that of a building manager: to treat her as a trespasser.

Aimee's entry into the youth justice system was a direct product of the system's failure to provide for her basic needs. She stole food, shoes, and basic personal items out of necessity. She was charged multiple times with trespass for sleeping in locked public toilets and fire stairwells. The Commission heard that, because Aimee was subject to a child protection order, she was ineligible for funded homelessness services. That order was taken as proof that she had a guardian willing and able to protect her from harm. The result was that the very existence of State guardianship blocked her from accessing other safety nets, while the guardianship itself provided no meaningful protection.

Aimee's experience in residential care illustrated the fundamental limitations of that placement model. She described an environment that was clinical, impersonal, and structurally hostile to the formation of the safe attachments she needed. Rotating shifts, prohibitions on physical

[44] Ibid 4164:33.

affection, alarmed doors, locked kitchens, and constant strangers in the 'home' were particularly harmful for a child whose trauma history included significant abuse, physical and sexual. Quality varied dramatically between providers. At one facility, she was so heavily sedated she could not move from the floor; medication was used to manage behaviour rather than to assist in addressing underlying trauma. The system's structural design re-traumatised her.

Aimee's case highlighted the vulnerability of traumatised girls in residential care to predators, both within and without the system. Deprived of family-based care and security, Aimee formed inappropriate attachments to men she considered were showing her love – no matter how distorted. Her case demonstrated how a lack of information sharing, and the siloed nature of residential care providers, allowed a predatorial youth worker to operate across multiple facilities, allowing ongoing employment in the sector and further abuse of children in care. Aimee's search for love, connection, and safety led her to relationships with older men who exploited her sexually and for criminal purposes, including for car theft and sex work. Her plea for assistance, which was more than simply a request for a lift home, but a request for an adult in her life to demonstrate genuine concern and care for her, fell on deaf ears. This response, to a child in State care who was being sexually exploited, reflected a profound failure of institutional duty. QPS had at least some awareness of what was occurring and had informed the Department; it was unclear what, if any, intervention was attempted.

Aimee's case demonstrated the battle a child within residential care may face to have basic needs met: transport to school when in a remote location or injured; medical attention as an under 16-year-old without a Medicare care or orthodontic work on the ground of cost.

In circumstances where a stable, caring adult was willing to care for Aimee, the system response was extraordinarily brittle: it denied the carer application on the erroneous ground of "conflict of interest" because the potential carer was a police officer and Aimee a child with a youth justice history. Thus, the system denied Aimee the very thing she needed.

Taken together, Aimee's case demonstrated multifarious failures across the span of her childhood: failing to protect her from known harm, rendering her homeless, criminalising her survival responses, exposing her to further abuse within the care system itself, and then punishing her legally for the consequences of its own failures. Her evidence was that what she needed, but never received, was a safe, consistent adult whose commitment to her was not conditional on placement dates, contract terms, or turning 18. The system's structure made that impossible.

Aimee's story cannot be rationalised or excused when the basic facts are considered in their totality, stripped of comment or editorial. Lamentably, Aimee's story exposes a child protection system which failed to listen to her, compounded the harm from which she sought protection by failing to provide her with nurturing care, and rejected her for rejecting a system that was exacerbating the harm she was trying to avoid.

An aspect of Aimee's evidence worthy of particular attention is her experience of "restrictive practices". Aimee's experience underscores the need for expert professional care for children requiring medication for mental health treatment. While Aimee questioned the need for secure care, her own experience of being over-medicated suggests that there is a place for therapeutic secure care, while acknowledging her warnings and the necessity to ensure proper and independent oversight of any secure care facility.

A further, alarming, feature of Aimee's evidence concerned the belated discovery of a serial abuser working within the residential care system. There have been recent notorious examples in similarly vulnerable environments such as childcare centres. Whilst acknowledging that opportunistic abusers operate covertly, targeted information sharing, accreditation and screening processes must be as robust as they can be made to ensure that predators are discovered at the earliest opportunity. There is no shortage of evidence of the vulnerability of children in care, particularly girls, to such predators, as well as in cognate environments such as schools and childcare centres. Children in care are more vulnerable because they are living in the home (residential care or family-based care) of their abusers. This is a round-the-clock opportunity for abuse.

The likely most effective protection against such abuse going undetected in the Child Safety context is to ensure that the CSO with responsibility for the child is able to, and prioritises, a close relationship of trust and support with the child. In Aimee's case, such a relationship was notably absent, leaving Aimee vulnerable to the residential care environment which she generally found to be unconducive to forming such a relationship. There are, of course, other important opportunities for the broader child protection system to act protectively, in particular in the places where children routinely interact with responsible adults such as schools, hospitals, health care centres and the like. At the most broad and general level, any programme which supports children in care to engage with community, from school to after school activities, sporting, social or cultural, help to bring the child in care from behind the walls of the home into plain sight.

Another troubling aspect of Aimee's case was her known frequenting of a motel or motels at which she was sexually abused. The residential care home was aware this was occurring, as it refused to pick her up on the stated ground that to do so would amount to 'enabling child prostitution'. This was a curious response, to say the least. Surely, the question was not whether Aimee should be picked up but what steps were to be taken to engage with her, to find out what was happening, notify the police and do everything possible to put a stop to the abuse. The evidence about notification to the police and any ensuing investigations is incomplete and generally unclear. However, on the available evidence, it appears that insufficient action was taken to support Aimee.

The risks of sexual exploitation and other abuse for self-placing children, particularly for girls, are self-evidently more acute, as graphically illustrated by Aimee's case. These risks surely confirm the need for a more comprehensive and systemic approach to reaching out and supporting self-placing children. They are the most vulnerable group of children in care, precisely because as a matter of fact they are not in care. They are the least visible, hiding where they can, sleeping on couches and, in Aimee's case, on one occasion in a skip-bin.

YP

Background

YP entered the child safety system at age two and a half. Following extensive placement instability and breakdown, he first came to police attention at age 14. He proceeded to engage in persistent and escalating criminal offending, ultimately participating in an incident with a tragic outcome for a vulnerable member of the community (Significant Offending Event). YP 'aged out' of the child safety system whilst on remand in youth detention.

This case was chosen to examine several issues:

- the link between the child safety system and the youth justice system;
- the experiences of children on dual orders;
- the issue of self-placing and the adequacy of the Departmental response to self-placing children;
- the prioritisation of LTG-CE orders over LTG-O orders contrary to the permanency principles in the *Child Protection Act 1999 (Qld)*; and
- The importance of providing permanency and stability to children in care.

The case of YP was presented to the Commission by Senior Counsel Assisting during the Toowoomba public hearings,[45] based on documentation concerning YP that the Commission obtained via compulsory notices to the Department and QPS.[46] Regional Executive Director Leanne Black was called by the Commission and examined on YP's care history, focusing predominantly on the two years immediately prior to the Significant Offending Event. Following the hearing, the Commission issued further compulsory notices regarding various aspects of the Department's intervention with YP. [47] In response, the Department provided statements by the Acting Chief Practitioner, Victoria Van Houdt (Ms Van Houdt).[48]

Evidence

The table below is a snapshot of YP's combined Child Safety and Youth Justice experience during his 15 ½ years under the custody and/or guardianship of the State. [49]

[45] The evidence was heard at the Toowoomba public hearing on 19 February 2026, Transcript beginning at 4326:10.
[46] Notice to Produce 269 was issued to the Department on 7 January 2026.
[47] Notice to Produce 345 issued to the Department on 24 February 2026 and Notice to Produce 352 issued to the Department on 3 March 2026.
[48] Statements of Victoria Van Houdt dated 10 March 2026 (Notice 345) and 13 March 2026 (Notice 352).
[49] See Table 1 on page 30 of this annexure.

Placement Type	Number
Foster Carers	22 *(8 primary, 14 respite)*
Kinship Care	3
Residential Care	6
Commercial (Motel)	1

Placement Type	Days
"Self-placement"	778
Police Watch-House	30 *(14 admissions)*
Youth Detention	425 *(6 admissions)*

Removal from parents and rolling short term orders

YP was removed from his family home and placed into state care due to his mother's drug and alcohol abuse, neglect, lack of parental supervision and aggressive parenting practices.[50] YP seemingly had no contact with his biological father throughout his childhood.

Following the granting of emergent orders, YP was subject to a series of short-term orders granting custody or guardianship to the Chief Executive for almost 10 years, before an LTG-CE order was made. This delay is discussed further below.

Prolonged instability and upheaval: 20 foster carers at age 9, including three relinquishments

By age 9, YP had cycled through 20 different foster carers. This was caused primarily by repeated use of respite carers, as well as multiple breakdowns of primary placements resulting in relinquishments. For example, in one instance carers were "unable to manage [YP's] behaviour", and in another the "sexualised behaviour" of one of his siblings placed with him in foster care.

At age 10, a Child Strengths and Needs Assessment (CSNA) conducted by Child Safety referred to YP's diagnosis of Reactive Attachment Disorder (RAD), his difficulties coping with the grief and loss, placement instability and the trauma YP had experienced due to neglect and continued placement breakdowns. In essence, the assessment reflects that YP was a child in need of placement permanency and stability.

[50] Transcript, Evidence of Leanne Black (19 February 2026) 4331:4.

A period of stability: a stable foster placement from age 9 to 13 – and the making of LTG-CE orders

YP's twentieth foster care placement provided a period of relative permanency and stability, lasting 3 ½ years. During this period, LTG-CE orders were made, by which time YP had spent close to a decade in State care. It is not entirely clear why long-term orders took this long to achieve, but may be a result of Child Safety, for a period of 7 or 8 years endeavouring to achieve reunification with his mother as the primary permanency goal for YP.[51] Subsequently, the permanency goal became long term out-of-home-care (OOHC) due to YP's mother failing to meet case plan goals for reunification including, curbing substance misuse, maintaining stable and appropriate accommodation and maintaining contact and connection with YP.

It is unclear if YP's foster carers were considered for assessment for suitability as long-term guardians for YP – despite the fact that YP had been in a stable placement with these foster carers for 2 ½ years at the time the long-term orders were granted. In what would become the last months of his placement, YP (at 13 years old) was described in a Departmental case notes as 'stable' and articulated that he felt 'loved by everyone in [foster family]." It is further noted that:

> *[YP] is expressing curiosity in becoming LGT-O to the [foster] family, however [YP] is not really concerned about guardianship, he simply feels that the regular visits from child safety and other services serve only to bring focus on him being in care rather than just growing up with the family he is now a part of. [YP] loves his biological mum but he has grown to accept that his life is with the [foster family], and that is really ok, and good.*

It appears that, at this time, YP saw his long-term future with his foster family and wanted to solidify his attachment to them.

When YP was 13, a harm report was recorded in respect of YP and other children in the foster household. YP's carers actions (or inactions) were asserted to have contributed to the (alleged) harm. The concerns were significant, although none of the notified concerns directly related to YP. YP was removed from his long-term carers under s 89 of the *Child Protection Act* (Qld)[52] , within a short period he cycled through a foster care, residential care and self-placing before being placed with kinship carers as a new primary placement. YP was interviewed as part of the investigation. He did not disclose any concerns about those alleged to be the cause of harm to others in the placement, nor any worries about his concerns about his foster carers.

[51] Statement of Victoria Van Houdt (13 March 2026) [27].
[52] Section 89 of the *Child Protection Act 1999* (Qld) allows the chief executive to remove the child from the care of the child's carer if the chief executive is satisfied it is in the child's best interests.

Child Safety found "insufficient evidence to indicate that [YP had] suffered physical or emotional harm of a detrimental nature due to actions or inactions of [his foster carers] or any of the children within the household[53]."Child Safety concluded that YP had not been harmed and that the legislated standards of care had been met in respect of YP at all relevant times. Child Safety also concluded that YP was not at unacceptable risk of harm on the basis that he was, by that time, 'residing under a family arrangement': apparently a reference to his primary kinship care placement.

It appears that there was ultimately no risk assessment undertaken as to whether YP ought to be returned to his long-term carers, as he was in a new primary placement, which was also a kinship care placement. YP had never been placed with these kinship carers before, despite having been in care for more than a decade at that point. Furthermore, only months earlier, YP had spoken of exploring LTG-O orders to his foster family. Based on the information provided to the Commission, there is no evidence of any discussions with YP regarding his removal from his carers, explaining the outcome of the harm report/standards of care process or what, if any, support may be provided to YP in light of his removal from his long-term foster care placement. This is a notable omission given the context of his traumatic history of placement breakdown and his diagnosis of RAD.

The kinship care placement broke down after 141 days, at which time YP commenced 'self-placing'. From this point, YP was not placed with foster carers again. [54]

Regrettably, the breakdown of this long-term foster care placement – occurring at age 13.5 – appears to have been a critical turning point in YP's trajectory. In the following six months, YP began a rapid descent into absconding from non-family-based care placements, self-placing and criminal offending.

Offending commenced aged 14 following removal from stable foster carers and placement into the residential care system

At age 13.5, YP was placed in residential care for the first time – on a respite basis. After two weeks in that placement, YP first started to 'self-place'. YP's first primary placement with kin followed (referred to above). It lasted a little under five months, after which time he once again resorted to 'self-placing'. YP's first formal contact with police (a caution for public nuisance) occurred at age 14, one day into this period of 'self-placing'. Within a month of his first caution by police, and

[53] Harm Report Assessment and Outcome provided by the Department (DFS.0345.0001.0096) 10.
[54] Based on the Department's records, when he was 16 years old, he 'self-placed' for 94 days with his former foster mother.

during a period of 'self-placing', YP was admitted to the city's watchhouse and charged with 12 counts of wilful damage.

During periods of self-placing, YP typically stayed with extended family or kin — aunts in particular — as well as with community members he had come to know informally. He was repeatedly bailed to addresses that were not formally assessed or approved as kinship placements, and he did not always remain at the nominated address. The Department's after-hours responses frequently amounted to little more than acknowledging there were no available placements to which he could be bailed.

It is clear on the face of Child Safety and QPS records – when read together – that the vast majority of YP's subsequent youth offending (which unfortunately escalated over time) occurred when he was 'self-placing'.

Absconding from residential -care and reported missing; and a 'prescribed home visit'

After a considerable period of self-placement (and a further admission to the watchhouse), YP was transitioned into his fourth residential care placement. He absconded after 13 days; was reported 'missing'; was located 10 days later and thereafter noted in Departmental records as 'self-placing'.

Each placement breakdown led to further periods of self-placing, further watch house admissions, and further detention,

Financial support from the Department during periods of self-placing was minimal: a Departmental case note of a prescribed 'home visit' to his 'self-placing' address showed that he was given a $50 Woolworths voucher and a sports equipment voucher; YP's request for clothes was deferred for approval as YP had received clothes the previous month.

Child Safety's assessment of YP's strengths and needs: evidence of failure to meet basic needs

A CSNA was prepared when YP was aged 15 – a year and a half after his long-term foster placement breakdown. It makes for disheartening reading. In summary, at that time:

- YP was abusing substances to the point of hospitalisation, particularly chroming (inhaling aerosols), is refusing treatment for substance misuse and is predominantly engaging with peers who are also engaged in substance misuse;
- YP's mental health was in decline, he was emotional unstable and engaging in outbursts and verbal abuse within the community;

- YP was disengaged from education, social and sporting activities;
- YP was engaged in criminal activity, including stealing food and other essential items — essentially survival-driven offending, which reflected his basic needs not being met by his corporate parent; and
- YP's extended family did not want him to reside with them, due to a breakdown in their relationship with his mother.

Despite these facts, Child Safety assessed YP's 'family connection' overall as a 'strength' and that found that YP was demonstrating 'significant resilience and coping skills'. It is hard to reconcile these conclusions with the basic facts recorded in the document.

Escalation of offending

YP's offending escalated steadily: from stealing essential items and public nuisance to wilful damage, possession of a knife, trespass, entering premises with intent, robbery with violence causing harm to an elderly semi-disabled man, unlawful use of motor vehicles, and burglaries.

Release from youth detention to a motel 'placement' – "cruising around"

After his first detention centre stay (53 days, age 15), YP was released into a commercial motel placement. Child Safety records showed that he told his CSO that "he is OK and the motel was good…just been cruising around".[55] QPS records show that during this motel stay, YP was offending - committing burglaries and stealing.

A further residential placement breakdown

At age 16, the Department organised a residential care placement at a fee-for-service provider. Less than a month in, YP was recorded as "experiencing significant escalation at placement",[56] was threatening to steal vehicles at or near the placement and refusing to return. YP spent his 16th year self-placing, in watchhouses or in detention.

At one point, YP was found by police in a stolen vehicle that had crashed into another vehicle. At the time of this offending, YP did not have a departmentally approved placement. An aunt was said to be the point of contact for the child. Child Safety records reveal that the CSO stated that she was "unable to comment further [to the QPS officer] upon whether the aunt is an appropriate person to care for the child." Child Safety also refused a QPS request to assist with transport for YP because YP was 'without a Departmentally-approved placement'.[57]

[55] Transcript, Evidence of Leanne Black (19 February 2026) 4359:34.
[56] Ibid 4361:15-41.
[57] Ibid 4363:3.

Overnight stays in a police stations foyer and hospital interactions

On at least one occasion, YP slept in a police station foyer. Another night he was offered a 'social admission' at a hospital whilst he awaited a placement. At one point, he attended hospital voluntarily because 'he [had] been trying to jump in front of cars and was extremely angry'. Overall, a sadly chaotic picture emerges of YP's life, careering between watchhouses, detention, homelessness, hospital and the occasional placement when incidentally available. YP was trapped in a system that was ill-equipped and ill-prepared to intervene. Plainly his basic needs were not met over an extended and critical period in his life, leading to escalating detachment from society and escalated offending.

Significant Offending Event whilst in a Department-approved kinship care placement

After a period of 133 days of self-placing, a kinship care placement was found. Whilst in this formally approved placement, YP aged approximately 17, engaged in criminal conduct with others, which led to tragic consequences for an innocent and vulnerable member of the community.

YP was arrested and remanded and spent 499 days in pre-sentence detention. He turned 18 in detention, aging out of the child safety system. No conviction was ultimately recorded; a reprimand was issued and the pre-sentence detention was deemed time served.

Knowledge of the Office of the Director General at or around the time of the offending

At the time of this offending, Youth Justice and Child Safety were part of the one department. Records show the Deputy Director General of the Department was informed of a 'significant incident' in which YP was involved and of its 'tragic results'.

Lack of subsequent review of processes and procedures

By compulsory notice, the Commission interrogated the Department for details of:[58]

> "any review of processes or procedures triggered by the offending behaviours and any details of any subsequent changes to legislation, policy or procedures that resulted."

[58] See, Notice to Produce 269 (7 January 2026).

The Department put forward Ms Black, Regional Executive Director, South West Region, a senior, experienced and long-standing officer of the Department to give evidence on these matters. In her witness statement, Ms Black wrote:[59]

> "As the incident was not a child death or a serious injury to a child or a young person, there was no review of processes or procedures triggered by the offending behaviour, nor any subsequent changes to legislation, policy or procedures that resulted" (Underline added).

In her evidence during the Toowoomba public hearings, Ms Black confirmed that the reason there was no review was because the qualification or trigger for a review is the death of a child or serious injury to a child,[60] notwithstanding that, at the time, the department was a single department concerned with both Child Safety and Youth Justice.[61] In short, the policy of the Department at the time did not require a review; therefore a review did not occur.

Ms Black was asked whether she considered that the circumstances for triggering a review of processes or procedures should be widened to include occasions where significant deaths or injuries to members of the community involve children in care. Ultimately, Ms Black said that she was 'not opposing that there would be value in having any review of any significant outcome involving a child in care.'[62]

Subsequent observations by Child Safety regarding YP

Following the presentation of this case study at Toowoomba, compulsory notices were sent to the Department about aspects of YP's care. In a responsive witness statement, the Acting Chief Practitioner made the following observations:

- there were 'missed opportunities for robust collaboration involving the participation of [YP's] family, community and relevant stakeholders in the case planning process.'[63]
- there was 'limited focus' within YP's case plan on "building and sustaining positive relationships".[64]
- that contact with YP during periods when he was 'not in an approved placement' was inconsistent, and that contact was frequently reactive – that is to say, triggered by arrests, school suspensions or court appearances – rather than proactive.[65]

[59] Transcript, Evidence of Leanne Black (19 February 2026) 4373:21-27.
[60] Ibid 4373:38-4374:8. It is worth noting s 245 of the *Child Protection Act 1999* (QLD) requires the Department undertake an internal review in the event of death or serious injury to a child.
[61] Ibid 4374:10-13.
[62] Ibid 4376:18.
[63] Statement of Victoria Van Houdt (13 March 2026) [31].
[64] Ibid [83].
[65] Ibid [66].

- attempts to locate YP were sporadic and that enduring attempts were not made to locate him.[66]
- There was limited evidence that the Department sought multi-agency involvement in locating YP, and that contrary to procedural requirements, only one missing person report was recorded across the entire relevant period.[67]
- There was limited evidence that YP was engaged in safety planning, regularly offered placement options or engaged in discussion about where he wanted to reside – all of which was required as a matter of procedure.[68]
- There was no evidence that the Department made referrals for YP to an alcohol and other drug service or a mental health service following the ceasing of his long term foster placement – notwithstanding that his Child Strengths and Needs Assessments from 2020 onwards recorded drug use and mental health diagnoses as identified needs.[69]
- Following the long-term placement cessation, there appears to be information suggesting that risk factors were present for YP indicating a high-intensity response and strong safety and support network was required, but did not occur – and that such a response may have strengthened communication between agencies, identified further supports and improved responses to his needs and behaviours.[70]
- There was limited evidence of a comprehensive exploration of kinship care placement options after his approved placement ended.[71]
- There were missed opportunities to strengthen efforts to achieve permanency for YP (whilst noting that LTG-CE was likely the most appropriate order in the circumstances).[72]
- It is unclear from ICMS records what work and provision of services was being delivered by Youth Justice and that regular collaborative agency meetings may have strengthened service delivery.[73]

What this case shows

The prolonged failure to achieve permanency compounded harm

YP entered the child safety system at the age of two and a half. By the time a long-term guardianship order to the Chief Executive (LTG-CE) was finally made, he had spent almost a

[66] Ibid [67].
[67] Ibid [68].
[68] Ibid [69].
[69] Ibid [48].
[70] Ibid [49].
[71] Ibid [85].
[72] Ibid [87].
[73] Ibid [50].

decade in care. That delay had an evident human cost – predominately to YP. Reunification with his mother remained the primary permanency goal for the better part of a decade, notwithstanding that she was unable to meet reunification targets. During that time, YP cycled through 20 foster carers - a pattern of repeated placement breakdown that the Department's own case notes identified as a source of profound grief, loss and trauma.

LTG-CE was seemingly prioritised over LTG-O by default

When stable foster care was eventually achieved, YP was not simply placed safely — he was thriving. Departmental case notes recorded that he felt 'loved by everyone' in his foster family, that he identified his long-term future as being with them, and that he was actively curious about the prospect of long-term guardianship to them. Yet there is no evidence that the concept of LTG-O was ever explored with his foster carers, including their willingness to be assessed for suitability as long-term guardians, or that a meaningful analysis was conducted of whether LTG-O would better serve YP's need for permanency and belonging than LTG-CE. It appears that LTG-CE was adopted as a default, rather than as the outcome of a considered assessment of YP's specific circumstances and his expressed wishes in accordance with the paramount principle.

Self-placing is a failure of the system, not a choice of the child

From the moment YP's kinship placement broke down, he was never again placed in stable foster care. The 778 days he spent self-placing were characterised by homelessness, hunger, unsafe environments and escalating offending.

Financial support from the Department during these periods appeared limited and inadequate. Below Centrelink age and outside an approved placement, YP had no income, no stable address and no means of meeting basic needs. The correlation between self-placing and offending in YP's case is direct and documented.

The Department's own Acting Chief Practitioner acknowledged, in responding to Commission notices, that contact with YP during periods of self-placing was inconsistent, frequently reactive rather than proactive, and that enduring attempts to locate him were not made.

A child under LTG-CE orders is entitled to expect more from his corporate parent.

The child safety and youth justice interface failed to produce a coordinated response

At the time of YP's most serious offending, Child Safety and Youth Justice operated within the same department. Despite this, the evidence discloses limited evidence of meaningful inter-agency collaboration. The Acting Chief Practitioner acknowledged that it was unclear from ICMS

records what work and provision of services was being delivered by Youth Justice, and that regular collaborative agency meetings may have strengthened service delivery.

The Department refused a Queensland Police Service request to assist with transport for YP because he did not have a Departmentally approved placement, a response that prioritised administrative status over the immediate welfare of a child in crisis. A child safety officer attending Children's Court appearances was, in practice, the primary mechanism by which Child Safety remained aware of YP's criminal history. That arrangement is plainly inadequate as a substitute for systematic, coordinated case management between child protection and youth justice services for a young person presenting with multiple, intersecting and escalating risk factors.

The Department's failure to review its own processes reflected a critical gap in accountability

The Department's policy at the relevant time required a systems and practice review only in the event of a child death or serious injury to a child. Because the Significant Offending Event did not involve the death or serious injury of a child in care, no review was conducted, notwithstanding that a vulnerable member of the public was gravely harmed, and that one of the young persons responsible had been in the continuous custody or guardianship of the State since he was two.

The absence of secure care as a placement option in Queensland

YP's trajectory from the breakdown of stable foster care to escalating offending, self-placing, watch house admissions and detention is a trajectory that the existing placement mix was unable to interrupt.

The Commission does not say that secure care would necessarily have altered YP's trajectory. However, the placement mix available to the Department in YP's case was plainly inadequate, and the continued absence of a secure care option in Queensland limits the Department's capacity to respond to children presenting with the most complex and acute risk profiles.

Conclusion

The Commission acknowledges the acute difficulties involved in meeting the needs of YP and in providing a stable nurturing placement for him. Regrettably, YP's story is by no means unique, nor an outlier on the scale of difficulty when it comes to placing and caring for young people with fraught and traumatic histories of abuse, neglect, detachment, serial placements, drug abuse, self-harming behaviours and, too often, allied offending.

Self-placement is both a scourge upon, and a damning failure of, the child safety system. Both YP and Aimee's are heart-breaking examples of the likely consequences which ensue when a child abandons the system intended to protect them from the consequences of having already been effectively abandoned by their parents. Self-placement is the quintessential example of abject system failure, the abyss into which children fall from which, with rare exceptions like Aimee, their journey is set upon a known trajectory, usually starting with self-harm and concurrent youth offending. Their journeys led to entrenched alienation from society which very often follows them throughout their lives, causing even greater harm to themselves and to the community.

Table 1 – placements for YP across his journey through the child protection system[74]

Days in placement	**Age at placement start**	**Location type**
350	17 Years, 0 Months	Detention
15	16 Years, 11 Months	Watchhouse
48	16 Years, 10 Months	**Kinship care**
133	16 Years, 6 Months	Self-placing
2	16 Years, 6 Months	Watchhouse
1	16 Years, 5 Months	Watchhouse
1	16 Years, 3 Months	Watchhouse
94	16 Years, 2 Months	Self-placing
19	16 Years, 1 Months	Detention
6	16 Years, 1 Months	Watchhouse
0	16 Years, 1 Months	Watchhouse
19	16 Years, 0 Months	Self-placing
27	15 Years, 11 Months	**Residential**
1	15 Years, 11 Months	Detention
14	15 Years, 11 Months	**Commercial**
53	15 Years, 9 Months	Detention

[74] Spreadsheet of placement history provided by the Department under Notice to Produce 269, manipulated (DFS.0269.0003.0001). Primary placements are marked in bold.

Days in placement	Age at placement start	Location type
0	15 Years, 9 Months	Self-placing
2	15 Years, 9 Months	Watchhouse
1	15 Years, 9 Months	Watchhouse
25	15 Years, 7 Months	Self-placing
20	15 Years, 6 Months	Self-placing
18	15 Years, 6 Months	Self-placing
10	15 Years, 5 Months	Self-placing
16	15 Years, 5 Months	Self-placing
1	15 Years, 5 Months	Watchhouse
203	14 Years, 10 Months	Self-placing
18	14 Years, 10 Months	Self-placing
10	14 Years, 10 Months	Missing Child
13	14 Years, 9 Months	**Residential**
1	14 Years, 9 Months	**Residential**
1	14 Years, 9 Months	Watchhouse
0	14 Years, 9 Months	Watchhouse
0	14 Years, 8 Months	Watchhouse
44	14 Years, 8 Months	Self-placing
30	14 Years, 7 Months	Self-placing
0	14 Years, 6 Months	Watchhouse
49	14 Years, 5 Months	Self-placing
20	14 Years, 4 Months	**Residential**
23	14 Years, 3 Months	Self-placing
0	14 Years, 1 Months	Watchhouse
100	14 Years, 0 Months	Self-placing

Days in placement	Age at placement start	Location type
2	13 Years, 9 Months	Foster care
141	13 Years, 8 Months	**Kinship care**
14	13 Years, 7 Months	Self-placing
12	13 Years, 6 Months	Residential
8	13 Years, 6 Months	Foster care
1328	9 Years, 10 Months	**Foster care**
3	9 Years, 10 Months	**Foster care**
4	9 Years, 10 Months	Foster care
8	8 Years, 4 Months	Kinship care
555	8 Years, 4 Months	**Foster care**
2	8 Years, 3 Months	Foster care
10	8 Years, 3 Months	Foster care
3	8 Years, 2 Months	Foster care
3	8 Years, 2 Months	Foster care
5	7 Years, 11 Months	Foster care
0	7 Years, 11 Months	Foster care
169	7 Years, 10 Months	**Foster care**
2	7 Years, 10 Months	Foster care
1	7 Years, 10 Months	Foster care
1	7 Years, 10 Months	Foster care
2	7 Years, 10 Months	Foster care
2	7 Years, 10 Months	Foster care
3	7 Years, 9 Months	Foster care
2	7 Years, 5 Months	Foster care
11	7 Years, 4 Months	Foster care

Days in placement	Age at placement start	Location type
996	5 Years, 2 Months	**Foster care**
8	5 Years, 1 Months	Foster care
1	5 Years, 1 Months	Foster care
15	5 Years, 0 Months	Foster care
3	4 Years, 11 Months	Foster care
114	4 Years, 10 Months	**Foster care**
4	4 Years, 7 Months	Foster care
679	2 Years, 11 Months	Foster care
3	4 Years, 2 Months	Foster care
12	2 Years, 7 Months	**Foster care**
9	2 Years, 6 Months	**Foster care**

Baby Nathan[75]

Background

The circumstances of Baby Nathan were initially drawn to the attention of the Commission by the Queensland Indigenous Family Violence Legal Service (QIFVLS) to highlight issues associated with birth suite removals and the work of QIFVLS in advocating for parents, both to Child Safety and in court proceedings.

QIFLVS Executive Director, Thelma Schwartz, made a statement and gave evidence at the public hearings in Cairns on 22 and 23 September 2025 about these issues, including in respect of the removal of Baby Nathan to assess his protection needs. Subsequently, the Commission sought information and documents from the Department about Baby Nathan's removal and the Department's method of evaluating future risks in like cases.[76] A Departmental manager of a Child Safety Service Centre provided two statements[77] and gave evidence at a subsequent public hearing.

This case study explores the Department's practice of delaying investigations of unborn notifications; its conduct of safety assessments in respect of unborn and newborn children, particularly where the concerns are based on the treatment of older children previously removed from the mother; the Department's casework supporting new mothers to bond with newborn children, and the process for obtaining a emergent orders from a Court to remove a newborn child from his or her mother for assessment purposes.

Evidence

Baby Nathan, an Aboriginal child, was born in April 2025.

In mid-August 2024, Baby Nathan's siblings (aged between 1 – 13 years) were placed in out-of-home-care, due to the Department's assessment that the children were at risk of physical and emotional harm from both parents due to family and domestic violence, mental health, homelessness and substance misuse.[78]

[75] Baby Nathan was discussed at public hearings in Cairns on 22 September 2025 (Transcript 1469-1470) and Brisbane on 25 November 2025 (2681:8).
[76] Data provided by the Department under Notice to Produce 177 issued on 27 October 2025.
[77] Statement of Witness M (4 November 2025); Supplementary statement of Witness M (13 November 2025).
[78] QIFVLS did not suggest that these removals were unjustified.

The Department's subsequent investigation concluded that Nathan's siblings were in need of protection This assessment was based on information that included:

- the father had used a cord to assault one of Nathan's siblings as a form of discipline resulting in injuries, (June 2024 – see further detail below);
- the father had choked the mother causing marks on her neck (August 2024);
- the mother had breached a DVO against the father (February 2024);
- the family had been evicted from housing and were then living in a shanty with a mattress under a tarp with no running water or electricity, and advised child safety that they intended to live out of their care in the bush from September 2024 (July and August 2024).
- the mother's disclosure that she had chronic PTSD as the result of sexual abuse as a child
- the mother had been intercepted driving under the influence of alcohol, with a blood alcohol level of 0.198 (February 2024), and told Child Safety her drinking was not their business, was self-managed and did not affect her parenting; and
- the mother's statements to Child Safety that she and the father had the right to parent how they saw fit and that Child Safety would have her children 'over [her] dead body' and she would need to be tasered for that to happen.[79]

Applications for Child Protection Orders granting custody to the Chief Executive for two years were made in respect of each sibling.

Physical harm and failure to protect

Notably, in a subsequent case plan completed in late 2025 for one of those children, Child Safety recorded that Nathan's father had (presumably prior to removal of the child) physically assaulted one of Nathan's sisters by whipping her with a phone charger cord, resulting in not only marks to her body, but also a limp. Nathan's father was charged by QPS, following its investigation, with assault occasioning actual bodily harm, and bail conditions requiring no contact with the victim child. The case plan also detailed that:

> "*Child Safety is aware that [the mother] had prior knowledge of [the father's] intention to hit [the child] with the phone cord and although she initially denied knowledge of what happened, she later disclosed being aware of [the father's] intentions and not doing anything to stop him as it is their right, as parents to discipline the child…[There have been] several occasions where [the mother] has failed to prevent [the father] from using excessive force towards [the child] and has led to red marks across [the child's] body, a limp and her feeling unsafe at home.*"[80]

[79] CL-24, *Witness M tender bundle,* tendered 25 November 2025, 30.
[80] CL-24, *Statements of Witness M and attachments*, tendered 25 November 2025, 91.

Unborn notification

The mother self-disclosed her pregnancy to the Department on 19 November 2024 in the context of ongoing intervention regarding her other children.

On 3 December 2024, a notifier told the Department that the mother was homeless, using marijuana regularly, lacked insight on why her children were removed and had spent time in hospital during the past two months due to homelessness and abusive situations with the father. An unborn notification was recorded with a 'standard' 10-day response and allocated to a Child Safety Service Centre (CSSC) for investigation. Additional notified concerns were made to the Department on 13 December 2024, reporting alleged alcohol and drug misuse by the mother.

Decision to complete 'alternate pathway' and delay commencement

On 6 February 2025, the relevant service centre decided "to complete an alternate pathway"[81] and delay the commencement of the investigation, for the stated reason of the mother's mental health and instability.[82] The Commission asked the Department what it meant to 'complete an alternate pathway' in this context. The Department was not able to answer this question.[83]

The Department's belief that the mother was experiencing mental health instability at this time was based on documented concerns over time, including:[84]

- that the mother had 'demonstrated erratic behaviour and mental processing in most interactions with Child Safety' (noted in a Parental Strengths and Needs Assessment (PSNA) dated 2 September 2024);
- that Child Safety was 'aware that [the mother] has suffered substantial historical trauma during her time in care' (PSNA, 2 September 2024) and regularly referenced this trauma in conversations with Child Safety;
- a notifier advised Child Safety that the mother appeared to have presented at hospital via a police escort following a breakdown (late October 2024);
- Police were called to attend a meeting between the mother and Child Safety and reported that the mother was 'very angry and wanted to see her children (November 2024); and
- a case plan for one of Nathan's siblings noted that the mother 'displayed erratic behaviours and thought processes seeming to have difficulty maintaining focus on

[81] Statement of Witness M (13 November 2025) [23].
[82] Ibid [22]-[23].
[83] Ibid [3].
[84] Ibid [39]-[40].

questions asked and often having difficulty regulating her emotions' and that she had expressed unwillingness to explore mental health assessments further.

Although these concern about the mother's mental appeared genuine, and may have correctly identified a vulnerable and struggling parent, nonetheless, they did not justify a decision to delay the investigation: the Manager confirmed that, under the Child Safety Practice Manual, the only basis on which the Department is permitted to delay commencing an unborn notification investigation is if there is a high probability that the pregnant woman would relocate or stop accessing medical support to avoid intervention.[85] The Manager stated that, in her professional opinion, the mother was unlikely to have re-located or ceased engaging with ante-natal care if alerted to Child Safety's concerns.[86] Thus, the Department's decision to delay the investigation was not in accordance with policy or practice and was contrary to the CSPM.[87]

On 6 March 2025, the CSSC sought approval to transfer the investigation regarding Baby Nathan (unborn at this stage) to a centralised investigation and assessment CSSC due to the negative effect that undertaking the investigation would have Child Safety staff's attempts to build a trusting relationship with the mother in respect of the children already removed from her."[88] The Manager agreed to this request. She asked that an unborn child high risk alert (UCHRA) be sent to the local hospitals and that a consult with the Office of the Child and Family Official Solicitor (OCFOS) be arranged. She also instructed the new CSSC to work closely with Child Safety Officers (CSOs) from the transferring CSSC as 'a lot of evidence will come from mum's progress/lack of engagement'[89] to address current concerns.

On 7 March 2025, Child Safety submitted an UCHRA as requested by the Manager. This decision is consistent with the Child Safety Practice Manual when a decision is made to delay contact with a pregnant mother.[90]

Evidence from QIFVLS regarding the mother's corrective actions pre-birth

The Commission heard evidence from Thelma Schwartz, Executive Director of QIFLVS[91], that Nathan's mother engaged QIFVLS at around approximately 33 weeks' gestation (around early

[85] Transcript, Evidence of Witness M (25 November 2025) 2740:47-2741:5.
[86] Ibid 2740:22-24.
[87] Witness M accepted that this decision was not in line with the CSPM, however noted it is within the delegation of the Senior Team Leader. Ibid 2740:30-32.
[88] CL-24, *Statements of Witness M and attachments,* tendered 25 November 2025, 7 [24](b). See also Email chain with Witness M (DFS.1077.0001.0030).
[89] CL-24, *Statements of Witness M and attachments*, tendered 25 November 2025, 72.
[90] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual – Respond to a notification* (1 August 2025) (DFS.0021.0001.0717) 135. Note: this is also the position within the manuals as at 2020 and 2022.
[91] Witness Statement of Thelma Schwartz (19 September 2025) [56]; Transcript, Evidence of Thelma Schwartz (22 September 2025) 1468-1470. QIFVLS itself had leave to appear at the public hearings and was represented by Counsel.

March 2025 - around the same time that the UCHRA).[92] Ms Schwartz gave evidence that, prior to the birth, Baby Nathan's mother had:

> ...referred herself to health services to receive immediate ante-natal care, engaged in substance misuse counselling, and worked with a housing support provider to implement strategies to ensure her house was a 'dry' house (free of alcohol and drugs). [The mother] also obtained several support letters from various organisations, including an Executive Officer from her tenancy support organisation, which spoke highly of [the mother] and her ability to remain and act protectively to ensure her unborn baby would not be at risk of harm.[93]

Accepting that the mother did take these actions as summarised in QIFVLS's evidence, it is relevant to the Department's later steps that these actions were only taken in four weeks leading up to Nathan's birth – that is, the mother was in the early stages of obtaining support and was not at the point where sustained behavioural change could be demonstrated at the time of birth, despite encouraging signs and reasons for hope. Further, the basis on which the tenancy support organisation could reliably attest to the mother's ability to act protectively to ensure her unborn baby would not be at risk of harm was not evident from QIFVLS' evidence. No objective evidence was proffered that the mother had in fact ceased drinking, such as that she had submitted to testing and returned clean tests.

Commencement of investigation and first safety assessment (safe with a safety plan)

Baby Nathan was born in early April 2025, almost 5 months after the Department was first told of the pregnancy. Two CSOs attended at the hospital, hours after the mother had given birth to commence the investigation, which caused the mother to become understandably anxious. [94] During this visit, the mother was supported by phone by both an independent person from a Family Wellbeing Service; and a QIFVLS lawyer.[95]

The CSOs told the mother that they were there due to child protection concerns the Department had for Baby Nathan's siblings and discussed whether 24-hour support for the mother upon discharge was feasible. The mother advised that she had, prior to going to hospital, moved into a motel arranged for her by a domestic violence support service. The mother referred Child Safety to a friend, who advised that she was happy to provide babysitting services and emotional

[92] Although this may be correct in respect of Nathan, it is clear from the documents that QIFVLS was engaged earlier in respect of the elder children, as QIFVLS was engaged in case planning for at least one of the children (see DFS.0177.0001.0043 provided in response to Notice to Produce 177 issued to the Department).
[93] Witness Statement of Thelma Schwartz (19 September 2025) [56]. See also Transcript, Evidence of Thelma Schwartz (22 September 2025) 1468:31.
[94] Transcript, Evidence of Witness M (25 November 2025) 2691.
[95] Transcript, Evidence of Witness M (25 November 2025) 2692:2

support to the mother. The mother also told Child Safety that she was 'engaged with' multiple services, a statement corroborated by the independent person and her lawyer. However, the mother was unable to identify at that time an informal support person to stay with her and the baby around the clock. The mother also disclosed that the father had strangled her but did not admit responsibility, that they were now separated and that he had asked to have the baby but she told him that was not happening and he cut her off in December 2024.

It was established that the hospital would permit the mother remaining in hospital overnight as a social admission.

The Department's evidence to the Commission was that the conversation with the mother raised issues of a lack of stable support, recent relocation and concerns about the mother's capacity to care for Nathan unassisted. The CSOs undertook a safety assessment (First SA), which identified two immediate risk factors (that is, factors that reflect current harm present at the time of this assessment):

> "Parent caused serious physical injury to the child or is likely to cause serious injury to the child in the immediate future";[96] and
>
> "Parent mental health concern, emotional instability or intellectual or physical impairment results in behaviours that create imminent danger to the child."[97]

No details of what facts were relied upon by the CSOs to determine that these indicators were currently present is revealed in the document. No acts of protection by the mother were noted. [98] However, it was separately noted, under 'strengths and resources' that 'at least one safety and support network member is participating in the immediate safety plan' (though it is unclear who that partner was), and under 'immediate safety interventions' that the mother 'uses community agencies or services as safety resources'

The CSOs concluded that Nathan was 'safe with a safety plan'. The rationale for the decision was recorded as follows:

> "[The mother] provided a family plan and is willing to meet Child Safety's immediate safety plan actions overnight while she is in hospital. [The mother] was supported by Queensland Health staff, lawyer from QIFVLS [and the independent person]."[99]

An immediate safety plan (ISP) was put into place with a review date of the following day. The ISP recorded that child safety's concerns were that the mother lacked 24-hour support and may use

[96] Ibid 2698:4-5.
[97] Ibid 2701:30-31.
[98] Specific acts by a parent that have been demonstrated over time that reduce but do not yet fully resolve the immediate harm.
[99] Transcript, Evidence of Witness M (25 November 2025) 2700:13-18.

excessive discipline if the baby is crying a lot and will not settle. It was agreed that if the mother was struggling she would contact her friend and professional supports and contact Child Safety by phone. The mother also agreed to complete a drug test.

When the reasonableness of this timeframe – one day – was put to the Department witness, she confirmed she considered one day to find a support person was reasonable.[100] However, the witness also conceded that had the mother known the baby was at risk of removal earlier, she could have had a longer period of time to identify a support person as assist in safely planning.[101]

Mental health assessment arranged by Queensland Health

In light of Child Safety's mental health concerns for the mother, Queensland Health's Child Protection Unit arranged for the hospital's consultation and liaison psychiatric service to assess the mother on the morning after the birth. The assessment concluded that the mother did not have acute psychiatric concerns that presented a barrier to discharge, that she was not psychotic, manic or profoundly depressed, rather she described proportionate and understandable anxiety regarding the Department's intervention at birth and previously.[102] Ultimately, as will be seen below, Child Safety did not wait for the outcome of the assessment before applying for the Temporary Assessment Order (TAO), although email exchanges between Child Safety, the Independent Person (IP), and Queensland Health show that Child Safety was aware the assessment was imminent.[103]

Second Safety Assessment: Unsafe

In light of the need to review the First SA, the CSO rang the mother that morning in an attempt to establish an immediate safety plan, requiring, as a non-negotiable, the presence of a safe adult to support the mother and provide protection for Nathan. [104] The mother was reported to state that the call was stressing her out and hung up.

The CSO made contact with the IP via phone and email. The IP advised of a friend of the mother's who had children and was also caring for elderly parents, was willing to provide a room in her home. This was deemed unsuitable by the acting Senior Team Leader (STL) - although, as can be seen below, there were additional reasons that made this person unsuitable. The reasoning could

[100] Ibid 2759.
[101] Ibid 2720-2759.
[102] Ibid 2745.
[103] At 10:33am, Queensland Health emails that "I have also arranged for a mental health consult liaison team to see the mother in the next half hour or so to do an assessment on her mental health, as this is a concern for Child Safety." Child Safety acknowledged the email at 11:23am. At 12:16pm, the Acting STL decided to apply for the TAO. The results of the consult were sent to the Department at 1:46pm. Email exchange between Queensland and the Department (DFS.0177.0004.0032).
[104] Transcript, Evidence of Witness M (25 November 2025) 2691-2692; 2706.

be clearer but it seems that the concerns were that the mother might be physically abusive to the children in the household, and that a safe person with children and elderly parents to care for would not be able to provide necessary 24-hour support to the mother. Details of an aunt were also provided by the IP as a potential support person. Child Safety attempted to contact the aunt during a twenty-minute window that morning, but could not reach the aunt.

A specialised, Aboriginal and Torres Strait Islander mother and baby shelter was contacted but it advised that it did not have capacity for more than two weeks.

The second safety assessment (Second SA) recorded the presence of two immediate harm indicators. The first was the mental health concern noted the day before. However, the second factor identified was now as follows:

> "Parent, adult household member, or intimate partner (past or present) of parent is violent and controlling towards an adult in the child's household AND poses a danger of serious physical or emotional harm to the child."[105]

The rationale recorded was:

> "Concerns for mental instability of [the mother] and [the father] trying to get custody of [Nathan] whilst he was assessed as unsafe when his other children were removed in August 2024. Newborn baby is highly vulnerable."[106]

The Second SA also recorded that a placement intervention was necessary, namely that the child would be placed in custody under an assessment order because no other interventions are available to adequately ensure the child's immediate safety.

Accordingly, when plans to find a safe person to provide 24-hour support to mother and baby could not be achieved that morning, the Department applied for a custodial TAO.[107] The decision to seek the TAO was made by the Senior Team Leader, who held the relevant delegation.

Although aware that the assessment was taking place, Child Safety made the application for the TAO without waiting for the result of the assessment, even though "mental instability" was a primary reason for seeking the TAO. Presumably it did so because the mother was due to be imminently discharged from hospital, and the risks it perceived to Nathan once back in the community. It is notable that the Department did not - via its Court material, alert the Court to the

[105] Ibid 2701:24-31.
[106] Ibid 2701:42-47.
[107] Ibid 2701.

fact that the assessment was taking place, and, in fact, asserted to the Court that the mother's mental health vulnerabilities were "unassessed and untreated".[108] It should have done so.

TAO

The TAO application was made the day after birth.[109] By its application, the Department indicated that statutory intervention was required to ensure Nathan's immediate care and protection as:

- There were significant concerns surrounding domestic violence, mental health, substance abuse and housing;
- There were concerns that the mother is not able to act protectively of the child;
- Voluntary intervention was not appropriate because an ISP was not able to be established; and
- It had assessed that Nathan would be at immediate risk of harm without the order.

The application indicated an intention for the child to be placed in foster care. No kin was suggested as a suitable carer, by the Department, QIFVLS or the IP. The Department's position was that, due to the urgency and necessity of the TAO, there was insufficient time to discuss arrangements with possible kinship carers, but that these discussions would occur as a priority during the assessment period, with the support of a Cultural Practice Advisor (CPA).

On the issue of the necessity of a custodial order in order that the investigation could be carried out properly, the Department relied upon the significant concerns of domestic violence, alcohol misuse and housing, noting that:

- both parents were currently subject to domestic violence protection orders which named the other as the aggrieved;
- both parents had a history of contravening a DVO;
- the mother's alcohol misuse escalated incidents of violence within the home;
- The mother was assessed as having mental health vulnerabilities which remain 'unassessed and untreated.'; and
- The mother was currently residing in motel accommodation and disclosed that she had been almost kicked out following an argument with the manager.

The Department flagged in its application that it intended that the child would have supervised contact with the mother multiple times per week to ensure that the mother is able to breast feed the baby and build an attachment.

[108] See TAO [33](a)(iv) (DFS.0177.0002.0022).
[109] Ibid 1.

The hearing was conducted by phone.[110] The mother was represented by QIFVLS. The independent person was also present. The father was absent and indeed may not have been aware of the hearing taking place. Attempts were made to call the mother but either she hung up or the line was otherwise disconnected. QIFLVS opposed the application, on the basis that the mother had plans to go to a friend's house who had a room for the mother and baby. A discussion occurred between the parties as to whether children were present in the house and their ages, as there was some uncertainty about this. A further potential option of an aunt was raised, seemingly by QIFVLS.

OCFOS argued that attempts had been made and exhausted to fine a safe place for the baby to be discharged to, and that safety planning had not been achieved. OCFOS told the Court that further attempts would be made to locate a safe place for the mother and baby taking into consideration current child protection concerns.

After obtaining confirmation from OCFOS that further attempts would be made to locate a safe place during the TAO, the magistrate was satisfied that the order was necessary to ensure the safety of Nathan.

The TAO was granted for a period of 5 days as the order period fell on a weekend.[111]

Removal of Baby Nathan

Child Safety Officers attended the hospital and advised the mother that a TAO had been granted due to child protection concerns and the lack of informal support persons who could reside with mother and baby. The mother disagreed with the decision and was in tears.

Baby Nathan was removed from the mother the day after birth and taken into non-indigenous general foster care 80km away. A week later, Nathan was moved to another non-indigenous foster carer who lived closer to the city in which the mother was staying. According to documents subsequently filed with the court, family contact was established within 3 days of the TAO being granted, and that daily contact of 2 hours had occurred from that time, until custody was returned to the mother.

[110] Email detailing summary of the court mention provided by the Department (DFS.0177.0002.0019) This email was sent to other involved Child Safety staff.
[111] Both Temporary Assessment Orders and Temporary Custody Orders are granted for a maximum period of 3 "business days" rather than calendar days. See s 29(2) and s 51AG (2) *Child Protection Act 1999* (Qld).

Further attempts to locate a safe person to stay with mother and baby

During the TAO both the friend and the aunt referred to in the lead up to and during the TAO hearing were contacted by Child Safety and enquiries made into their suitability.

In respect of the friend, an urgent information response[112] from QPS provided information that, in the previous six weeks, the friend had been involved in three domestic violence incidents, including attending the house of a neighbour and making threats to kill the neighbour; that she attended a police station and advised that she had been assaulted by a family member at a local supermarket, and that police had been called to the friend's house due to a family member threatening to attend her residence and 'get her' following an argument. The mother also indicated that she did not want to stay with this friend. Ultimately, Child Safety deemed the friend unsuitable due to domestic violence involvement and the wishes of the mother. When this was notified to the IP, the IP said that she was aware that the friend had a good behaviour DVO (it is unclear whether the IP disclosed this prior to supporting the friend as a safe person), but the Child Safety officer advised that the concern went beyond this.

The aunt was also assessed, but disclosed that she could not stay with the mother at present; the mother could not stay with her because she was staying with family; she had other family commitments in a weeks' time, but she could stay with the mother for a few days in the future to assist her with breastfeeding. As a result, the aunt was not a suitable option.

A further option presented itself in the form of an aunt and uncle of the mothers, who were former foster carers who lived in a remote location but were willing to have the mother and baby. This option was discussed with the mother. Child Safety and the IP raised concerns that if the mother was to move to that location, she would lose access to the services in her current locale and would need to be re-referred to services, which would likely have a long wait time in such a region and this would jeopardise her progress.

As is apparent from the Court Assessment Order (CAO) hearing dealt with below, the concerns about the remote region evidently lessened over time, as arrangements were on foot at the time of the CAO hearing for the mother and baby to reside with this couple.

Court Assessment Order application and hearing

An application for a CAO was made prior to the expiry of the TAO and heard approximately 2 weeks later.

[112] The Department is able require prescribed entities to provide information pursuant to Section 159N of the *Child Protection Act 1999* (Qld).

The mother and father were both present in person and represented by QIFVLS and ATSILS respectively. The IP was also present to support the mother. The mother did not oppose the granting of the CAO but submitted that the CAO ought to be non-custodial.[113] The Department was agreeable and orally sought to amend its application at the hearing to align with the mother's request. The Department submitted that there had been significant progress, including that the mother: had submitted to drug tests, which were returned clear; had been engaging with Child Safety and support services; and had arranged to travel that day to a locale to reside with her maternal aunt and uncle under a safety plan, which would require the father's visits to be supervised to mitigate risk whilst the assessment was carried out.

The judge acknowledged the significant progress and granted the order for a non-custodial CAO. Nathan was returned to the mother on this basis and relocated that day to her maternal aunt and uncle.

Assessment and outcome

Approximately three weeks later, the Department concluded its investigation and assessment in respect of Nathan, determining that Nathan was an unacceptable risk of significant emotional and physical abuse and neglect by his mother and his father, and that an intervention with parental agreement with directive orders was the most suitable and least intrusive statutory intervention to adequately address the child protection concerns.

The assessment acknowledged that the mother had been engaging with multiple support services and had moved in with family when Nathan was placed in her care. It also acknowledged that the mother had acted protectively, but noted the child's young age and his complete dependency on his caregiver for his needs, which makes him highly vulnerable. Without sustained support, stable housing and continued engagement with services, Child Safety considered that there was a significant risk of emotional and physical harm to Nathan.

As to the need for directive orders, these were said to be required:

> *for [the mother] to ensure continuation of DV and mental health services engagement, building parenting skills around safe and age-appropriate discipline for growing children and now allow [the father] contact with [Nathan].*
>
> *[The mother] has acknowledged the need to address the [Child Protection] concerns, to build capacity and a support network to be able to provide an ongoing, safe, nurturing and stable home environment for [Nathan].*

[113] The father did not oppose the order.

> *[The father] did not acknowledge the [Child Protection] concerns and has not engaged with services. Directive Orders are need[ed] to direct [the father] not to have contact with [Nathan] without a departmentally approved person present, and to engage with an appropriate DV services and parenting program.*

The records available to the Commission indicate an application for a non-custodial Child Protection Order has been made, however the outcome of such is unknown.

What this case shows

Before identifying the systemic failures illuminated by this case study, it is important to acknowledge that the Department's concern for Nathan's immediate safety was both legitimate and appropriate. A newborn is, by definition, completely dependent on his or her carers and wholly unable to protect itself. Child protection concerns about Nathan's parents were serious and well-documented. His father had been violent towards Nathan's sibling and had choked Nathan's mother. Both parents had a history of breaching DVOs, suggesting that these orders did not have a protective effect. The mother had been intercepted driving with a blood alcohol reading of 0.198 in the company of her children, had articulated an intention to resist Child Safety's involvement, and had been assessed as having chronic PTSD and a history of erratic presentation. The fact that none of these matters related specifically to a newborn does not mean legitimate questions do not arise about whether the unborn child may be in need of protection once born, and whether, in order to properly assess this, a custodial assessment order might be necessary.

Thus, the critique that follows is not directed at the legitimacy of the underlying protective concern, but at the quality of the processes by which the Department sought to respond to it. That critique matters for a particular reason that this case study makes plain: where processes are deficient – where assessments are inadequately documented, where the mother is not given reasonable time to arrange supports, where courts are not given complete information – the credibility and proportionality of the Department's intervention is undermined, and the risk that a well-founded concern will not receive the best response it could is increased.

The systemic significance of delay in unborn notification investigations

The most significant systemic issue demonstrated by this case study is structural: the consequences of delaying the investigation of an unborn notification until after the child is born.

Nathan's mother disclosed her pregnancy on 19 November 2024. Nathan was born in early April 2025. The investigation did not commence until the hours after his birth; some five months after the Department was first informed. Over that period, two separate and potentially unconnected matters emerged as causes of delay: first, a decision on 6 February 2025 to complete an 'alternate pathway', a decision the Department was unable to explain, on the stated basis of the mother's mental health instability; and second, a transfer of the investigation to a different CSSC on 6 March 2025 to insulate the ongoing relationship-building work with the mother in respect of her older children.

Neither of these was a permissible basis for delay under the Child Safety Practice Manual. As the Manager's evidence confirmed, the CSPM permits delay in the commencement of an unborn notification investigation in only one circumstance: where there is a high probability that the pregnant woman would relocate or stop accessing medical support to avoid intervention. The Manager did not consider that circumstance to apply. The delays therefore occurred contrary to policy.

The consequences of the delay were profound, and they compound in a way that the case study illustrates with unusual clarity. First, the mother was not informed that the specific child protection concerns it had regarding the older children were also relevant to Nathan, nor of what she might do to address them in the context of caring for a vulnerable newborn. She therefore had no opportunity to demonstrate sustained behavioural change before the birth. The steps she did take - entering substance misuse counselling, securing motel accommodation through a domestic violence service, and engaging with health services for antenatal care - were all taken in the four weeks before the birth. While those steps were encouraging, they did not amount to the type of sustained behavioural change that would have materially altered the Department's assessment of risk due to the limited time period. As the Manager herself acknowledged, had the mother been aware of the concerns specific to Nathan at an earlier stage, she could have had a longer period to identify a support person and assist in safety planning.

Second, the delay meant that the investigation was necessarily conducted in the most compressed and difficult period for any mother: in the hours immediately following birth, while breastfeeding, recovering from delivery, and acutely anxious about her child's removal. The assessment was conducted against a hard deadline namely the anticipated discharge from hospital and the mother was left with effectively one day to demonstrate that she could implement a safety plan before the TAO application was made. The urgency that drove the TAO application was not inherent in Nathan's circumstances on the day of birth; it was a direct product of the failure to commence the investigation months earlier.

Third, the delay meant that the Department went into the post-birth assessment period without having gathered, prior to birth, the current and contemporaneous information that would have given it a reliable picture of the mother's circumstances and trajectory. It was instead relying, in significant part, on a Parental Strengths and Needs Assessment completed six months earlier. The case thus illustrates a self-reinforcing dynamic: delay produces urgency; urgency produces an incomplete assessment; an incomplete assessment resulted in significant reliance on historical information; historical information may not reflect the mother's current circumstances. The result is a removal that might, in some cases, have been avoided if a more timely and comprehensive engagement had occurred.

This dynamic is not unique to this case. The Commission heard evidence suggesting that there is a practice within the Department of deferring unborn investigations, whether as a result of misunderstanding about legal powers, risk-aversion about the therapeutic relationship, or resource constraints, is not uncommon. That practice should not continue, save in the event of exceptional circumstances. Early, transparent, and structured engagement with expectant parents is in the interests both of those parents and of the children they are expecting.

Legal misunderstanding about the power to investigate: section 22 of the Act

The evidence of the CSSC Manager revealed a significant and consequential misunderstanding about the Department's legal powers in relation to unborn children. The Manager gave evidence that she understood a pregnant woman's consent was required before the Department could commence an investigation or even discuss its concerns with her;[114] and that if consent was refused, no assessment could commence until after the birth. This understanding was incorrect. Section 22(2)(a) of the *Child Protection Act 1999* (Qld) expressly authorises the chief executive to have an authorised officer investigate the circumstances of an unborn child and assess the likelihood that the child will need protection after birth. [115] No consent is required to commence that investigation. However, the mother cannot be compelled to participate in the investigation.

The significance of this misunderstanding extends beyond this case. If this view is held more widely within the Department - and there is no basis to assume it is confined to this Manager – then it is likely that some unborn cases will be mismanaged at their earliest and most critical point, not out of systemic indifference to children's welfare, but due to an incorrect understanding of what the law permits. The Department's capacity to protect unborn children

[114] Transcript, Evidence of Witness M (25 November 2025) 2721, 2724, 2727.
[115] *Child Protection Act 1999* (Qld), s 22(2)(a) provides that the chief executive must take the action the chief executive considers appropriate including, for example, having an authorised officer investigate the circumstances and assess the likelihood that the child will need protection after he or she is born.

depends, at a fundamental level, on its officers understanding the legal framework within which they operate. Baby Nathan's case pointed to a training and communication deficit that should be remedied.

Separately, the Manager's evidence identified a practical difficulty that is worth acknowledging: when a CSO introduces themselves to a pregnant woman in connection with the department's concerns about the unborn child, the woman may refuse to engage. If this occurs, the department cannot explain, face-to-face the mother's options, the specific concerns, or the steps that might be taken to address them. The Manager's concern about this dynamic is understandable and reflects genuine experience. However, the appropriate response is not to delay the investigation; it is to find alternative means of communicating with the mother that do not require in-person engagement as a precondition. It is difficult to see why a clearly worded letter setting out the Department's concerns, the mother's choices, and the consequences of different choices could not be provided[116]. The Department does not require a pregnant woman's consent to provide her with information.

The quality of safety assessments in the birth suite context

The safety assessments conducted in this case exhibited several deficiencies that reflect broader concerns about the adequacy of the Department's assessment processes when conducted in the acute post-birth setting.

The assessments relied upon a Parental Strengths and Needs Assessment that was over six months old. That assessment had been prepared in a very different context, that is, when the older children were being taken into care, and could not solely be relied upon to reflect the mother's current circumstances, presentation, or capacity. In this case at least in respect to the TAO application, without the benefit of the most current information about the family. In this instance, that meant the court was not told about the steps the mother had taken in the weeks before Nathan's birth. While those steps were recent and unverified, they were nonetheless relevant to a complete picture.

The first safety assessment identified two immediate harm indicators, a risk of serious physical injury and a mental health concern creating imminent danger, but did not specify the factual basis for either. It did not state whether the physical injury concern related to past conduct or

[116] It is noted that the Child Safety Practice Manual 'Respond to a notification' provides guidance and various versions of a template 'Engagement letter' to provide notice of the standard or priority notification and to encourage they contact the Department. The template includes a generic brochure regarding contact with the Department. The guidance does not include prompts to disclose the details of the concerns or consequences for not engaging an investigation, nor is the brochure specific to unborn investigations. The guidance refers to the privacy principles and compliance with the privacy provisions in the *Child Protection Act 1999* (QLD) when sharing information.

anticipated future conduct, what the injury was or was likely to be, or why that risk was imminent in the birth suite on the day of assessment. The mental health indicator was similarly unparticularised: the assessment did not identify the relevant behaviours that had been observed, when they had occurred, or by whom. A safety assessment that identifies risk indicators without specifying the underlying facts is difficult to interrogate, difficult to challenge, and difficult for a court to evaluate. That is a deficiency that cuts both ways: it may lead to under-intervention in some cases and over-intervention in others. In either case, the integrity of the assessment process is compromised.

The assessments also failed to record any acts of protection by the mother. The Department's own practice guidance requires that a safety assessment be an analysis of current attitudes, behaviours and family functioning. The mother had, in the weeks prior to the birth, engaged with ante-natal care, commenced substance misuse counselling, and secured accommodation through a domestic violence service. These were plainly relevant to any current assessment of her capacity to act protectively. The Department's evidence was that there was insufficient time on the day of birth to verify these matters. That is understandable, but it reinforces rather than resolves the systemic concern: the failure to commence the investigation earlier meant that matters which should have been verified during the assessment period remained unverified at the critical moment, and that the mother's positive steps were effectively discounted on the basis that they could not be confirmed, while historical adverse information was relied upon without qualification.

Equally significant was the failure to undertake any observational assessment of the mother and baby in situ. The case notes record that the attending doctor had reported both mother and baby were doing well. There is no record of any attempt by the CSOs to observe whether the mother was tending to Nathan's needs, whether she was successfully breastfeeding, whether bonding was occurring, or of any consultation with nursing staff who had observed the mother with her newborn in the hours since birth. In a case where one of the primary concerns was the mother's capacity to care for her child, these matters were of direct relevance. The absence of any contemporaneous observational assessment was a significant omission.

The concerns articulated in the first safety assessment, which were subsequently carried forward as the basis for the TAO application, read, in places, more as generalised risk statements than as well grounded facts. The 'worry' that the mother 'may use excessive discipline if the baby is crying' was not linked to any specific conduct or statement; it appears to have been an inference drawn from the history with the older children, the circumstances of which were not detailed in the assessment. The 'worry' about the absence of '24/7 in-person support' was not accompanied by

any explanation of why a lesser level of support, including the mother's engagement with multiple community services, was insufficiently protective. These omissions matter because a safety assessment that does not articulate its reasoning cannot be properly scrutinised, and an order made on the basis of such an assessment rests on less secure foundations than it should.

The duty of candour in applications to the court

The Department's handling of the Queensland Health psychiatric assessment raises a discrete concern about its obligations of candour on urgent court applications.

The mental health assessment of the mother was arranged by Queensland Health's Child Protection Unit following the birth. The assessment concluded that the mother did not exhibit acute psychiatric symptoms that were a barrier to discharge, was not psychotic, manic or profoundly depressed, and that her anxiety was proportionate and understandable in the circumstances of her engagement with Child Safety. This was clearly material to the question of whether a TAO was warranted on mental health grounds.

The Department was aware the assessment was imminent when it made the TAO application. It chose not to wait for the result. The Commission accepts that there may have been legitimate reasons for that, and does not find otherwise. However, the Department did not disclose to the court that the assessment was in progress. And it asserted to the court, as a basis for the order, that the mother's mental health vulnerabilities were 'unassessed and untreated.' That assertion was, at the time it was made, misleading. An assessment was being conducted. The fact that the result was not yet known does not transform a statement that the mother was 'unassessed' into an accurate one.

The Commission notes that this application was not made ex parte; the mother was represented by QIFVLS. Nonetheless, the principle of candour in applications to courts, and especially on urgent, protective applications where the court is necessarily reliant on the Department's account, is fundamental.

Where the system responded well

It would be incomplete not to acknowledge the aspects of this case in which the Department, and the broader system, responded appropriately.

The Department's response to the mother during the TAO and CAO period was measured and appropriate. When the mother produced negative drug tests, engaged consistently with Child Safety and support services, and arranged a suitable living situation with family, the Department did not maintain an inflexible position. It agreed at the CAO hearing to amend its application to

seek a non-custodial order, supported Nathan's return to his mother, and at the conclusion of its investigation adopted directive orders with parental agreement rather than proceeding to seek a custody order. That outcome, engagement with directive orders requiring the continuation of domestic violence and mental health services, reflects a genuine attempt to support the mother's capacity while addressing the ongoing risks. The fact that Nathan was returned to his mother, and that the assessment resulted in a collaborative rather than adversarial outcome, should not be overlooked. The department facilitated daily breastfeeding.

The involvement of QIFVLS throughout the process, in the period before birth, in the birth suite, during the TAO hearing, and at the CAO hearing gave the mother a genuine voice in proceedings that directly and profoundly affected her. The Commission notes the significance of that advocacy role, and the fact that it was QIFVLS that identified and organised the support arrangements that ultimately enabled Nathan's return to his mother. The availability of independent legal advocacy for parents in these circumstances is a matter of significant importance to the integrity of the process.

The Commission also acknowledges the role of Queensland Health's Child Protection Unit in promptly arranging an independent psychiatric assessment, which provided an up-to-date professional evaluation of the mother's mental state that was directly relevant to the Department's concerns. That assessment process was valuable and appropriate.

Baby Nathan's case study illustrates a cluster of systemic issues that are likely to recur whenever the Department encounters a pregnant woman with a child protection history and does not act on that knowledge promptly and transparently. The case does not demonstrate a Department indifferent to Nathan's welfare. It demonstrates a Department that, through a combination of legal misunderstanding, policy non-compliance, and procedural compression, arrived at a decision to remove a newborn without the quality of assessment, the completeness of information, and the candour before the court that so significant a decision required.

The core systemic lessons are these. Delay in unborn notification investigations is not protective of vulnerable mothers; it transfers risk to the post-birth period and makes removal more likely. The Department's legal powers to investigate unborn notifications without parental consent must be understood and exercised. Safety assessments at or around the time of birth must be grounded in current, verified, and particularised findings, and must actively seek and record evidence of maternal protective capacity rather than relying exclusively on historical adverse information. The Department's obligations of candour to courts, including on urgent applications, must be observed.

Ellen

Background

This case study formed part of the Commission's inquiry into the experiences of foster carers with the care system and the impact upon children in care.

At the Cairns public hearings, the Commission heard evidence from Ellen. Ellen is an experienced foster carer and trained nurse who gave evidence during the Cairns hearings about her experience caring for Murphy, an Aboriginal child, over the past 8 years.

Her evidence traverses the Department's failure to attend to Murphy's serious medical needs while under its care; the chronic absence of allocated Child Safety Officers; the Department's failure to pursue permanency despite a legislative obligation to do so; and the decision to remove Murphy from Ellen's stable and nurturing care and place her with her elderly and ailing grandmother - a decision made without any genuine assessment of Murphy's best interests, without the completion of proper assessments, and without seeking Ellen's views. The kin care placement - predictably, in the circumstances - broke down.

The Department was issued with compulsory notices to produce documents relevant to Ellen's evidence and given an opportunity to give evidence publicly about its dealings with Ellen, Murphy and Murphy's extended family. Witness A gave this evidence for the Department. Witness A, although not involved in the management of Murphy's case, had acquainted herself with the file and the relevant evidence. Witness A's evidence was candid and of considerable assistance to the Commission. Where the Department had erred, she said so; and where better practice was required, she identified it.

Evidence

Murphy's early life and entry into care

At the time of Murphy's birth in early 2016, her three older siblings were already subject to guardianship orders in favour of the Chief Executive and we placed in kin care with her maternal grandmother. Her parents had a documented history of neglect, alcohol abuse and domestic violence, known to the Department before Murphy was born.

A voluntary intervention with Murphy's mother commenced after her birth, but her compliance deteriorated: she resumed alcohol misuse, was observed driving with Murphy while intoxicated,

and regularly left the child in the care of others while she went out to drink. Murphy was removed at approximately six months of age and placed in kin care with a maternal aunt.

A worsening medical condition and a Department that failed to act

Several months after entering kin care, Murphy's GP identified that she was suffering from scabies (a skin condition) and notified the Department in March 2017. By June 2017, it had become persistent and extensive — scabies covering her hands, feet, arms, legs and torso, requiring antibiotics four times daily. According to Witness A, scabies is commonly seen by Child Safety and is largely the result of environmental factors, such as unclean living conditions and poor hygiene.[117] The presence of scabies should, according to Witness A, prompt questions about the child's living arrangements and the carer's ability to meet the needs of the child; no such questions were asked. [118] Further, the Department did not speak with Murphy's treating physician to obtain a full picture of Murphy's health.[119]

When that kin placement broke down in July 2017, Murphy's skin condition was not recorded in the referral to the Placement Services Unit.[120] It ought to have been.[121] The incoming foster carers were not told of Murphy's medical needs. Her condition worsened in their care. They raised their concerns about Murphy's condition with the Department repeatedly.

In September 2017, the foster carers informed the Department that Murphy's GP had recommended a private dermatologist and suspected an immune disorder (as opposed to scabies), advising that a blood test was needed.[122] Parental consent was required, as Murphy was not under a guardianship order. The CSO's response was to ask the foster carers to request the GP to contact the Department. There is no record that the CSO ever spoke to the GP. There is no record that consent was sought from the mother. No blood test was obtained nor an appointment with a private dermatologist approved.[123]

By October 2017, the placement broke down: the carers requested to relinquish Murphy because they could not manage her medical needs. A CSSO, on a home visit following this request, found Murphy's skin blistering, with a rash covering her feet, legs, thighs, stomach and face. She was sixteen months old. The placement breakdown due to Murphy's acute medical condition did not prompt an attendance by the CSO. On 21 October 2017, Murphy was admitted to hospital and

[117] Transcript, Evidence of Witness A (3 February 2026) 3869:20-22.
[118] Ibid 3869:32-37.
[119] Ibid 3870.
[120] Ibid 3871.
[121] Ibid 3872.
[122] Ibid 3872-3873.
[123] Ibid 3873-3875.

discharged with antibiotics. The Department had known of Muphy's serious, worsening, unresolved medical condition for seven months, yet it had approved no specialist referral and had not spoken to her treating doctor, despite Murphy's medical needs causing a placement breakdown.[124]

Ellen's care — and what was achieved within days

On 23 October 2017, Murphy was placed with Ellen and her husband. Ellen was identified as suitable because of her nursing background. She was told to take Murphy to hospital if any medical concerns arose.

Ellen took immediate action. She consulted Murphy's GP, who recommended a private dermatologist. When she contacted the Department for approval, she was asked for more information, directed to a public hospital waiting list, and told the GP could manage the condition.[125] Ellen, unwilling to accept an answer she considered inadequate given what she had observed, arranged and funded the private appointment herself. Within days, she had obtained a full assessment.

Murphy was found to be suffering from:

- scabies;
- impetigo;
- secondary dermatitis;
- anaemia, confirmed by blood test; and
- fluid behind both ears, potentially requiring grommet surgery.

The anaemia — a condition that develops over months — would in all likelihood have been detected earlier had the blood test recommended by Murphy's GP been obtained when first requested. There is no explanation for the Department's lack of timely action to address Murphy's obvious and acute medical needs.

Eight days after Murphy came to live with her, Ellen reported all of this to the Department. She had also arranged follow-up appointments with a paediatrician and dermatologist and identified the need for an ENT referral.[126] Ellen paid for it all.[127] The Department's own records show that no child-related cost payments for private medical expenses were ever approved or made to Ellen

[124] Transcript, Evidence of Witness A (3 February 2026) 3876-3877.
[125] Transcript, Evidence of Witness AB (12 September 2025) 594.
[126] Transcript, Evidence of Witness A (3 February 2026) 3878-3879.
[127] Ibid 3878.

— consistent with her evidence that requests for reimbursement were either not acted upon or refused, until she stopped asking.

What followed was eighteen months of intensive daily treatment: medicated baths, steroid cream applied across Murphy's entire body and full-body moisturising – initially twice daily – then several times a week. Ellen administered this regime with the discipline and care of an experienced nurse. Murphy's condition dramatically improved.

Nine Child Safety Officers in four and a half years[128]

Between October 2017 and April 2022, Murphy had at least nine different Child Safety Officers. For periods totalling more than a year across that span — including extended gaps in 2019, 2020 and 2022 — he had no allocated CSO. Witness A explained that children in stable placements are routinely deprioritised over children deemed at higher risk. Further, long-standing high caseloads and high CSO vacancy rates in the Far North Queensland region may explain why a child has no allocated CSO.[129] Over the relevant period, Murphy should have received approximately fifty-five monthly visits. Department records show that eight took place. It is probable that the Department deprioritised Murphy's care due to a combination of resourcing demands and the stability of Murphy's placement with Ellen.

Witness A agreed that a failure to maintain regular visits with a child can have a sizeable impact on the relationship between the Department, the child and the child's carers, and can adversely affect the Department's level of awareness of the child's development and well-being.[130]

Lack of information about siblings

Ellen also discovered, by chance at a local daycare, some eight or nine months after Murphy came to live with her, that she had three older siblings. No provision for sibling contact had been included in the initial placement agreement. No CSO had arranged it. Murphy had been deprived of contact with her siblings for nearly a year.

The promise of permanency, and what became of it

On 21 February 2019, a long-term guardianship order was made in favour of the Chief Executive. Around that time, discussions began about a permanent care order in favour of Ellen. In March

[128] Statement of Witness A (28 January 2026) [107].
[129] Transcript, Evidence of Witness A (3 February 2026) 3888-3889.
[130] Ibid 3890-3891.

2019, the Department committed to assessing Ellen for long-term guardianship[131], with completion by September 2019.

Nothing happened. Over the fifteen months that followed, Ellen wrote to the Department repeatedly. She received acknowledgements, expressions of goodwill, assertions of attempts to locate Murphy's mother, and explanations that the CSO was prioritising other tasks. The correspondence, produced in evidence, records a succession of promises unfulfilled. By early May 2020, the assessment had still not been commenced. These circumstances are consistent with Ellen's evidence that Murphy's CSO was overworked and overburdened by her caseload, such that there was minimal time to attend to non-crisis work.

A Practice Panel was convened on 4 June 2020 — before any assessment of Ellen had been completed – which Witness A described as unusual.[132] The Panel declined to support a permanent care assessment, despite noting that Murphy was thriving in Ellen's stable care. Its stated reason was that kin had not yet been explored, and the Department had a legislative duty to explore kinship options. This inaction could, of course, only be laid at the Department's feet – apart from one contact in July 2017, no steps had been taken to identify kin for nearly three years. The consequence of that failure was now being visited on the child - and, by extension – her devoted carer. That is, the outcome of the practice panel was informed by Departmental failings, not what was in the best interests of Murphy *per se*.

At a meeting on 15 July 2020, a Departmental manager stated that she did not agree with permanent care orders for Aboriginal children being made to non-Aboriginal carers, and that this would never have been a discussion point under her oversight.[133] Witness A was unequivocal: there is no legislative or policy basis for that position; it is contrary to both; and it is a view capable of being contrary to the best interests of a child.[134] Ms Corinne Porta, Regional Executive Director for Far North Queensland, confirmed that this view was contrary to the legislation and it raised concerns that privately held views were impermissibly influencing permanency decisions.[135]

The decision to place Murphy with her elderly and ill grandmother

After the permanent care assessment for Ellen was shelved, the Department decided to place Murphy (back) with her aunt. No records were produced showing that any assessment of whether this was in Murphy's best interests was undertaken before the decision was made.[136] That

[131] Due to legal advice, this commitment was changed to pursuit of a permanent care order.
[132] Transcript, Evidence of Witness A (3 February 2026) 3901.
[133] Ibid 3908.
[134] Ibid 3908-3909.
[135] Transcript, Evidence of Witness Corinne Porta (21 November 2025) 2501.
[136] Transcript, Evidence of Witness A (3 February 2026) 3910.

placement broke down within months due to unforeseen personal circumstances of the aunt's. After this occurred, Murphy's grandmother was considered as a potential kinship carer.

At a family meeting on 11 November 2020 to discuss next steps, family members voiced concerns that the maternal grandmother was not suitable as a full-time carer for Murphy – a significant matter according to Witness A.[137] The grandmother herself said she could offer respite but not full-time care. She was elderly and recently suffered under significant medical issues. She already had full-time care of Murphy's three older siblings.

Nonetheless, the Department placed Murphy with her grandmother.

No assessment of Murphy's best interests

The decision to place Murphy with the grandmother was not preceded by any assessment of whether doing so was in Murphy's best interests, as against returning her to Ellen, (who was willing and able).[138] There was no evaluation of how Murphy's particular needs — including her complex medical history — would be met in the proposed placement. Nor did the Department apparently give weight to the family's concerns about the grandmother's capacity to care for Murphy, as well as the other three siblings.

Defective assessments

Two formal assessments of the grandmother as a prospective carer were conducted by a third-party agency. Both were defective.

The Provisional Approval Assessment was undertaken without the child protection history for the grandmother, for Murphy, or for any member of the grandmother's household. This information was held by the Department and was fundamental to the assessment, rendering it defective and incomplete.[139]

The Initial Assessment Report – designed to be a more comprehensive assessment – also suffered due to lack of critical information: the assessor was not provided with Murphy's case plan or her strengths and needs assessment, and accordingly had no reasonable basis for evaluating whether the grandmother could meet the needs of this particular child, particularly in light of her current caring load for Murphy's three siblings. What was produced was a general

[137] Ibid 3912.
[138] Ibid 3913.
[139] Ibid 3919.

assessment of the grandmother's capacity to care for a child. A third and final assessment required by the process was never completed.[140] The placement continued regardless.

Further, the grandmother had a history as a kin carer: the Department ought to have had regard to that history,[141] but did not. Kin care support agencies had raised concerns over several years about her parenting capacity and her ability to maintain the required standard of care, with no improvement observed.[142] None of this was provided to the assessing agency which was reliant on the Department for such information. Why it was not provided was unexplained.

Ellen was not consulted

Throughout this period, Ellen had been providing regular respite care for Murphy and attending to Murphy's medical needs, though they were the grandmother's responsibility. She had known and cared for Murphy for three years. Her knowledge of the child's history, needs and development was detailed and direct.

She was not asked for her views.

Witness A accepted that Ellen's observations and feedback should have been obtained and presented to the Practice Panel and to the assessing agency.[143] She also agreed that the Department's processes governing placement decisions do not require a foster carer's views to be sought.

A predictable outcome – and a return to Ellen's care

From late 2020, welfare concerns about Murphy accumulated. The grandmother's house burned down, admittedly a coincidental unfortunate event. Murphy spent increasing amounts of time on respite with Ellen, who continued to attend to her medical needs. In early 2022, the placement broke down. Witness A agreed that this was a predictable outcome. None of this is to criticise Murphy's grandmother, who had herself expressed the view that she was not suited to taking on another child's full-time care, and was the subject of defective assessments of her capacity to care for Murphy.

It can be reasonably inferred from the above that the Department's hurried placement of Murphy was motivated by a determination to place Murphy with kin, consistent with the Departmental

[140] Ibid 3928.
[141] Ibid 3914.
[142] Ibid 3915-3916.
[143] Ibid 3935.

Manager's determination that Murphy should not be placed in a long-term arrangement with a non-Aboriginal carer.

There was no recorded decision-making process for what happened next. What is plain is this: that Murphy was returned to Ellen's care, where she remains to this day.

No steps taken towards permanency since Murphy's return

Murphy returned to Ellen's care in April 2022. In the four years that have elapsed, the Department has taken no steps to assess Ellen for a permanent care order — notwithstanding positive legislative obligation under the Act to give priority to guardianship orders to 'other' (e.g. foster carers) over long-term guardianship orders to the Chief Executive.

Witness A confirmed that the assessment of Ellen for permanent guardianship should have been revisited upon Murphy's return to Ellen's care.[144] She also confirmed that in her experience, it is generally the foster carer who raises the question of a permanent care order, rather than the Department.[145] That inversion of the statutory obligation is consistent with what occurred throughout this case.

Witness A also confirmed that LTG-O orders are not routinely being explored when a child is in a long-term stable placement due to competing priorities but accepted that they should be.[146]

Murphy has since developed additional needs requiring NDIS support. Without guardianship, Ellen cannot navigate that system on Murphy's behalf. Every decision must be referred through the Department. The practical consequences of the failure to pursue permanency are felt by both of them daily.

Present day

Murphy continues to live with Ellen. She is, by all accounts, settled and cared for. Ellen continues to advocate for her — for medical approvals, for developmental support, for the permanency that the law contemplates and that Ellen has not yet been given.

What this case showed

This case study has exposed deep and sustained failures across every stage of Murphy's time in the child safety system. It is significant that the Department's own witness, Witness A, did not

[144] Ibid 3938.
[145] Ibid 3939-3941.
[146] Ibid 3942-3943.

seek to defend those failures. Where the Department had erred, she said so; and where better practice was required, she identified it. The failures this case exposed were not the product of individual misjudgement at a single point in time. They were systemic, and they were repeated.

Murphy's case illustrated the Department's failure to treat a child's obvious and deteriorating medical condition as a matter requiring urgent action. For seven months, the condition worsened. In that time, no CSO spoke to the treating doctor, no specialist was consulted and no consent for blood tests was sought. The condition worsened to the point of causing a placement breakdown. Only when Murphy came to Ellen - a nurse - did the situation change. Within eight days, Ellen had obtained a full diagnosis, arranged follow-up referrals, and funded the private appointments herself, because the Department had declined to approve them. The Department's own records showed that no child-related cost payments for private medical expenses were ever approved or made to Ellen.

Murphy's case demonstrated the consequences of chronic CSO vacancy and the Department's practice of deprioritising children in stable placements. Over four and a half years, Murphy had at least nine different CSOs. For periods totalling more than a year, she had none. Of approximately fifty-five monthly visits that should have taken place, eight did. The Department's explanation — that stable placements are routinely deprioritised in favour of children at higher risk — cannot justify this outcome. The stability was Ellen's achievement, sustained through her own resources and commitment.

Murphy's case exposed the failure of the permanency principle to be implemented as the legislation requires. The Department carries a positive obligation to prioritise guardianship orders to suitable persons, such as foster carers, over ongoing guardianship by the Chief Executive. That obligation was not met. Kin searching and planning for Ellen to become guardian should have been occurring from the outset of the placement with Ellen - it did not. The Department committed in March 2019 to assessing Ellen by September 2019. Nothing happened. When a Practice Panel finally convened in June 2020, before any assessment had been undertaken, it declined to support permanency on the ground that kin had not been explored. That failure of kin exploration was itself the Department's and the product of three years of inaction. That inaction was then used to justify deferring the outcome it had caused to be delayed. Witness A confirmed that it is generally the foster carer, rather than the Department, who raises the question of permanency. That is precisely what occurred in Murphy's case. Four years after Murphy's return to Ellen's care, no assessment has been commenced. Without a guardianship order, Ellen could not access the NDIS on Murphy's behalf; every decision had to pass through the Department. The practical consequences of the failure to pursue permanency are felt by both of them daily.

The decision to place Murphy with her grandmother illustrated how placement decisions can be made in the absence of the most basic requirements: a best interests assessment, complete carer assessments, and regard for the evidence and information held by the Department. The grandmother was elderly, recently ill, already providing full-time care for three other children, and had herself expressed doubt about her capacity to take on another child's full-time care. Family members raised the same concern at the November 2020 meeting. Both formal carer assessments that were conducted were defective. Neither was completed with access to Murphy's child protection history, case plan, or strengths and needs assessment. A third required assessment was never done. The placement proceeded regardless. There is a further dimension to this case that the Commission considers warrants particular note: a Departmental manager stated, on the record, that she did not agree with permanent care orders for Aboriginal children being made to non-Aboriginal carers, and that this would never have been a discussion point under her oversight. Witness A was unequivocal: that position has no legislative or policy foundation; it is contrary to both; and it is a view capable of being contrary to the best interests of a child. This raises serious concerns about privately held views impermissibly influencing decisions contrary to the legislation.

In circumstances where a stable, experienced and devoted carer was willing and able to provide Murphy with permanency, the Department's response was to remove Murphy from Ellen's care without proper process, place her in a predictably unsuitable arrangement, and then — when that arrangement failed — return her to the same carer, again without process, and again without permanency. Throughout this period, Ellen was never asked for her views. She had cared for Murphy for three years. She had continued to provide respite and attend to Murphy's medical needs during the grandmother placement. Her knowledge of Murphy was detailed, direct and irreplaceable. Witness A accepted that Murphy's observations should have been obtained and presented to the Practice Panel and to the assessing agency. She confirmed that Departmental processes do not require it. That a system can make consequential decisions about a child's life without consulting the person who knows her best is not a procedural oversight. It is a structural failure.

Murphy's case demonstrated how a child in State care can be failed across every dimension of the system's responsibility: failed in her medical care, failed through the chronic absence of an allocated officer, failed by a refusal to comply with the permanency hierarchy that the legislation requires, placed into an arrangement the evidence did not support, and then returned, without process, to the carer the Department had sought to replace. What Ellen provided, namely

stability, advocacy, medical attention, and the daily commitment of a devoted carer, was not the Department's achievement. It was provided despite the Department, not because of it.

The above conclusions arise directly from Ellen's story, but her experience is of significance to an appreciation of broader themes which underlie the present operations and policies which guide the Department's decision making and practice.

The first theme of wide relevance is the Department's manifest attitude towards foster carers, in particular its unapologetic disregard for the views of foster carers when it comes to highly consequential decisions, such as removing a child from a stable placement, irrespective of the apparently worthy objective of placing the child with kin. The Department's processes should, but do not, require or even encourage consultation with carers. This is a matter of significant concern both in relation to the need for an informal assessment of the child's best interests, and in the interests of ensuring that selfless, dedicated carers like Ellen are encouraged and respected, rather than being treated with indifference at best and, at worst, disdain. Needless to say, this is no way to encourage foster carers, much less abate their decline. Ellen's case is unfortunately far from unique in this regard.

A further matter of pervasive relevance and concern, which is brought into sharp focus by Ellen's case was the wrongful subordination of the paramount principle to the objective of placing Murphy with kin. Ellen's case reveals the danger of placement decisions biased towards achieving outcomings which though generally desirable for broader reasons, for example to give effect to the ATSICPP, are not necessarily consistent with the paramount principle in a particular case. The views expressed by the Department Manager, founded upon an intractable, ideological perspective, inevitably lead to a non-genuine evaluation of the child's best interests. Having regard to Murphy's medical history, serial unsuccessful placements, the practical constraints already faced by her grandmother, compared with the expert and dedicated care provided by Ellen, it is difficult to conceive of a rational basis to remove Murphy from Ellen's care, or how it could have been reasonably assessed to have been in Murphy's best interests in all of the circumstances.

Ellen's case, as well as other cases noted throughout the Commission's work, strongly supports the need for court oversight of long-term placement decisions and reunification decisions to ensure that they are made in accordance with the paramount principle and the permanency hierarchy.

Francis, 8 months of age

Why this coronial investigation was chosen

The Commission reviewed the coronial investigation into the death of this 8 month old baby boy due to its focus on systemic responses to pregnant women, missed opportunities for targeted intervention and diversion, the quality and validity of support programs offered and systemic failures to intervene to keep children safe, especially highly vulnerable children.

Circumstances of death and subsequent action

Francis was an 8-month-old baby boy of Maltese and Aboriginal heritage who died at his mother's home in June 2019.[147] His mother left him in a cot with his twin brother (Twin 2) during her and her partner's three-day drug binge, in such time his (and his twin's) basic needs were severely neglected.[148] Francis died from severe acute dehydration and acute malnutrition.[149] At time of death, his growth parameters were all well below the expected range for his age.

Francis's death was reported to the coroner, and a coronial investigation was undertaken and findings made in respect of his death. The Department conducted an internal review (IR) and a systems and practice review. A Child Death Review Panel (CDR Panel) was also formed and provided a report.

Relevant circumstances

The twins' mother had an *interstate* child protection history as a parent dating back to 2008 in relation her two older children, which recorded concerns about, amongst other things, her methylamphetamine use and her failure to feed her younger child regularly.[150] However, for reasons set out below, the Department was not aware of this history prior to Francis's death.

[147] Non-inquest findings into the death of an eight month old twin whose family was known to Child Safety (Coroners Court of Queensland, Coroner Kirkegaard, 25 June 2025) 1 (Findings). His mother ultimately pleaded guilty to and was convicted of, amongst other things, manslaughter in late 2024 and sentenced to imprisonment for nine years with parole eligibility on 23 June 2025.
[148] Twin 2, fortunately, survived. He was diagnosed with severe dehydration consistent with no or minimal fluid intake over 24 hours. He had severe nappy rash and dermatitis, which resolved with regular nappy changes and barrier cream to the affected area.
[149] Francis's mother pleaded guilty to and was convicted of, amongst other things, manslaughter in late 2024 and sentenced to imprisonment for nine years with parole eligibility on 23 June 2025.
[150] Findings 26.

Late August 2018

The Department became aware of the twins whilst they were in utero in late August 2018 because the mother was not engaging in regular antenatal care.[151] The Department made two Family and Child Connect (FACC) referrals, one before and one after their birth. The FaCC referral was closed in September after four unsuccessful attempts to establish contact with the mother via different means (letter, telephone and unannounced home visits)[152].

September / October 2018

The twins were born in September 2018. There were multiple documented concerns from hospital staff raised with the Department about the mother's disengagement from the twins and their half-sister. For example, the mother needed prompting to visit the twins in the special care nursery and could not be contacted when the twins were ready for discharge on 11 October 2018.

Upon the twins' discharge, hospital social workers obtained support services for the mother in circumstances where she had no clothes, no car seats, no formula, and no cot for the twins.

October / November 2018

In October 2018, the Department referred the family for Intensive Family Support (**IFS**) because it held concerns about the mother's capacity to meet all three of her children's basic care needs due to her reported history of substance abuse, mental health worries, overdose attempts at times of stress, exposure to domestic violence and current limited support network.[153] At the time the twins were discharged, an IFS case worker had not yet been allocated.

A Child Concern Report dated early November 2018 noted that "it is known that for the family to make changes that are long term and sustainable **there needs to be a period of meaningful engagement in the intervention process.**"[154] (Emphasis added) This warning was prophetic and, ultimately, not heeded.

December 2018

A service provider assisted the mother to obtain daycare for the children. Childcare staff observed all three children to be hungry, dirty, and wearing stale nappies; they were also concerned that the mother may be using drugs in light of their observations of her deteriorating

[151] Ibid 29.
[152] Ibid 30.
[153] The twin's father was incarcerated and was no longer in a relationship with the mother.
[154] Findings 37.

behaviours and presentations (ie. rapid and erratic speech, twitching, no eye contact, picking at her skin, sores on her body and face).[155]

February 2019

In February 2019, the Department received separate notifications from different services expressing concerns about the mother's ability to meet the children's needs and hygiene. The information was recorded as a notification on 13 February 2019: the children were assessed as being risk of neglect due to inadequate basic care and emotional harm. A five-day Response Priority Timeframe was recorded.

The children were not assessed within the five-day timeframe, and, as set out below, the I&A was not allocated to a CSO until 1 April 2019 due to "competing demands" on the I&A team.[156] Furthermore, the Department (wrongly) believed that IFS was still working with the family at this time and thus a monitoring mechanism in place.

Given that multiple services had referred concerns to the Department, the mother's minimal engagement with support services and the twins' vulnerability due to their age and lack of visibility in the community, an urgent departmental response was required. It was not provided.[157]

CSOs told the internal departmental review team that, if they had been aware of the mother's interstate child protection history at intake, this would have indicated a pattern of similar concerns in respect of an infant in the mother's care, and a 24-hour Priority Timeframe would have been recorded. Departmental officers noted that, due to the high volume of work at intake, they did not have the capacity to look at every intake event in detail.[158] The IR team did not think that possession of this information would have altered the I&A, though it identified a systems issue regarding the importance of interstate child protection histories and the need for them to be immediately accessible.

However, the Commission notes that, if there is a lack of resourcing to review this information in the first instance, it is hard to see how availability and visibility will, of themselves, necessarily result in improvement in intake decisions. Having readily accessible information is only part of the answer.

[155] Ibid 42.
[156] Ibid 65.
[157] Findings 61 and 66, which refers to observations of the Child Death Review Board on this point.
[158] Findings 62.

March 2019

By 18 March 2019, three months prior to Francis's death, the family had ceased engagement with IFS and the children stopped attending daycare. The Department was still yet to commence its I&A. Around this time, the Department received information of further concerns, including the twin's disparate body size, the mother's drug use and financial poverty, and failure to engage with AOD services, which were recorded as Additional Notified Child Concern Report.

April – May 2019

Despite the five-day Response Priority Timeframe recorded in February 2019, it was not until early April that the Department commenced I&A. The outcome of the I&A outcome was not approved until 31 May 2019.

The twins were sighted on 4 April 2019 during a home visit and appeared clean and appropriately dressed. The nappy rash was explained away by the mother. No concerns were documented about the mother's interaction with the children. The mother stated that she was being supported by IFS, although by this time, she had disengaged from the service (though this was not reported to Child Safety until over a week later). She reported having been referred to AOD services, thought the Department had received information in March that in fact she was not engaging with AOD services. The mother agreed to a referral to the Family Participation Program (FPP) for an independent person. In the result, the initial safety assessment determined that the children were 'safe'.[159]

By contrast, the twin's 17 year old aunt, who lived locally, noticed things 'going downhill' around April 2019, due to the mother's apparent increased drug use. She observed a scarcity of nappies and food and a worsening of the twin's nappy rash, which the aunt tried to fix.

There was a subsequent lapse in progressing the I&A by the Department between April and May 2019. This was due to the allocated CSO taking leave and the case not being re-allocated in the officer's absence due to the lack of staff and the facts that the CSO had already commenced the process, sighted the children and the initial assessment concluded the children were safe.

No other services were engaged with the family during time lapse. On 15 April 2019, IFS reported to the Department that it had formally closed its engagement with the family, having reportedly conducted twenty in-person visits with the family. IFS expressed ongoing concerns about the children's health, safety, wellbeing, and development and that the mother's "lack of participation

[159] Ibid 59.

and disengagement sabotaged any change towards addressing concerns, including in respect of her drug use." [160] Furthermore, whilst the FPP referral was received on 10 May 2019, there was a two-month waiting period and no capacity to allocate the case at the time, and, as it turned out, the case had not been allocated at the time of Francis's death.[161] The IR team noted that FPP was a three-person team carrying a six-person case load during February – September 2019.[162]

In early May, the aunt started spending more time at the unit to ensure the children were taken care of because the mother as "becoming more scatterbrained".[163] The aunt bought food for the children and was getting up at night to attend to the twins. Eventually feeling overwhelmed, the aunt told her mother of the situation. It is unclear what action, if any, her mother took in respect of the children. It is also unclear if, as part of the I&A, Child Safety officers spoke to the aunt or her mother or indeed the neighbours who were also observing at this time the deterioration of the mother's state and attempting to assist with the care of the children.

On 31 May 2019, the I&A was approved with an outcome of "Substantiated – Child in Need of Protection". By this time, a Family Risk Evaluation recorded a high risk of future harm.[164] The mother consented to Intervention with Parental Agreement (IPA) and entered an IPA plan. The plan included, amongst other things, regular and unannounced home visits, re-enrolling the twins in daycare, working with a family intervention service, having the twins seen by health clinicians, and the mother abstaining from using illicit drugs.[165]

The Department attempted to obtain information from the Health Clinic without success. The Internal Review noted that a non-response from the Health Clinic was a common experience for Departmental officers during I&A processes. The I&A process was finalised without this information.

The Child Death Review Process identified missed opportunities for information gathering to strengthen the I&A process namely: input from the family doctor; requiring the mother to undergo urine drug screening; recording observations of the twins' physical appearance: question the mother on eating routines and requiring to sight formula and medications said to be used on the twins' nappy rash.

The IR considered the decision to leave the children in the mother's care and commence an IPA was appropriate, noting 'strong engagement'[166] with the mother, the absence of any immediate

[160] Ibid 67.
[161] Ibid 70.
[162] Ibid 71.
[163] Ibid 53.
[164] Ibid 73.
[165] Ibid 75.
[166] Ibid 76.

harm indicators and the mother being assessed as willing and able to work with Child Safety and a family support service.[167] The IR also considered the IPA Plan to be comprehensive. However, the Child Death Review Panel considered the plan should have required as 'non-negotiables' that the mother comply with Child Safety contact visits and opportunities for Department officers to sight the children.[168]

The IPA was to remain in place until a Case Plan could be prepared. This was to have considered exploring the mother's extended family, although the mother was very reluctant to provide details of her family as she did not want them to be aware of Child Safety's involvement with her family.[169]

June 2019

Child safety officers unsuccessfully attempted to conduct a home visit on 7, 13 and 14 June 2019.[24] [170] The children were not sighted during these two weeks. The mother did not answer the door or respond to calls. The CDR Panel considered the six day delay from 7 June was inadequate and, further that the mother's non-engagement throughout the IPA should have been considered more thoroughly and triggered more intrusive intervention.[171]

The IR noted that the minimum contact requirement for in-home cases with a high Family Risk Evaluation were four face-to-face visits per month with parent and child, and that the CSOs should have contacted a Team Leader for advice when they attended on 14 June 2019 and heard noises from inside the unit.

A home visit eventually occurred on 17 June 2019 (a few days prior to Francis's death). The visit was conducted at the home of a neighbour, rather than the mother's home, at the request of the mother. In truth, this was because there were dog faeces in the mother's unit which she did not want Child Safety officers to see.

During the visit, the officers observed the twins' nappy rash but were not concerned by its severity nor were the officers concerned by the babies' weight and appearance, telling the Internal Review that the twins "did not appear malnourished" to them. [172] The officers characterised the mother as 'anxious', failing to properly assess her drug dependence and increasing pattern of disengagement and avoidance.

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[167] Ibid 85.

[168] Ibid 91.
[169] Ibid 89.
[170] A CSO separately dropped by the family home on other occasions during the first two weeks of June but the mother was not home.
[171] Findings 112.
[172] Ibid 108.

Day of death

When called to the mother's home, paramedics made the following observations about the mother's home:

> ...[the unit smelled] terrible, like unwashed bodies, sweat, human and animal faeces and rotting food. There were animal faeces all over the floor. The floor was sticky. The boys' room was untidy with dirty nappies and clothes everywhere, cat faeces on the floor, broken toys, food wrappers and other mess on the floor. The kitchen was dirty with dirty dishes, food scraps and animal food. There was no food in the fridge. There was an extremely soiled nappy on the bathroom vanity. It had red staining on the waist area and the front and back were heavily caked with faeces.[173]

A Child Safety officer observed Francis's older sibling to ask his mother at the hospital whether Francis died "because you didn't feed him, to which the mother replied, "maybe, we just have to see."[174]

Coroner's observation and findings about Francis's death

The Coroner noted, amongst other things:

- the importance of specialist medical input to assessment and decision making around child protection concerns relating to health and neglect, particularly regarding infants;[175]
- that the CDR Panel queried how comprehensive training was for new staff to understand and recognise when an infant is suffering severe neglect or failing to grow and develop within normal parameters;
- that a referral to a Suspected Child Abuse and Neglect (SCAN) forum should have been considered;[176]
- for vulnerable young infants who have experienced a significant history of neglect, health status can deteriorate rapidly, and thus there is, at various stages of departmental intervention, a need to consider removal of the children to ensure immediate safety whilst department officers assess ongoing risks;[177]and

[173] Ibid 115.
[174] Ibid 123.
[175] Ibid 124.
[176] Ibid 127.
[177] Ibid 128.

- the importance of equipping Child Safety officers with guidance to recognise and respond to emerging pattern of parental avoidance or disengagement, particularly where there is a known history of parental substance use.[178]

Further to this last point, the Coroner discussed at some length the need to strengthen Child Safety practice in response to parental substance use, noting that the impact of problematic parental substance use on children has been a focus of attention for the Child Death Review Board in recent years.[179] The Coroner noted that:

> The Board observed that while there was often awareness of parental polysubstance use and concerns about their ability to parent safely, this did not always trigger effective responses towards managing the associated risk of harm to their children. Research commissioned by the Board confirmed it can be difficult for practitioners to recognise parental substance use and impact on children. Further, the trajectory of methylamphetamines use to becoming problematic is often quite rapid.[180]
>
> ...[The Board] recommended the Queensland Government invest in a practice guide to support frontline practitioners in their risk assessments of children whose parents have problematic substance use. The recommendation highlights the need for the practice guide to incorporate a framework of identifiable risk indicators, the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety and clear definition of the thresholds for intervention types.[181]

Commentary

Twin 1 life and death highlight a number of systemic issues faced by the Department in seeking to protect vulnerable children, support families and prevent entry into the tertiary system.

Sabotage of early intervention

Even where, as here, the need for intervention is identified very early (i.e. during pregnancy), and a provider assigned to assist in a timely way, failure by a parent to engage can and does sabotage efforts to prevent entry into the tertiary system.

[178] Ibid 138.
[179] The Coroner referred to the Child Death Review Board's Annual Report 2022 – 2023.
[180] Findings 142.
[181] Findings 143.

Lack of effectiveness of early intervention

IFS conducted 20 home visits between approximately October 2018 and March 2018. This is roughly 4 visits a month to a mother with 3 young children (including newborn twins), about whom myriad parties had expressed concerns about her ability to provide for the children's basic needs. This raises s serious preliminary question as to whether this truly amounted to "intensive" support for this family. It is unclear on the Findings what support was provided and, in any event, more than five months in, IFS itself acknowledged that, due to lack of engagement, there had been no progress on addressing the child protection concerns, including the mother's drug use.

The consequences of lack of resourcing at intake and I&A

A lack of resourcing led to (a) an under-prioritisation of the need to assess the twin's future risk of harm; (b) an unacceptable delay of 6 weeks to begin an investigation that was required to be commenced within 5 days in respect of highly vulnerable infants in the context of concerns of serious neglect and parental substance misuse.

Lack of training of frontline staff

The quality of the Department's assessments in this case were severely hampered by lack of adequate training of frontline staff, particularly on indicia to recognise signs of neglect and signs of parental substance use, particularly methylamphetamine.

The scourge of methylamphetamine use

It is imperative that the Department is able to respond in an agile and robust fashion to the risks posed to children by parental methylamphetamine use. Due to its truncated timeframe, the Commission was not able to investigate this issue in-depth, including whether the Government's response to the CDRB Panel's recommendation regarding a practice guide has been fully implemented; whether any such resource has had the desired effect (that is, has it led to triggering of effective responses which manages the associated risk of harm to children, and the removal of children where the risk of harm cannot be managed), and whether further measures are required to provide the best possible protection to vulnerable Queensland infants and children.

Helen and Patrick

Background

Helen and Patrick are former foster carers who gave evidence at the Commission's hearings in Toowoomba. Regrettably, their tenure as foster carers lasted a little over a year, before they resigned due to feeling inadequately supported by the Department to meet the needs of the children in their care, and the distress associated with the Department's conduct in raising an Harm Report against them, which could have had serious consequences for Helen's work as an allied health professional and which ultimately led to a placement breakdown.

The Commission has chosen to highlight their story as a case study because it neatly illustrates how the system's treatment of – and, at times, hostility towards – carers contributes to the high number of foster carers existing the system and the critical shortage of family-based care in Queensland. Their story captures the central tension: the system needs carers, but its own processes are driving committed carers away.

Evidence

Becoming Carers

Helen always wanted to become a foster carer because of a desire to help vulnerable children.[182] In her role as an allied health worker, she often saw children in care and heard from their foster carers that they desperately needed a break but there were no respite carers.[183] Patrick thought that it would be a chance to give some children that are less fortunate a stable home environment and a better childhood.[184]

Helen and Patrick were approved as weekend respite carers. As they both worked full-time and had not cared for children before, they wanted to be respite carers first to decide whether they could accept full-time foster care placements in the future with their current working hours and, if not, what changes to their work schedules or lifestyle would be required to ensure they could provide the most stable home for the children.[185]

[182] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4217.
[183] CA-59 *Outline of evidence of Witness L and Witness G* tendered 17 February 2026, 4.
[184] Transcript, Evidence of Witness G (17 February 2026) 4217:39.
[185] Transcript, Evidence of Witness L (17 February 2026) 4218:11.

Limited information regarding the children

Initial weekend respite placement

Helen and Patrick's first placement was weekend respite for a four-year old child. The only information provided to Helen and Patrick was the name and age of the child, the pickup and drop off locations, food and activity preferences and the primary carer's details.[186] Once in placement, Helen's view was that the child was exhibiting symptoms of Reactive Attachment Disorder. The child was very reactive to anything Helen said or did, did not sleep at night and eventually physically assaulted Helen.[187] On contacting the primary carer, Helen discovered that the child was due to see his biological family that weekend, but that the contact had been cancelled by Child Safety and the child was therefore likely to be confused as to why he was with Helen and Patrick and not with his family.[188]

Helen ended the placement early and took the child back to his primary carer on the Sunday as she considered this to be in the child's best interests.[189]

Principal placement

Initial respite care

In September 2024, Helen and Patrick took on a respite placement for two Aboriginal brothers, 10 and 8, who were in residential care and under LTG-CE orders. At the outset of the placement, the Department provided limited information about the children's backgrounds, including that they had been through a failed reunification attempt with their mother and that they had a sister in foster care. As to their developmental and medical needs, they were told that one child had a diagnosed developmental disorder and the other child had a well-managed medical condition. It quickly became apparent to Helen and Patrick that this was not accurate; their medical and behavioural needs were significantly more complex than what the Department had represented, and that the 'well-managed' medical condition was significant and required a lot of medical intervention – in addition to being the type of medical issue Patrick had explicitly noted that he did not feel equipped to deal with.[190] Helen also identified a number of unmet medical and health needs of the children.

[186] CA-59 *Outline of evidence of Witness L and Witness G* tendered 17 February 2026, 11.
[187] Ibid 12.
[188] Ibid.
[189] Ibid 13.
[190] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4219. See also CA-59 *Outline of evidence of Witness L and Witness G* tendered 17 February 2026, 16-17.

When the carers requested the children's child protection history to better understand how to support them, the Department refused, stating that this type of 'in-depth' information was not something that carers 'need to know' because it tarnishes relationships between foster carers and biological parents.[OBJ] What wasn't explored by the Department was understanding in more detail the information that Helen was requiring to support the placement and then determine the appropriate provision of information. Helen's evidence about this positioning by Child Safety was as follows:

> I think it can be quite dangerous…If we're not informed, then how are we able to meet those care needs of the children…[e]specially if we don't know any sort of background of their child protection history and any of those triggers, how can we support them with their emotional and psychological needs…I think it's definitely something that needs to be revised and carers should be able to understand…the history of the children and then be able to use that information to really support them to be able to thrive and overcome the adversity that they've experienced.[191]

Transition to full-time care

About two months into the respite care placement, the Department approached Helen and Patrick about taking the children on a full-time permanent basis as part of the Director-General's 'What Would it Take' pilot, an initiative to transition young children out of residential care and into family-based placements.[192] This transition to full-time foster carers was sooner than Helen and Patrick anticipated. Helen and Patrick agreed in principle to becoming full-time carers but sought to negotiate with the Department a gradual transition.[193]

Helen wrote to the Department outlining the following six supports they required from the Department to successfully transition the children from their residential placement into Helen and Patrick's full-time care, taking into account that Helen and Patrick worked full-time and the children's school was quite far away from where they lived:[194]

(a) outside school hours care as Helen and Patrick worked full-time;

(b) assistance in transporting the children to their many medical and therapeutic appointment which included two weekly appointments scheduled during school hours;

[191] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4220:18.
[192] The Commission received information about this initiative via NTP 28. Email in relation to the What Would It Take Project provided by the Department (DFS.0028.0001.1165) notes the intention behind the project was to identify Aboriginal and Torres Strait Islander children placed in residential care who may be transitioned to family-based care, identify those who return to residential care to understand themes and learnings.
[193] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4222.
[194] Ibid 4222-4224.

(c) additional and specialist counselling for the children as Helen observed that the children had more significant needs than what their current counselling could meet;

(d) further developmental and behavioural assessments and additional allied health supports based on Helen's' observations of the children's needs;

(e) a consistent time for family contacts each week as the ad hoc schedule maintained while the children were in foster care was not feasible given their work commitments; and

(f) increased allowances to meet the children's needs.

Helen also prepared a mock transition plan for the children which proposed a gradual five-month transition period.[195] The Department called Helen and Patrick into a meeting to discuss the proposed transition plan.

The Senior Team Leader and the Senior Practitioner in the meeting told Helen and Patrick that a gradual transition was not possible because the cost of maintaining the children's full-time placement in residential care while they spent increasing time with their foster carers was not financially feasible.[196] With respect to the mock transition plan, Helen's evidence was the Department essentially told her to 'get back in your place' and 'this is who we are as Child Safety. This is what we do".[197]

Helen said the Department told her it makes all decisions for the children and has the final say, and that carers were entitled to advocate for the needs of the children but that the Department has the final say and makes all the decisions.[198] The Department officers were aware of Helen's role in working with children as an allied health provider and she was told she needed to take off her "worker hat" and accept the volunteer role as a foster carer,[199]that is, as a voluntary non-parent.[200]

Helen and Patrick ultimately agreed to accept the Department's timing, and the children were placed in the full-time care of Helen and Patrick the next month without a transition plan. The children were given a week's notice of the change. Child A, once notified, refused to leave Helen and Patrick's (respite) care.[201] Child B needed more time to process the change. Helen's evidence

[195] Ibid 4226.
[196] Ibid 4222.
[197] Ibid 4226.
[198] Ibid 4227.
[199] Ibid 4226.
[200] Ibid 4225:42-44.
[201] CA-59, *Outline of evidence of Witness L and Witness G* tendered 17 February 2026, 28.

was that the children adjusted to the change quite well, that it was quite a positive change and the children were very excited.[202]

Departmental responsiveness

The CSO had monthly home visits with the children where she spent 30 to 45 minutes with them when she picked them up from school and then spent about an hour with the carers after the CSO dropped the children home.

The CSO assigned to the children worked a five-day fortnight.[203] Helen and Patrick say that approvals for appointments and treatment were consistently delayed as a result. The CSO spent her working days trying to catch up on matters that had accumulated during her absence and in some instances, responding to emails on her non-working days.[204]

No other CSO was allocated to cover the days the CSO was not working.[205] Helen was advised to copy the senior team leader (STL) into her emails. She found the STL to be somewhat more responsive, but there were still times where she did not receive a reply.[206]

Helen described the communication style from the Department as directive rather than collaborative.[207]

Issues with the Department

During the placement, Helen and Patrick experienced delays and resistance from the Department in response to Helen's requests for approvals for appointments and treatment for the children and increased carer payments and reimbursements.[208]

In March 2025, Helen sought an assessment for one of the children after the paediatrician recommended a specialist referral. Helen says the Department accused her of 'manipulating' the doctor and did not agree the referral was necessary. When the CSO later attended the appointment and heard the recommendation directly from the paediatrician, the Department still declined to act, saying it would be reviewed in four months.[209]

In April 2025, Helen emailed the Department advising of a large number of upcoming appointments for the children. The CSO told Helen that the table was 'very overwhelming'. Helen

[202] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4227.
[203] Ibid 4228.
[204] Ibid 4228, 4259.
[205] Ibid 4259.
[206] Ibid 4228.
[207] Ibid.
[208] Ibid.
[209] Ibid 4229-4230.

and Patrick's agency worker advised them to stop arranging appointments for the children if they were unable to take them to the appointments themselves. Helen and Patrick expressed their need for support, as they felt they were struggling to meet the needs of the children and had not received assistance from the Department.

The need to take the children to appointments had a particular impact on Helen's work. She gave the following evidence about this impact:

> [O]ver the course of my time with the children I had taken 100 hours of annual leave, and that included me taking the children to their appointments and…when they had extended hospitalisations…So it was very challenging, and being a professional and managing my own case load as well as …the children's medical needs…[T]here was no question I was going to do that, but it did take a lot from me as well. I was worried that I wouldn't have any annual leave to support myself over Christmas time, and it was just the travel to and from the appointments as well…[O]ne of the biggest barriers for me was having to travel from work to the school…to the appointment, bringing them back to school…then…drive back to work.[210]

Helen asked her QFKC case officer for assistance to organise a meeting with Child Safety Service Centre (CSSC) Manager to discuss ongoing issues.[211] During the meeting on 20 June 2025, Helen discussed the outstanding carer payments and reimbursements and asked for a change of CSO to fix the communication issue. [212]There was consideration of increasing the payments, but the Manager denied the request for a CS change.[213]

Harm Report

On 9 July 2025 (approximately five months into the full-time placement), Helen received a phone call from the CSO advising that a harm report had been raised. During the call, the CSO did not explain the specifics and Helen was not even sure who were the persons alleged to be responsible for causing the harm to the children.[214]

That same day, the carers received a formal letter notifying them that they were the subject of the harm report. The concerns were as follows:

- Information has been received that indicates a pattern of behaviour and behavioural management strategies that diminish the children's sense of belonging and safety.

[210] Ibid 4230:27.
[211] Ibid 4230.
[212] Ibid 4231.
[213] Ibid 4232.
[214] Ibid 4232-4233.

- The children are having their belongings sold/taken from them for excessive periods of time as consequences for the choices that is not in line with positive guidance.
- This is resulting in the children articulating that they are sad to multiple people and demonstrating indicators of distress in play therapy.
- The children have made statements that they are sad and restricted in their activities and observations of changes to the children's presentation indicate that the pattern of behaviour may have caused emotional harm to the children.

The letter stated in broad terms that information had been received by the Department indicating a pattern of behaviour and behavioural management strategies by the foster carers that diminished the children's sense of belonging and safety.[215] It referenced concerns that belongings had been sold or taken from the children and listed several legislated standards of care that were said to have been breached.[216]

The letter did not identify the specific conduct alleged. In the absence of any particulars, Helen prepared a written response to the letter addressing each of the standards of care and prepared examples of how she and Patrick believed they had met each one.[217]

On 14 July 2025, Helen and Patrick attended a meeting at the CSSC with the CSO and STL to discuss the harm report with their QFKC case officer. The CSO verbally provided some further detail regarding the allegations. However, even then, the carers' QFKC case officer repeatedly asked how the case had reached the threshold of a harm report, and the Department was unable to answer.[218]

After the meeting, Helen was experiencing extreme distress. She reports that she stood outside the CSSC vomiting into the bushes.[219] The Department staff offered her a rubbish bin to vomit into. Helen gave evidence about the severe emotional impact of the harm report:

> [I]t was a very hard time for me, and for Patrick, but I struggled emotionally with that, firstly…because we really cared for these children, we saw them as our own, and it was really distressing to hear those allegations because that's not something we ever wanted those children to ever feel. And we felt like we were being questioned for everything and just trying our absolute best. So it was a very emotional time. There [were] a lot of insensitive comments made. So I had said to them in that meeting that I hadn't been sleeping, I had been quite unwell, I was vomiting a

[215] Ibid 4233.
[216] Ibid 4233.
[217] Ibid 4235-4236.
[218] Ibid 4238.
[219] Ibid 4239.

> lot, hadn't been eating, and during the harm report meeting the senior team leader offered me food straight after I had said that: "Do you want a cookie?"; that's what she said.

QFKC escalated the issue to the Regional Director on behalf of Helen and Patrick.[220]

In the meeting with the Regional Director on 21 July 2025, the Department disclosed the full list of nine specific concerns which triggered the harm report. These were

a) Patrick allegedly not assisting or playing with the children;
b) the children saying they were only allowed to lie on the bed;
c) the children stating they had no toys; d) a child being sad about chores;
d) a child fearing their Lego set would be sold;
e) the children having a bowl of vegetables and presenting as deeply sad and upset about this;
f) a child mentioning a teddy bear being taken away for bad behaviour;
g) the children presenting as flat and withdrawn; and
h) the children sleeping for excessive periods.[221]

Patrick explained that the teddy bear allegation related to a youth worker's suggestion to vacuum-seal excess stuffed toys to free up bed space — the children could swap them at any time, and none were taken.[222]Helen explained the iPad had been temporarily moved after a child threw it at her and the dog, but it remained accessible and was still used for the child's sleep routine.[223]

The Regional Director advised that the outcome of the harm report was 'unsubstantiated' with each of the standards of care being met.[224]

The CSSC Manager acknowledged the case was *"a learning"* and that 'scope exists for further assessment work to occur on some cases before generating Harm Reports.'[225]

The Regional Director outlined how 'future matters that are not clear in meeting the threshold of a Harm Report can involve the Regional Practice Leader (RPL) to look at the information and assist before a decision is made which could have applied in this case.'[226]

Helen understood from the meeting that a standards of care review can be escalated to a harm report if required. However, a harm report cannot be downgraded to a standards of care review.[227]

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[220] Ibid 4239.
[221] Ibid 4239-4240.
[222] Ibid 4241.
[223] Ibid 4236.
[224] Ibid 4242.
[225] CA-59 *Outline of evidence of Witness L and Witness G* tendered 17 February 2026, 103.
[226] Ibid 103.
[227] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4242.

Helen gave evidence on the consequences of the harm report for her career. As an allied health professional, her employment depended on holding a Blue Card. A substantiated harm finding would deprive her of her Blue Card and effectively end her career. Further, the *existence* of the harm report on her record even though unsubstantiated was itself a source of ongoing concern for Helen.

As a result of their experience, the carers ultimately ended the placement and resigned as foster carers.[228]

When asked in the course of her evidence if there was a chance that she would reconsider here preparedness to be a foster carer in the future, Helen gave the following evidence:

> I would say yes, but also I think there needs to be some changes into the harm report process and the potential outcomes of that with regard to Blue Cards. I'm fearful of returning as a carer and experiencing this again, and not having the support I did from QFKC and how...the outcome could have been different.[229]

What this case showed

The status of carers

The evidence revealed a culture within the Department in which foster carers are positioned as subordinate to the Department rather than as collaborative partners in the care of children. Helen and Patrick were repeatedly told they were '*just volunteers*'.[230] This characterisation sits in sharp tension with the practical reality of the caring role. Carers have the children in their home every day. They are the people who take children to medical appointments, manage behavioural crises at 2 a.m., negotiate the children's emotional responses to contact with family, and make the countless daily decisions that constitute the actual substance of a child's care. The 'volunteer' label reflects neither the intensity of that work nor the degree of responsibility it carries.

The characterisation is also difficult to reconcile with the Department's own policy framework. The CSPM emphasises collaborative approaches and partnership with carers as a guiding principle, and the Department's Statement of Commitment to Foster Carers expressly contemplates genuine consultation and engagement with carers as partners in meeting children's needs.[231] The Department's conduct in this case departed from those commitments in several identifiable respects.

[228] Ibid 4243.
[229] Ibid 4246.
[230] Ibid 4225.
[231] Child Safety Practice Manual, Support a care arrangement, 'Statement of Commitment to Queensland's foster and kinship carers'.

First, Helen's professional expertise as an allied health worker — expertise which gave her an informed basis for assessing the children's clinical needs — was treated by the Department as an interference rather than an asset. When she identified unmet medical needs and sought specialist referrals supported by paediatric advice, the Department asserted that she was *"manipulating"* the doctor and declined to act. When she prepared a detailed transition plan based on her assessment of what the children needed, the Department's response, on Helen's evidence, was to tell her to *"get back in your place"* and further told to remove her *"worker hat"* and accept a role as a voluntary non-parent.[232] This is not collaboration. It is the subordination of a carer's directly acquired knowledge of the children to the Department's institutional authority.

Second, the carers' advocacy for the children was met with systemic resistance at every escalation point, from the CSO to the STL, from the STL to the CSSC Manager, from the CSSC Manager eventually to the Regional Director — before any meaningful engagement was achieved. The burden of that escalation was borne entirely by the carers, without acknowledgment of the time, energy and distress it cost them. A collaborative partnership does not require carers to fight their way up a management hierarchy to obtain basic responsiveness.

Third, the harm report process itself, whatever its origins, was deployed in a manner that treated the carers as subjects of investigation rather than as partners whose perspective should have been sought before the threshold question was determined. The carers were not informed of the specific allegations; they were not given an opportunity to provide context; the Department did not weigh the allegations against the CSO's own regular contact with the children and the carers before initiating a formal process with serious career consequences.

The Department's positioning of carers as subordinate volunteers is inconsistent with its own commitments and, more fundamentally, with the paramount principle. The children's wellbeing is best served by carers who are genuinely supported and whose knowledge of the children is treated as a resource. The "*this is who we are as Child Safety"* response to Helen's transition plan captures, in a phrase, the institutional disposition that drives committed carers out of the system.

The working carer deficit

A defining feature of this case, which runs through the evidence from beginning to end, is that Helen and Patrick were both employed full-time, and the Department's support structures were not designed to accommodate that reality. The result was a placement that was set up to fail: not

[232] Transcript, Evidence of Witness G and Witness L (17 February 2026) 4226.

through any fault of the carers, but through the Department's failure to provide the logistical infrastructure that working carers with complex children require.

The carers' reasonable and foresighted approach

Helen and Patrick did not enter the foster care system impulsively. They began as respite carers precisely because they wanted to assess whether full-time care was feasible given their working hours, and to identify what adjustments to their schedules, their working arrangements, or the supports available would be required before they took on a full-time placement. This was a responsible and foresighted approach. It is the kind of measured commitment to the role that the Department should be seeking to encourage.

When the Department approached them about the full-time permanent placement, some two months into the respite arrangement, it was the Department, not the carers, who drove the accelerated timeline. The Department's refusal of a gradual transition was not based on any assessment of the children's wellbeing; it was based on the cost of maintaining the residential care placement while the transition proceeded. The financial interest of the Department was placed ahead of the assessed needs of the children and the reasonable operational requirements of the carers.

Six reasonable prerequisites

Before agreeing to the full-time placement, Helen set out in writing the six supports she and Patrick required: outside school hours care; assistance with transporting the children to medical and therapeutic appointments; additional and specialist counselling; further developmental and behavioural assessments; a consistent family contact schedule; and increased carer allowances. None of these requests was extravagant. Each addressed a specific operational gap that was directly predictable given that both carers worked full-time and the children had complex needs.

The Department did not substantively address these requests. The carers were told to proceed on the Department's terms and timeline. The placement was stood up without transition planning, without outside school hours care, and without any reliable arrangement for appointment transport. What followed was inevitable.

One hundred hours of annual leave

The clearest evidence of systemic failure in this case is Helen’s evidence that over the course of the placement she took 100 hours of annual leave to meet the children's medical and

appointment needs. Annual leave is a finite personal resource that employees accumulate to manage their own health, rest and personal commitments. It is not, and should not be, the mechanism by which a foster carer absorbs the logistical gaps in a child protection system's support model.

This evidence was not challenged. It reflects a placement in which a motivated, capable and committed carer was being progressively depleted by a system that provided little practical support for the gap between what the children needed and what the carers could provide within their working lives. The loss of 100 hours of annual leave represents not merely a personal cost to Helen, but a measurable and foreseeable consequence of the Department's failure to provide the appointment transport and OOSH supports that she had requested from the outset.

The agency worker's advice

In April 2025, when Helen wrote to the Department outlining a large number of upcoming appointments for the children, the CSO described the table as *"very overwhelming."* The agency worker's advice to Helen and Patrick was to stop arranging appointments for the children if they were unable to take the children to those appointments themselves. This advice is, in effect, a direction to working carers that they cannot function as carers of children with complex medical needs. It places the entire burden of medical coordination and transport on carers with no acknowledgment that the system has an obligation, and the institutional capacity, to assist.

The Commission considers this advice to be emblematic of the systemic problem. It treats the carers' inability to personally attend every appointment during business hours as a failure of the carers, rather than as a predictable consequence of the absence of departmental support. It inverts the relationship: instead of the Department asking what it can do to enable the carers to maintain the placement, the carers are told to manage within the constraints of an unsupported system.

The systemic implications

The current carer support model implicitly assumes that carers are either not in paid employment or have employment flexible enough to absorb the appointment, transport and supervisory demands of a complex placement. This assumption may have always been questionable. In the contemporary labour market, where both partners in a household are typically in employment and household income depends on both, it is operationally untenable. The effect is to narrow the

pool of eligible carers to those with non-working or part-time schedules: a narrowing that occurs at a time when the shortage of family-based placement is at crisis point.

Helen and Patrick were highly capable and motivated carers - one a trained allied health professional - whose employment made the placement more sustainable and the household more stable, not less. The Department recruited them, accelerated their entry into full-time care, and then did not provide meaningful infrastructure to support them. The cost was borne by the carers, by the children, and ultimately by the foster care system as a whole, which lost two carers of demonstrably high quality.

The Commission considers that the working carer deficit is not an isolated feature of this case. It is a systemic gap in the design of carer support, and it requires systemic reform.

Inappropriate escalation to the harm report process

The standards against which the care of a child in out-of-home care is measured are set out in section 122 of the *Child Protection Act 1999* (Qld), which establishes eleven standards encompassing the child's dignity and rights, physical and emotional care, cultural needs, education, positive guidance, medical and therapeutic services, social participation, family relationships, and disability-related support. Section 9 of the Act defines "harm" as any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing.

The Child Safety Practice Manual (CSPM) establishes two distinct response pathways when concerns arise about a child's care.[233] A **standards of care review** is the appropriate response where the care may not have met the section 122 standards but there is no information the child has experienced harm.

A **harm report** is the more serious pathway, triggered where there is a reasonable suspicion that a child in care has experienced harm caused by the actions or inactions a carer. It requires an investigation and assessment of the allegations. Even where the harm report is unsubstantiated, the outcome is recorded in the carer's file.

The distinction between the two processes carries materially different consequences for carers, including recording a harm report on a carer's file and its potential implications for Blue Card status.

[233] Child Safety Practice Manual: Provide and review care, *Respond to concerns about the standards of care or harm to a child in care*.

The key issue arising from the evidence was the Department's decision to initiate a harm report rather than a standards of care review. The nine matters eventually disclosed as the basis for the report, including a child being sad about chores, the children being given vegetables, concerns about stuffed toys being stored in a cupboard, do not, on their face, disclose conduct capable of constituting significant harm within the meaning of section 9 of the Act. They describe, at most, matters that could warrant a collaborative discussion about whether the standards of care were being met.

The Regional Director acknowledged this implicitly as she described the case as a 'learning experience' and there was scope for future matters to engage in further assessment of the concerns before escalating to a formal harm report. While the harm was found to be unsubstantiated, and the standards of care met, the carers are left with a record of a formal harm investigation arising from matters that did not warrant one.

The Department should be wary before instigating a harm report in circumstances where it is not clear whether the concerns on their face meet the threshold for a harm report, because of the significant consequences such a process carries for carers. This is not to limit the Department's capacity to promptly investigate concerns regarding children in care, as all decisions must be made with the paramount principle in mind. However, a failure by the Department to properly assess the concerns and decide whether to progress by way of a standards of care review or a harm report will act as a strong deterrent to carers, particularly those whose professions rely on a Blue Card. The Regional Director suggested that further assessment of concerns could be undertaken in future cases before a harm report is generated. This seems sensible.

This case also exposed fundamental deficiencies in how the carers were afforded procedural fairness. The notification letter did not identify the specific conduct alleged to have amounted to the reasonable suspicion of significant harm. The carers were required to attend a meeting with the Department and account for their conduct without knowing what the allegations were. They were required to explain why they had not caused harm in a vacuum as to any allegations that they had failed to do so. In essence, the onus was placed on the carers to prove they had not caused harm, rather than the Department specifying and substantiating the concerns. This is a departure from basic principles of natural justice, particularly when regard is had to the potential ongoing consequences for the carer's record and livelihood.

For Helen, this carried concrete professional consequences. Her employment as an allied health professional required a Blue Card, and believed that a substantiated harm finding would have ended her career. Even an unsubstantiated finding created ongoing anxiety about future

allegations and the cumulative effect on her record. The mishandling of harm reports can have a direct impact on carer advocacy and, ultimately, on carer retention.

The evidence of Helen and Patrick does not describe an exceptional series of events. It describes, with unusual specificity and documentation, the ordinary experience of motivated foster carers navigating a system that is structurally misaligned with the support those carers need to sustain complex placements. The case illustrates four distinct but reinforcing failures.

First, the Department's harm report process was misused. The nine concerns that triggered the harm report — including a child's sadness about chores and concerns about vegetable servings — did not, on their face, disclose conduct capable of constituting significant harm within the meaning of section 9 of the Act. The failure to apply the threshold correctly exposed the carers to a formal investigation with serious professional consequences, including a permanent record and a risk to Helen's Blue Card and livelihood. This misuse was acknowledged implicitly by the Regional Director's description of it as "a learning" and her suggestion of future pre-escalation assessment. The Commission regards that acknowledgment as insufficient. The Department should be required, as a formal process requirement, to engage senior practice oversight before initiating a harm report where the threshold is not clear on the face of the concerns.

Second, the Department's culture towards carers — characterised by the carers experience being made to feel like *"just volunteers"*— is directly corrosive of carer retention. When carers' professional knowledge is dismissed, their transition plans are rejected without substantive engagement, and they are directed to remove their "worker hats," the message received is that the Department neither values nor needs what they bring. The foster care shortage is, in part, a cultural product of that message.

Third, the working carer deficit is a structural failure of the carer support model. The model cannot accommodate dual-income households caring for children with complex medical and therapeutic needs without fundamental reconfiguration. Addressing this is not a peripheral concern: it is central to the expansion of family-based care that the Commission has identified as the overarching priority for reform.

Fourth, the absence of mandatory CSO coverage for children in the Department's guardianship on days a part-time CSO is not working is a failure of the Department's statutory duty as guardian. It is a baseline operational standard, not a matter of aspiration. Whilst it is acknowledged that children on long-term orders are considered “more stable” and require less support, during periods of transition for children (such as a new placement) or children with high medical needs, the availability of child safety officers is critical.

Jarred[234]

Background

This case study was chosen to explore a multitude of issues: the use of delegated authority, the assessment or evaluation of risk, reunification to a parent under s 82(2) of the *Child Protection Act 1999* (Qld), applications for revocation of long-term orders, the concept of self-determination, the desirability of court oversight, and the issue of objectivity and independence of the Department's internal legal department, the Office of the Child and Family Solicitor (OCFOS).

The following de-identified case study, based on the documents received under notice[235] and the evidence given publicly by the Principal Legal Officer (PLO) of OCFOS and the Director of Child Protection Litigation (DCPL). It examines the decisions made in 2024 - 2025 to give delegated authority to the ATSICCO, to formally reunify Jarred with his mother under s 82(2) of the *Child Protection Act 1999 (Qld);* the change of assessment of the Chief Executive regarding the need for LTG-CE orders for Jarred and the referral to DCPL.[236]

About Jarred

Jarred had been in care since he was approximately three years old, and under LTG-CE orders since 2017. By 2021, he appeared to have been relinquished by at least one family-based carer for behavioural issues and was in residential care. In January 2022, Jarred left his residential care placement to self-place with his mother – and his father from time-to-time.

According to a 'child strengths and needs assessment' (CSNA) conducted in July 2024, Jarred (aged 15) was facing significant challenges. He had diagnoses of ADHD, FASD, and Reactive Attachment Disorder, which affected his daily functioning and behaviour. He struggled to manage his emotions and had volatile outbursts. He had limited intellectual functioning/developmental delay and severe educational issues: he had not attended school on any regular basis, if at all, since August 2022, and had been suspended from at least two different schools for violent incidents.

[234] Clare Martin and Nigel Miller gave evidence at Brisbane public hearings on 12 December 2025, 2 February 2026 and 5 February 2026.
[235] Note: the Commission did not receive the child's file in its entirety from the Department.
[236] Documents sought from DCPL (via NTP 278) included: the Form A Referral Summary Form and accompanying brief of evidence, file notes of meetings or consultations with the Department regarding the referral. Documents sought from the Department (via NTP 277) included: correspondence between the Department and the ACCO relating to the s 82(2) placement decision and the referral of a revocation application to the DCPL, copies of documents provided to the ACCO by the Department to inform the ACCO's assessments and decisions in respect of same and legal advice provided by OCFOS to the Child Executive regarding the Chief Executives change of assessment and the referral to DCPL. Note: the Commission did not request the child's file in its entirety.

Evidence

Mid-June 2024: Review of permanency arrangements

In early June 2024, a mandatory review of Jarred's permanency arrangements was conducted[237] to consider whether alternative permanency options would best achieve permanency for Jarred: namely, whether should Jarred be reunified with and cared for by his family, or, if this was not possible, whether another family member, or other suitable person, be granted LTG-O orders.[238]

Departmental officers conducted the review, together with the local delegated authority manager from the ATSICCO. At this time, Jarred had been 'identified' for delegated authority, though no consent had been obtained from the family, nor delegations formalised. No member of Jarred's family participated in the review itself, but their views were sought 'via casework'.

The review required the family's views to be sought about whether the current order best achieves permanency for the child. The family's views, obtained via casework (and, with respect to Jarred via his mother's report only) were said to be as follows:

- Jarred had told his mother to "get rid of the order";
- Jarred "keeps going off at [his mother]...Mum if you're so smart why can't you get rid of the order?";
- Jarred was "sick of workers contacting him";
- Jarred's mother (who was unemployed) would "prefer to see [the LTG-CE] order revoked then to worry about financial benefits when [Jarred] transitions from care."; and
- Jarred's father's specific views were not obtained because 'he has recently dropped off from a level of contact'.

This demonstrated the family's focus on the fact of the order per se, and a keen desire for its removal, but was not illuminative on permanency issues and how best to achieve them in Jarred's best interest in any material way.

The review required consideration of the option that best addressed Jarred's physical, relational and legal permanency. What the record discloses is that the panel focused heavily on the fact

[237] This was done pursuant to s 51VAA of the *Child Protection Act 1999* (Qld), which was introduced in line with the Carmody Report and a consequential suite of permanency legislative amendments, which came into effect (re section 51VAA) in April 2021: *Child Protection and Other Legislation Amendment Act 2021* (Qld) s 9

[238] If Jarred was not Aboriginal, consideration would also have been required to be given as to whether he should be adopted.

that Jarred had been 'self-placing' for two years – said to be an act of self-determination by Jarred – with 'no significant concerns' noted. [239]

It was not noted what those concerns were, and why they were not considered 'significant'. There was no reference to the two Child Concern Reports (CCR) that had been made during that period. There was no apparent review of the case work from those two self-placing years, nor an examination of why the Department had not previously seen fit over that period to consider a s 82(2) placement. The reviewers gave weight to the fact that the family had 'strong views against' the Department, that Jarred didn't want to engage with Child Safety, and the mother had ceased engaging well when she learned that Jarred's CSO was from a particular Child Safety Service Centre (CSSC).

There was no discussion of how Jarred's permanency needs were currently being met (or not met) by the LTG-CE orders, Jarred's diagnoses and challenges, whether the child protection concerns that justified the order were still present and how a formal placement with the mother under s 82(2) (that is, reunification strictly speaking), and/or revocation of the orders would better meet Jarred's permanency needs. No consideration was given as to whether Jarred ought to remain on LTG-CE orders and whether he would benefit from a therapeutic residential care placement in light of his significant challenges.

Nevertheless, it was determined that both a s 82(2) placement decision and an application to revoke the LTG-CE order would be explored.

Late June 2024: Consent to delegated authority

Shortly after the permanency review, both Jarred and his mother consented to Jarred being subject to delegated authority.[240]

In late June 2024, in a series of emails between the Department and the DA ATSICCO preparing the necessary paperwork for the delegations, both organisations had referred to the "historic moment": for the community controlled sector; for Mob; and for the Department and its DA team within the Chief Practitioner's office.[241] This was a reference to Jarred being the first child under delegation to this ATSICCO. The Cultural Practice Advisor wrote: "Congratulations everyone! I am so happy for the family in being all safely back together at home."[242]

[239] CA-56, *Clair Martin tendered bundle,* tendered 5 February 2026, 3.
[240] Jarred's father could not be contacted, despite multiple attempts by the Department.
[241] CA-56, *Clair Martin tendered bundle,* tendered 5 February 2026, 4.
[242] Ibid.

Early July 2024: "Concerns" raised with Department regarding domestic violence incidents involving Jarred

On 1 July 2024, a professional notifier contacted the Brisbane Regional Intake Service with the following concerns (July DFV Intake): Police had been called to the mother's house. Jarred's mother told police that, due to Jarred's behaviour, she was unwilling to parent and house him any longer and wanted him out of the house. She verbally threatened to 'bash' Jarred to police and admitted that she had called his older siblings to come and 'set him straight'.

The notifier described Jarred as having "significant mental health issues, and reported that there had been repeated calls to police services due to DFV incidents between Jarred and his mother, sometimes Jarred was the aggrieved; sometimes his mother. The notifier reported that the mother was either the respondent or aggrieved in seventeen different relationships with family or ex-partners and described her as likely suffering from "undiagnosed mental health". The notifier asserted that Jarred did not have a "supportive family dynamic with positive role models or persons willing to care for him and help manage his mental health concerns and developmental challenges", although he receives "the necessary needs for life". At the request of the mother, Jarred was removed to his father's/aunty's house which was described as "not ideal" by the notifier because they were persons known to "abuse drugs/alcohol" but there were no other options available to Jarred.

The Department's case note recorded that the information contained in the July DFV Intake, recorded as a CCR, was provided by email to the CSO responsible for ongoing intervention "for further discussion with family and management via casework."

The July DFV Intake appears to be reference in the ATSICCO records as follows:

> "*there was a recent CCR received around Police attending the family home, [Jarred] escalating and Mum saying she is not going to look after [Jarred]. [DA Manager] addressed the intake with [the mother]; continue to address through AYS/FWS case management." There is no detail about how the July DFV Intake was 'addressed' by the Manager with the mother.*"

Early July 2024: Referral to DG and approval of delegations

On 2 July 2024, the Director General of Child Safety approved the delegation of powers in respect of Jarred to the ATSICCO related to case planning, reunification and connection. The briefing note provided that "a decision is required" because:

- *the family has long standing history with child safety intervention;*
- [Jarred] *does not feel comfortable working with Child Safety;*

- [Jarred] *was placed in residential care, however, is now self-placing with family;*
- [Jarred] *disclosed the residential placement is not meeting standards; and*
- *to maintain family connection to support reunification 82(2).*

Whether or not it was appropriate to delegate authority in this instance is explored below.

The briefing note provided that "[t]his delegation of legal authority supports the Our Way Strategy and Family Matters campaign and is an important step in Aboriginal and Torres Strait Islander self-determination over matters relating to children and their families." The nominated CEO of the DA ATSICCO was described as "a proud member" of a particular nation and a "passionate advocate" for the health and wellbeing of Aboriginal and Torres Strait Islander people with decades of experience in leadership roles.

The briefing note made no mention of the domestic violence and other concerns raised with the Department the day previously.

Mid-July 2024: Section 82(2) placement and reunification decision

On 18 July 2024, the ATSICCO DA Manager told the Department that Jarred and his mother "would like to see an 82(2) decision be made" in light of his self-placing history. She noted that the father had been uncontactable. The ATSICCO sought "feedback and thoughts that the Department believes is important to take into consideration in making the recommendation" to the delegate. Each of the Manager, Child Safety Officer (CSO), Cultural Practice Advisor (CPA), Senior Team Leader (STL) and Senior Practitioner (SP) responded saying that they "support" or "endorse" a decision to place under s 82(2). No substantive feedback was provided. No one mentioned the July DFV Intake, or any case management done in respect of those concerns. The STL went further and suggested endorsing a s 82(2) placement for Jarred's father's house, despite the father's history of being uncontactable – including in respect of this recommendation.

Two months later, the ATSICCO was yet to discuss the matter with Jarred. The Department wrongly advised the ATSICCO there had been no "new" concerns received since Jarred started living with his mother. This is despite there being four notifications made which were screened as "child concern reports" to child safety since Jarred commenced living with his mother, in addition to July DFV Intake.

On 2 October 2024, the ATSICCO formally decided to place Jarred in his mother's care. The ATSICCO's letter to the mother discloses that this decision was based on factors which included:[243]

- the period of self-placement;
- Jarred's wish to remain living with the mother;
- 'no new information has been received by Child Safety that suggests increased risk of harm to [Jarred] whilst in your care';
- the mother had achieved the 'majority' of Child Safety's case plan goals;
- the mother had agreed to work with the ATSICCO's intensive family support service for support and to address outstanding case plan goals;
- the mother was supportive of Jarred spending 'natural family time with his father'; and
- The mother was currently providing for Jarred's 'basic need and have expressed commitment to continuing to work towards addressing [Jarred's] health, education and disability needs'.

Early December 2024: Endorsement by Child Safety and ATSICCO to seek revocation of LTG-CE orders

On 2 December 2024, a panel was held regarding a proposed revocation of the LTG-CE orders.[244] The child protection concerns that led to the LTG-CE orders were identified as: (a) domestic and family violence; (b) drug use; (c) neglect and (d) parental mental health. The panel concluded that the only outstanding concerns were lack of school attendance and NDIS access.

It is difficult to see how the panel could reasonably have formed this view.

First, there was no discussion of DFV concerns, except for a reference to the mother experiencing chronic pain as a result of injuries sustained because of DFV and her consequent use of pain relief. DFV ought to have been front and centre of the discussion about whether it was appropriate to seek revocation of the order. It was not. Neither the July DFV Intake, nor any case management steps taken in respect to it, was recorded as discussed.

Second, the fact that drugs and alcohol were no longer a concern was said to be because there was 'no evidence of continuing use' without any disclosure of circumstances that led to this view other than that the mother referred to alcohol as 'evil and makes people do stupid things'. This is a point later taken up with the Department by DCPL.

[243] The letter is attached to the draft affidavit that was provided with the Form A referral provided to DCPL.
[244] CA-56, *Clair Martin tendered bundle,* tendered 5 February 2026, 7.

Third, there was no reference to parental mental health nor any parental strengths and needs assessment.

Fourth, there is no attempt to deal with whether the father had addressed the child protection concerns. It is noted only that the father "hasn't been engaged with DA – just wants [Jarred] out of the system – happy to spend time with [Jarred] in line with his views and wishes'.

Fifth, in respect of neglect, Jarred had not attended school regularly for multiple years at this time and his NDIS plan is said to be "depleted in funds [and] is not being accessed". These 'outstanding issues' are significant, particularly for a child with Jarred's diagnoses and behavioural challenges. There is an open question at this point as to whether, during self-placement, the mother had been able to meet Jarred's health, developmental, educational and well-being needs. Furthermore, the s 82(2) decision was predicated on, in part, the mother commitment 'to continuing to work towards addressing [Jarred's] health, education and disability needs'. Serious progress is yet to be made, but does not appear to cause any pause to the panel.

Sixth, the panel made no reference to Jarred's child strengths and needs assessment from July 2024, nor how the revocation of the order would be consistent with best ensuring his various needs were met.

There are conclusory statements about the desires of the family: the mother "would like [Child Safety] to revoke LTG-CE", Jarred "would like [Child Safety] to get out of their life", the father "just wants [Jarred] out of the system".

In the result, the panel supported revocation, as did the ATSICCO.

On 10 December 2024, legal advice was provided by OCFOS, which led to a referral with respect to revocation of the LTG-CE orders being prepared for the DCLP, which is dealt with further below.[245]

Late December 2024 - Family plan

On 24 December 2024, a family plan was endorsed by the ATSICCO, family and the Department, who all agreed that no further statutory intervention was required, and that "Community will continue to work with the family and [Jarred] and the least intrusive and most appropriate next step is to revoke the [LTG-CE order] and close the current event with no further Child Safety intervention required". Again, the rationale was stated to be on the basis that the original child

[245] Ibid 8.

safety concerns had been addressed. This conclusion was contrary to fact. Two examples will suffice.

First, the plan denotes that domestic and family violence is no longer a current concern because the mother is currently single. There is no reasonable basis to suggest that, simply because the mother is not currently in a relationship, that there is no DFV risk. More concerning is that this conclusion elides the relevant fact, namely, the most recent history showed that DFV incidents had occurred between the mother and Jarred.

Second, the plan denotes the father's use excessive physical discipline and inappropriate emotional responses towards the children was no longer a concern because Jarred's primary placement is with his mother. Yet it was known that Jarred had unlimited access to his father's residence. It is unexplained how the fact Jarred's primary placement was to be with this mother meant that his father was no longer a significant risk to him.

Early March 2025: Further DV incident

On 5 March 2025, the ATSICCO's records show that Jarred's mother disclosed that: she had been physically assaulted by Jarred with a wooden stick, causing a black eye; she had reported the incident to police, who released Jarred without charge; and she was distressed, upset and frustrated that there were no consequences for Jarred's behaviour.

On 10 March 2025, the DA Manager reported to the Department that police had attended at Jarred's mother's home due to allegations by Jarred's mother that he had hit her in the face with an implement. The cause of the incident was said to be Jarred becoming escalated by the fact that the mother was leaving the house to pick up the family vehicle that Child Safety had paid to repair with "his" money.[246] (It is worth noting here that this is precisely why statements by a child that he doesn't want Child Safety in his life should be treated with caution – the child may not have a true sense of what that might mean for him, as it seems clear that Jarred did not here.) The child was reported to be staying with his aunt. The mother expresses that she considers this safe, but at the same time concern that his older cousin has been recently released from prison and might influence Jarred to participate in anti-social activities. The mother also noted that Jarred cannot return to the house whilst the police investigation is ongoing.

The DA Manager expressed the following views:

[246] Ibid 9.

> *[I]t is important that we offer therapeutic support [as soon as possible] to the family. There is so much hurt and trauma that has been experienced due to removal, child safety involvement and ongoing grief and loss. [The mother's] response to [Jarred] is influenced by her previous experiences of domestic violence, disempowerment and violence experienced from the system/s. [Jarred's] responses to [his mother] are influenced by his previous experiences of removal and time in care which has significantly impacted his attachment with his mother, as well as lack of access to appropriate support and resources over the years to meet [Jarred's] disability and developmental needs.*

In response to this email, the CSSC Manager expressed the hope that this is "only a minor setback" and suggested a "specialised cultural camp". Inquiries were made as to the timing of holiday 'healing' camps.

Mid-March to Mid-July: Referral to DCPL

On 11 March 2025, the matter was referred by OCFOS to DCPL for the purpose of applying for revocation of the LTG-CE order on the basis that the Chief Executive was satisfied that the order in place is no longer appropriate or desirable for the child's protection and should be revoked. The reasoning provided was:

> *The [LTG-CE order] should be revoked, noting that [Jarred] has been reunified to the care of a parent. This order is in [Jarred's] best interests, as it ensures that [Jarred] will remain with his family and his culture for the remainder of his children, free from government intervention.*
>
> *This is based on the following:*
>
> *a. [Jarred] has been in [his mother's] care since 18 January 2022;*
> *b. [Jarred's] reunification was formalised on 2 October 2024;*
> *c. [Jarred's mother] has addressed the child protection concerns that relate to her as a parent and has demonstrated her ability to provide safe care and protection to [Jarred];*
> *d. [Jarred] is now able to grow up in his family of origin where his connection to his family and culture is preserved.*

A draft affidavit with corresponding exhibits was provided within the brief of evidence provided to DCPL.

In late March 2025, the DCPL acknowledged the rationale for revocation, but sought further critical evidence, in particular how the parents had addressed the child protection concerns and what supports the child had in place without the Department that would result in Jarred no longer being a child in need of protection.

OCFOS acknowledged the following day that "more substantial information could be provided to evidence how the parents have remediated the child protection concerns".[247] These requests were passed onto the ATSICCO.

On 12 June 2025, DCPL consulted further with the Department about the revocation application. The Department reported (inaccurately) to DCPL that there 'ha[d] been no DFV or Drug Use (or any suspected) in the household for a long period of time.' The concerns reported during the consult included:

- Jarred's lack of attendance at school for the past three years;
- that Jarred had not been accessing his NDIS plan for OT and other services and that there had been no support or engagement for the family to assist them to utilise the package;
- there was a need to find support services for Jarred and his mother to help manage and support his emotional outbursts and dysregulation due to his FASD diagnosis; and
- that Jarred's mother has not received support to navigate this, which made her feel overwhelmed.

The Department agreed to work with the DCPL to draft a new affidavit for revocation, including for instance, that more specific information was provided by the ATSICCO regarding statements like '[the mother] does not drink alcohol and does not use illicit substances and reports she has no history of substance use'.

By mid-July 2025, this information was still outstanding. At this time, the DCPL identified the following further gaps in the evidence;

- how the father had addressed the child protection concerns, noting that Jarred spends time with him
- limited direct evidence of how the mother ensured:
    - that Jarred is not exposed to any conflict or violence, particularly in the context of the CCR earlier in the year and Jarred moving between family members and the lack of confirmation of s 159N[248] to QPS confirming no call outs;
    - that Jarred received disability support, in the context of a report from NDIS about the difficulty in engaging Jarred.

[247] The PLO also acknowledged that "there were vulnerabilities in Child Safety's brief of evidence"; Transcript, Evidence of Clair Martin (2 February 2026) 3778:32.
[248] The Department is able require prescribed entities to provide information pursuant to Section 159N of the *Child Protection Act 1999* (Qld).

- Limited direct evidence demonstrating, on an objective basis, that the mother had addressed other child protection concerns.[249]

DCPL followed up with the Department a number of times between April and June 2025. The Department stated that they were awaiting information from the ATSICCO. When this further information wasn't received, DCPL referred the matter back to OCFOS in July.

Mid-July to November 2025: Facts and circumstances that occurred after the refer back[250]

On 15 July 2025, concerns were received by Child Safety that Jarred's behaviour had caused fear to his mother. The notification stated they had an argument and Jarred caused property damage. Police found alternate accommodation for Jarred.

On 31 July 2025, at a stakeholder meeting the main concern discussed was that Jarred's mother no longer felt safe having him in the home.

In August 2025, Jarred disclosed to a CSO that he felt uncomfortable with his father when he is drinking excessively, his father spends his money on alcohol, rather than food and he hasn't eaten for over a day. Jarred told the CSO that he was fine to go back to his father's house and would call family to pick him up if things get bad again. The CSO sought funding for a food voucher.

In September 2025:

- The Department received allegations that Jarred had been aggressive towards his mother resulting in police attendance.
- The ATSICCO told the Department that it did not believe that Jarred's father's house was a safe place for him. The Department provided a food voucher for the family.

In October 2025:

- The Department received allegations that Jarred had assaulted his mother with stick. Police were called to attend, and transported Jarred to a 'safe person'. The CSO spoke to Jarred who expressed remorse for his actions. Jarred went to stay with a friend for a week.
- Jarred's school social worker called Jarred's CSO to discuss his non-attendance at school.

[249] The email from DCPL's principal lawyer provided specific, detailed wording of how to address this: "ie. of the XX number of home visit[s] completed of XX time there has been no observations of alcohol in the home of mother] appearing under the influence or drug paraphernalia. [Mother] has produced xx clean drug screens, [mother] has a relapse plan and is engaged in ADOS etc"; CA-56, *Clair Martin tendered bundle,* tendered 5 February 2026,13.

[250] The following details are provided based on documents provided by the Department under NTP 277 issued on the Department on 16 January 2026 and NTP 278 issued on the Director of Child Protection Litigation on 21 January 2026.

- The Department received allegations that Jarred had caused property damage at the home. The notifier also stated that his mother made threats towards him if he keeps doing this. The notification also referred to domestic violence incidents between Jarred and his mother that caused police attendance three times in July and twice in September.

In November 2025, the CSO reviewed spoke with Jarred's mother to review Jarred's case plan and noted that Jarred had been 'engaged in work experience alongside his father'. The CSO asked the mother's view about revocation of the LTG-CE order. The mother affirmed that she "hopes the CPO is revoked" and she wants Jarred reunified to her. This last comment suggests that Jarred was no longer placed with the mother.

At the time of publication of this report, a revised application for revocation had not been sent to the DCPL.

Departmental response

During a discussion between the Commissioner and a PLO of OCFOS on assessment and evaluation of risk and differing level of risk tolerance between decision makers in a child protection context, the PLO noted that these differences were seen "frequently in the 'getting-Child-Safety-uninvolved' space."[251] The PLO spoke of Jarred's matter and reported that the difference in risk assessment or tolerance was this: the ATSICCO with DA formed the view that the child was "safe enough at home and the State no longer need[ed] to have an order and be involved".[252] The Department agreed, on the strength of the evidence of the ATSICCO that the child protection risks to Jarred had been mitigated supported a s 82(2) placement and, through OFCOS, referred the matter to the DCPL for revocation of the LTG-CE order. [253]

Whilst acknowledging the rationale for revocation, the DCPL formed the view that critical pieces of evidence were missing, particularly in respect of whether the parents had addressed the child protection concerns that led to the LTG-CE orders, and asked for further material to be prepared. In the result, after the passage of months, the DCPL was not satisfied that its evidentiary concerns had been adequately addressed and referred the matter back to OCFOS.

The PLO told the Commission that the question of whether the risk to the child had been adequately mitigated to the point that the State ought be required "to step out of the family's life"[254] ought to have been put to the Court, and not, in effect, stymied by the DCPL at that point.[255]

[251] Transcript, Evidence of Clair Martin (12 December 2025) 3643:27.
[252] Ibid 3643:33.
[253] Ibid 3644:30.
[254] Ibid 3643:42.
[255] Ibid 3643:39.

In her experience, families in the child protection jurisdiction may never resolve every single child protection concern. Where – as here - there is an ATSICCO stating that "we can manage this in community", and the child had self-placed for over two years, the revocation application should "properly be put before a court".[256]

What the case shows

The reasonable inference to be drawn from the facts and circumstances described above is that the panel wanted to give the family the outcome they desired, in line with the object of supporting 'self-determination'. Having regard to the above facts, which viewed objectively were contra-indicators to the proposed formal reunification of Jarred, the Commission regards this case study as a stark example of the danger inherent in decisions determined on the basis of collateral social and cultural objectives rather than, as they should, upon a bona fide evaluation of the child's best interests as required by the paramount principle. The Department in this case overlooked, or elided, the serious contra-indicators without analysis or explanation, leading the Commission to conclude that it was concern rather to join with the ATSICCO to realise the objective of reunification as a tangible expression of self-determination. These objectives were pursued by the ATSICCO and the Department in concert, with the result that the paramount principle was subordinated to those broader objectives.

This case study provides an analogous example also of the tensions that may arise in a given case between the application of the paramount principle and the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).

The case illustrates a cascade of flawed decision-making, inadequate risk management, and institutional pressure toward a predetermined outcome that was inconsistent with the proper application of the paramount principle.

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The permanency review process was substantively deficient

The mid-June 2024 mandatory review under s 51VAA was not a cogent evaluation of how to best achieve permanency for Jarred. The record reveals no:

[256] Transcript, Evidence of Clair Martin (2 February 2026) 3776:76.

- analysis of Jarred's existing diagnoses (ADHD, FASD, Reactive Attachment Disorder) and how his permanency needs were (or were not) being met;
- discussion of the child protection concerns that originally justified the LTG-CE orders, and whether those concerns remained operative;
- consideration of whether formal reunification with the mother would actually improve Jarred's situation; and
- assessment of whether a therapeutic residential care placement might have better served Jarred's complex needs.

Instead, the review gave outsized weight to cultural connection and was substantially driven by the family's hostility to child safety involvement, with Jarred's wish to 'get rid of the order' treated as a significant factor. The review also took unexamined at face value the assertion that Jarred had been self-placing for two years with 'no significant concerns', without reviewing the relevant casework. The discussion concerning permanency equated the period of self-placing with proof of a lack of child protection concerns and sufficient capacity by the parents to meet Jarred's needs (i.e. good enough parenting), thus treating a lack of willingness to engage with Child Safety as evidence that the LTG-CE orders were no longer desirable and appropriate. It treated self-placing *per se* as an act of self-determination by Jarred that ought be formally endorsed by Child Safety.

The inference the case study invites is that the review was oriented toward facilitating an exit from statutory intervention rather than genuinely evaluating Jarred's best interests.

The delegated authority approval process was deficient

The statutory basis for delegating authority under s 148BB of the *Child Protection Act 1999 (Qld)* requires that the child be 'in need of protection' or likely to become so. The briefing note provided to the Director-General for delegation approval contained no explanation of how this threshold was met in Jarred's case.257 This was a significant legal deficiency in the gateway decision, because it directly affected the decision-makers ability to be satisfied of the requisite matters to make the order. The briefing note's framing was notably outcome-oriented rather than child-focused: the delegation was described as supporting the 'Our Way Strategy and Family Matters campaign' and as 'an important step in Aboriginal and Torres Strait Islander self-determination'.

257 The Commission notes that, there were concurrent discussions between the Department and the ATSICCO at that time were premised on the view that the LTG-CE order could be revoked (with no replacement order) - a position difficult to reconcile with the child being in need of protection – however, the Commission accepts that until such time as a Court determined the revocation application, Jarred's status as a child in need of protection was extant.

The CEO of the ATSICCO was supported by reference to personal identity and advocacy credentials. While none of this is improper in itself, the absence of a corresponding child-focused analysis in the briefing is telling.

The timing of the delegation is also troubling. The Director-General approved it on 2 July 2024 - one day after a professional notifier had reported serious concerns to a Regional Intake Service, including the mother's statement to police that she was unwilling to parent and house Jarred, her threat to "bash" him, her calling his siblings to "set him straight", and a history of repeated police attendances for domestic violence. There is no mention of this notification in the 2 July briefing note, possibly due to processing delays, but this is precisely the kind of contemporaneous risk information of which the decision-maker ought to have been on notice.

The s 82(2) reunification decision was made without adequate information

When, on 18 July 2024, the ATSICCO sought the Department's views on a s 82(2) placement, the responses from the Child Safety staff amounted to bare endorsements with no substantive consideration or evaluation. No one mentioned the July DFV Intake. No case management undertaken in response to those concerns was discussed. A STL even suggested endorsing placement at the father's address despite the father being uncontactable and having outstanding child protection concerns of his own.

Two months later, the Department erroneously advised the ATSICCO that no new concerns had been received since Jarred started living with his mother — despite four notifications screened as child concern reports and the July DFV Intake. The October 2024 formal placement decision reflected this informational vacuum: the ATSICCO concluded, on false premises, that there was ‘no new information indicating an increase in risk of harm’.

The December 2024 revocation panel's reasoning was demonstrably inadequate

The panel tasked with considering revocation of the LTG-CE orders identified the ‘only outstanding concerns’ for Jarred as school attendance and NDIS access. This is difficult to reconcile with the material before the Commission. Domestic and family violence - explicitly identified as one of the original child protection concerns - received almost no substantive analysis. The 1 July 2024 incident was not referenced. Parental mental health was not addressed, nor were any parental strengths and needs assessments conducted. The mother's use of pain relief consequent upon DFV injuries was noted, but not interrogated.

The family plan endorsed on 24 December 2024 contained reasoning that is at times circular or unsupported. The conclusion that DFV was 'no longer a current concern' because the mother was currently single did not grapple with the fact that the most recent DFV incidents had been between Jarred and his mother - not involving any partner. The conclusion that the father's use of excessive physical discipline was no longer a concern because Jarred was primarily placed with his mother did not address the conceded fact that Jarred had unlimited access to his father's home.

Cultural considerations, while legitimate, were permitted to override child safety analysis

This case illustrates the risk - flagged in different terms by the PLO in oral evidence - that cultural and broader aspirations such as self-determination considerations can distort risk assessment. The language used throughout – 'historic moment', 'for Mob', 'self-determining', 'in line with self-determination' - reflects an organisational culture that had invested in the outcome of reunification before a proper assessment had been completed, and then – despite inadequate progress by the mother to support Jarred – doubled down with an application for revocation of orders. The December 2024 panel's reasoning suggests that the desire to give the family the outcome they wanted, framed as self-determination, crowded out analysis of contra-indicators. That is not a justification in line with legislation. The focus was consistently on promises or assurances from the ATSICCO that community could, in effect, 'handle' any child protection concerns whilst at the same time minimising DFV incidents and engaging in plainly erroneous assessments of whether legitimate child protection concerns still existed.

The child's expressed wishes were treated uncritically

Jarred's consistent expression that he wanted Child Safety 'out of his life' and that his orders should be 'got rid of' was treated as a significant indicator throughout. This is problematic. Whilst it is important that children's voices are heard in the child safety system, their feedback must also be properly weighted. A 15-year-old with limited intellectual functioning who struggled to regulate his emotions and behaviour may not have the capacity or the information base to give materially useful views about long-term guardianship arrangements and what type of arrangement will best meet his permanency needs. The fact that Jarred's distress about a vehicle being repaired with 'his' money precipitated an assault on his mother with a wooden implement is illustrative: Jarred did not appear to have a realistic – or at least had an inconsistent - appreciation of what Child Safety's involvement meant for him and his family.

The referral to DCPL and the revised affidavit process reveal systemic problems

The formal revocation referral to DCPL in March 2025 was made on the basis that the mother had 'addressed the child protection concerns' and demonstrated 'her ability to provide safe care and protection'. This was made five days after the ATSICCO's own records documented that Jarred had struck his mother in the face with a wooden stick. DCPL's subsequent requests for evidence of how the parents had addressed child protection concerns were not satisfactorily addressed after months, and a revised application was never delivered. By the time of the Commission's review, Jarred's situation had further deteriorated: escalating violence, no school attendance, no NDIS access, Jarred feeling unsafe and having little to eat when with his father, and his mother expressing to a stakeholder meeting that she no longer felt safe having him at home.

Objectivity and independence of OCFOS

The PLO's evidence before the Commission raised the question of OCFOS's independence and objectivity. The case study provides some support for concern. OCFOS drafted the revocation application based on assessments made principally by the ATSICCO and endorsed, without substantive independent analysis, by the Department. It appears OCFOS did not independently interrogate whether the child protection concerns had in fact been addressed; it accepted the conclusions of Aboriginal and Torres Strait Islander actors in the system. The referral to DCPL was also made in factually and legally inadequate terms, requiring DCPL to do much of the analytical work that OCFOS should have done.

Criticisms of DCPL were misplaced

This case study vindicated the DCPL's approach to the revocation application: the DCPL was not, as was suggested, applying a too-onerous bar to the filing of the application. The DCPL, in the Commission's view, correctly assessed that the evidentiary basis was insufficient at the time of referral to warrant an application to the Court, and properly sought that further evidence be presented.

Further, assertions in evidence from OCFOS to the effect that the DCPL had sought direct evidence in affidavit form from the ATSICCO's delegated authority team – something that the PLO had never seen the DCPL seek from other external stakeholders – and were not supported in this - were not borne out on the documents.[258] ATSICCO staff expressed interest in affidavit writing,

[258] Transcript, Evidence of Clair Martin (2 February 2026) 3777:17 - 3778:14.

which was then facilitated by OCFOS. Furthermore, the DCPL gave very specific advice about the form the evidence ought to take, not simply, as was asserted, requesting "an affidavit from the delegated authority about why the child's not in need of protection."[259]

Broader themes

Delegated authority requires robust threshold assessment

The gateway decision to delegate must engage with the statutory criteria, not just with policy objectives. Further, decision-makers must have relevant and sufficient facts before them to enable them to satisfy themselves that statutory threshold criteria have been met.

Risk assessment must be insulated from outcome-driven reasoning

The case study illustrates what can occur when multiple actors in a system converge on a desired outcome – in this case, reunification and revocation and then strain to find reasons in its support rather than conducting a genuine assessment. This is a known feature of institutional decision-making and requires structural safeguards.

Cultural self-determination and child safety are not in tension as a matter of principle, but can be in practice

The ATSICCO, the Department and the CPA appeared at times to treat reunification and the revocation of the order as goals that were inherently consistent with the child's interests, because they aligned with self-determination principles. That is problematic. Delegated authority does not modify the statutory imperative that the child's interests are paramount.

Court oversight of revocation serves a protective function

The child and family's wish to exit the child safety system was a legitimate input, but not a determinative one for the purposes of an application for revocation of LTG-CE orders. Judicial oversight provides an independent evaluative forum that is less susceptible to the convergent pressures that characterised the pre-litigation process in Jarred's case. However, this case study demonstrates the need for, and effectiveness of, the role of the DCPL as an independent evaluator of matters that may properly be brought before the Court. It would be highly undesirable if the court was to be vexed by ill-considered, incomplete evidentiary material upon which to determine such applications. The DCPL performs a vital independent role to ensure that

[259] Ibid 3778:42.

applications are made supported by cogent evidence and that there is a proper basis for the application.

Information integrity across agencies is critical

The Department's erroneous advice to the ATSICCO that there had been no new concerns, the failure to bring the 1 July notification into subsequent decision-making, and DCPL's inability to obtain the evidence it required from the Department and the ATSICCO, all reflect failures of information management that directly impaired the quality of the decisions made.

The child's voice required mediation by professional assessment

Jarred's expressed preference to exit the system was entitled to weight but required contextualisation by reference to his diagnoses, his cognitive capacity, and his actual circumstances. It was not sufficient, of itself, to drive decisions of the magnitude being made. The Commission acknowledges that Jarred's self-placing manifested his own will and agency and that fact may be regarded as rending the question of whether the LTG-CE was somewhat academic. But that really is not the point. Jarred's self-placing did not alter the Department's and the ATSICCO's duty to evaluate the bases upon which such an application may be made, notwithstanding Jarred's self-placing.

The test for revocation under s 65 of the Child Protection Act 1999 (Qld)

When making a CPO, the Court must be satisfied, pursuant to s 59(1)(a) that the child is in need of protection and the order is appropriate and desirable for the child's protection. However, in the test for revocation of an order under s 65, only requires the court to be satisfied that the order is no longer appropriate and desirable for the child's protection. This asymmetry was pointed out to the Commission by the PLO in her evidence to highlight that the Court does not need to decide whether or not the child is in need of protection, because that requirement is, when s 65(6) is read with s 59(1)(a), no part of the test.

On reflection, this asymmetrical "loosening" of the test at revocation is probably more apparent that real. First, the Court must be satisfied that the order is not appropriate and desirable for the child's protection, so embedded in any analysis of this element must be whether the child remains in need of protection. Second, it would be entirely incongruous, Sisyphean even, if a jurisdiction which sets up as the predicate for action the pre-condition of a child being in need of protection, would, at the 'back end' so to speak, abandon an analysis of whether, if the CPO is revoked, the child may be safely returned to family; presumably because the harm, or risk of harm, that warranted the CPO in the first place is no longer applicable. Third, as the PLO

conceded, the Court would consider evidence of whether there had been a material change in circumstance of that nature in determining whether the order was appropriate and desirable in any event.[260]

[260] Ibid 3781:15.

Judith

Why was this case chosen

This case study examines the Department's practice of allowing a CPO to lapse in circumstances where the child has nonetheless been assessed as a child in need of protection, and who had complex needs and violent tendencies and how that decision sat with the paramount principle and Department's protective jurisdiction. It also looks at how the concept of self-determination was brought to bear in coming to this decision, and the potential ramifications of this decision for the safety of the child, her family and the community. This case study is based on information provided by way of witness statement and corresponding documents in response to a compulsory notice to the Department.[261]

Background

Judith, one of seven siblings, is the child of an Aboriginal mother and Maori father.

Departmental records indicate that there is child protection history in relation to Judith and her siblings. This history commenced in September 2007 (prior to Judith's birth) and until November 2021, there were 75 Child Protection Intakes, including 55 Child Concern Reports (CCRs) and 13 Child Protection Notification (CPNs).

The primary themes throughout the Child Protection History include:

- domestic violence perpetrated by the father and other partners of the mother to which the children were exposed
- substance misuse by parents;
- unhygienic state of the home;
- failure to provide necessities including food and clean clothing; and
- maternal mental health.

Child Protection Orders - history

Judith was first placed into Departmental care in 2015 when she was 7 years old. She remained in Departmental care for a three-year period under short term custody orders. In May 2018, the child was returned to her mother's care under a one-year protective supervision order (**PSO**).

[261] Statement of Clair Martin (3 November 2025) 88-102 provided by the Department in response to NTP 143 issued on 23 October 2025.

Following the expiration of the PSO in May 2019, there were 15 Child Protection Intakes recorded. In May 2022, the Department assessed that Judith had suffered significant harm of a detrimental nature, namely **cumulative emotional harm as a result of emotional abuse** at the hands of his mother. The Department assessed that Judith was at unacceptable risk of further significant emotional harm in the care of her parents. Judith re-entered Departmental care at this time. A further 2-year, short term custody order was made in December 2022.

Planning for further intervention in 2024

In September 2024, when Judith was 16, the Department convened a pre-Practice Panel consultation to determine the appropriate intervention for her on the expiration of the current CPO. The CSO told the Panel that her assessment was that Judith remained a child in need of protection and that a short-term order granting custody to the Chief Executive for 24 months was the most appropriate order to support Judith's transition to independent living.

That assessment relied upon the following information:

- Judith had an extensive trauma history and a PTSD diagnosis due to exposure to domestic violence since infancy, emotional abuse, and neglect
- Judith had a diagnosis of ADHD, anxiety and depression
- Judith had significant emotional dysregulation resulting in physical aggression, property damage and verbal abuse in the home, placement, and community
- Judith's aggressive and violent behaviour was putting herself and others at risk of significant physical and emotional harm. During family contact, Judith had variously hit, strangled, punched and headbutted her mother and siblings, including causing multiple concussions and a lacerated scalp to her mother, such that her family had to move into crisis accommodation
- there was no parent willing or able to care for Judith, which could result in homelessness, criminal engagement, and neglect for Judith
- there was no other option in relation to friends or family that could support Judith.

With respect to Judith's parents not being willing and able to care for her, the CSO reported that:

- The mother was not willing to care for Judith due to the ongoing violence being perpetrated towards her, and her inability manage Judith's escalating behaviours of concern in a way that was safe for Judith, herself and the other siblings. The mother was in fear for her life due to the level of violence demonstrated by Judith

- The father had continued to demonstrate a pattern of violent behaviour in his domestic relationships and in the community as demonstrated by his extensive criminal offending and was not willing or able to model appropriate behaviour to Judith or manage her behaviours of concern in a way that is safe.

With respect to Judith's mental health, the CSO reported that:

- Judith had expressed suicidal ideation and had threatened to kill herself and others with a knife in front of her siblings.
- There had not been significant progress in addressing Judith's use of violence.
- Judith demonstrated concerning attitudes and beliefs about the use of violence and has demonstrated a pattern of using violence to get what she wants and believes this behaviour is justifiable.
- Judith had engaged in long term medication refusal, believed that psychotropic medication does not help her and stated that she used marijuana to self-medicate

Other matters:

- Since Judith has returned to care there has been 8 placement breakdowns, due to her use of violence and intimidation towards cotenants and her care team. Judith has repeatedly stated she 'will do whatever it takes' to have her placements closed as she believes this will result in returning to her mother's care.
- Judith has refused to attend school since she was excluded for bullying and threatening to bring a gun to school.
- Judith has refused to engage in vocational training programs organised for her. Judith states she does not need an education and will apply for the DSP and live in Social Housing.
- Judith has previously been cared for informally by an aunt interstate however this arrangement broke down due to her behaviours. Judith's maternal grandparents are not willing (nor able) to provide care for Judith due to her behaviours.
- Judith appeared in Children's Court regarding a wilful damage charge regarding her mother's property. She was referred to the Restorative Justice Program however she refused to engage. When the matter was re-referred to Court, the matter was dismissed.

The Panel ultimately endorsed – on a split decision - that the matter be referred to the Director of Child Protection Litigation for a CPO granting long-term guardianship of Judith be granted to the Chief Executive until she attains the age of 18.

In October 2024, the Department engaged with discussions with the family, about an arrangement whereby Judith would stay with a family friend who was on parole – and thus could not be an approved carer – once she had suitable accommodation. The friend was aware of at least some aspects of Judith's behavioural issues because she had previously physically assaulted her. On the strength of these discussions, and a perception held by at least some within Judith's care team that the Department was not adding value to the child's life, in circumstances where Judith was not being offered a placement and did not accept assistance from the CSO or TL, the Department commenced a process of considering whether it would cease intervention for Judith. This included seeking further advice from OCFOS. Legal professional privilege was claimed over this advice, and thus it cannot be disclosed.

In November 2024, the Practice Panel was convened to determine what orders – if any – ought to be sought were revisited. It did not seem to be in dispute that Judith has no parent who was willing or able to provide for her primary care[2621], no kin to step into the breach, and that she remained a child in need of protection. Nonetheless, by a split decision of 6 to 3, the Panel endorsed an outcome of the Department ceasing involvement when the current order expires, rather than seeking LTG-CE orders.

The rationale against seeking LTG-CE (and, as a corollary, ceasing intervention) as recorded in the document stemmed predominantly from a concern that, because of Judith's strongly expressed view she did not want Departmental involvement in her life, were it to seek LTG-CE orders, it "may be perceived that the Department is wilfully obstructing this Aboriginal child's right to self-determination" and that this would result in "repeating the pattern of harmful government interference in the lives of a self-determining Aboriginal family".

An additional consideration was that the Department did not 'value-add' because Judith refused placements, did not have placement options available to her in any event due to her escalating violence, and the Department's ongoing involvement prevented her from accessing other community-based services that did not service children in State care.

The rationale for seeking LTG-CE orders included that Judith did not have stable housing and was at times sleeping rough in the community, could not be reunified to family and that an LTG-CE order would afford the Department the opportunity to continue offering support services to addressed Judith's untreated mental health issues and aggressive, intimidating and violent behaviour towards others.

[262] The panel noted that Judith's mother maintains a supportive relationship with Judith via phone calls and visits in the community but was not willing to provide Judith with her address due to the safety risk to her and her other children.

The decision to cease intervention was not supported by the Cultural Practice Advisor, who considered that Judith required support and positive guidance whilst in community that only Child Safety can provide. Nor was it supported by the ATSICCO in attendance at the panel, whose representative was concerned about the violence that Judith might perpetrate on her mother.

Subsequently, it appears that, in order to justify its decision to cease intervention, the Department formed the view that the mother was willing and able to provide for Judith's care and protection needs because she had been able to provide her with some support in her transition to independent living, such as assisting her to initiate a Centrelink application and to access medical appointments. This view was formed despite the fact that the mother had not addressed the child protection concerns, was in fear for her life and safety (and that of her children) due to Judith's violence towards her, such that she kept her address secret from her and wished to provide support "from a distance", that Child Safety felt the need to notify QPS that Judith was a risk to her mother and that these factors plainly indicated that there was a considerable risk that the mother would not be able to provide consistent support to Judith.

The week prior to the CPO elapsing, the Department indicated that it was seeking the mother's consent to an IPA, in recognition of the fact that Judith continued to be a child in need of protection. Given the above constraints, it is unclear how an IPA would be appropriate or would sufficiently address Judith's significant care and protection needs, including the need to protect her from harming herself and others.

The paramount principle required that Judith's safety and best interests drive the decision

The starting point for any decision about the continuation or cessation of statutory intervention is the paramount principle: that the safety, wellbeing and best interests of the child are the paramount consideration. Under the *Child Protection Act 1999 (Qld)*, this principle governs every decision made in the exercise of the Department's functions. It is not one consideration among many to be weighed against the child's preference for non-engagement, the Department's assessment of its own utility, or the language of self-determination. The question the November 2024 Practice Panel was required to answer was not 'should the Department step back to respect Judith's self-determination' but rather 'what does Judith's safety, wellbeing and best interests require?'

The Panel's majority decision does not appear to have been structured around this question. The primary recorded rationale for ceasing intervention was not that Judith's safety and best interests would be better served by the order lapsing, but rather that seeking LTG-CE orders 'may be

perceived' as wilfully obstructing an Aboriginal child's right to self-determination and would risk repeating patterns of harmful government interference. This is a significant inversion of the statutory framework. The paramountcy of child safety cannot be displaced by concerns about how an intervention decision will be perceived externally, or by institutional reluctance to be seen as perpetuating historical injustices — however genuine those concerns may be in other contexts.

There was no proper basis for the State to abandon its protective responsibility to Judith

A foundational premise of the child protection legislative framework is that where no parent is willing and able to protect a child, the State assumes the protective responsibility. The November 2024 Panel does not appear to have been in real dispute about Judith's circumstances on this point: there was no parent willing or able to provide for her primary care; no kin or family friend who could appropriately do so (the proposed family friend was on parole and had himself been assaulted by Judith); and Judith remained, by the Panel's own assessment, a child in need of protection. Those findings did not point toward the cessation of intervention. They pointed, in the Commission's view, firmly in the opposite direction.

The child protection framework provides that where a child cannot be safely reunified with a parent and no suitable alternative family carer is available, the child should have stable long-term care that provides for his or her developmental, educational, emotional, health, intellectual and physical needs. The November 2024 decision bypassed this framework entirely. No analysis was undertaken of what stable long-term arrangements could meet Judith's complex and multiple needs. The Panel's reasoning did not engage with the consequences for Judith of the order lapsing: the risk of homelessness, criminal engagement, untreated mental health, and the absence of any structural support for an adolescent with PTSD, ADHD, anxiety, depression, and significant emotional dysregulation.

Judith's expressed wishes required contextualisation, not deference

Judith's consistently expressed view that she did not want Departmental involvement in her life was a relevant consideration, and the Commission acknowledges it is both appropriate and important that children's voices be heard in decisions affecting their care. However, the weight to be given to those views is not unlimited and must be calibrated by reference to the child's age, diagnoses, cognitive functioning, and his or her capacity to appreciate the consequences of the outcome sought. In Judith's case, there were significant reasons to approach her expressed preferences with care rather than deference.

Judith was sixteen years old. She had a diagnosis of PTSD arising from sustained exposure to domestic violence since infancy, ADHD, anxiety, and depression. She had significant emotional dysregulation, refused medication, self-medicated with marijuana, and had demonstrated a consistent pattern of using violence to achieve her desired outcomes, including the deliberate sabotage of eight placements by violence toward co-tenants and care workers in order - as she stated - to force a return to her mother's care, who required hospitalisation as a result of her violence towards her. Her expressed desire to exit the child safety system was itself, in part, a product of the same emotional and behavioural patterns that constituted the risk requiring ongoing intervention. The Panel's decision to treat that preference as a meaningful indicator pointing toward the cessation of intervention is therefore difficult to reconcile with a genuine assessment of Judith's best interests.

The analogy with Jarred's case is direct. In that case, Jarred's consistent expression that he wanted Child Safety 'out of his life' and his orders 'got rid of' was treated as a significant driver of both the permanency review and the revocation process. The Commission observed in the Jarred case study that a child with limited intellectual functioning who struggled to regulate his emotions may not have the capacity or information base to give materially useful views about long-term guardianship arrangements. Jarred's subsequent assault on his mother with a wooden implement over the repair of a vehicle - paid for with 'his' money - illustrated that he did not have a realistic appreciation of what Child Safety's involvement meant for him. The same concern applies with equal or greater force in Judith's case, where the child's opposition to intervention was shaped not by an informed assessment of his circumstances but by the same dysregulated, trauma-driven behaviour patterns that made intervention necessary in the first place.

The self-determination rationale was misapplied

The majority's central concern — that seeking LTG-CE orders may be perceived as wilfully obstructing Judith's right to self-determination and as repeating patterns of harmful government interference — reflects an understanding of self-determination that is not consistent with the statutory framework governing child protection in Queensland. Self-determination, as a principle informing the child protection system in its application to Aboriginal and Torres Strait Islander children, concerns the manner and cultural context of intervention, not the threshold question of whether the State should intervene at all where a child is assessed as being in need of protection. The ATSICPP does not operate to override the paramountcy of child safety; it operates within it.

The comparison with Jarred's case is again instructive, though the present case presents a starker instance of the same error. In Jarred's case, the language of self-determination — 'historic

moment', 'for Mob', 'self-determining' — was used to frame reunification as an intrinsically appropriate outcome, crowding out analysis of the contra-indicators. In Judith's case, self-determination was deployed not to support an alternative form of culturally appropriate intervention, but as the justification for the State's withdrawal from responsibility for a child whom the Department had assessed as remaining in need of protection, who had no parent willing or able to care for him, and who was at high risk of harm to himself and others. This represents a more acute misapplication: in Jarred's case there was at least a family prepared to take him in, an ATSICCO prepared to exercise delegated authority, and an institutional framework within which intervention could continue. In Judith's case, the self-determination rationale was used to justify the absence of any protective framework at all.

It is also noteworthy that in Judith's case - unlike in Jarred's - neither the CPA nor the ATSICCO representative present at the Panel supported the majority decision, principally due to concerns about the perpetration of violence: a concern was well-founded on the evidence before the Panel.

The difficulties of working with a non-engaging child, while real, did not justify withdrawal

The Commission acknowledges that the circumstances confronting Judith's care team were genuinely difficult. A child who refuses placements, is excluded from school, repeatedly assaults those around her, declines medication and therapeutic engagement, and is perceived by workers as resistant to any support the Department can offer presents a serious practice challenge. The view held by at least some within Judith's care team that the Department was not 'adding value' to the child's life is understandable from the perspective of those working with her daily. It is nonetheless not a sound basis for determining that a child in need of protection should be left without the statutory protections afforded by a CPO.

The difficulty of engaging a child is not, and cannot be, a proxy for a conclusion that intervention is no longer needed or appropriate. If it were, the most at-risk and hardest-to-reach children would systematically lose the protections of the statutory framework - precisely the cohort for whom those protections exist. The second rationale recorded in the Panel's documents, that the Department's involvement prevented Judith from accessing other community-based services that did not service children in State care, warranted interrogation rather than acceptance. The Commission is not aware of any evidence in the Panel record that specific services that would otherwise be available to Judith were identified, assessed as appropriate to his needs, and confirmed as prepared to accept her. This rationale appears to have been offered as a general proposition rather than a finding based on Judith's actual circumstances.

The post-hoc rationalisation regarding the mother's capacity was contrary to the evidence

Following the Panel's majority decision, the Department appears to have formed the view that the mother was willing and able to provide for Judith's care and protection needs — a view based on the mother's assistance to Judith with a Centrelink application and access to medical appointments. This conclusion is not consistent with the evidence available to the Department at the time. The mother had not addressed the child protection concerns that led to Judith re-entering care. She was in fear for her life and the safety of her other children due to Judith's violence toward her, a fear sufficiently serious that she kept her address secret from her. Child Safety had considered it necessary to notify QPS that Judith posed a risk to her mother. The mother's expressed willingness to support Judith 'from a distance' does not amount to a capacity or willingness to provide for her care and protection.

This finding appears to have been reached not on the basis of an objective assessment of the evidence but in order to provide a justification, after the fact, for a decision the majority had already taken. That concern is consistent with a pattern observed in the Jarred case study, where the Commission notes that multiple actors converged on a desired outcome and then strained to find reasons in its support rather than conducting genuine assessments. In Judith's case, the desired outcome appears to have been the cessation of intervention; the finding about the mother's capacity served to make that outcome appear consistent with the statutory framework, despite being plainly inconsistent with the evidence.

An IPA was not an adequate substitute for the continuation of the CPO

In the week before the CPO was due to elapse, the Department indicated it was seeking the mother's consent to an Intervention with Parental Agreement. The fact that an IPA was being sought at that point implicitly acknowledged that Judith remained a child in need of protection — otherwise there would be no jurisdictional basis for the IPA. However, an IPA was an entirely inadequate response to Judith's circumstances. An IPA is a voluntary arrangement that depends on parental engagement and consent. The mother had already demonstrated that her capacity to engage with Child Safety was constrained by her fear of Judith; she wished to support her 'from a distance' and would not disclose her address to her. The mother was not in a position to provide the stable, consistent primary care and structured support that Judith's complex diagnoses required. In the Commission's assessment, a voluntary arrangement with a parent in those circumstances could not adequately address Judith's significant care and protection needs, including the need to protect her from harming herself and others.

The risk to Judith, her family, and the community

The evidence before the Panel disclosed that Judith presented a serious risk of harm to herself and to others. Her violence was not minor or historical: during family contact, she had variously hit, strangled, punched and headbutted her mother and siblings, causing multiple concussions and a lacerated scalp to her mother, and had threatened to kill herself and others with a knife in front of her siblings. Her mother was in fear for her life. These are not background matters. They are central to an assessment of what the interests of Judith, and the protection of those around her, require.

The Panel's reasoning does not appear to have engaged seriously with these risks in the context of the decision to allow the order to lapse. The prospect of Judith transitioning to independent living, without stable accommodation, untreated mental health conditions, no engagement with education or vocational training, and a consistent pattern of using violence to manage her circumstances, was foreseeable as a significant risk not only to Judith herself but to those around her, including her mother, siblings, and the broader community. A decision made without confronting that prospect cannot be said to have been made in Judith's best interests.

There is a further analogy with the YP case study. In YP's case, the Commission examined the correlation between the child self-placing without adequate support, the absence of financial provision, and escalating offending, including offending for survival purposes. In Judith's case, the risk profile was, if anything, more acute: the child had existing diagnoses, a documented pattern of violence, expressed suicidal ideation, and, on the Department's own assessment, faced the prospect of homelessness and criminal engagement in the absence of a continuing CPO.

Broader Themes

The paramountcy principle must be the analytical anchor, not a residual consideration

Judith's case illustrates what can occur when the paramount principle is treated as one consideration to be weighed against competing institutional, cultural, or practical objectives rather than as the governing standard against which all other considerations are assessed. The practical pressures that confronted Judith's care team, namely a non-engaging child, resource constraints, the difficulty of finding suitable placements for a young person whose behaviour had resulted in eight placement breakdowns, are real and the Commission does not minimise them. However, those pressures cannot substitute for a rigorous, child-focused analysis of what the child's safety and best interests require.

Self-determination is a principle about how the State engages with Aboriginal children and families, not a basis for the State's withdrawal from its protective obligations

The misapplication of self-determination in Judith's case (as in Jarred's case) reflects a pattern the Commission regards as warranting systemic attention. In both cases, self-determination was invoked as a reason to reduce or remove statutory intervention regardless of the child's assessed safety needs. That is not the function the principle is intended to serve, and its application in this way is inconsistent with the paramountcy provisions of the *Child Protection Act 1999* (Qld) and with the ATSICPP as a whole.

Panel processes require structural safeguards against outcome-oriented reasoning

In both the Jarred and Judith case studies, the panel or review processes that produced the decisions under scrutiny show features consistent with what the Commission described in Jarred's case as institutional convergence on a desired outcome. In Judith's case, the desired outcome appears to have been the cessation of intervention framed as respect for self-determination; in Jarred's case, it was reunification as a tangible expression of self-determination. In both cases, the record of deliberation does not reflect a structured, evidence-based analysis orientated by the paramount principle. The Commission considers that panel processes of this kind, particularly where they result in split decisions on questions of significant consequence for a child's safety, require clearer procedural standards to ensure that the paramount principle is applied as the governing framework, and not displaced by competing objectives

Melanie

Background

This case study was chosen to explore a parent's perspective of long-standing engagement with Child Safety and to gain a deep understanding of the Department's casework practices around removal (including with respect to newborns).

Melanie made an initial submission to the Commission through a Family Wellbeing Service (**FWS**). Melanie shared her perspective as a parent who had had a number of her children removed pursuant to the Act (including a newborn) and her struggles to achieve reunification.

At the time of giving evidence, several of Melanie's children were in foster care, two were self-placing with her, and one (the youngest) was at home with her pursuant to a Protective Supervisor Order (with conditions). All but the youngest were either under LTG-CE orders, or were currently on STG-CE orders and the subject of an application by the DCPL for LTG-CE. None of the children on guardianship orders have been formally reunified to Melanie, although as can be seen below, some attempt was made with respect to each newborn.

Melanie understood Child Safety's main concern to be that she did not know 'the right way to speak to or discipline a child'. She gave evidence that she had bruised her son's face and scratched her daughter's wrists, and that she had put her children 'through physical and emotional abuse' – resulting in Child Safety's involvement and the removal of her older children children – a step she now recognises as 'fair for the kids at the time'. Melanie explained that, when she was growing up, the 'right and proper' way to raise a child was through physical discipline – that this was 'a normality to most families in the society I was raised in. I didn't know any better but to raise my kids the same way.' It was a way Melanie was taught, of 'straightening a child'[263] – like a tree – to ensure it grew up right.

She has now undertaken 13 family and parenting programs, seen numerous psychologists, undertaken counselling and has an ongoing relationship with the FWS. Melanie said that she had been in denial about her wrongful behaviour towards her children and it was not until she had saw psychologists and undertook parenting programs that she realised this. She considered that there has been no recognition by Child Safety of her efforts, progress or growth as a mother. She spoke of her determination to be the loving parent her children expect and deserve and her current devotion to 'fighting for my children until they are back in my care'.

[263] Transcript of Private Hearing, Evidence of Witness T (16 September 2025) 849:44.

At the invitation of the Commission, Melanie gave evidence at a private hearing supported by the FWS and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP). Following Melanie's evidence, the Commission sought – and obtained - documents and information from the Department in relation to Melanie and her children. A CSSC Manager provided a written statement[264] and was publicly examined across several days during public hearings to provide a Departmental response regarding myriad matters raised in Melanie's evidence and to explain its decision making and case work in respect of the family.

Evidence

Child protection history

Melanie's child protection history as a parent began in 2007, when Child Safety received information about Melanie being headbutted by her then-partner whilst pregnant. Domestic violence concerns in respect of her children were raised again with Child Safety in 2010, but following an investigation, no substantiated findings of harm to the children were made.

Until May 2017, there were no further child protection notifications recorded regarding Melanie's parenting of her children.[265] The Manager stated in her evidence that it was likely that harm was occurring during this period – it simply wasn't reported. When challenged as to whether this amounted to building professional speculation about unreported events into risk assessments, the Manager maintained that it was appropriate professional inference from a pattern of behaviour.

Non-custodial intervention

In 2017, Child Safety received notified concerns regarding excessive physical discipline by Melanie – now the mother of five - against some of her children. Child Safety investigated, but ultimately found that the children were not in need of protection because it assessed that there was 'sufficient safety provided within the home without further Child Safety intervention.'[266] Melanie had identified to the CSO a funded service (external to Child Safety) that she was willing to work with to address parenting concerns and link her with counselling, but Melanie later declined the referral – which couldn't proceed without her consent.[267]

Further additional notified concerns of physical harm soon followed. Upon investigation – conducted jointly with QPS – the assessors found some of the children had been physically

[264] CI-16, *Redacted statement of Witness W with supporting documents,* tendered on 17 November 2025.
[265] Transcript, Evidence of Witness W (17 November 2025) 2041:5-18.
[266] Ibid 2064:19
[267] Ibid 2064:32 – 2065:18.

harmed. Furthermore, physical harm to children was identified as an immediate risk indicator. Child Safety therefore intervened, with parental consent – by way of an immediate safety plan (**ISP**) to mitigate the risk to the children. The ISP required a relative with a very positive relationship with the children, who had been apprised of Child Safety's concern – to come and stay with the family for a seven-day period. The Manager described this as a very positive intervention in the first instance,[268] and the least intrusive option to mitigate the risk.[269] It was supplemented by a referral to a Department-funded FWS for intensive family support in an attempt to divert the family away from the child safety system.[270] Additionally, following engagement with Melanie, another family member was also brought into the area to support her.[271]

The Department's response at this time reflected its assessment that the children were not at an unacceptable risk of harm in the future and that they had a parent both willing and able to meet their care and protection needs in the future.[272] The Manager described this as a good example of a non-custodial intervention.[273]

Removal of older children

In early 2018, despite its previous interventions, Child Safety received further reports of concerns of escalating physical violence by Melanie against her children, requiring an immediate response. The reported injuries included facial bruising, facial swelling and scratches. The children had made disclosures that Melanie used weapons to hit them, including a frying pan, a broom, and a rake. At the time, Melanie denied the concerns and said that the children were lying.[274] Child's Safety concluded that the children had experienced physical and emotional harm resulting from physical and emotional abuse.[275]

Initially, with Melanie's consent, the children were placed in the care of kin under an **ISP**. Subsequently, the children were assessed as unsafe because, due to a breach of the ISP, as some of the children had unsupervised contact with Melanie. Further, the relevant member of kin was no longer in a position to look after the children as it was placing a lot of strain on them as the couple had their own family to look after as well.[276] The children were then placed into foster care

[268] Ibid 2069:24.
[269] Ibid 2068:34.
[270] Ibid 2070:18 – 41.
[271] Ibid 2074:4.
[272] Ibid 2072:17.
[273] Ibid 2075:24.
[274] As noted above, Melanie now accepts the abuse occurred, says that she was in denial at the time and thought her parenting practices were normal and what was necessary to raise well-behaved children.
[275] Melanie was charged with occasioning actual bodily harm in respect of her physical abuse of her children. Some of the charges were dropped due to lack of evidence. Melanie was sentenced to probation for two years.
[276] Transcript, Evidence of Witness W (17 November 2025) 2094:32.

under an Assessment Care Agreement[277] with Melanie's consent. The children remained in foster care from that point.

Child Safety's assessment of the risk of future harm to the children disclosed the following concerns: the significance of the violence that had been perpetrated by Melanie on the children; Melanie's denial of her involvement in perpetrating the violence, which may indicate lack of insight; Melanie's stated belief that her involvement in programs with the FWS were unnecessary, which may indicate an unwillingness to change; the breakdown in family relationships, including in respect of her sibling who initially had care of the children, and her mother; that over a significant period of time there had been 19 DFV incidences at the home and Melanie's related denial about DRV within the home; and issues with respect to the children's various fathers, including drug and alcohol misuse and unwillingness by some of those men to be involved in their children's lives.[278]

Each of the children in the home were assessed as children in need of protection. Consequently, the Director of Child Protection Litigation (DCPL) filed applications for child protection orders (CPO) granting short-term custody of the children to Child Safety for two years.

Attempts to locate kin for assessment as carers

The Manager was taken to Departmental documents which recorded the Department's extensive efforts to locate family members for the older children. Its efforts were supported by a Cultural Practice Advisor. A wide range of persons and organisations were consulted: Melanie, the children's fathers, the children themselves, extended members of the maternal and paternal family, QPS, Queensland Health, the FWS (as the nominated RE) and the children's schools, amongst others. Despite the breadth of the inquiries, most available kin were unable to proceed to a formal carer assessment for reasons that included: one, difficulties obtaining blue cards; and two, kin reluctance due to parental conduct.

First birth suite removal (Oliver)

Melanie's unborn child was included in the investigation and assessment that took place in respect of the older children during early 2018 (with her consent). Child Safety concluded that the unborn child was at significant risk of detrimental emotional and physical harm resulting from emotional and physical harm and medical neglect. It was noted in the Child Safety's records that immediate investigation and assessment would occur at birth.

[277] A voluntary 30 day agreement whereby a parent can agree to the children being placed in a Departmentally-approved placement whilst an assessment about the children's care and protection needs is undertaken: Ibid 2095:27 – 41.
[278] Ibid 2125:7 – 2127:29.

According to the Manager, the factual basis for the conclusion that the unborn child would be at significant risk upon birth was based on evidence that DFV was occurring within the home, not only the physical discipline of Melanie towards the older children, but also physical assaults by both parents towards each other. The Manager referred to the existence of research that demonstrated that exposure to DFV in the womb is not healthy for a foetus's development and growth.[279] The Manager clarified that the 'medical neglect' referred to as a risk to the unborn was derived from Melanie's failure to seek medical assistance for the children who had wounds to their heads.[280]

The Manager was closely questioned about the connection between the conduct of the mother towards the older children and the assessment that there was an immediate risk of harm to the unborn child upon birth. The Manager explained that there had been an increase in the frequency and severity of the parental behaviour and harm to the children over at least a nine month period.[281] Further, Child Safety's research showed that parental behaviour over a sustained period of time takes a substantial amount of time to change.[282] Therefore, Child Safety concluded that, at this point, it was reasonable to infer that the unborn child would be at the same level of risk as the living children at the time of his birth.[283]

The Manager agreed that Child Safety had no information, at that time, to suggest any history of the mother harming any of her children as newborns.[284] However, she did not accept that it was relevant that the mother had a history of harming older children as opposed to newborns, because harming a child at any age to the extent that the mother did was significant and, further, it had been done on a repetitive basis, and the risk was current.[285] The inquiry centres less on the age of the child and more on the parent's ability to contain and regulate herself in the face of distress or defiance or whatever the current trigger may be.[286] The Manager declined to accept the premise that a mother's natural instinct to protect her newborn should be factored into any risk assessment, stating that such an instinct could not be assumed across all parents, particularly those experiencing significant adversity. She maintained that the paramount consideration was the child's safety.

[279] Ibid 2110:15.
[280] Ibid 2112:36.
[281] Ibid 2113:12.
[282] Ibid 2113:17.
[283] Ibid 2113:20.
[284] Ibid 2118:40.
[285] Ibid 2119:18.
[286] Ibid 2141:15.

The Manager agreed that the opportunity for a newborn to form an attachment to its mother at or about the time of birth is critical to the development and well-being of the child,[287] and that there is consequential harm associated with removing a newborn child in this way.[288] It was suggested to the Manager that this factor ought to be assessed in weighing the risk when coming to make a decision as consequential as removal of a newborn.[289] The Manager stated that there are many ways in which the Department seeks to facilitate this bonding, including by the continuation of breast-feeding.[290] She did not directly address whether or not she thought the harm of removal should be weighed in the balance.

Melanie was recorded in Child Safety's records as having refused – at the time that she was informed of the Department's conclusions of its investigation and assessment into all the children – to engage in a support service case in respect of her unborn child. As a result, in accordance with child safety policy a high-risk alert was sent to the hospital requesting that Child Safety be notified immediately upon the birth.

It is tolerably clear that Melanie was not told that, a consequence of not cooperating with the Department by engaging in a support service case, that the child would be removed (or orders would be sought for his removal): the Manager agreed this had not occurred because "that hadn't been assessed at this point.'[291] The Manager stressed that "if we're not engaged with the mother under a support service plan, we can't discuss with her about her unborn child, all plans around that.'[292]

However, contemporaneous notes show that, approximately two months before the birth, during a meeting at the FWS's premises, Melanie was informed that a temporary custody order would be sought by the Department and the baby placed in foster care, if the order was granted, and that this would mean that the baby would leave Melanie's care at the hospital once the baby was healthy and ready to leave.[293] This is consistent with Melanie's evidence that she asked whether Child Safety would remove her unborn child once born and was told that would be determined following the birth – consistent because, as was stressed by the Manager – it was a ultimately decision for the Court, not Child Safety.

[287] Ibid 2124:15-26.
[288] Ibid 2124:24.
[289] Ibid 2124:32.
[290] Ibid 2124:35.
[291] Ibid 2116.1.
[292] Ibid 2116:22.
[293] Ibid 2129:22 – 2130:5.

The Child Safety team leader asked Melanie if she could identify kin who would be able to be assessed to care for the baby.[294] Further discussion was had the next month with the Recognised Entity (RE), regarding a person identified by the mother as potentially able to support Melanie and her new baby after birth.[295]

Melanie and Arthur (her partner and Oliver's father) prepared for Oliver's arrival, including purchasing a cot and clothes and preparing the nursery, believing that it was possible that their baby would be able to come home with them with the support of a live-in family member and intensive support from a family wellbeing service.

The day before the birth, there was contact between the RE and the Department, wherein the Department clarified its intention to see custodial orders in respect of the soon-to-be-born child – to align with the other children – and noted that Melanie had been asked for, but not provided, contact details of kin who were able to be assessed as carers. The RE explained that Melanie still had hopes of lesser forms of intervention that would enable her to take her child home from the hospital. This was ultimately not to be.

On the day of Oliver's birth, the Department sought and was granted a temporary custody order for Oliver – a three-day order that allows the Department time to apply for a longer CPO. In the TCO application, Child Safety referred to the investigation and assessment that had been completed in March 2018, five months before Oliver's birth, which showed that Child Safety was concerned Melanie would hurt Oliver in the same way she had hurt the older children. The Manager's evidence was that relying on the earlier assessment is supported by the Act and practice guidelines.[296]

Four hours after her caesarean surgery, a CSO entered the room with a breast pump and asked Melanie to express milk for Oliver. The CSO told Melanie that the milk was for Oliver when he was discharged. The CSO served Melanie with the TCO at the hospital, where she was in the ward with Oliver sleeping on her chest. Melanie was still groggy from the pain relief given to her for her caesarean, but was nonetheless profoundly shocked at these actions. Melanie's FWS worker was present at the time.

Melanie was told that she would be able to remain at the hospital with the baby under discharge – a period of three days – and was able to hold and feed him during this time. Over this period, Melanie requested that the child be placed with an aunt and uncle – to whom Oliver was in fact

[294] Ibid 2130:5.
[295] Ibid 2130:17.
[296] Ibid 2285.

discharged – who were approved as foster carers. Arrangements were made for Melanie to attend at the placement twice a week to facilitate breastfeeding (in addition to expressing milk for Oliver).

Two days following his birth, the DCPL filed a CPO application seeking STC-CE of Oliver for two years. The CPO application asserted that Oliver was at unacceptable risk of suffering significant harm due to Melanie's abuse towards her older children, as well as exposure to domestic violence.

On the third day, Oliver was discharged to Melanie's aunt and uncle. This placement was ultimately short-lived – a matter of weeks - as the carers found it untenable to support a newborn in addition to the other young people they were supporting. They also found the arrangements for the breastfeeding 'intrusive'. Oliver then moved between foster care placements for a short time.

When Oliver was a few weeks old, the Department facilitated Oliver's return to Melanie and Arther, under an ISP that required a family member to live with the family, remain in Oliver's presence at all times, and inform Child Safety immediately of any concerns. Regrettably, the ISP arrangement broke down a month later, as the result of a domestic violence incident within the family home: Arthur threatened Melanie multiple times (including threats to take Oliver from her) and struck her in the head whilst she was holding Oliver and trying to shelter Oliver from the incoming blow. Melanie suffered a significant injury but refused treatment. Arther was arrested for contravening an existing DVO and was taken to the watchhouse. Whilst at the home, QPS noted that the house was neat and clean, that Melanie was very attentive to Oliver's needs, and that Melanie seemed very dedicated and involved with the care and safety of her child. Police noted that in shielding Oliver, Melanie's main priority was to protect her son from the violence of his father.

The Department was notified of the incident. A Departmental case team meeting was immediately convened with the parents, a maternal aunt and uncle and representatives of the FWS. Child Safety advised the participants that it not satisfied that the ISP had been followed. It assessed the situation as creating unacceptable risk to the infant Oliver and placed him in foster care. The maternal aunt and uncle who had attended the meeting were approved as carers some weeks later, having undergone a carer's assessment and Oliver was then placed with them. It is unclear when Oliver's placement with this couple broke down – but at some point, he returned to general foster care and was placed with his siblings.

In July 2019, the court process was finalised. Melanie attended a Court Ordered Conference where she agreed to the CPO applications. However, Melanie wanted the reunification period to

reflect the time she needed to be able to meet each child's individual needs. Following the conference, the court made final orders granting custody of the children to Child Safety. Between December 2019 and June 2020, the court made further short-term orders for all children.

By June 2021, Child Safety assessed that Melanie had not made sufficient progress towards reunification, and made a referral to the DCPL seeking Long-Term Guardianship (**LTG**) orders for the older children and Oliver to place them in the Department's care until they turned 18. From Melanie's perspective, the Department's approach was difficult to understand: she had undertaken all actions, programs, courses, and supports required of her by Child Safety since her children were removed in 2018. Yet, Melanie stated that each time she met a goal set out for her, Child Safety would "*shift the goalposts*" – raising new concerns, insisting on a new therapy, or completing a new assessment. The Department and the DCPL disagreed, insisting Melanie and Arthur had failed to properly engage with supports and had not demonstrated behaviour change. The Manager's evidence on this point was that Melanie did not reflect what she had learned in her actual parenting practice during observed supervised contact.

The records seen by the Commission demonstrates that, since 2018, Melanie had undergone a Psychiatric Assessment, a Social Assessment Report (**SAR**), and two Parenting Capacity Assessments (PCA), completed Dialectical Behavioural Therapy (**DBT**) with a psychologist nominated by Child Safety, completed numerous parenting programs, completed individual counselling and relationship counselling, completed a qualification and gained employment, obtained and maintained a three-bedroom house, abstained from substances, attended church, and remained engaged with the FWS, including by way of the Family Participation Program (**FPP**)**.** For what it is worth, the Department did not deny that these things had occurred. It is perhaps unhelpful for the Department to use terms like "lack of engagement with services" or "failure to properly engage with supports" as it does not give the parent (or the reader) a clear idea of what was missing but required from the interaction.

Plainly, Child Safety had formed a largely negative view of Melane's parenting capacity, noting that Melanie had voiced "*consistent minimisation of harm resulting from her past actions toward her children*". Child Safety "*accepted advice of the report writers* [i.e. the authors of the PCA and SAR] *that she would require extensive and ongoing interventions to further understand her behaviour, work through triggers and maintain the mental health stability to be able to demonstrate good parenting practices*".

In February 2022, the primary permanency goal for the three older children was formally changed from reunification to long-term out-of-home care, coinciding with applications for long-term guardianship.

In April 2022, the court made final orders granting LTG of some of the older children to Child Safety until they turn 18. On the same date, the court accepted amended applications in relation to the other children and granted further STC orders for each child for a further period of two years.

Birth of Matthew

In April 2023, Child Safety became aware that Melanie was 10 weeks pregnant. Child Safety undertook an investigation and assessment, and Melanie agreed to a support plan. The support plan outlined that Melanie would continue to engage with her support services.

During her pregnancy, Melanie's evidence was that she was told by Child Safety that there was a 'fifty-fifty chance' he may be removed. Child Safety cited the previous child protection concerns of excessive physical discipline, and said that an assessment would be made at the time of birth.

In October 2023, Melanie gave birth to Matthew. Child Safety did not seek custody of Matthew upon birth, and he was allowed to remain in Melanie's care. In doing so, it is reasonable to infer that Child Safety acknowledged Melanie's progress (with support services) and extensive engagement with Child Safety, FWS, and other supports such as day care.

In December 2023, the DCPL filed an application seeking a Protective Supervision Order (PSO) with directives in relation to Matthew, which required both parties to engage immediately with therapeutic services, DV counselling and family wellbeing support; ensure the home was free from DFV, unmanaged parental mental health and harmful parenting practices, and required the child's care needs to be met. In September 2024, the order was granted with Melanie's consent.

The Manager gave evidence that she did not consider the PSO approach taken by the Department in Matthew's case to be appropriate given the risk profile established across all assessments: PSOs cannot prevent DFV or physical harm from occurring and noted that the directives contained no meaningful mechanisms for actually ensuring that the child was not exposed to harm short of after-the-fact home visits.

In April 2024, the DCPL filed another application seeking LTG of the remaining children (bar Matthew) to Child Safety until they turn 18. The applications again stated that neither Melanie nor Arthur had adequately addressed the child protection concerns.

Incident in January 2025

In January 2025, there was an incident in the home following which Oliver disclosed to his carer that Melanie choked him and threatened him. Melanie stated that Oliver bit Matthew's finger, she separated them and tried to correct Oliver's behaviour and held Oliver on his mouth to see if there was blood (Matthew's finger was bleeding). It was reported to Child Safety that Melanie had choked Oliver, pushed him against a wall, squeezed his throat, and pinched his ear during family contact. Oliver was examined by a doctor who observed that he had visible marking and swelling around his neck and a scratch inside his ear. Melanie was interviewed by Police following the incident. Charges were not laid and it was noted that Oliver gave an inconsistent account.

Child Safety placed Matthew under an Immediate Safety Plan (**ISP**) which required, among other things, that Melanie be supervised on a 24/7 basis while caring for Matthew. The effect of the ISP was that Melanie's former-mother-in-law moved to Melanie's location to reside in the home; and later, Melanie's sister took this role. This safety intervention was still in place at the time that the Manager gave evidence in November 2025.

Departmental records of home visits reflect that Matthew has been happy and healthy, and that Melanie has built a positive relationship with her CSO. Family Wellbeing Workers have noted that Melanie's home is functioning positively, and both parents appear to be taking on equal roles when parenting Matthew.

In April 2025, the DCPL filed an application seeking LTG of Matthew to Child Safety until he turns 18. The application states, among other things, that neither Melanie nor Arthur have addressed the child protection concerns and relies on the child protection history pertaining to Matthew's siblings.

Upon filing the application, the DCPL sought interim temporary custody of Matthew however interim court orders reflect that this was not granted.

At the time of this case study, these applications remain before the court.

Older children self-placing at home (from 2024) following abuse in out-of-home care

In 2024, Melanie's daughter, Chloe, left her foster care placement and returned to live at home with Melanie ('self-placed'). Child Safety visited Chloe at Melanie's house. Chloe expressed clear wishes to stay in Melanie's care. Child Safety encouraged Chloe to return to placement, but she refused. A Safety Plan was developed to assist Chloe to feel safe at home with Melanie. Child Safety terminated the foster placement. Shortly afterwards, another of Melanie's daughters,

Dana, refused to return to her placement after family contact and also commenced to 'self-place' with Melanie ('self-placed'). There was no evidence of safety planning in relation to Dana.

During 2024, Chloe and Dana each made disclosures to Melanie of historical sexual abuse by the adult sons of their former foster carers – that is, the foster carers with whom they had been placed before leaving to 'self-place' with Melanie – between 2018 and 2022. ICARE interviews with the girls were conducted by QPS. In August 2025, the Department finalised a Harm Report in relation to those disclosures by Chloe and Dana: emotional harm was substantiated for both girls. The carers had since moved interstate and refused to engage with the Department's investigation process; they were no longer approved carers

The Manager confirmed that there is no national carer register and that the Department had no proactive obligation to inform interstate departments of the carers' history, though she accepted that if the carers applied to become approved carers interstate, information from Queensland would likely be sought through the assessment process. Both the adult sons were charged with criminal offences in relation to the alleged abuse.

The Manager confirmed the two older daughters had been offered counselling and victim assist referrals. Both had declined counselling. She was not aware whether the school had been informed of the sexual abuse allegations. She was also not aware whether the girls had been provided with any legal advice about potential claims against the Department for the abuse they suffered while in its care. She noted they had access to a separate representative, community visitors through the OPG, and the wellbeing service, through which those conversations might have occurred, but she could not confirm it.

Since Chloe and Dana have been 'self-placing' with Melanie, Child Safety has checked in on their safety during monthly or bi-monthly home visits to Matthew (as required under the PSO). No concerns have been noted in the Department's case notes in relation to Matthew, Chloe or Dana and all were noted at each visit to be safe and well, and Chloe and Dana were attending school. However, the Manager's perspective on the girls' welfare whilst at home with Melanie was decidedly more pessimistic. The Manager, who gave evidence from her direct current knowledge, described both girls as refusing to engage with the Department, as looking down or towards their mother before responding to questions, and responding with verbal abuse to departmental officers. The Manager gave two explanations for this behaviour: that Melanie exercises coercive control over the children and told them not to speak to the Department; and that the girls are likely motivated by a desire to be present for their baby sibling now living in the household. When asked whether the girls might equally be motivated by distrust of the Department, given they had

suffered harm while in the Department's care, the Manager acknowledged the dynamic but maintained that the coercive control was the more likely primary driver. The Manager's evidence pointed to the rather fraught and intractable relationship between Melanie and the Department at this juncture.

When questioned about whether the Department should seek a warrant to apprehend the girls and return them to a placement (assuming one was available), given they are under LGT-CE orders, the Manager said that a warrant had been considered but assessed as effectively futile – give the girls' age, expressed views and capacity to physically leave any placement, they would simply return to their mother – a rather circulate and defeatist position for the girls' long-term guardian to take.

What this case shows

Melanie's case study is instructive, not because it discloses egregious individual failures, but because it acts as a de facto longitudinal study about the ordinary day-to-day operation of the child safety system, viewed through the prism of the relationship between the Department and an affected parent. Across more than seven years of sustained engagement, encompassing multiple removals, extensive litigation, a birth suite removal, dozens of assessments, and hundreds of case notes, the system's strengths and weaknesses are revealed.

Significant non-custodial intervention was tried prior to removal and the removal was justifiable

Melanie's narrative commenced at the point of removal of her older children. This was understandable from her perspective. However, the case study reveals the significant attempts by Child Safety to preserve the family unit and keep the children safely at home with their mother through non-custodial interventions: deploying an Immediate Safety Plan, engaging extended kin, referring Melanie to the FWS. It could not reasonably be said that there was an indefensible rush to remove the children from Melanie (that is, remove-first ask-questions later, an accusation the Commission has heard made against the Department from time to time). Melanie herself also agreed – to her credit, and with the benefit of hindsight – that the initial removal of the children in 2018 was 'fair for the kids at the time.'

Barriers to kin care

When escalating violence in the household necessitated removal, the older children were removed under an ISP to kin. Furthermore, when Oliver was removed from Melanie at the hospital, he was placed with an aunt and uncle, for a limited period of time. Yet the children's long-term placements have all been in foster care, rather than with kin. This was so despite

extensive engagement by Child Safety with the parents, children, kin and wider agency network, and extensive genogram which mapped the children's kin. To be clear, it was not Melanie's evidence to the Commission that there were appropriate kin carers who were overlooked. Her evidence was primarily focused on the refusal to reunified her children to her – what the Commission describes as 'reunification strictly speaking'.

Melanie's case highlights the pressure that kinship care places on the kin carers , both in terms of the time and resources required to support children removed from their parents, by kin carers who are often supporting their own large families, and the strain that kinship care places on family relationships, particularly between the kin carers and the parents, and the difficulties kin carers face when attempting to maintain appropriate boundaries for the safety of the children – for example, in preventing unsupervised contact.

Newborn removals

During the Commission's initial scoping visits, some Aboriginal and Torres Strait Islander community-controlled organisations (ATSICCOs) expressed the view that Aboriginal and Torres Strait Islander newborn children were being removed without prior notice to the mothers, and in circumstances where those removals were not justified, including because there were adequate community support networks in place to provide 'wraparound support' to mother and baby. This is discussed more broadly elsewhere in the Commissions work, which deals with newborns specifically.

Prior notice

Here, the evidence disclosed that, with respect to Oliver, the prospect of the Department seeking orders for removal was raised with Melanie two months prior, and again with the FWS the day prior to birth. Communication could, however, have been improved. Melanie was not told in plain terms that failing to engage in a service support case in respect of her unborn child would, at a minimum, be viewed very unfavourably by the Department when it came to any assessment about the risk she posed to her child upon his birth. There also appeared to a misunderstanding, at least on the mother's side, about whether having a safe adult family member in residence with her to support her was available as an alternative to removal. It is important that the Department speaks as plainly as possible to expectant mothers in the lead up to the birth about the range of action it is considering taking and how the mother can best demonstrate the abatement of risk to the newborn.

Were the removals justified?

The removal of Oliver demands careful analysis because the circumstances that gave rise to it, escalating and serious physical harm to older children which required their removal, and broader concerns about DFV in the household, were not trivial. The Department's conclusion that a parent who had repeatedly and seriously harmed older children posed an immediate risk to a newborn upon birth was, on its face, a reasonable professional inference based on the evidence available. That inference was articulated by the Manager with care, and it rested on documented evidence rather than speculation.

Nonetheless, it would be highly desirable if the known harm that is caused to a newborn child by depriving it of bonding opportunities with its mother ought to be weighed into the assessment as to whether removal is required. In her evidence, the Manager agreed that the opportunity for a newborn to form an attachment to his or her mother at or about the time of birth is critical to the child's development and wellbeing, and that there is consequential harm associated with removing a newborn in the way described. The Commission acknowledges the attempts of the Department to facilitate the continuation of breast-feeding by the mother, but, as this case study demonstrated, this is sub-optimal and subject to vicissitudes such as foster carers' schedules and concerns about the 'intrusiveness' of the practice, which lacks a sufficiently child-centric focus. This is not to say that newborns must never be removed – clearly sometimes they must, including in this case – but simply that the harm to the newborn is weighed in the balance. Applied to newborn removals, the paramount principle demands that the harm of removal be placed squarely in the balance, not treated as an unfortunate but acceptable incident of risk management.

The Commission notes that the Department intended to, but it did not, undertake an investigation and assessment regarding Oliver upon his birth. This did not occur. Rather, the safety assessment from five months earlier was relied upon. This is plainly not best practice and, even if it was unlikely to make a difference here to the ultimate decision, safety assessments contemporaneous to the birth ought to be conducted when considering removing a newborn from his or her mother. Public confidence in the Child Safety system demands that the Court is given up-to-date information, including in respect of the mother's mental health or state of mind, observations from hospital staff and the mother's engagement with support services and Child Safety and behavioural changes during the pregnancy, to name a few.

Attempt to reunify newborn rendered unviable due to domestic and family violence

The Commission also recognises the Department's attempt to reunify Oliver safely with Melanie, only for hopes of a new beginning to be dashed by Arthur's threatening and violent acts towards Melanie, whilst she was holding Oliver, then only a few weeks old. The Commission has seen overwhelming evidence of domestic and family violence as a proximate cause of children coming into the tertiary system and a scourge keeping children from being safely reunified with their families.

Rolling short-term orders and asymmetry of the Court system

A recurring pattern in the Commission's record - evident also in the YP case study - is the protracted reliance on rolling short-term custody orders before long-term arrangements are finalised. In Melanie's case, the chronology of court events discloses five distinct phases of litigation spanning from March 2018 to the present, with multiple iterations of short-term custody orders for each child before long-term guardianship applications were ultimately filed. For Oliver, short-term custody orders were made in June 2018, extended in June 2020, and amended again in April 2022 before an LTG application was eventually filed in April 2024 — a period of six years.

As identified in other sections of this Report, the present court jurisdiction as asymmetric: a child may only be removed into state care with court approval, but long-term placement and reunification decisions are generally made unilaterally by the Department, without court oversight. That asymmetry is vividly demonstrated in Melanie's case. While each custody order required court involvement, the critical decision, namely whether and when reunification was achievable, what was required of Melanie to achieve it, and whether the goalposts were being fairly applied, was made entirely within the Department's administrative discretion. This has plainly led to Melanie feeling disenfranchised and without recourse to an independent umpire.

Self-placing

As observed early in this report, the increasing number of self-placing children is both literally and figuratively an exit poll of the system's customers, dissatisfied with what the system has to offer. Chloe and Dana's decisions, in 2024, to leave their placements and return to live with Melanie, having been victim-survivors of sexual assaults in foster care, are a case in point. Both girls were under long-term guardianship orders (orders made by the Court) and yet their legal guardian, the Department, assessed enforcement as futile. The Manager's evidence was that a warrant had been considered but that, given the girls' age, expressed wishes, and physical capacity to leave any placement, they would simply return. That assessment may well be

practically accurate. But it discloses a profound tension at the heart of the system: the Court has made orders in respect of children whose expressed and enacted preference is inconsistent with those orders, and the Department, as their legal guardian, has no effective mechanism for bridging the gap between legal obligation and practical reality.

The Commission notes that both Chloe and Dana were attending school and accessing counselling while self-placing at Melanie's home, and that no safety concerns were identified during the regular home visits. The Manager offered two explanations for the girls' reluctance to engage with the Department: coercive control by Melanie, and a desire to be present for their infant sibling. These explanations are not mutually exclusive, and neither has been formally assessed. What the evidence demonstrates is that, once again, the children's own expressed views - and the family relationships that sustain those views - are a resource of genuine significance that the formal system has limited capacity, at times, to engage with constructively.

Conclusion

Melanie's case study does not yield easy conclusions. The harm caused to her children was real, serious and prolonged. The Department's engagement with the family was sustained and, in many respects, genuine. And yet, across the arc of more than seven years, the trajectory of the family, namely children under long-term guardianship orders, a failed attempt to reunify a newborn child, two teenagers self-placing with their mother, another newborn subject to a fresh LTG application, and a parent who has demonstrably engaged with every program the system placed before her, cannot be described as a successful systemic outcome.



Appendix C

Timeline of Major Child Protection Reforms in Queensland

Appendix C: Timeline of Major Child Protection Reforms in Queensland

Date	Reforms
1997	• Release of the *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* report
1999	• Release of the *Final Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (the Forde Inquiry)
2000	• Introduction of the new *Child Protection Act 1999*
2002 2003	• Queensland Ombudsman investigations into Brooke Brennan and Baby Kate.
2004	• **January**: Release of the *Protecting Children: an Inquiry into the Abuse of Children in Foster Care* (CMC Inquiry) • **February**: Creation of the Department of Child Safety (to give effect to the CMC recommendation) • **August**: Child Death Case Review Committee established.
2004 - 2006	• Amendments to the *Child Protection Act 1999* in response to the CMC Inquiry, including changes to: o Child Guardian's functions and powers o Community Visitor Program o Children Services Tribunal's jurisdiction o Child death case reviews o Case planning o Responses to an unborn child notification o Mandatory reporting by nurses o Suspected Child Abuse and Neglect (SCAN) teams o Information sharing between departments, agencies and non-government organisations o Assessment and approval of carers.
2009	• Endorsement of the *National Framework for Protecting Australia's Children 2009-2020*. • **March:** Department of Communities, Child Safety and Disability Services established.
2010 2011	• The *Child Protection and Other Acts Amendment Act 2010* made various amendments to: o Support implementation of the Helping Out Families initiative o Provide earlier and more effective intervention for at-risk families o Provided for a new Temporary Custody Order to secure the safety of children in need of protection o Improve decision-making to promote children's safety and wellbeing o Recognise the status of long-term guardians

2012	• The National Quality Framework (NQF) commences and is jointly governed by the Australian Government and all state and territory governments.
2013	• **July**: Release of the Child Protection Commission of Inquiry (Carmody Inquiry) *Taking responsibility: a Roadmap for Queensland Child Protection* report.
2014	• Introduction of the *Child Protection Reform Amendment Act 2014*, the *Public Guardian Act 2014* and the *Family and Child Commission Act 2014* in response to the Carmody Inquiry. • **July:** Child Death Case Review Committee replaced with new child death case review panels. • **July:** Establishment of the Queensland Family and Child Commission • **July:** Establishment of the *National Senate Inquiry into Out of Home Care*
2015	• **February**: Release of the Special Taskforce on Domestic and Family Violence *Not Now, Not Ever: Ending domestic and family violence in Queensland* report • **May**: Establishment of Family and Child Connect and Intensive Family Support. • **August**: Release of the government response to the Special Taskforce on Domestic and Family Violence *Not Now, Not Ever: Ending domestic and family violence in Queensland* report • **August**: The Senate Community Affairs References Committee Inquiry into Out of Home Care report is released. • **December**: The government finalised the Domestic and Family Violence strategy 2016–2026 and first action plan for 2015–16.
2016	• Introduction of the *Director of Child Protection Litigation Act 2016* and the *Child Protection Reform Amendment Act 2016* as part of reforms in response to the Carmody Inquiry. • **June:** Release of the QFCC *When a Child is Missing: Remembering Tiahleigh – A report into Queensland's children missing from out-of-home-care* report. • **July:** QFCC is engaged to oversee review and investigate into the death of Mason Jet Lee. • **July:** Release of the Queensland Ombudsman *Management of child safety complaints: An investigation into the current safety complaints management processes within the Department of Communities, Child Safety and Disability Services* report. • **December:** Release of the QFCC *When a child is missing: Recommendation 28 Supplementary Review* report.
2017	• Introduction of the *Child Protection Reform Amendment Act 2017,* including to legislate the Child Placement Principle in the *Child Protection Act 1999*. • Release of the QFCC *Keeping Queensland's children more than safe: Review of the blue card system, Keeping Queensland children more than safe: Review of the foster care system, and Strengthening capacity across Queensland's child protection system* reports

	• **March:** Release of the QFCC *A systems review of individual agency findings following the death of a child* report. • **May:** The Queensland Government released *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037*. • **December:** Release of the *Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse* report (Royal Commission report).
2018	• The National Office for Child Safety was established in response to recommendations by the Royal Commission report. • Introduction of the National Principles for Child Safe Organisations.
2019	• Release of the QFCC's *Implementation Evaluation of Queensland's child protection reforms*. • **November:** The National Standards for Working with Children Checks was endorsed by all states and territories, developed in response to recommendations by the Royal Commission report.
2020	• The *Child Death Review Board* is established and hosted by the QFCC. • **March:** Release of the Queensland Ombudsman *Management of child safety complaints – second report: An investigation into the current safety complaints management processes within the Department Child Safety, Youth and Women*. • **June:** Release of the Queensland Coroner findings of the *Inquest into the death of Mason Jet Lee* and closure. • **July**: The National Agreement on Closing the Gap is established, of which Queensland is a signatory.
2021	• Release of the national *Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031*. • Release of QFCC *Counting lives, changing patterns: Findings from the Queensland Child Death Register 2004-2019, Principle Focus and Measuring What Matters* reports. • **March**: Establishment of the *Child Protection and Other Legislation Amendment Act 2021* in response to findings of the Coroner's inquest into the death of Mason Jett Lee. • **June:** Release of the *Queensland Coroner findings of the Inquest into the death of Tialeigh Alyssa-Rose Palmer* and closure. • **September:** The National Office for Child Safety releases the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030* as part of the national response to the Royal Commission.
2022	• Establishment of the *Child Protection Reform and Other Legislation Amendment Act 2022* to legislate the Child Placement Principle as part of decision-making. • **June**: Release of the *Let the sunshine in: Review of culture and accountability in the Queensland public sector* report.
2023	• **December**: The National Quality Framework delivered the *Review of Child Safety Arrangements under the National Quality Framework: Final Report*.

2024	• Establishment of the *Queensland Child Safe Organisations Act 2024* to legislate Child Safe Standards and a Reportable Conduct Scheme. • Establishment of the *Victims' Commissioner and Sexual Violence Review Board Act 2024* including the Charter of Victims' Rights in Queensland.
2025	• **October:** The first phase of the implementation of the Child Safe Standards commences.
2026	• **July**: Reportable Conduct commences in Queensland.



Appendix D

Newborn Project

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

Appendix D: Newborn Project

Background

During its initial scoping trips to Cairns in July and August 2025, the Commission was told that there was a practice of the Department conducting birth suite removals of newborn Aboriginal and Torres Strait children, in circumstances where the removal was unnecessary. Consequently, the Commission prioritised the issue of the removal of newborns at its Cairns public hearings.[1]

During those public hearings, various witnesses gave evidence of circumstances that they considered amounted to the unwarranted removal of newborn indigenous babies.[2] The Commission also heard evidence from a mother who had experienced a birth suite removal.[3]

In light of the seriousness of this evidence, and its potential contribution – if true – to the overrepresentation of Aboriginal and Torres Strait Islander children in State care, the Commission sought the Department's response to this evidence by seeking information regarding children who had been subject to an order within seven days of their birth within a four-year period (2021-2025) in Far North Queensland.[4] This gave rise to a cohort of 66 newborn babies for whom emergent or other orders had been sought by the Department (noting that not all of the orders sought were custodial in nature). Following interrogation of this material, further notices were issued to the Department and additional notices issued to the Director of Child Protection Litigation and the Department of Health.[5] The Commission also heard from Departmental witnesses giving evidence regarding selected newborn removals during its public hearings in November 2025.

The following information is a result of the data and case files obtained from the department and interrogated by Commission staff. The validity of the information is impacted by the data provided via the notices.

[1] Child Safety Commission of Inquiry, *Cairns Public Hearing List of Issues* (Publication) Section I.
[2] Transcript, Evidence of Alana Mitchell (16 September 2025) 901:32-38; Transcript, Evidence of Emily Hapea (17 September 2025) 1007:5-19, 1015:39-46; Transcript, Evidence of Rachael Ham (17 September 2025) 1110:7-16; Transcript, Evidence of Thelma Schwartz (22 September 2025) 1498:20-26, 1500:13-42; Transcript, Evidence of Michelle O'Connor (23 September 2025) 1558:33–1562:47.
[3] Transcript of private hearing (16 September 2025) 842:35-889:6; see also the case study of Melanie located in Appendix B of the Executive Report.
[4] Notice to Produce 21.
[5] Notices to Produce No.116, 132 and 177 were issued to the Department, Notice 135 was issued to the Director of Child Protection Litigation and Notice 133 was issued to the Department of Health.

Overall, the Commission received and reviewed approximately 3,578 documents related to the project. The methodology applied – in terms of documents and information sought and received – is set out at the end of this annexure.

Statistics[7]

	Total number of applications (custodial and non-custodial)	Percentage of orders sought on day of newborn's birth
2021	16	44%
2022	7	29%
2023	6	0%
2024	13	31%
2025[6]	12	8%

Orders

- **Number of applications for court orders**: Between 1 January 2021 and 7 August 2025, 66 newborns aged between 0 and 7 days were the subject of an application for emergent or other orders.
- **Percentage of newborn cases in which the Department sought custodial orders:** approximately 95%.
- **Percentage of newborn cases in which custodial orders were sought but refused**: approximately 9%.

Attributes of children and parents

- **Cultural identity of children**: 86% of the children were Aboriginal, or Torres Strait Islander or both.
- **Cultural identity of the parents**
    - Almost 80% of the mothers were Aboriginal, or Torres Strait Islander or both; 20% were non-Indigenous.

[6] Includes statistics to 7 August 2025 only.
[7] For example, 16 applications were sought in 2021, 44% of which were sought on the day the child was born.

    - 65% of the fathers were Aboriginal, or Torres Strait Islander or both; 35% were non-indigenous.[62]
- **Mothers who were children themselves and subject to a CPO**: 8% of the mothers were children under the age of 18 and subject to child protection orders at the time of the births of their children.
- **Parents with intellectual disabilities**: 12% of the parents had intellectual disabilities of some description.
- **Child protection history of parent**: 83% of the newborns had at least one parent with a previous child protection history. This is 77% of mothers and 84% of fathers.[8]
- **Mothers who had already had other children involved in ongoing intervention by the Department at the time for birth**: 65% of the mothers had children that were the subject of ongoing intervention by the Department, including children previously removed and currently subject to CPOs.

Engagement with the Department prior to birth

- **Families who engaged with the Department prior to birth**: in 34% of cases, the family engaged with the Department prior to the birth.
- **Support Service Case initiated prior to birth**: in 31% of cases, there was a support service case initiated, of these, 85% had agreed Support Service Plans. There was at least one case where the support service plan, despite being entered into 6 months prior to birth, had not been allocated before the newborn was born.

Referrals to services prior to or after birth[9]

- **Referral to FWS and/or FPP**: For Aboriginal and Torres Strait Islander families, a referral made to:
    - both FWS and FPP: 7%
    - FWS only: in 16 cases: 28%
    - FPP only in 9 cases: 15%

[8] Some parents have been counted multiple times in the situation of multiple newborns.
[9] The information held by the Commission relates to the pregnancy period and up to 4 to 6 weeks post birth (during the emergent order litigation period.)

NB: these figures do not take into account whether there was engagement with the service, just that the referral was made.

No referrals were made in 49% of cases (noting that consent is required for a referral).

- **Referrals to other services**: In 38% of cases, a referral was made to general, non-ATSICCO services.

High Risk Alerts

- **High Risk Alerts in place before birth:** in 75% of cases, a High Risk Alert was in place before the birth of the child.

Investigation process

- **Standard vs priority notification**: in 75% of cases, a standard notification response was allocated in respect of the unborn child; 25% had a priority notification response (either 24 or 72 hours).
- **Average days between notification**[10] **being made to Child Safety and birth**: There was an average of 136 days between notification and birth.
- **Average days between notification and the commencement of the investigation:** 22% of all unborn investigations within the region (not just the 66 subject to orders) were commenced within the required timeframe. Of those not commenced in timeframe, 89% were due to workforce capacity. Of the workforce capacity impacted investigations:
    - 29% were commenced over 100 days after the notification was recorded.
    - 8% were commenced at least six months after the notification was recorded.
    - One investigation took 386 days to commence.[11]

[10] This date is taken from the data provided by the Department via Notice to Produce 21. It is not clear if this date relates to date of receipt of the intake or date of screening as a notification (as the material uses both terms throughout). As such, this date may differ within a period of 48 hours as per the finalisation timeframes in the Child Protection Practice Manual respond at intake procedure as of 2022 and 2025 (current), which appear to have remained a consistent timeframe. Department of Child Safety, Seniors, and Disability Services, *Child Safety Practice Manual: Receive and respond at intake* (Procedure, 26 April 2022) (DFS.0021.0001.0119); Department of Child Safety, Seniors and Disability Services, *Child Safety Practice Manual: Receive and respond at intake* (Procedure, 18 July 2025) (DFS.0021.0001.0001).

[11] Department of Families, Seniors, Disability Services and Child Safety, *Investigation and Assessment Spreadsheet* (Spreadsheet, 3 November 2025) (DFS.0132.0004.0001). This spreadsheet details unborn investigations in the relevant time period and region inclusive of commencement dates and reasons for delay in commencement. See also Explanatory Note provided to the Commission in response to Notice 132.

- Of the 66 newborns relevant to the project, 36% of the investigations commenced within the required timeframe. The investigations that were not, ranged in commencement dates between 21 to 213 days.
- **Investigation completed prior to birth**: in 83% of cases, investigations were completed prior to the birth of the child; in 17% the investigations were not.
- **Decisions to delay contact until after birth:** Was there a decision to delay contact with the mother about the child protection concerns until after birth? Not often. In 8% of the cases, the Department made a decision to delay contact with the expectant mother. Of these, 60% were due to an identified increased risk to the unborn once born if aware of the investigation, 40% were delayed as the expectant mothers were not willing to participate in the assessment.

Notification to mother of intention to seek orders regarding the newborn

- **Average time between being advised of the intention to remove the newborn and the newborn's birth:** approximately 27 days.
- **Were the parents advised of the Department's intention to make an application to the Court before the application was made?** In 31 cases, yes; in 35 cases, no. Further, of the 31 cases where the Department did advise the parents before making the application to the Court, 8 parents were advised after the birth and 3 were advised before birth but only on the day of birth.

Information about application contesting application

- **Parents provided with information about contesting the application for removal of the child and obtaining legal representation?** in 47% of case, yes; in 7% of cases, no; and the Department does not hold records of this information with respect to the remaining parents.

Court orders

- Type of order granted on initial application:
    - Temporary Assessment Order – 61%
    - Court Assessment Order 2%
    - Temporary Custody Order 35%
    - Child Protection Order 3%

- **Did the Court grant the orders requested by the Department?** No, not always. In 10 court events, the Court made a determination that was not consistent with what was sought by the Department (including order length, custody refused or order wholly refused).
- **Did custodial emergent orders always lead to long term removal?** Not always. 42% have resulted in long term removal.
- **Did the Department always seek custodial orders?** No, it didn't. There were examples of both TAOs and TCOs being sought and granted on non-custodial terms, indicating that the Department did not, as a matter of course, seek removal.
- **Legal advice –** of the newborn cases that resulted in an assessment that a child was in need of protection and required a child protection order (and subsequent referral to the Director of Child Protection Litigation), 24% have recorded legal advice which had been provided to the Department by the Office of the Child and Family Official Solicitor.

Removal

- **Child removed within a week of birth** (where custodial order sought): 93%
- **Were there examples of children being removed but later returned to parents?** Yes. For example, there were several children who were the subject of a custodial TAO, but then a non-custodial CAO was granted (including Baby Nathan) or a CAO was sought and not granted.
- 23% of these newborns are not currently subject to orders (none of the newborns that court refused custody of have entered care),[12] however, of those who are:
    - 29% are currently subject to granted or applications for Child Protection Orders seeking short term custody to the chief executive;
    - 23% are currently subject to granted or applications for Child Protection Orders seeking long term guardianship to the chief executive;
    - 8% are currently subject to granted or applications for Child Protection Orders seeking long term guardianship to family or suitable person; and
    - 6% are currently subject to granted or applications for other orders including a CAO or non-custodial child protection orders.

[12] One matter is unclear if custody was granted on the original TAO order due to an administrative error, however it is clear that custody was at least later sought and granted, and that child remains in care.

- Of the 66 newborns, 23 are subject to a Child Protection Order (or applications for) Long Term Guardianship to the chief executive and 5 are subject to a Child Protection Order (or applications for) Long Term Guardianship to a suitable person or family.

Placement of children

- **Where the child was removed under Court orders, in what type of care were they placed?** 43 were placed in general foster carer; 10 were placed in kinship care. The remainder were not removed from the parents, either because the Department did not seek custodial orders, or the Court refused to grant custodial orders.

Themes

1. **Delay in investigating is a serious issue.** The Commission identified delay in investigating unborn notification as a significant issue in investigating unborn notifications. This is further explored in Baby Nathan's case study.

2. **Lack of engagement by parents is a significant issue in newborn removals**. In the majority of cases where orders were sought with respect to newborns, the mother had declined to engage with the Department or support services (including a Family Wellbeing Service) prior to the birth of the child despite multiple attempts at outreach. This lack of engagement had clear ramifications in respect of Child Safety's ability to be satisfied that there was not an immediate safety risk to the newborn upon birth, and/or to be satisfied the child's longer-term care and protection needs could be met by a willing and able parent.

3. **There is no default position of removal if there are child protection concerns in respect of a newborn.** The evidence showed that the Department does not have a default position of removal for newborns where there are child protection concerns – it will, at times, seek TAOs, CAOs and TCOs in non-custodial form, or seek a PSO. Further, the Court does not automatically grant custodial orders simply because they are sought by the Department. Thus, there are clear checks and balances both in Departmental practice and in the Court's juridical practice in determining applications for emergent orders *vis-a-vis* newborns.

4. **There were rational reasons for seeking custodial orders in respect of the newborns, but casework could be improved.** Even where the Department's applications were unsuccessful, the evidence showed that there were rational, compelling reasons at the time to make the application and allow the Court to assess the evidence. Generally, the

application will hinge on whether the child protection concerns have been adequately addressed – substance misuse, a history of excessive discipline on older children, and the extent to which the child's father's DV history is a present threat to the mother and baby are common - or there are sufficient protective factors in the mother's wider network (such as supportive extended family or engagement with intensive support services) - such that a child as vulnerable and hidden from view as a newborn child does not require a custodial intervention.

The Commission notes that there were a high number of cases in which TCOs were sought for a newborn – indicating that the assessment had already been made prior to birth and a custodial option determined in advance. In many of these cases, there was not a contemporaneous safety assessment conducted. This ought to be mandatory in circumstances of a newborn custodial removal. Although this will not necessarily change the decision – either of the Department to made the application, or the Court in granting the application – an up to date assessment ought to be conducted, recorded and put before the Court in order to maintain public confidence that, when such drastic examples of statutory intervention are taken with Court approval, the decision is being made with the best and most current information available.

Methodology

The Commission sought information under Notices to Produce, the content of which is listed below.

1. Notice to Produce 21 was issued to the Department on 7 August 2025 and required:
    - A witness statement with an explanation of the approach relevant to assessing risk of harm to children aged up to seven days old (newborn children) and seeking emergent orders for such children.
    - Details of newborn children subject to an order within the timeframe and region as well as the following:
        - The order history for both parents.
        - Outcomes of the court applications.
        - Reunification status.
        - Current order for the child.
    - Copies of relevant policies, procedures and protocols.
    - Details of any complaints received within the region specifically about newborns.

- Copies of any briefing notes provided to managers, regional directors or regional executive directors on relation to newborn children subject to applications for orders.

2. In response, the Department provided:
   - A witness statement from Acting Chief Practitioner Victoria Van Houdt.
   - 780 newborn children between 0-7 days old were subject to an order sought by child safety.[13] 66 of these were located with the requested region.
   - There had been no complaints in relation to newborn children in the relevant region.[14] Briefing notes in relation to newborn children was not a requirement in the Child Safety Practice Manual, and are such, none were located.[15]
3. To clarify matters and seek further details, the Commission sought further information.
4. Notice to Produce 116 was issued to the Department on 1 October 2025 and required:
   - In relation to the newborn children identified in Notice 21:
     - The safety assessment resulting in the decision to remove the newborn.
     - All emergent applications and orders relevant and the related forms.
     - A copy of legal advice provided by the Office of the Child and Family Official Solicitor in relation to the decision to remove the newborn.
     - The High Risk Alert form sent to relevant hospital service.
5. Notice to Produce 117 was issued to the Department on 1 October 2025and required the following:
   - In relation to the newborn children identified in Notice 21:
     - Location of birth;
     - Date of unborn notification;
     - Consent for support service and support provision to family before the birth;
     - Referrals to Family Wellbeing Program and Family Participation Program;
     - Advice to parents about intention to remove the child and legal representation and consenting of the Childrens Court proceedings.

[13] Explanatory notes Notice to Produce 21 part 2.
[14] Explanatory notes Notice to Produce 21 part 5.
[15] Explanatory notes Notice to Produce 21 part 7.

6. Notice to Produce 132 was issued to the Department on 15 October 2025 and required the following:
    - In relation to the newborn children identified in Notice 21:
        - Records of the decision to delay contact with a pregnant person.
        - Support Service Plans and reviews of these plans.
        - Practice Panel minutes for those assessed in need of protection with a Child Protection Order being required.
        - A copy of legal advice provided by the Office of the Child and Family Official Solicitor in relation to a referral to the Director of Child Protection Litigation.
7. Notice to Produce 133 was issued to Queensland Health on 21 October 2025 and required the following:
    - Referrals to health services by the Department in relation to pregnant women.
8. Notice to Produce 135 was issued to the Director of Child Protection Litigation on 21 October 2025 and required the following:
    - In relation to the newborn children identified in Notice 21, all material related to the Children's Court proceedings.
9. Notice to Produce 177 was issued to the Department on 27 October 2025 and required the following:
    - In relation to one particular newborn removed, a witness statement addressing a number of additional questions upon review of the material.
    - Further departmental material in relation to the child.

Note: it is important to note the data is impacted by anomalies and record keeping gaps (including varying definitions of reunification for example) and is intended to capture themes and systemic issues rather than to be a determinative finding.



Appendix E

KPMG Report

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

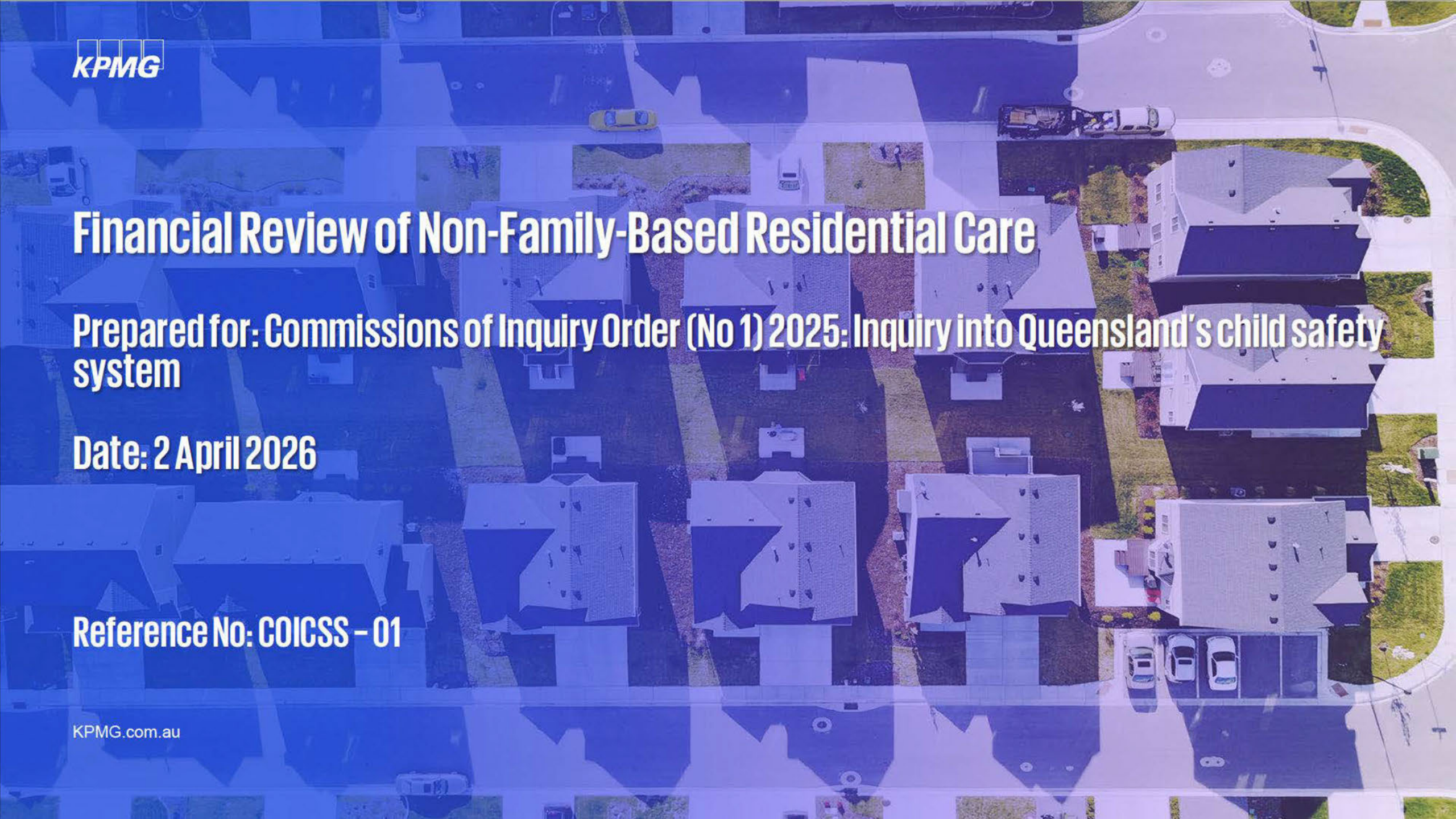
For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/



KPMG

Financial Review of Non-Family-Based Residential Care

Prepared for: Commissions of Inquiry Order (No 1) 2025: Inquiry into Queensland's child safety system

Date: 2 April 2026

Reference No: COICSS – 01

KPMG.com.au

Acknowledgement of Country

KPMG acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

At KPMG, our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia's First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

Guided by our purpose to 'Inspire Confidence. Empower Change', we are committed to placing truth-telling, self-determination and cultural safety at the centre of our approach. Driven by our commitment to achieving this, KPMG has implemented mandatory cultural awareness training for all staff as well as our Indigenous Peoples Policy. This sincere and sustained commitment has led to our 2021-2025 Reconciliation Action Plan being acknowledged by Reconciliation Australia as 'Elevate' – our third RAP to receive this highest level of recognition. We continually push ourselves to be more courageous in our actions particularly in advocating for the Uluru Statement from the Heart.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.

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This deliverable has been prepared as outlined with the Department of Justice in the Scope Section of the engagement contract dated 30 January 2026. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this deliverable are based on a review of data and documentation provided by the Department and the Commission of Inquiry, and publicly available information. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by the Department of Justice as part of the process.

KPMG have indicated within this deliverable the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this deliverable, in either oral or written form, for events occurring after the report has been issued in final form.

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Glossary (1/2)

Abbreviation	Definition
$	In Australian Dollars (AUD)
$'000s or k	Thousands of Australian Dollars
ACNC	Australian Charities and Not-for-profits Commission
AI	Artificial Intelligence
ATSICCO	Aboriginal and Torres Strait Islander Community-Controlled Organisation
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principle
Average IPS Funding Per Placement Per Day	Total IPS contract divided by number of children and contract duration; and averaging the result across each Provider's five IPS Pricing Schedules
Average OSD Funding Per Placement Per Day	Total FY25 OSD funding divided by number of equivalent full year placements and further divided by 365 (the number of days in the year). All information is taken from Provider Witness Statements
Base Rate	Ordinary hourly pay rate – it excludes penalties, overtime, allowances, bonuses and casual loadings
Business Rules Benchmark	Attachment 1 to the Individualised Placement and Support Business Rules (Version 5.1, September 2022)
CEO	Chief Executive Officer
Commission	Commission of Inquiry into the Child Safety System
Contract margin	The value of a Provider's IPS Schedule less the estimated value of the IPS Schedule based on the Business Rules Benchmark
Department	Department of Families, Seniors, Disability Services and Child Safety of Queensland
Dual funded	Providers that receive funding under both OSD (Outsourced Service Delivery) and IPS (Individual Placement and Support) arrangements
FBC	Family Based Care - A form of OOHC where children are placed with families, such as foster and kinship care.

Abbreviation	Definition
FIFO	Fly-In Fly-Out
Fit for purpose	Throughout Part C, 'fit for purpose' is assessed against the purpose described in each source report, and separately against potential reliance for funding, workforce or long-term planning decisions
FP	For-profit
FY	Financial Year
HSQF	Human Services Quality Framework is Queensland's quality and safeguarding framework for organisations that deliver government-funded human services across child protection, residential care, youth services, family support, disability mental health and community services. Features the Human Services Quality Standards (HSQS), certification processes and a framework for quality improvement
Income Rate	Base rate for a residential youth worker in IPS Pricing Schedules
Intake	The point at which concerns about a child are received by the child protection system
IPS	Individual Placement and Support
IPS Business Rules	Individualised Placement and Support Business Rules (Version 5.1, September 2022)
IPS Contract	IPS agreement between the Department and the provider that sets out the requirements for the delivery of services
IPS Pricing Schedule	A standardised pricing template completed by a Provider that sets out the full cost of delivering an IPS package for a specific young person
Licensed	Licence to provide care services in accordance with section 125 of the Child Protection Act 1999
m	Millions of Australian Dollars
Model of care	A model of care describes the organising principles, values and practices that guide how services are delivered to keep children safe and promote their wellbeing. There is not one standard model of care utilised in Queensland residential care settings

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Glossary (2/2)

Abbreviation	Definition
Monte Carlo Simulation	A method used in SAM where child pathways are simulated using randomness based on past patterns, so each model run represents one possible future rather than a guaranteed outcome
NDIS	National Disability Insurance Scheme
NFBC	Non-family-based care
NFP	Not-for-profit
NP	Not provided
NSW	New South Wales
OOHC	Out of Home Care - The statutory care of children who are unable to live safely with their parents, including family-based care (foster care and kinship care) and non-family-based care (residential care and other approved placements)
Ordinary hours	Hours worked between 6:00 a.m and 8:00 p.m., Monday to Friday (i.e. hours that do not include any loadings or penalty rates)
OSD	Outsourced Service Delivery
PBFM	Parameter-Based Funding Model - The cost model used by Government to translate future demand into funding estimates under defined targets and assumptions
PD	Probability Distribution - A statistical representation, which is currently derived from historical data, of the likelihood that a child will transition between stages or pathways within the child protection system
Placement supply mix	The distribution of children across different OOHC placement types (FBC and NFBC), and the distribution of available placement capacity within each of those care types
Provider	An organisation that delivers out-of-home residential care
QFCC	Queensland Family and Child Commission

Abbreviation	Definition
RC	Residential Care - A form of OOHC where children are placed in staffed residential settings, typically involving higher resource intensity. In this Review, ‘NFBC’ refers to staffed residential care settings (RC). Where source documents use ‘residential care’ or ‘RC’, this report uses ‘NFBC’
Related Party	A person or entity that can control, jointly control, or significantly influence the reporting entity, or is subject to such influence by the entity
RFI	Request for Information
SAM	Simulated Analytical Model - The demand model used by Government to forecast future volumes and flows of children at each stage of the QLD child protection system
SAM-to-PBFM	For this Part C Review, the combined SAM and PBFM models, treated as a single model system because SAM demand outputs are used directly by PBFM to calculate funding
SCHADS CA	Social, Community, Home Care and Disability Services Industry Award for Social and Crisis Accommodation employees
SCHADS SaCS	Social, Community, Home Care and Disability Services Industry Award for Social and Community Services employees
Staff Margin	The difference between the Income Rate and the base rate paid to residential youth workers on an hourly basis
Witness Statement	Written response to the Notice to Produce issued by the Commission of Inquiry into the Child Safety System dated 19 December 2025
Youth Worker Margin	The staff margin multiplied by the number of staffing hours in an IPS Pricing Schedule

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01

Executive Summary



Analytical approach and structure

ES.1. KPMG was engaged on 30 January 2026 by the Commission of Inquiry into Child Safety System (the Commission) through the Department of Justice to provide analysis on the current market for residential out of home care in Queensland, the financial position of a sample of providers and the models that have been constructed or published to assess future demand and cost for these services.

ES.2. Our analysis has been conducted in three streams of work with clear linkages between the components. Our analysis was conducted based on a range of datasets that were collected by the Commission under their powers of inquiry and included:

a. [redacted] dataset which includes service types and contract characteristics - document ID: [redacted];

b. Additional departmental data and documentation, including briefing notes, internal strategy papers and supporting materials, used to provide policy, commissioning and market context for the analysis;

c. Provider-submitted financial information including financial statements, pricing schedules, payroll and witness materials which underpins an analysis of costs, margins and funding patterns;

d. IPS Business Rules describing departmental benchmarks defining acceptable labour, overhead and cost assumptions used to assess pricing reasonableness;

e. Departmental procurement documentation containing guidance on contracting and oversight used to evaluate procurement assurance and governance effectiveness;

f. [redacted] – document ID: [redacted] and

g. Buyer Beware report – document ID: [redacted].

ES.3. The approach and scope of each stream is outlined to the right.

Stream 1: Understanding the residential out-of-home care market in Queensland

ES.4. Stream 1 examined the structure and operation of Queensland's residential care market using desktop research as well as contract data provided by the Department of Families, Seniors, Disability Services and Child Safety (the Department). The analysis assessed market size and composition, including the number and types of providers, regional distribution, funding flows and participation over time. Provider characteristics and funding outcomes were compared by contract type, licensing status and organisational form. This included analysis of Outsourced Service Delivery (OSD) arrangements and Individualised Placement and Support (IPS) contracts. Differences between licensed and unlicensed providers and not-for-profit and for-profit providers were examined to identify variation in scale, funding concentration, cost growth and market stability.

Stream 2: Assessing the financial health of the residential care market

ES.5. Stream 2 reviewed the financial position of 20 residential care providers selected by the Commission as a representative cross-section of the market. Using the Provider Witness Statements together with their financial statements, selected IPS Pricing Schedules, OSD budgets, a payroll extract and roster data we sought to identify the reasonableness of the profit margins.

ES.6. The analysis focused on identifying labour and operational costs against recommended benchmarks and highlighting related party transactions. The outcomes were used to compare the performance to different operating, funding and employee models and detail underlying trends and themes.

Stream 3: Forecasting future demand for residential care

ES.7. Stream 3 assessed the projected non-family-based care (NFBC) and Out of Home Care (OOHC) demand and cost models identified by the Commission through to FY2030. The analysis reviewed the robustness of those existing projections based on their documented methodology, assumptions and stated use, and identified targeted enhancements to support clearer interpretation, stronger sensitivity testing, and a better understanding of the cost impact of potential interventions by decision-makers.

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Summary of findings (continued overleaf)

ES.8. Our findings, outlined in detail in the full report, can be summarised into six main themes:

Theme 1 – Inelastic demand and changing market composition are impacting the efficiency and quality of the residential care service system

ES.9. The state of current market supply presents risks to sustainable, cost effective and high quality service provision due to limited growth in longer term, licensed arrangements and an unstable level of provision in some regions. Queensland's residential care market experienced sustained cost growth driven by inelastic demand and rising input costs, including housing, utilities and insurance costs. Expenditure increased overall and on a per-provider basis. The out-of-home care service mix included a greater use of residential care placements where family-based alternatives were unavailable, as well as high-cost short-term placements.

ES.10. In terms of market composition, a small number of providers continued to receive a large share of funding. The number of unlicensed providers increased while the numbers of licensed providers remained stable, with for-profit participation expanding as a share of the market. IPS contracts accounted for a growing share of placement nights and funding and became increasingly more expensive per day compared to OSD arrangements.

ES.11. Supply conditions varied significantly by region, with uneven provider availability, funding levels and cost growth. Aboriginal and Torres Strait Islander Community Controlled Organisations represented a small share of providers, noting delivery demand for Aboriginal and Torres Strait Islander children and young people increased markedly.

Theme 2 – Strengthening market stewardship capabilities

ES.12. Building a stronger commissioning model for residential care requires action at all stages of the commissioning cycle. This includes measures that deepen long term planning capability, introduce proactive market shaping in areas of low supply, regularise 'entry to market' thresholds and quality expectations and systematise data collection to monitor and manage performance.

ES.13. Observed market outcomes indicate weaknesses in current stewardship and commissioning arrangements. Limited long-term planning and poor visibility of future supply constrain proactive demand management. Reliance on short-term and surge contracting has improved responsiveness but weakened incentives for investment in licensed capacity, contributing to cost escalation and market volatility.

ES.14. Current contract, quality and performance information does not enable a robust assessment of provider performance. Inconsistent data, limited outcome measures and inadequate oversight restrict the ability to compare providers, monitor quality and identify emerging risks, reducing the scope for early intervention.

ES.15. Interjurisdictional approaches, ranging from implementation of stronger performance frameworks to greater direct government involvement, illustrate options to improve quality and sustainability.

Theme 3 – Profitability, growth and scale of IPS Providers

ES.16. The financial analysis shows that the net profit reported by the Providers in our sample is not a reliable indicator of financial performance, as owners and related parties often extract economic value through a variety of mechanisms - including above-market remuneration, management fees, acquisition of non-core assets, dividends and related-party charges - rather than through reported profit.

ES.17. The key driver of profitability is the labour inputs used when completing an IPS Pricing Schedule where average Department benchmarks are frequently exceeded. This is in part because operating cost and salaries and wages benchmarks have seemingly remained unchanged since August 2020 and December 2020 respectively, but also because once staff costs have been agreed during the procurement process, they are not revised down and appear to be used for future tender submissions.

ES.18. Consequently, for-profit IPS-only providers demonstrate rapid revenue growth over short periods, often without significant working capital or a need to invest in the business. Growth appears driven by placement access and pricing schedules rather than demonstrated efficiency, service maturity or measurable quality of care outcomes for children.

Theme 4 – Lack of incentives to transition IPS to OSD and incomplete IPS oversight under current procurement approach

ES.19. IPS Provider Witness Statements acknowledge OSD as a policy objective, but providers do not demonstrate an active intention to transition under current settings. Willingness to move to OSD is described as contingent on changes to funding, cost recovery or regulatory arrangements.

ES.20. The outputs reviewed indicate that current IPS funding and procurement settings make IPS more commercially attractive than OSD for providers, offering little incentive for providers to transition. At the same time, limited scrutiny of IPS Pricing Schedules reduces confidence that prices reflect efficient or value-for-money service delivery.

ES.21. The Queensland Government is seeking to convert a number of Provider contracts from IPS to OSD which could offer security for Providers and support cost reduction for the State. However, Providers have noted in their Witness Statements that this may undermine their ongoing financial viability which would in turn reduce supply in the market and undermine the State's ongoing ability to deliver residential care services.

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Summary of findings (continued)

Theme 5 – Strengthening the forecasting model

ES.22. Existing demand and cost models, including modelling in the Buyer Beware Report, provide clear signals about the likely scale and direction of future NFBC demand and associated cost risk if current pressures persist. They have been useful for agenda-setting and illustrating potential system pressure, but were developed for specific, point-in-time purposes and rely heavily on trend extrapolation, fixed assumptions and single-point estimates. As a result, they are not well suited to ongoing system management, funding planning or decision-making that requires sensitivity to changing conditions and uncertainty.

ES.24. Among the models reviewed, the Simulated Analytical Model (SAM) to Parameter-Based Funding Model (PBFM) system represents the most credible platform for more decision-useful analysis because it is already embedded in government forecasting and budget processes, provides a system view and supports more localised analysis of demand and cost. However, in its current form, its outputs remain conditional on externally specified inputs, historical pathway assumptions and target-driven settings.

ES.25. There is therefore a risk that current outputs, particularly from the PBFM, are interpreted as forecasts of funding required rather than conditional funding benchmarks. The report accordingly concludes that the official model system should be strengthened to support a broader, more transparent and more decision-useful view of future demand, funding requirements, and the cost implications of potential interventions in Queensland's OOHC system.

Theme 6 – Better modelling for demand capacity and market stewardship

ES.26. A better-practice modelling approach would incorporate driver-based demand inputs, transparent governance over key system pathway assumptions, explicit representation of placement type supply (including family-based care and NFBC), capacity and substitution constraints, and reporting that reflects the uncertainty inherent in the system rather than relying only on single-point outputs. Current models do not adequately explain why demand changes or how outcomes would respond to shifts in policy, system behaviour or external conditions.

ES.27. In the current SAM, future intakes are externally specified rather than generated from observable drivers, and probability distributions, which determine the likelihood of a child moving through each stage of the child protection system, are largely derived from historical patterns without a formal process to ensure they remain representative as system conditions evolve. This limits confidence that the model structure can appropriately reflect future changes in demand dynamics or pathway behaviour.

ES.28. Current modelling also does not explicitly represent placement supply, capacity or market constraints, which limits confidence where placement availability materially affects outcomes and cost. In the PBFM, cost escalation assumptions are largely indexation-based and outputs are commonly reported as single figures, which can obscure uncertainty and interpretation risk. Accordingly, the report recommends targeted enhancements to the SAM-to-PBFM model system so that it better integrates demand drivers, system pathways, behavioural parameters and capacity constraints, supported by sensitivity ranges that inform budget planning, workforce planning, intervention testing and market-shaping decisions across Queensland's OOHC and related sectors contributing to placement demand.

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02

Introduction



Background and introduction

Background

BI.1. Queensland's residential care system has expanded rapidly over the past decade, shifting from a last-resort, short-term placement option to a core component of the out-of-home care system. The number of children in residential care has more than tripled since 2015, driven largely by the marked reduction of foster and kinship care supply and increasing placement of younger children and those with highly complex needs into group-based settings not designed for long-term care. As a result, residential care has become a default response to system pressure rather than a therapeutic intervention of choice.

BI.2. Evidence has consistently demonstrated that this growth has occurred alongside poor and, in some cases, worsening outcomes for children and young people. The 2024 Children in Care Census and subsequent reporting highlighted high rates of trauma, self-harm, suicide attempts, unmet mental health needs, placement instability, children going missing from care, and exposure to further abuse while in residential placements. These issues were widely understood as systemic and longstanding, rather than isolated provider failings.

BI.3. At the same time, the residential care market has become increasingly costly and fragmented, growing into a billion-dollar sector without corresponding improvements in safety or wellbeing. Persistent concerns regarding provider oversight, profit extraction, workforce shortages, and the State's effectiveness as a corporate parent have remained unresolved despite multiple reviews and reform efforts. It was this convergence of rapid growth, demonstrably poor outcomes, market and workforce dysfunction, and repeated failure to implement earlier reforms that led the Queensland Government to establish a Commission of Inquiry into the Child Safety System in 2025, with residential care at its core.

BI.4. In May 2025, the Queensland Government established the Commission of Inquiry into Child Safety Sector (the Commission) with the aim of identifying and addressing systemic issues within the child safety system. Led by Commissioner Paul Elias Anastassiou KC, the Commission's goal is to improve outcomes for children, carers and families across Queensland, and to create a safer community for all Queenslanders.

BI.5. The Terms of Reference for the Commission of Inquiry instruct it to examine the following four areas:

- **Reforming the Residential Care System:** Investigating models of care and the factors contributing to the growth and reliance on a billion-dollar residential care sector.
- **Fixing a Broken System:** Reviewing the effectiveness of Queensland's child safety system to keep children safe, including governance, financial and procurement processes.
- **Safer Children:** Exploring failures both systemic and policy that have impeded the Department to provide support to families and protection to children at risk of harm.
- **Safer Communities:** Evaluating the effectiveness of the Department as a corporate parent and whether it is able to meet community expectations around parenting.

BI.6. Of relevance to the Commission's Terms of Reference is recent economic modelling by the Queensland Family and Child Commission (QFCC), which found that Queensland's Out of Home Care system is under severe financial strain, with residential care costs increasing from $200 million in 2015 to $1.12 billion in 2024. The QFCC estimates that annual costs are projected to exceed $7 billion by 2030. It noted that the State Government operates as a "price taker", with little market oversight and generic contracting that prioritises volume over value. It highlights that a lack of financial stewardship has entrenched inefficiencies and escalated costs, leaving the system vulnerable to unsustainable growth [3].

BI.7. The Commission, through the Department of Justice, has engaged KPMG to complete a report providing findings and opinions on the demand for and costs currently incurred and expected to be incurred by the Department of Families, Seniors, Disability Services and Child Safety (the Department) in relation to the delivery of non-family-based residential care services to children in state care.

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Scope of Work & Purpose

BI.8 The review comprises three distinct but related components, set out as chapters of this report. The scope of each component is described below, with additional details including the purpose and limitations described in detail in relevant sections of the report.

Scope

Understanding the market for non-family-based residential care in Queensland

BI.9 Part A analyses the current structure of the residential care sector, including quantitative information on delivery volume and funding by provider type, region and cohort of delivery. Longitudinal analysis supports identification of patterns of entry, exit and changes in market composition. This report also sets out qualitative information on provider quality and performance, jurisdictional regulatory arrangements and alternative tertiary care providers.

BI.10. In addition, Part A develops a theoretical basis underpinning demand and supply of residential care services. This includes a summary of the inelastic nature of residential care demand and drivers for the increase in demand, as well as labour and non-labour supply constraints and availability of services for particular cohorts.

BI.11 Finally, Part A sets out market interventions across the commissioning cycle to support quality improvements, based on interjurisdictional examples.

Assessing the financial health of the residential care market

BI.12. Part B considers the profit margins generated by 20 Providers selected by the Commission as a representative cross-section of suppliers and comment on the reasonableness of those margins having regard to:

a) The input costs incurred by Providers (including labour and overheads);

b) The different models of care offered by residential care Providers;

c) The procurement practices of the Department;

d) The availability of alternative suppliers in the market (covered in Part A); and

e) Any other factors deemed relevant.

BI.13. Suppliers were selected by reference to the following criteria: for-profit v not-profit; licensed v not licensed; large providers v small providers; providers in different regions; and providers with different focus areas or models of care.

Forecasting future demand for residential care

B1.14. The Commission identified projected demand and cost models for non-family-based care (NFBC) through to 2030 for KPMG to review. Part C assesses the robustness of these existing projections based on their documented methodology, assumptions and stated use. It examines underlying model methodology, identifies opportunities for further sensitivity testing of key demand and cost drivers to strengthen forecasts, and provides reasoned commentary on the reliability of projections, including key uncertainties and risks.

BI.15. In addition, Part C summarises the context, purpose and intended use of each model as presented in the source reports, including how the models are positioned within broader reform objectives and decision-making processes. This is intended to support appropriate interpretation of the modelling results prior to detailed methodological assessment.

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03

Understanding the market for non-family-based residential care in Queensland



Part A. Scope of Work & Purpose

Scope

Part A analyses the current structure of the residential care sector, including quantitative information on delivery volume and funding by provider type, region and cohort of delivery. This longitudinal analysis supports identification of changes in market composition. This report also sets out qualitative information on provider quality and performance, jurisdictional regulatory arrangements and alternative tertiary care providers.

In addition, Part A develops a theoretical basis underpinning demand and supply of residential care services. This includes a summary of the inelastic nature of residential care demand and drivers for the increase in demand, as well as labour and non-labour supply constraints and availability of services for key cohorts.

Finally, Part A sets out market interventions across the commissioning cycle to support quality improvements, based on interjurisdictional examples.

Purpose

Given the significant increases in residential care expenditure in recent years, Queensland is considering policy options to limit cost increases while maintaining standards of quality and safety for children and young people. Part A key findings support the identification of potential market interventions to shift patterns of demand from high-cost options, re-shape the mix of providers, and alleviate critical supply constraints.

Limitations

This review was undertaken without consulting providers. As a result, while patterns are identified in terms of net increases and decreases, there is limited data on the rationale for these changes. Additionally, the quantitative data provided does not support analysis of attribution or causality.

There was limited opportunity to validate categorisations and definitions with data owners. Noting the complexity of categorising service groupings and that particular services may cross multiple service types, analysis has aligned with Departmental-provided definitions of ‘residential care’ as compared to ‘family-based care’ and ‘other’ service types.

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Part A. Summary Findings

1. Over the last four financial years Queensland saw sustained cost increases for residential care, due to inelastic demand pressures and labour and non-labour supply constraints.

- From FY2021-22 to FY2024-25, expenditure grew overall and at a per-provider level for residential care. This reflected increased demand at three levels: firstly, for out-of-home-care, which is often associated with worsening social drivers; for residential care, which may be exacerbated by limited availability of family-based care alternatives; and for high-cost short-term residential care placements, which may be associated with limited forward planning to establish lower-cost placement options.
- Supply was also constrained due to increases in underlying labour, housing, electricity and utilities and insurance costs, resulting in cost increases being passed on to the Queensland government.

2. The provider market shifted in composition across the four years in scope of analysis.

- The market was dominated by a relatively small group of providers, with the top fifteen providers receiving half of the total residential care funding.
- Across FY2021-22 to FY2024-25, while the number of licensed providers remained stable, the number of unlicensed providers increased significantly, meaning that by FY2024-25 licensed providers comprised less than a quarter of total providers in the market.
- Between FY2021-22 and FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS contracts also became increasingly expensive compared to OSD contracts on a per-day basis between FY2021-22 and FY2024-25.
- For-profit participation in the market increased over the four years; by FY2024-25, over two-thirds of providers were for-profit. Not-for-profit providers continued to receive more funding at a per-provider level.

3. Supply conditions varied significantly across regions and cohorts.

- Provider numbers, funding levels and daily rates differed significantly by region, with uneven cost growth.
- Aboriginal and Torres Strait Islander Community Controlled Organisations formed a small proportion of the market (with under ten active providers per year from FY2021-22 to FY2024-25), though demand consistently grew over the same period.

4. There is limited visibility of available quality and performance data.

- Available contract and performance management information does not support a comprehensive assessment of provider quality across the residential care market.

5. Queensland could consider incorporating further policy and contractual mechanisms to shape the residential care market proactively, respond earlier where performance concerns arise, and ensure ongoing visibility, continuity and required standards of care.

- Ongoing reforms in Queensland, including a focus on robust demand forecasting and shifting procurement mechanisms, will provide a stronger basis to manage cost escalation while maintaining quality and safety standards.
- Queensland could also consider incorporating commissioning reforms seen in New South Wales and Victoria, spanning a spectrum of complexity from implementing more comprehensive performance frameworks for providers through to considering a greater direct role for government in service delivery.

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Part A. Key Findings

#	Finding	Ref
1	The number of providers delivering residential care in Queensland remained relatively stable from FY2021-22 to FY2024-25. The market was dominated by a relatively small group of providers, with the top fifteen providers receiving half of total residential care funding.	p. 18 and p. 19
2	Across FY2021-22 to FY2024-25, while the number of licensed providers remained stable, the number of unlicensed providers increased significantly, meaning that by FY2024-25 licensed providers comprised less than one quarter of total providers in the market.	p. 20
3	Between FY2021-22 and FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS contracts also became increasingly expensive compared to OSD contracts on a per-day basis between FY2021-22 and FY2024-25.	p.21
4	For-profit participation in the market increased over the four years; by FY2024-25, over two-thirds of providers were for-profit. Not-for-profit providers continued to receive more funding at a per-provider level.	p. 22 and p. 23
5	Provider numbers, funding levels and daily rates differed significantly by region, with uneven cost growth. The South East region saw the greatest fluctuation in the number of providers, while North Queensland saw the biggest increases in daily cost of residential care provision over FY2021-22 to FY2024-25.	p. 24
6	Aboriginal and Torres Strait Islander Community Controlled Organisations form a small proportion of the market (with under ten active providers from FY2021-22 to FY2024-25), despite an over-representation of Aboriginal and Torres Strait Islander children and young people in residential care.	p. 25
7	Available contract and performance management information does not support a comprehensive assessment of provider quality across the residential care market. Although there is scarce information on performance at a system level, our analysis in Part B of this report explored the nominated models of care and training requirements for a select cohort of providers.	p. 27
8	The regulatory system for residential care in Queensland is distributed across several agencies, compared to Victoria and New South Wales where functions and powers are vested in one entity per jurisdiction (the Social Services Regulator in Victoria and the Office of the Children's Guardian in New South Wales).	p. 28
9	Over the last few years, demand increased at three levels: firstly, for out-of-home-care, which may be linked to worsening social drivers; for residential care, which may be exacerbated by limited availability of family-based care alternatives; and for high-cost short-term residential care placements, which may be associated with limited forward planning to establish lower-cost placement options.	p. 33 to p. 37
10	Supply was also constrained due to increases in underlying labour, housing, electricity and utilities and insurance costs, resulting in cost increases being passed on to the Queensland government. Supply constraints were exacerbated in particular settings, including provision for First Nations children and young people and in regional and remote communities.	p. 39 to p. 41
11	Ongoing reforms in Queensland, including a focus on robust demand forecasting and shifting procurement mechanisms, will provide a stronger basis to manage cost escalation while maintaining quality and safety standards. Queensland could also consider incorporating reforms seen in New South Wales and Victoria, spanning a spectrum of complexity from implementing more comprehensive performance frameworks for providers through to considering a greater direct role for government in service delivery.	p. 43
12	A best practice commissioning model for residential care services would allow the Queensland Government to proactively plan for future demand for residential care placements through rigorous demand modelling, a deep understanding of the market and potentially new and alternative suppliers, a robust procurement process supported by monitoring, compliance and evaluation processes that measure performance, ensure high quality service provision and allow for continuous improvement over time.	p. 44

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3.1

Market Structure

Current State Overview

Residential care provider landscape and overall expenditure

A.1. Queensland's residential care market largely outsources its service delivery to non-government organisations. This structure means the Department of Families, Seniors, Disability Services and Child Safety (the Department) is the key buyer and system steward, while providers compete or are selected to deliver placements under contractual arrangements. The Department acts as a market steward to ensure continuity of supply and quality through commissioning settings, licensing and oversight mechanisms, rather than exercising direct operational control.

A.2. As shown in Figure A.1 below, in FY2024-25 there were 163 organisations receiving funding for delivery of residential care services in Queensland. This decreased from 169 organisations in FY2023-24, noting that overall funding provided to residential care providers increased in the same period. This indicated an increase in average funding per provider, as can be seen in Table A. A.1.

Figure A.1: Number of residential care providers and total residential care funding [1]

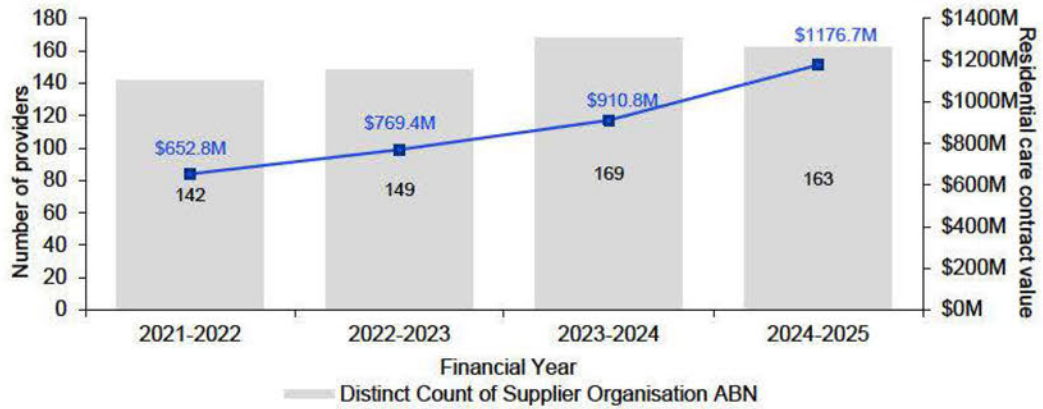


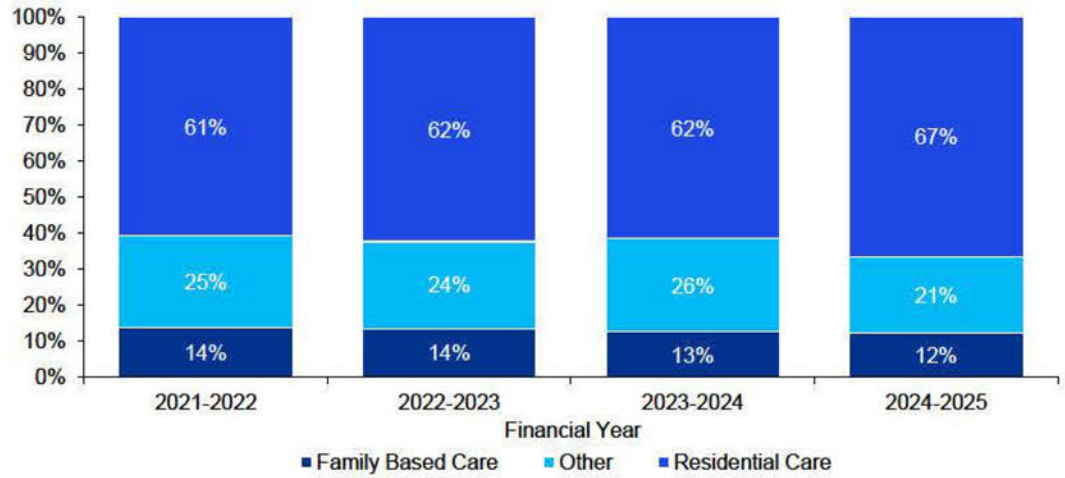
Table A.1: Average funding received per provider [1]

Financial Year	2021-2022	2022-2023	2023-2024	2024-2025
Average funding received per provider	$4.6M	$5.2M	$5.4M	$7.2M
Percent increase on previous year	N/A	12%	4%	34%

Residential care expenditure increase

A.3. Costs in Queensland residential care have increased rapidly and now represent a major fiscal pressure on the State. The FY2024-25 budget for residential care services overran by approximately $500 million [2], and the Queensland Family and Child Commission (QFCC) projected that out-of-home care (OOHC) costs could exceed $7 billion annually by 2030 without reform [3]. As shown in Figure A.2, residential care accounted for a growing majority of expenditure across Department-captured care types* between FY2021-22 and FY2024-25.

Figure A.2: Residential care funding as a proportion of expenditure across captured care types [1]*



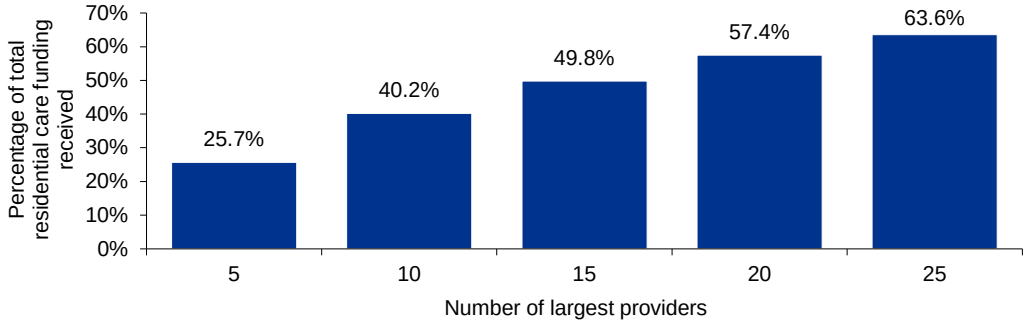
*Note that this was based on care types captured in Departmental-provided datasets, and on the Department's definition of residential care, family-based care and other services. The Department mapped residential care, family-based care and other services categories to investment areas including child protection – placement services, child protection – support services, direct payments, domestic and family violence services, families, family-based care, individual support, Making Decisions in Our Way (delegated authority support services), service system support and development, services for young people, and transition to adulthood services. This mapping may not be exhaustive and should not be interpreted as covering all OOHC categories.

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Provider breakdown: provider size

A.4. As can be seen in Figure A.3 below, in FY2024-25 five providers received 25.7% of total funding, while twenty providers received over half of total funding available. This meant that 143 providers received the remaining 42.6% of funding.

Figure A.3: Percentage of total residential care funding received by the largest providers FY2024-25 [1]



A.5. An overview of the top ten providers by funding amount in FY2024-25 is set out in Figure A.4, as well as total placement nights in Figure A.5. The two providers receiving the greatest amount of funding received more than $150m of funding between them. A summary of key characteristics of the top ten providers is set out in Table A.2.

Figure A.4: Top ten residential care providers by expenditure FY2024-25 [1]

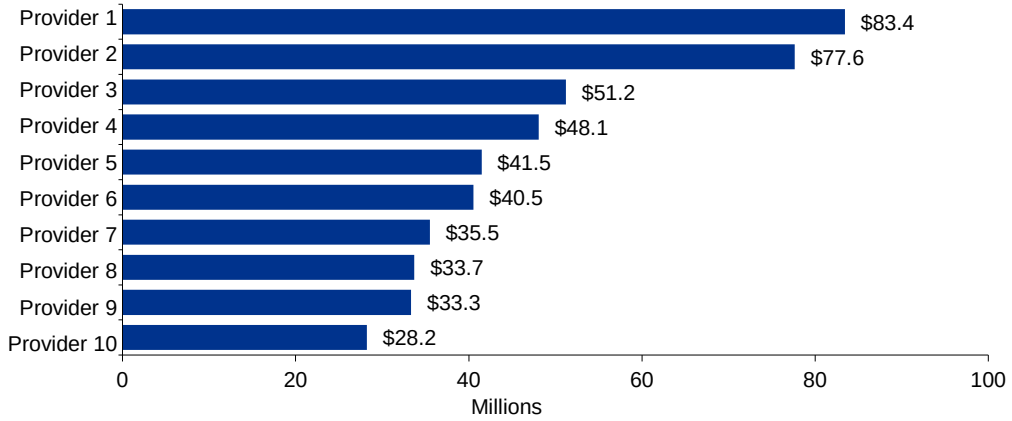


Figure A.5: Top ten residential care providers by total placement nights FY2024-25 [1]

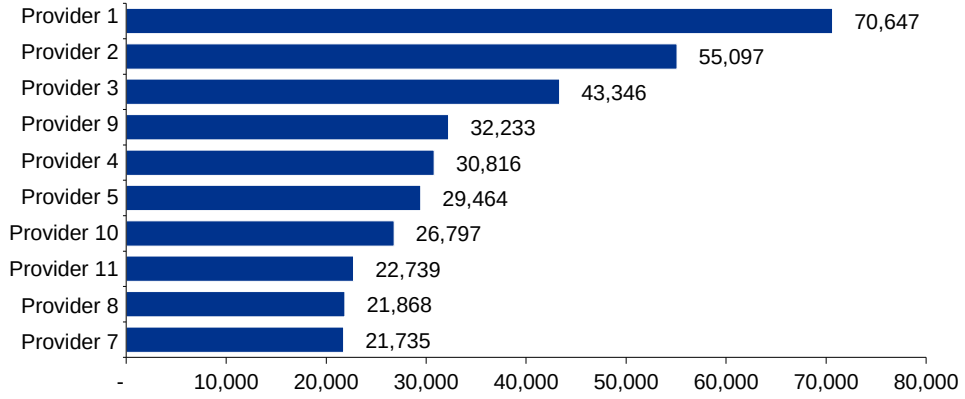


Table A.2: Summary of top ten residential care providers by expenditure FY2024-25 [1]

Supplier Organisation Name	FY2024-25 residential care contract value	Proportion of total FY2024-25 residential care contract value	ACNC Status	Licensed Status	Funding Stream
Provider 1	$83.4M	7.1%	No	Licensed	Dual Funded
Provider 2	$77.6M	6.6%	Yes	Licensed	Dual Funded
Provider 3	$51.2M	4.4%	Yes	Licensed	Dual Funded
Provider 4	$48.1M	4.1%	No	Licensed	Dual Funded
Provider 5	$41.5M	3.5%	Yes	Licensed	Dual Funded
Provider 6	$40.5M	3.5%	No	Licensed	Dual Funded
Provider 7	$35.5M	3.0%	Yes	Licensed	Dual Funded
Provider 8	$33.7M	2.9%	No	In scope	IPS only
Provider 9	$33.3M	2.8%	Yes	Licensed	Dual Funded
Provider 10	$28.2M	2.4%	Yes	Licensed	Dual Funded

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Provider breakdown: licensing status

A.6. Providers can be licensed or unlicensed. Licensed services are certified under the Human Services Quality Framework (HSQF) [4]. Unlicensed providers (often used for immediate or specialised placements) are regulated and monitored by the Department but not subject to certification assessment processes; some unlicensed providers may be in-scope for licensing and actively working towards certification [4].

A.7. Figures A.6 and A.7 show shows the relative numbers of licensed and unlicensed providers from FY2021-22 to FY2024-25. The number of licensed providers remained relatively stable across all four years, meaning that as the market grew, licensed providers came to occupy a decreasing share of total providers (from 27% in FY2021-22 to 23% in FY2024-25). The number of unlicensed providers increased significantly from FY2021-22 to FY2024-25 (104 to 125).

Figure A.6: Number of providers by licensing status [1]

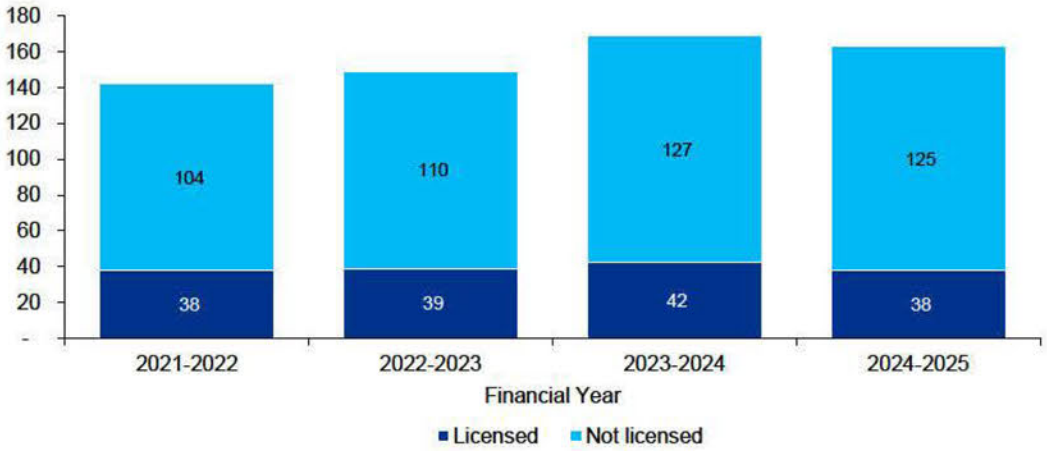
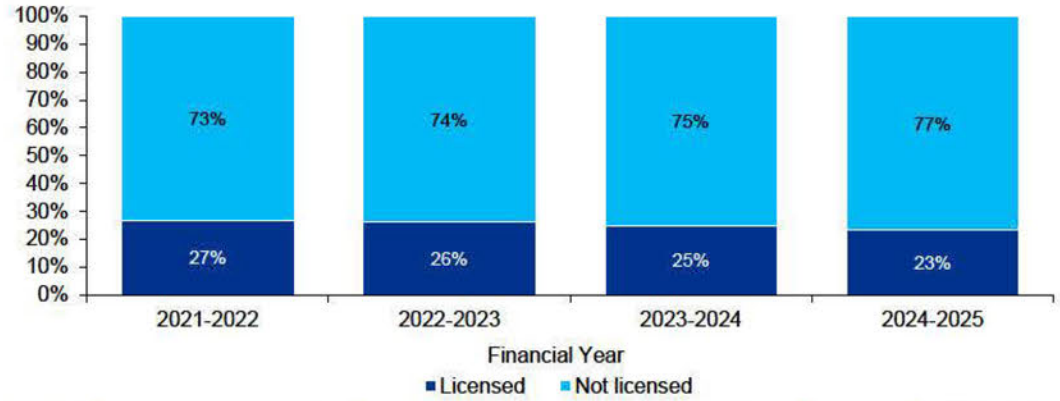


Figure A.7: Relative proportion of providers by licensing status [1]



A.8. While there were significantly more unlicensed than licensed providers from FY2021-22 to FY2024-25, most residential care funding flowed to licensed providers. In FY2024-25, more than half of total residential care funding went to licensed providers ($690.2m, out of a total pool of $1176.7m of funding to residential care).

Figure A.8: Total funding to providers by licensing status [1]



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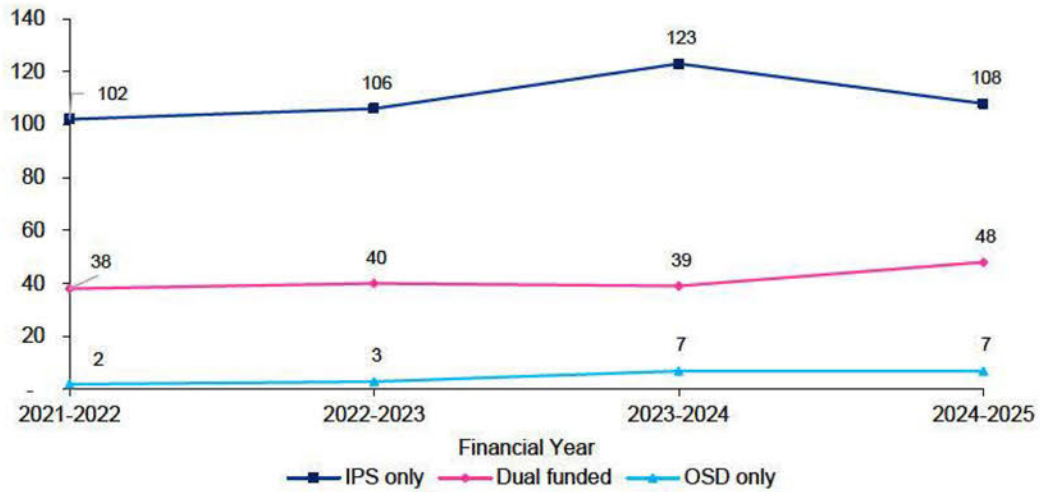
Provider breakdown: contract type

A.9. The residential care service provider market consists of a core layer of contracted providers and a secondary surge layer activated to fill capacity gaps: these are categorised as Outsourced Service Delivery (OSD) and Individualised Placement and Support (IPS) respectively.

Providers by the types of contract they deliver

A.10. OSD contracts are typically multi-year agreements under which licensed providers deliver defined residential care placements, providing the system's base of planned capacity. By comparison, IPS involves child-specific spot purchasing used where OSD beds are unavailable or where a child or young person's needs exceed existing capacity. IPS providers are not required to be licensed [3], can operate with less oversight than licensed OSD providers [5] and are also often more expensive. Providers can deliver both OSD and IPS contracts (categorised as 'dual-funded' providers). The number of providers that exclusively delivered IPS or OSD contracts as well as dual-funded providers is summarised in Figure A.9 below.

Figure A.9: Number of providers by types of contracts they deliver [1]



Key differences in contract types (volume procured and funding)

A.11. Table A.3 shows that between FY2021-22 to FY2024-25, IPS contracts formed a growing proportion of total placement nights and total funding compared to OSD contracts. IPS placement nights increased from 48% of total placement nights in FY2021-22 to 57% in FY2024-25; IPS funding increased from 61% of total funding in FY2021-22 to 66% in FY2024-25. Figure A.10 also reveals an increased cost gap between the two contract types. In FY2021-22 the median IPS contract was 28% more expensive per day than the median OSD contract; in FY2024-25 this difference rose to 39%.

Table A.3: Placement nights and total funding by IPS and OSD contract [1]

Contract type	Measure	Financial Year			
		2021-2022	2022-2023	2023-2024	2024-2025
IPS	Number of placement nights	306,585	331,637	378,526	473,331
	Total funding	$401.3M	$492.7M	$599.1M	$774.4M
OSD	Number of placement nights	326,419	337,626	400,530	354,064
	Total funding	$251.5M	$276.7M	$311.7M	$402.3M
Total	**Number of placement nights**	**633,004**	**669,263**	**779,056**	**827,395**
	Total funding	**$652.8M**	**$769.4M**	**$910.8M**	**$1176.7M**

Figure A.10: Median of daily cost by contract type [1]



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Provider breakdown: for-profit and not-for-profit status (continued overleaf)

A.12. In Queensland, residential care is delivered by a mix of long-established not-for-profit charitable agencies as well as a growing number of for-profit companies. For-profit providers are defined as any organisation not registered as a charity with the Australian Charities and Not-for-profits Commission (ACNC). As can be seen in Figure A.11, the number of for-profit providers increased significantly (by almost 40%) from FY2021-22 to FY2023-24, with a small decrease in FY2024-25. In contrast, the number of not-for-profit providers consistently decreased (at lower magnitude) every year. In FY2024-25, for-profit providers accounted for 70% of total providers while not-for-profit providers accounted for 30%, shown in Figure A.12.

Figure A.11: Number of providers that are for-profit and not-for-profit [1]

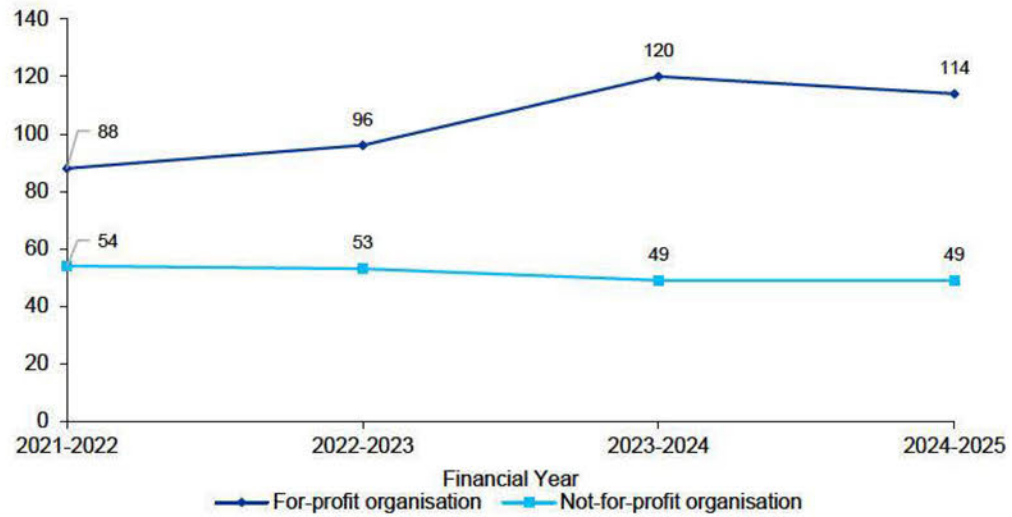
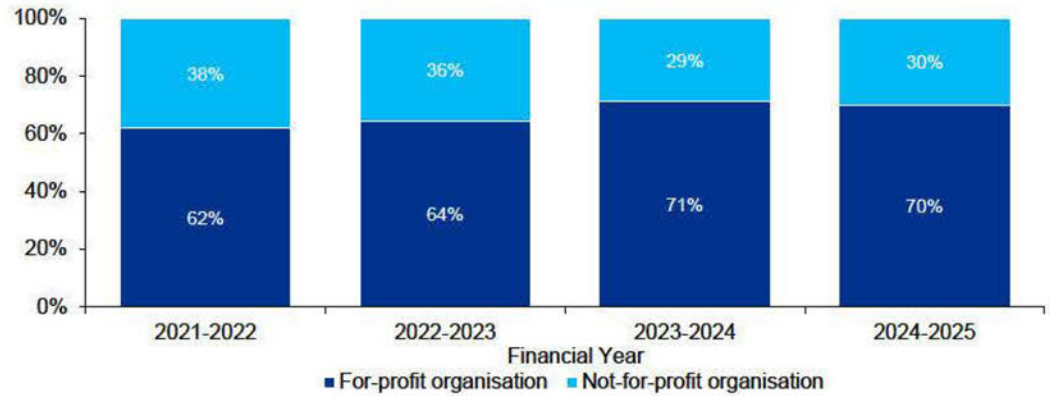


Figure A.12: Relative proportion of providers that are for-profit and not-for-profit [1]



Key examples of not-for-profit provider market exits

A.13. In June 2023, Churches of Christ – one of Queensland's major not-for-profit care providers – made a high-profile exit from youth residential care, supported independent living (SIL), and family support services. The Kenmore based organisation described its withdrawal as a "commercially necessary" decision [6].

A.14. In June 2024, Mercy Community Services, a significant not-for-profit provider operating across South East Queensland, South West Queensland, and the Brisbane and Moreton Bay regions, formally withdrew from residential care, foster and kinship care, and SIL. The withdrawal followed the discovery of a substantial wage underpayment liability, which rendered continued service delivery financially unviable [7] [8]. At the time of exit, Mercy was providing support to 863 children and young people. The Queensland government managed the transition of all affected children: 787 children in family-based care transitioned with their carers to other providers; 44 children in residential care and eight young people in SIL transitioned to new service providers; nine children were reunified with their families; and 85 children and young people were transitioned to First Nations service providers [7].

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Provider breakdown: for-profit and not-for-profit status (continued)

A.15. By proportion, Figure A.13 shows that not-for-profit organisations received nearly half of total funding despite only comprising one-third of total providers in FY2024-25. At a per-provider level, the average not-for-profit provider received around double the funding of the average for-profit provider from FY2021-22 to FY2024-25, as can be seen in Table A.4.

Figure A.13: Relative proportion of total funding by providers that are for-profit and not-for-profit [1]



Table A.4: Average funding received for-profit and not-for-profit provider [1]

Average funding per provider	Financial Year			
	2021-22	2022-23	2023-24	2024-25
For-profit organisation	$3.3M	$4.0M	$4.0M	$5.9M
Not-for-profit organisation	$6.7M	$7.2M	$8.8M	$10.3M

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Provider breakdown: by region

A.16. The number of providers per region was relatively stable for Brisbane and Moreton Bay, Far North Queensland and South West Regions between FY2021-22 and FY2024-25. In contrast, the number of providers in North Queensland, Sunshine and Central Coast, and South East Regions fluctuated across the four-year period, as shown in Table A.5.

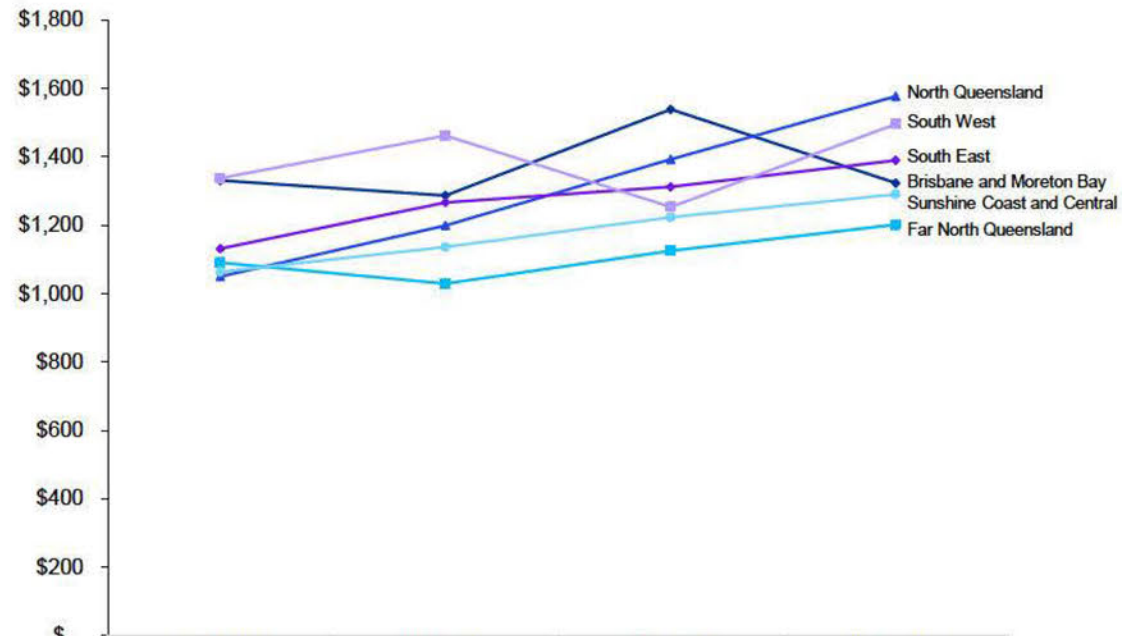
Table A.5: Count of providers and total funding per region [1]

Region	Measure	Financial Year			
		2021-2022	2022-2023	2023-2024	2024-2025
Brisbane and Moreton Bay	Number of providers	49	48	44	**46**
	Total funding	$123.8M	$154.9M	$184.3M	$196.0M
Far North Queensland	Number of providers	29	27	26	**31**
	Total funding	$79.4M	$79.5M	$95.1M	$117.6M
North Queensland	Number of providers	39	43	47	**46**
	Total funding	$59.5M	$87.3M	$138.6M	$243.7M
Sunshine and Central Coast	Number of providers	42	49	59	**54**
	Total funding	$103.4M	$103.8M	$108.0M	$116.5M
South East	Number of providers	36	36	50	**40**
	Total funding	$149.9M	$163.8M	$180.3M	$232.7M
South West	Number of providers	54	58	52	**48**
	Total funding	$136.8M	$180.1M	$204.5M	$270.1M
State-Wide*	Number of providers	0	1	0	0
	Total funding	-	-	-	-
Total	Number of providers^	142	149	169	**163**
	Total funding	**$652.8M**	**$769.4M**	**$910.8M**	**$1176.7M**

*There was one provider tagged as state-wide in FY2022-23 (Churches of Christ in Queensland), which may be a data error.
^Note that as providers operate in more than one region, the sum of providers per region is higher than the total number of distinct providers in the state.

A.17. Median daily costs for residential care differed significantly by region, as demonstrated in Figure A.14 below. North Queensland saw the highest cost escalation, moving from the lowest median daily cost in FY2021-22 to the most expensive by FY2024-25. The median daily cost rose from $1,050 per day in FY2021-22 to $1,577 in FY2024-25, a 50% increase.

Figure A.14: Median of daily cost by region [1]



	2021-2022	2022-2023	2023-2024	2024-2025
BMB	$1,332	$1,287	$1,539	$1,324
FNQ	$1,091	$1,029	$1,125	$1,202
NQ	$1,050	$1,199	$1,393	$1,577
SCC	$1,064	$1,137	$1,223	$1,291
SE	$1,132	$1,266	$1,312	$1,390
SW	$1,338	$1,462	$1,253	$1,496

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Provider breakdown: Aboriginal-led provision

A.18. There were six Aboriginal and Torres Strait Islander Community-Controlled Organisations (ATSICCOs) operating in the residential care market in Queensland in FY2024-25, forming a small portion of total providers (shown in Table A.6 below). Note that there were other providers recorded as Indigenous-led organisations without full ATSICCO status.

Table A.6: Number of providers by ATSICCO status [1]

ATSICCO Status	Financial Year			
	2021-2022	2022-2023	2023-2024	2024-2025
ATSICCO	5	7	8	6
Other	137	142	161	157
Total	142	149	169	163

A.19. In total, there were 15,503 placement nights available in ATSICCO-delivered residential care in FY2024-25. This was a significant increase from FY2021-22, as evidenced in Table A.7 below, meaning that the ATSICCOs in the market rapidly expanded capacity over the four years. However, given that there were 1,298 children and young people of Aboriginal and Torres Strait Islander descent* in residential care over FY2024-25 in Queensland [1], supply remained below demand.

Table A.7: Number of placement nights delivered by ATSICCOs [1]

ATSICCO Status	Financial Year			
	2021-2022	2022-2023	2023-2024	2024-2025
ATSICCO	3,265	7,506	14,187	15,503
Other	629,739	661,757	764,869	811,892
Total	**633,004**	**669,263**	**779,056**	**827,395**

*Note that this was based on care types captured in Departmental-provided datasets, and on the Department's definition of residential care, family-based care and other services. The count of individual children was calculated using the number of unique ICMS IDs during the period.

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Market stability

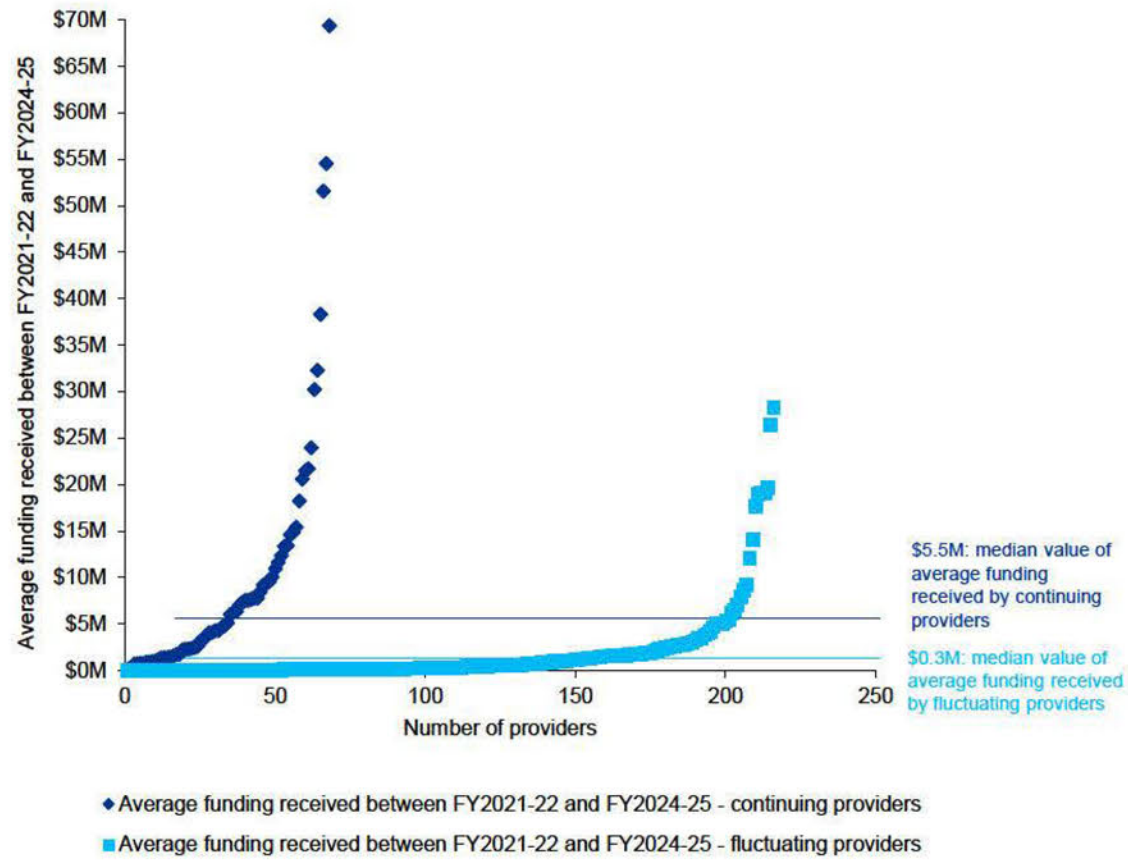
A.20. Available data does not allow inference as to the motivation of providers' entry or exit, nor whether decisions to commence or discontinue service delivery were at the discretion of the provider or the Department.* However, it is possible to analyse fluctuations in funding amount and average amount funded to test the stability of the market at a high level.

A.21. Across FY2021-22 to FY2024-25, providers that received a mixture of zero and non-zero funding across the four years were tagged as 'fluctuating', whereas providers that received non-zero funding across all four financial years were tagged as 'continuing'^. This analysis included providers that received OSD funding, IPS funding and/or both (i.e. dual funded).

A.22. Of the 284 providers that received any funding between FY2021-22 and FY2024-25, 216 fell into the 'fluctuating' category compared to 68 in the 'continuing' category. This indicated that more than 75% of residential care providers received zero funding for at least one year between FY2021-22 and FY2024-25. Around half of 'continuing' providers were initially tagged as 'OSD only' or 'dual funded' and around half were tagged as 'IPS only', noting that this categorisation may have shifted over the four years.

A.23. As can be seen in Figure A.15, average funding amounts for 'fluctuating' providers tended to be much lower than for 'continuing providers', indicating that larger providers (based on funding amount only) had a more stable market presence. The median of the four-year average funding amount was $0.3m for 'fluctuating' providers, compared to $5.5m for 'continuing' providers.

Figure A.15: Distribution of average funding received per provider between FY2021-22 and FY2024-25, grouped by 'continuing' or 'fluctuating' providers [1]



*While available data does show total funding amounts by provider, this does not allow reliable inference as entry or exit. For example:

- A provider may be inactive and receive no funding for several financial years before receiving funding again, or vice versa. If the quantitative dataset does not cover a large enough timeframe, this provider may erroneously be tagged as having entered or exited the market. Qualitative consultation is required to understand and validate provider intentions.
- Alternative quantitative datasets may have other limitations (e.g. date of ABN registration may not reflect true 'market entry' date, and providers may have registered initially to provide other types of care).

^For example, a hypothetical 'fluctuating' provider received $0.5m of funding in FY2021-22, no funding in FY2022-23, $0.7m in FY2023-24 and no funding in FY2024-25. A 'continuing' provider received funding for all financial years in scope.

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Quality and performance

A.24. The level of service quality being delivered to children and young people by residential care providers in Queensland is difficult to quantify. The Queensland Care Services Outcomes Framework [10] identifies child/young person, supplier and organisational outcomes under five overarching domains: Safe & Nurtured; Connected; Achieving; Healthy; and, Resilient. The Department measures the effectiveness of OSD providers through Service Agreements with measures generally relating to throughput, volume and costs with less focus on quality of service delivery. The Department, according to the Individual Support Supplier Guidelines DOC, monitor and regularly review Child Safety's expectations towards achieving these outcomes [9].

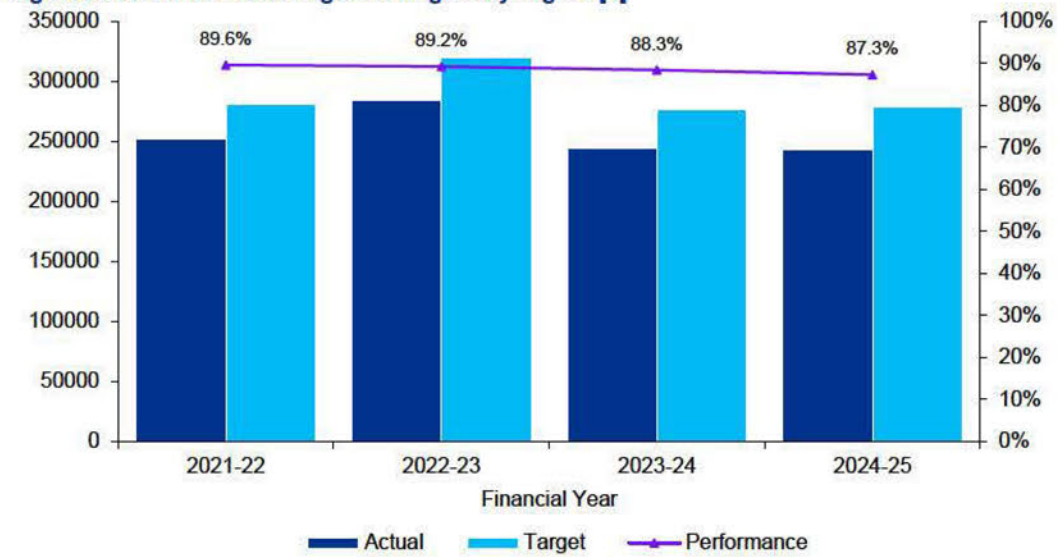
A.25. While the Commission sought information and records regarding the performance of providers of non-family based residential care, limited data was returned by the Department. The Child Protection Investment Specification describes the requirements for OSD-funded service providers, including performance expectations and measures to target investment and achieve intended outcomes. The lack of available data limits the ability to assess provider performance in upholding responsibilities to provide safe and supportive environments for young people to live.

A.26. Licenced providers are required to attain and maintain Human Services Quality Framework (HSQF) certification against the Human Services Quality Standards (that is, Governance and Management; Service Access; Responding to Individual Need; Safety Wellbeing and Rights; Feedback, Complaints and Appeals; and, Human Resources). Providers must go through a three-year certification cycle with an independent quality assessor which includes certification, maintenance and recertification audits. A review of a sample of 58 HQSS audit reports from 43 providers supplied by the Department showed that 32 (55%) achieved unconditional certification and 26 (45%) achieved certification with a condition that non-conformities are determined to be conforming within the required timeframe. At least six audit reports yielded overall outcomes of major non-conformity. HQSS assessments can cover a number of service types and are not restricted to residential care with many providers delivering services across the human and social services.

A.27. The Department received 76 complaints about residential care service providers between July 2021 and February 2026. Nine (11.8%) of these complaints were substantiated (or had components that were substantiated). Substantiated complaints related to standards of care and safety for young people and impact on neighbours. For an additional 14 complaints, further action was recommended including staff practice learnings.

A.28. Performance is recorded for OSD providers in relation to their progress towards target nights. Between FY2021-22 and FY2024-25, OSD providers combined to provide 1,023,280 residential care nights which was 88.6% of the total target for this period (1,154,714 nights) – see Figure A.16. Performance towards targets was relatively consistent across each region and in each year, with the greatest variability observed in North Queensland region which had an overall achievement of 84.7% which ranged from 78.9% in 2024-25 to 91.1% in 2021-22. This data relates to throughput information and does not reflect quality of service delivery.

Figure A.16: Performance against targets by region [1]



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Queensland and interjurisdictional approaches to residential care services regulation

A.29. It is critical to understand Queensland's approach to residential care services regulation to contextualise market dynamics and understand enablers of entry/exit. A description of the Queensland sector regulators, provider registration agencies and worker screening agencies is set out below, as well as information for Victoria and New South Wales.

Table A.8: Queensland and interjurisdictional approaches to residential care regulation

Dimension	Queensland	Victoria	NSW
Overview	Regulation is distributed across multiple agencies in Queensland. This arrangement may require more complex coordination to maintain end-to-end oversight, risk identification and intervention.	Victoria has implemented reforms towards regulatory consolidation and independence. The Social Services Regulator (SSR), established in July 2024, consolidates worker screening, reportable conduct, and provider registration under one entity.	Similarly to Victoria, New South Wales consolidates regulatory functions within one entity, the Office of the Children's Guardian.
Sector Regulator	The Queensland Family and Child Commission has powers to monitor and report on the Child Safe Organisations system under the Child Safe Organisations Act 2024. The Department of Families, Seniors, Disability Services and Child Safety is responsible for child protection and investigating concerns of harm, including issues that occur at residential care services [12].	The Social Services Regulator is an integrated sector regulator that regulates the Social Services Standards and the Child Safe Standards across a range of settings, including out-of-home-care, disability, family violence, homelessness and secure welfare services. The Social Services Regulator is an independent statutory authority and reports directly to the Minister for Children; Minister for Disability [11].	The Office of the Children's Guardian oversees regulation of the Reportable Conduct Scheme and Child Safe Scheme and leads accreditation and child-safe practices in statutory out-of-home care, children's employment, and other child-related organisations. The Office of the Children's Guardian is a statutory government agency with powers and functions defined in its own Act, reporting to the Parliament and the Minister for Families and Communities; Minister for Disability Services [13].
Provider Registration	The Department of Families, Seniors, Disability Services and Child Safety oversees registration of residential care providers. Note that following registration, providers can be licensed or remain unlicensed [14].	The Social Services Regulator oversees registration for all social service providers in Victoria, including residential care providers. Providers must meet the six Social Services Standards, Child Safe Standards, and any custom requirements determined at registration [15].	The Office of the Children's Guardian oversees registration for all residential care providers [16].
Worker Screening	Blue Card Services within the Department of Justice leads worker screening and associated compliance and enforcement activities (including maintaining worker registers and issuing penalties, suspensions and revocations) [17].	The Social Services Regulator maintains responsibility for all elements of the Working with Children Check scheme, the Worker and Carer Exclusion Scheme, Reportable Conduct Scheme and the NDIS Check [18].	The Office of the Children's Guardian oversees the Working with Children Check scheme, with the support of Service New South Wales [19].

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Availability of alternative providers

A.30. Market dynamics are shaped by the availability of alternative tertiary care providers that could provide appropriate services for children and young people. A summary of relevant alternative family-based care options is set out below, including descriptions, comparative strengths, risks, and relative cost.

Table A.9: Availability of alternative providers

Care option	Category	Definition	Strengths	Weaknesses	Evidence & stability	Relative cost
Standard residential care (focus of this report)	Non-family-based	Placement in a residential building with paid rostered staff, whose purpose is to provide placements for children. In Queensland, designated for young people over 12. Guided by the Hope and Healing Framework, which identifies needs for physical, emotional and cultural safety, nurturance, development and healing from trauma [25].	Provides 24/7 staffed care for young people with complex needs who cannot be safely placed in family-based settings. Can accommodate young people with histories of violence or absconding. Does not require individual carer recruitment, enabling faster placement responses.	Evidence consistently shows poorer outcomes vs family-based care. Queensland residential care population grew from 11.0% to 18.2% of all OOHC placements in 2024 [20]. Peer contagion effects in congregate settings [30]. High staff turnover and casualisation undermine relational continuity [21].	Lower stability than kinship-based care [27].	High
Kinship care	Family-based	Placement with a family member or person with a pre-existing relationship to the child (e.g. grandparent, aunt, neighbour). The Queensland Child Safety Practice Manual (CSPM) distinguishes "kin" (relatives) from "kith" (community members). Provisional approval available for urgent placements [24].	Maintains family and cultural connections, consistent with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) [31]. Children in kinship care experience fewer behavioural problems and fewer mental health disorders than those in non-related foster care [26].	Carers may receive less training and financial support than foster carers. Pre-existing family dynamics, including intergenerational trauma, may complicate the caregiving relationship. Kinship carers are disproportionately older and may face health and housing constraints.	Highest stability. "Placement in kinship care reduces the risk of a placement move and increases placement stability, especially for older children" [27].	Lowest
Foster care	Family-based	Placement in the private home of an assessed and approved carer receiving payment from the state. Carer assessment includes criminal history, domestic and family violence (DFV), child protection checks, Blue Card, pre-service training, and face-to-face interviews [24]. May be short-term (up to two years) or long-term (to 18+).	Normalised family environment supporting attachment and recovery. Treatment foster care is "a promising intervention for young people with behaviour problems, associated with decreases in antisocial behaviour and time in locked settings [28]. Assessment framework ensures baseline quality [24].	Declining carer supply: only 8,000 foster carer households nationally at 30 June 2024, half the kinship pool [23]. Challenging behaviour is linked to placement breakdown and carer intention to cease fostering; carers frequently report feeling unprepared and receiving insufficient support [29].	Lower stability than kinship-based care [27]. Promising evidence base for treatment foster care, though "less robust than that usually reported" [28].	Low
Family group homes	Family-based	"Homes for children provided by a department or community-sector agency which have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care" [33]. Sits at the intersection of family-based and residential care.	Family-like environment with consistency of live-in carers. Smaller group size reduces institutional dynamics [22]. Suitable for sibling groups who cannot be placed together in a single foster or kinship household [32].	Very limited availability in most jurisdictions. Capital-intensive (tends to require government-owned property and dedicated live-in staff). Live-in carer recruitment is challenging. Limited contemporary Australian evidence on outcomes [22].	Moderate stability - Limited evidence base.	Moderate

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Availability of alternative providers (continued)

A.31. There are additional tertiary care options that are suitable for particular sub-sets of children and young people, including Indigenous children and young people, children and young people with disabilities, and children and young people with other specific needs.

Table A.10: Availability of alternative providers (continued)

Care option	Category	Definition	Strengths	Weaknesses	Evidence & stability	Relative cost
Therapeutic residential care (TRC)	Non-family-based	Time-limited (12 to 18 months) placement that "prioritises young people with complex to extreme needs who are unable to be placed in foster or kinship care" [24]. Staffed by care practitioners with enhanced intervention skills using trauma-informed models. Multi-agency network approach (Health, Education, Police) [24]. For young people aged over 12 [24].	Explicitly designed for trauma healing. "Emerging consensus about the effective elements... including: shared understanding of young people's needs; therapeutic input tailored to needs; best possible connection to family and culture; and prioritising relationship-based work" [34]. Mandated minimum qualifications for staff [35].	Time-limited design creates transition pressure if step-down placements are unavailable. Significantly more expensive than standard residential care. Much of what occurs within TRC services remains a "black box" - processes and activities are not transparent or well understood [34]. Limited availability relative to demand.	Time-limited by design. Emerging evidence. "A relatively recent development in out-of-home care service provision" [34].	Very high
Supported independent living (SIL)	Non-family-based	Residential setting for a small number of young people aged 15+, where "workers generally do not live in the house but provide external support through regular visiting" [24]. Focuses on developing life skills for transition to adulthood [24].	Develops practical independence (budgeting, cooking, self-care) in a less restrictive environment. Step-down pathway from residential care. Lower cost than standard or therapeutic residential care due to reduced staffing intensity.	A Cochrane review found no evidence from randomised controlled trials (RCTs) on the effectiveness of independent living programmes [36]. Requires self-regulation and maturity that may not be present in young people with complex trauma. Risk of social isolation. Limited safety net for crisis escalation.	Variable stability. No randomised controlled trial evidence; non-randomised studies show "generally favourable results" but with "weak methodology" [36].	Moderate
Indigenous community residential care (safe houses)	Non-family-based	"Residential services specifically designed to meet the particular needs of Aboriginal and Torres Strait Islander children" located "in Aboriginal and Torres Strait Islander communities, to enable children to safely remain in, or return to, their communities of origin" [24].	Enables children to remain connected to Country, community, culture, and language, consistent with the ATSICPP [31]. Community-controlled governance supports self-determination. Addresses over-representation of First Nations children [37].	Limited to specific geographic communities, restricting availability for urban/peri-urban First Nations children. Workforce challenges in remote communities (recruitment, retention, clinical access). Funding and infrastructure constraints in remote locations.	Moderate stability. Limited evidence base [38].	High
Other entity placements	Non-family-based	Under s82(1)(f) Child Protection Act 1999 (Qld) [39], other entities may provide care including unlicensed non-family-based providers, mental health facilities, disability services, and interstate providers. The CSPM notes these placements "are not monitored via a licencing arrangement or a carer approval process" [24].	Legal mechanism for specialist placements (e.g. mental health inpatient, disability respite) outside standard OOHC categories. Flexibility to respond to individual needs. Can facilitate interstate placements for highly specialised needs.	Explicitly lacks regulatory safeguards of licensed care [24] [39]. Growth of unlicensed providers in Queensland raises quality and safety concerns. Monitoring burden falls on individual child safety officers rather than systemic oversight.	Unknown stability. No evidence base.	Variable

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Part 3.2

Market Dynamics

Demand factors

Overview: Demand in the residential care market

A.32. Demand for residential care services is inelastic: once a child reaches the established need threshold, the Queensland Government must procure care within a set time-frame regardless of price. Purchasing decisions are often constrained to immediate vacancies, irrespective of the alignment between the provider's model of care and the child's needs [3].

Inelastic demand is common across the human and social services sector. Examples include:

- Emergency health and ambulance services: Patients seek care based on their medical needs rather than competitive pricing or assessment of alternative options. Increasing unit costs does not reduce demand for services; rather, it contributes to higher system spending.
- Disability supports: National Disability Insurance Scheme (NDIS) participants with severe or profound disability access NDIS supports out of necessity rather than preference, and as such, demand is minimally responsive to price changes. Participants cannot 'shop around' for core services. Efforts to constrain prices have had unintended consequences of spurring provider exits, without reducing demand for services [40].
- Residential aged care: As there are limited suitable alternatives and services are linked to statutory obligations and clinical needs, demand for residential aged care is also inelastic. Attempts to regulate prices can result in cost shifting to other parts of the system [41].

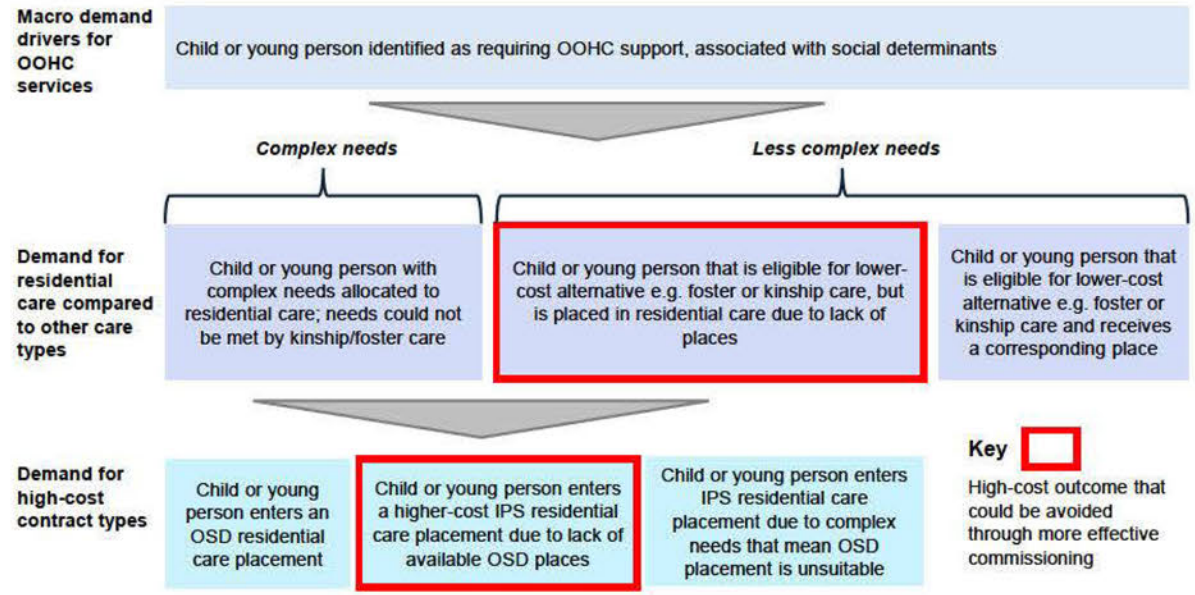
In the context of inelastic demand, there is limited flexibility for government to reduce the volume or change the mix of residential care services it procures, even in the face of price increases.

A.33. At the same time, underlying demand for residential care services has increased over the last decade. Changes in demand can be defined across three layers.

1. **Macro demand for OOHC services:** Social drivers such as domestic and family violence, homelessness, poverty and poor mental health, coupled with limited early intervention supports, may be associated with more children and young people requiring OOHC over the last decade.
2. **Demand for residential care compared to other care types:** Within OOHC, some children or young people have specific higher-threshold needs that can only be met by residential care. In other cases, a child or young person may be suitable for foster care or kinship care, but due to the limited availability of these supports, be placed in residential care. This cycle may drive greater demand for residential care services.
3. **Demand for high-cost contract types:** Within residential care, a child or young person may enter an IPS placement (short-term provider contract at high cost) or an OSD placement (provider with a longer-term contract, with greater quality and safety oversight mechanisms). Government has increased its reliance on IPS contracts as a flexible surge mechanism [3].

These three demand layers are set out in Figure A.17 below.

Figure A.17: Layers of demand drivers



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Macro demand for OOHC services

A.34. The number of children and young people requiring child protection services, including OOHC services, increased over the past decade in Queensland. Per 1,000 children aged 0-17 years, between 2015-16 to 2023-24, the number of notifications increased from 17.6 to 29.2; the number of substantiations increased from 5.0 to 5.8; and the number of care and protection orders increased from 8.4 to 10.9, as seen in Figure A.18. All three measures showed a consistent upwards trend throughout the decade. While national rates of OOHC declined over FY2019-20 to FY2023-24, in Queensland they trended upwards and surpassed the national average each year since 2021-22, as shown in Figure A.19.

Figure A.18: Notifications, substantiations and care and protection orders per 1,000 children aged 0-17 years [20]

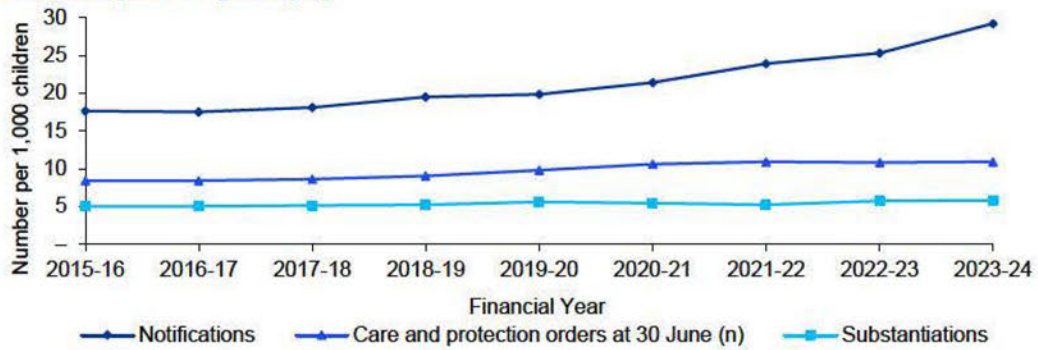
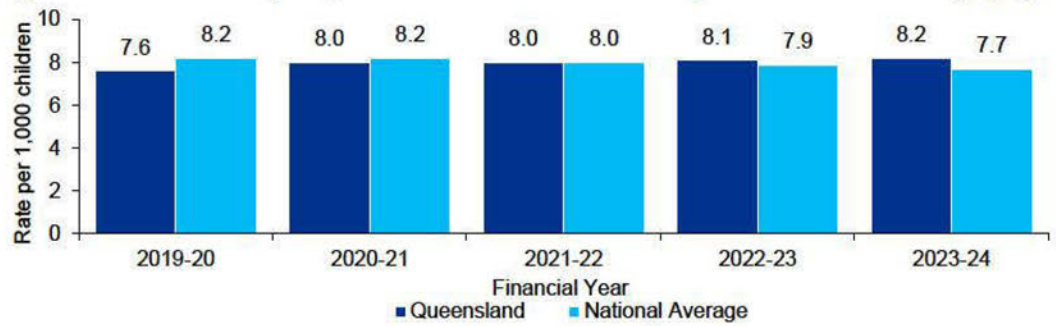


Figure A.19: OOHC rate per 1,000 children - Queensland compared to national average [20]



A.35. In its Buyer Beware report, the QFCC noted two key factors driving increased demand for OOHC services:

1. Increasingly complex and interdependent needs: The increasing number of children entering the child protection system may be linked with worsening social drivers such as domestic and family violence, homelessness, poverty, unemployment, drug and alcohol issues, and poor mental health [3].
2. Limited investment in early intervention: Investment in early intervention is comparatively low and delays in investigations can push the system toward reactive crisis management (including entry to residential care) rather than proactive support [3].

Increasingly complex and interdependent needs

A.36. The QFCC's *2024-25 Annual report* noted that children and young people increasingly face overlapping and complex life challenges. In 2024, half of the surveyed cohort of children and young people in OOHC had limited relationships or significant relationship problems with family, an increase of almost 10% from 2023; 31% had limited to severely limited intellectual functioning or developmental delay; 20% of respondents had a diagnosed or suspected mental illness; and 28% had extreme instability and/or extreme emotional responses that limit functioning [44].

A.37. As at June 2024, 634 children under 12 years of age were living in residential care, with 46 children under the age of five years [45]. There is evidence that more children are entering than exiting care, indicating that children may be remaining in care for longer durations [42].

Limited investment in early intervention

A.38. Early intervention programs reduce the incidence of children and young people entering the OOHC system and improve ongoing wellbeing. In Queensland, key early intervention programs include Intensive Family Support services and Aboriginal and Torres Strait Islander Family Wellbeing services [43]. Queensland Government also manages a holistic system of programs focussed on domestic and family violence, interactions with the justice system, homelessness, poverty, disability, mental health challenges, substance use, and education disengagement [44].

A.39. However, investment in early intervention remains low compared to other jurisdictions. In FY2021-22, Queensland invested the least in intensive family support services of any jurisdiction except Western Australia and Tasmania [43]. A QFCC annual report found that in FY2023-24 the average investment in intensive family support was $9,667 per child, below the national average of $11,403 [44].

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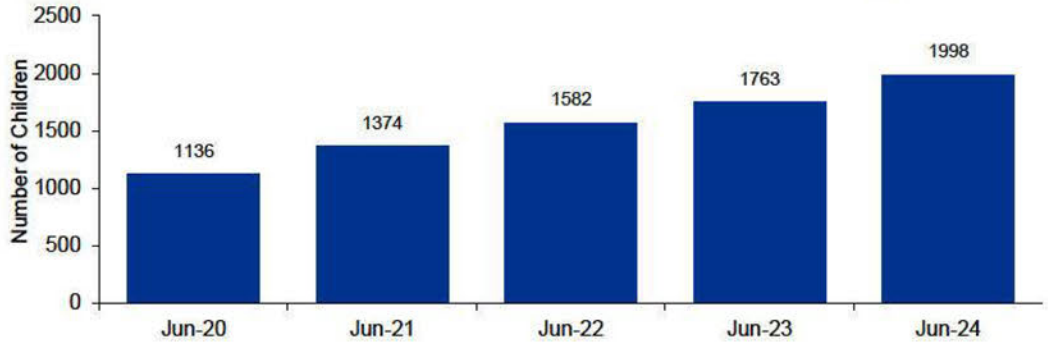
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Demand for residential care compared to other care types (continued overleaf)

A.40. Once it is determined that a child or young person requires out-of-home care, there are a range of family and non-family based care options available. Standard residential care is suitable for children and young people with more complex needs that may not be met by kinship and foster care [47]. However, a portion of children with less complex needs that are suitable for foster and kinship care are unable to access these places due to limited availability, resulting in rapid growth in residential care placements [42]. While there was a 12% increase in approved FBC families between FY2019-20 and FY2023-24, this was outpaced by demand growth (refer to Figures A.20 and A.21 below). Residential care is significantly more expensive than foster and kinship care, costing the Queensland government around $500,000 per child per year, compared to $50,000 for foster care and $20,000 for kinship care [50].

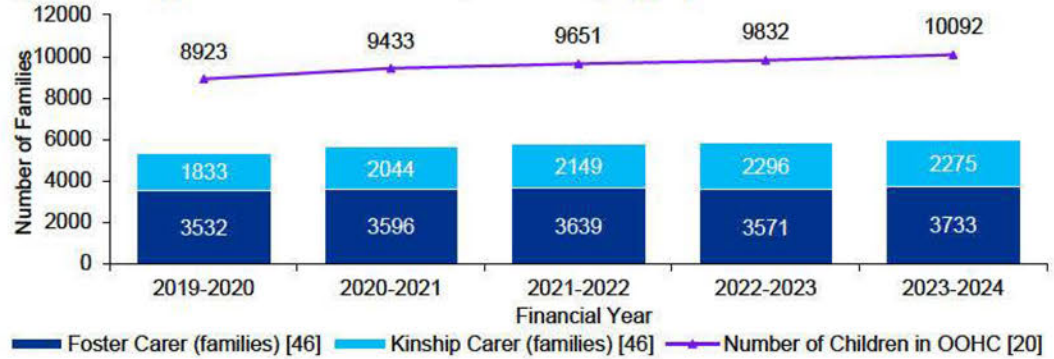
Figure A.20: Children in residential care at the reference date in Queensland [49]



2,388
Individual children in residential care (as of the 18th of February 2026) [48]

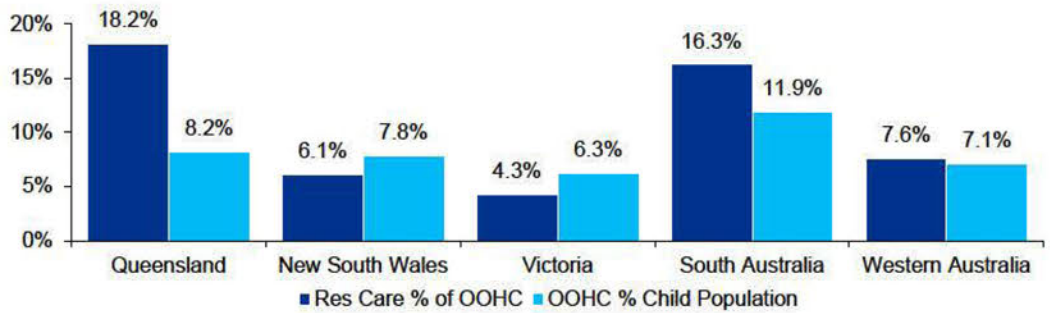
14.2%
Compound annual growth rate (period from June 2020 to February 2026) [48] [49]

Figure A.21: Approved carer families in Queensland [20], [46]



A.41. Queensland has higher rates of residential care placements than other jurisdictions. 2023 data showed despite only having 21% of the nation's children in care, Queensland had 40% of Australia's residential care placements, signalling disproportionate entry into residential care compared to alternative care types [3]. Based on 2024 data (shown in Figure A.22 below), almost one in five Queensland children in OOHC were in residential care, which was the highest proportion in the country. By comparison, New South Wales and Victoria had 6.1% and 4.3% of children in OOHC in residential care respectively.

Figure A.22: Residential care proportion of OOHC and OOHC rate by state jurisdiction in 2024 [20]



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Demand for residential care compared to other care types (continued)

A.42. The Queensland Government's ambition to decrease expenditure in residential care is challenging given emerging shifts towards greater incorporation of therapeutic supports within residential care, which generally constitute a more expensive care type [51].

A.43. The Australian Institute of Family Studies states that there is growing consensus about the effectiveness of therapeutic residential care integrated into standard residential care arrangements [34]. Benefits include greater understanding of young people's needs, more tailored placement and therapeutic inputs, and strengthened connection to family and culture.

A.44. Other Australian jurisdictions are increasingly adopting therapeutic residential care [34]. For example, Victoria has committed to enabling access to therapeutic supports for all young people in residential care by FY2025-26 through several mechanisms [52]:

- Funding growth: From 1 January 2024, around 75% of base four-bed residential care homes that did not already have a therapeutic loading attached received additional funding for therapeutic supports [52];
- Implementation of additional contractual requirements and monitoring: The Department of Families, Fairness and Housing conducts audits of residential care homes to ensure additional requirements for therapeutic care are met under renewed audit frameworks [52]; and
- Establishment of workforce strategies: The Department of Families, Fairness and Housing has developed a Residential Care Learning and Development Strategy in collaboration with the Centre for Excellence in Child and Family Welfare, which includes guidance on delivery of therapeutic care [53].

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Demand for high-cost contract types

A.45. Within residential care services, government is increasingly procuring IPS contracts at higher cost and with reduced accountability mechanisms [3]. Due to the inelasticity of demand and time-criticality of placement, if there is no immediate OSD funded capacity available, the child or young person's referral will be distributed to IPS-funded providers to locate the most suitable placement option [54].

A.46. Data shows that in the six-year period from 30 June 2016 to 30 June 2022, the shortfall between the number of children requiring a placement and OSD funded places increased from 502 to 1177 (134.5%) [55]. In addition to volume, the total value of IPS packages is growing due to higher unit costs, increasing the cumulative financial value of the arrangements [55].

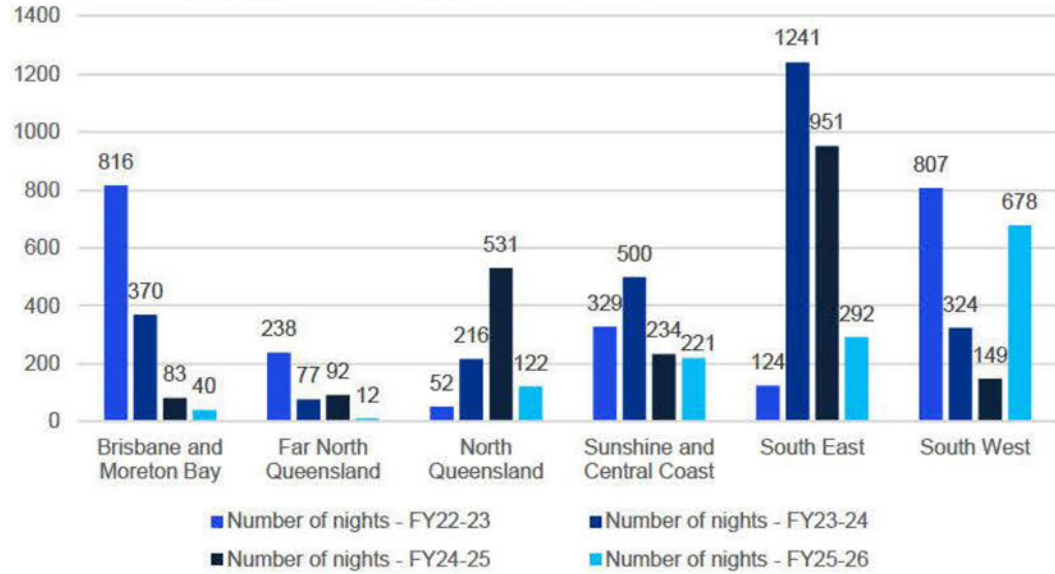
A.47. IPS cost escalation is especially significant for children and young people that have long-term service requirements or are likely to require care until they turn 18 years old. For this cohort, the Department may be paying a premium of at least 7% to 10% for short-term three- to twelve-month placements that may need to be renewed several times [42].

A.48. As shown in Figure A.23, between July 2022 and February 2026, a total of 1,181 emergency accommodation placements were made across Queensland, resulting in young people spending 8,541 nights in emergency-type accommodations, including hotels. This included 921 nights for young people aged up to ten years. The total cost of accommodations during this period was $2.1m, with the cost of servicing these emergency accommodations exceeding $10.0m. Emergency placement usage varied between regions.

A.49. To this end, Queensland Government has acknowledged the need to develop an approach to strategic commissioning that is flexible, adaptive to dynamic market conditions, and able to deliver quality care placements within tight timeframes [5]. This will support Queensland to more intentionally shape its demand profile.

A.50. The Queensland Government is undertaking a process to support IPS providers transition to OSD arrangements that would offer providers greater security while also building a stronger base of stable residential care providers and supporting cost reductions for the State. There is a potential risk for the Queensland Government that providers may self-select out of residential care delivery if there is perception that they are being pressured to convert to less profitable arrangements or to accept lower prices than would allow them to sustainably deliver operations, which could further impact supply.

Figure A.23: Emergency placement nights per region [1]



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Supply factors

Labour and non-labour cost increases

A.51. Supply side constraints in Queensland residential care are predominantly driven by the availability of a skilled workforce. Labour is the largest operating cost for suppliers, with around two-thirds of provider revenue spent on direct wages [58]; additionally, the Social, Community, Home Care and Disability Services (SCHADS) Award, which covers residential care workers, increased minimum wages by 3.8% in 2024 and 3.5% in 2025* [56]. The pool of available workers is further reduced through competition with the disability sector (which is also governed by the SCHADS Award) [57]; OOHC is often seen as a stepping stone to NDIS roles [59].

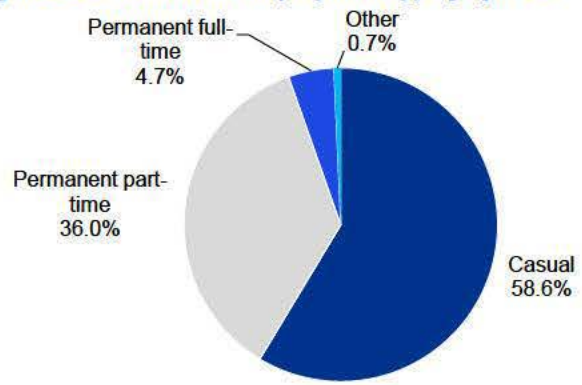
*KPMG has been advised by the Commission that notwithstanding these increases, the benchmark pricing in the IPS Business Rules has seemingly not been updated since in or around late 2020.

Workforce capacity

A.52. Providers need a large enough pool of trained staff to cover continuous rosters and manage high complexity behaviours in children and young people. However, the supply of consistent, stable ongoing labour is constrained. In 2024, 58.7% of workers in residential care in Queensland were on casual contracts, as can be seen in Figure A.24 below [21]. Casualisation may be incentivised within IPS contract structures due to significant fluctuations in placement requirements and demand [21].

A.53. Casualisation can reduce continuity of care and increase risk, particularly for children with trauma, disability or complex behaviours [60]. Additionally, casual workers incur a 10% to 15% loading and can therefore be more expensive over the same period compared to an ongoing worker [42].

Figure A.24: Workforce employment type [21] 2024



Workforce capability

A.54. A PeakCare report, *Insights and Opportunities: Queensland's Residential Care Workforce,* noted that current workforce capability is insufficient to manage escalating complexity [21]. Three-quarters of Queensland's frontline workers have fewer than five years' tenure [21], as shown in Figure A.25 below. Children and young people participating in Residential Care Expert Advisory Council workshops identified a lack of training in mental health, disability support, trauma-informed care, cultural capability, time management, and English communication as urgent capability gaps to be addressed [61]. In response, Queensland is investing in further training for workers. Residential care staff at licenced providers must hold or be enrolled in and working towards a recognised Certificate IV qualification, and must have completed additional mandatory training introduced in 2019 (Hope and Healing for Residential Care) [35]. The extent to which providers are ensuring that employees are working towards these qualifications, and the Department's visibility of this progress, is unknown.

Figure A.25: Proportion of workforce by tenure [21] 2024



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Labour and non-labour cost increases (continued)

A.55. Beyond labour, providers are facing challenges including limited stocks of suitable housing, increasing electricity and utilities costs, and rising insurance premiums. Financial analysis found that costs exceeded revenues for a selected sample of residential care facilities from FY2019-20 to FY2021-22, resulting a net sector deficit across all three years [64]. This suggests that cost escalation is a challenge for the sector [64].

Housing costs

A.56. Providers require suitable housing stock that meets safety requirements; delays in sourcing compliant houses can slow capacity growth [62]. Nationally, housing cost increases (which rose 6.8% in the 12 months to January 2026) were the largest contributor to Consumer Price Index increases [65]. While there is limited data pertaining to residential care housing, rental market data suggests that overall vacancy rates in Queensland are low and the property market may be under-supplied [66]. Fluctuations in property prices can significantly impact residential services providers' operational sustainability [62].

Electricity and utilities costs

A.57. Across Australia, electricity costs rose 32.2% in the 12 months to January 2026. This increase was primarily related to Commonwealth and State Government electricity rebates being used up by households [65]. As residential care services operate 24/7, they consume high volumes of electricity and other utilities compared to other sectors [62]. Residential care providers also reported increases in costs for repairs, maintenance, and preparing or reinstating houses to align with legislated requirements [62].

Insurance premiums

A.58. Residential care providers face reputational and operational risks, including serious incident exposure and workers' compensation claims. Providers reported significant increases to insurance premiums in recent years [62].

A.59. Between 2016 and 2021, providers saw a 93% increase in workplace violence claims in residential care settings [21], an average WorkCover premium rate of $2.635 per $100 of salary paid [63]. On average, residential care workers submitted 29.6 time-lost claims per 1,000 workers (versus a 19.7 average for the social assistance sector) [21]. These claims represented a significant operational cost for providers.

A.60. Providers across Australia also reported challenges in obtaining coverage for insurance claims related to sexual abuse or other types of abuse, as well as cost increases for General Organisation insurance, Public Liability insurance, and property and contents insurance [62]. In relation to these factors, providers may be adjusting their acceptable-risk thresholds, and in serious cases, exiting the market completely.

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Under-supply of services for specific cohorts

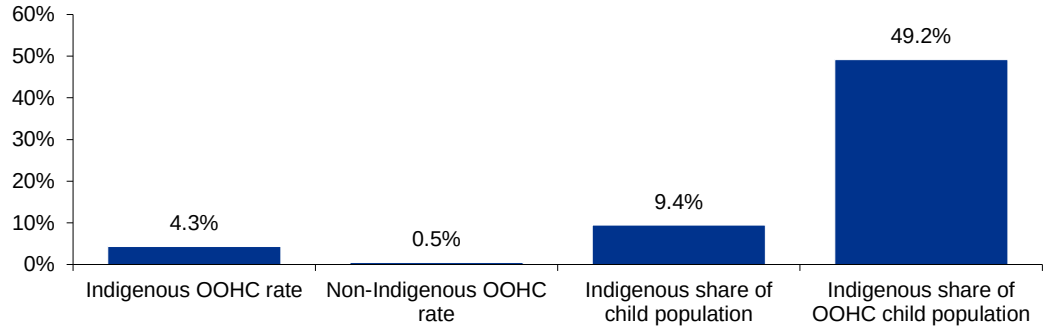
A.61. In addition to the overarching supply issues identified across the residential care sector, access for specific cohorts of children and young people is particularly affected by supply constraints. Two cohorts are explored in further detail below: First Nations children and young people, and children and young people living in regional and remote areas.

First Nations Children and young people

A.62. First Nations children and young people represent a significant share of residential care demand. Departmental point-in-time analysis as at May 2025 revealed that 1,164 children, or 47.8% of all children in residential care, identified as Aboriginal and/or Torres Strait Islander [5]. However, there are a limited number of providers delivering First Nations-specific residential care supports that are tailored and culturally responsive [5]. In FY2024-25 only six Aboriginal and Torres Strait Islander Community Controlled Organisations received funding to deliver residential care, providing around 15,000 placement nights [1]. Through consultations with the QFCC, Residential Care Expert Advisory Groups noted several examples of the current system failing to deliver culturally safe care, including removals of items of cultural significance (e.g. fishing spears), lack of culturally diverse staff, minimal effort from providers to connect young people to culture, and limited cultural support for young people and their family members at contact [60].

A.63. Cultural connection and culturally safe placements through residential care are critical to support social and emotional wellbeing, healing and ongoing connection to culture, Country and community. This is aligned with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) and greater efforts must be made to support market entry for Aboriginal-led providers to deliver culturally grounded residential care. Culturally safe placements are associated with improved placement stability, reduced placement breakdown and absconding, stronger engagement with education, health and other supports, and improved transitions from care [69].

Figure A.26: Indigenous over-representation in OOHC [20], [23] FY2023-24



Children and young people in regional and remote areas

A.64. Children in regional and remote areas may also be under-serviced without effective market shaping and intervention. Provider availability varies across Queensland and localised supply and demand gaps can result in costly and disruptive placement choices. Based on research conducted in the Queensland disability sector, which operates with similar workforce and infrastructure requirements, providers in regional and remote areas face higher operating costs, including housing, travel, and staffing premiums [67]. In particular, travel is a stronger cost pressure for regional and remote residential care providers than for metropolitan providers [62]. An NSW regional residential care provider cited an example of a young person's family contact arrangements requiring one to two staff to travel for two or three days to facilitate access visits.

A.65. Geographic gaps can be filled through more robust forecasting by local government area (LGA) to predict where future demand will arise, considering factors such as age, culturally and linguistically diverse (CALD) backgrounds, sibling groups, and children and young people with disability, to support strategic mapping of provisioning needs [68]. A more comprehensive commissioning approach that considers regional differences may also help to set more sustainable provider rates, build stronger capacity for licensed provision and reduce reliance on high-premium emergency arrangements.

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Consideration of potential market interventions

Market interventions: key mechanisms to shape supply and demand

A.66. As set out in the previous section, due to the inelastic nature of residential care demand, providers have greater discretion to pass on underlying cost increases, resulting in greater costs to government [3]. In some cases, providers appear to be taking advantage of procurement systems to increase profit margins. In May 2025 the Queensland government ordered a full forensic audit into a for-profit residential care provider, after finding that dividends paid to their three shareholders totalled $5.25 million in one financial year [71].

A.67. In this context, it is critical that government implements an effective commissioning approach to actively shape the market and ensure service quality, safety and sustainability. This section sets out a range of potential commissioning reforms Queensland could consider, informed by reforms in New South Wales and Victoria. Potential mechanisms are grouped by increasing complexity of design and implementation in Figure A.27 below.

Figure A.27: Mechanisms to shape supply, ordered by complexity of design and implementation



Strengthening contractual performance frameworks

A.68. Procurement and evaluation reform may form a significant opportunity for Queensland. Recent QFCC analysis noted that all new contracts since March 2024 were single sourced procurements, and that 173 placements were procured with single staff coverage, no explicit outcomes or monitoring or minimum qualifications [3]. This provides limited levers for intervention should services be sub-standard. Although the Queensland government currently requires all providers to adhere to a Supplier Code of Conduct, departmental policies, procedures, and guidelines, funding requirements, and the Human Services Quality Framework (HSQF) [5], evidence of compliance is mixed [21].

A.69. In response, Queensland is shifting from a traditional procurement method (i.e. accessing existing Queensland Government Supply Arrangements) to a 'limited agile procurement' approach, where the Department invites a selection of providers of its choice to apply for funding. These suppliers have met pre-established quality and safety criteria, as well as other criteria relating to probity, transparency and key selected outcomes (e.g. economic, environmental and social obligations) [5] .

A.70. This shift is aligned with NSW's approach. The NSW Government recently announced its commitment to ensure provider accountability by strengthening procurement policies, outcome monitoring and performance analysis [74]. Queensland is also considering transitioning to fully open tendering at a future stage through a public sourcing strategy, which encourages new suppliers to enter and boost sector diversity [5].

Exiting/winding down contracts that are not delivering value

A.71. Queensland could also consider discontinuing existing contracts where safety and quality standards are not being met. In NSW, government is winding down the 'Permanency Support Program' for outsourced OOHC delivery. This decision was based on internal audits that uncovered poor outcomes for children and low return-on-investment [73] – for example, output measures demonstrated that service provision volumes fell despite increased funding [73]. Analysis also found that this decision may result in some provider exits [73], providing an opportunity to reset the supply mix in NSW.

Strengthening regulatory powers

A.72. Queensland has a distributed regulatory approach split across multiple agencies [3]. Queensland could consider ways to strengthen regulatory coordination and information-sharing to ensure the ongoing effectiveness of residential care delivery.

A.73. Victoria introduced the integrated Social Services Regulator to lead a consistent approach across social services and ensure proactive information-sharing and risk identification. The Social Services Regulator's powers were recently strengthened in response to the Victorian Rapid Child Safety Review, which noted the importance of joining up 'breadcrumbs' of risk indicators that can be missed when monitoring and oversight responsibilities are distributed across several agencies [72]. The Rapid Child Safety Review also noted potential points of failure between sectors (for example, the potential for perpetrators of abuse to move between sector workforces), and the need to further integrate OOHC, early childhood education and care, disability and aged care regulation [72].

Direct government delivery of residential care services

A.74. Queensland could also consider bringing residential care delivery in-house to ensure visibility and maintain required standards. The NSW Government recently committed to funding 44 government-owned, purpose-built or upgraded residential care homes for children over 12 years of age with complex needs [70]. Note that this mechanism could result in significant change, including disruption to existing providers, reduced market diversity, design and implementation complexity, and reputational risk.

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Strengthening a commissioning approach to residential care services

A.75. As set out on the previous page, there are several points within the commissioning cycle where Queensland could consider reforming its approach, including proactive service planning, reconsidering volumes and types of services procured, and embedding robust approaches to measuring outputs and outcomes. A best-practice commissioning cycle for residential care services (represented in Figure A.28) could include the following stages:

Planning and policy

- Assessing population-level needs for residential care services in the current and future state, including identifying the relevant inputs, parameters and constraints to effectively forecast demand (explored in more detail in Part C of this report), including the impact of preventive and diversionary actions; and
- Understanding stakeholder landscape, policy priorities, place-based and budget considerations.

Market and service design

- Confirming the quality and viability of the market to meaningfully and responsibly respond to current and emerging needs and demands;
- Understanding the cultural and other demographic factors across each region/location to allow tailored service design considerations;
- Identifying whether needs will be met by existing body of contracted services or alternative mechanisms, which might include considering the role for government delivery;
- Agreeing volume, types and delivery partnerships for services that will meet population needs; and
- Developing commercial strategy and funding approach and mechanisms. This might include mechanisms to incentivise OSD provision or improve availability in underserved areas.

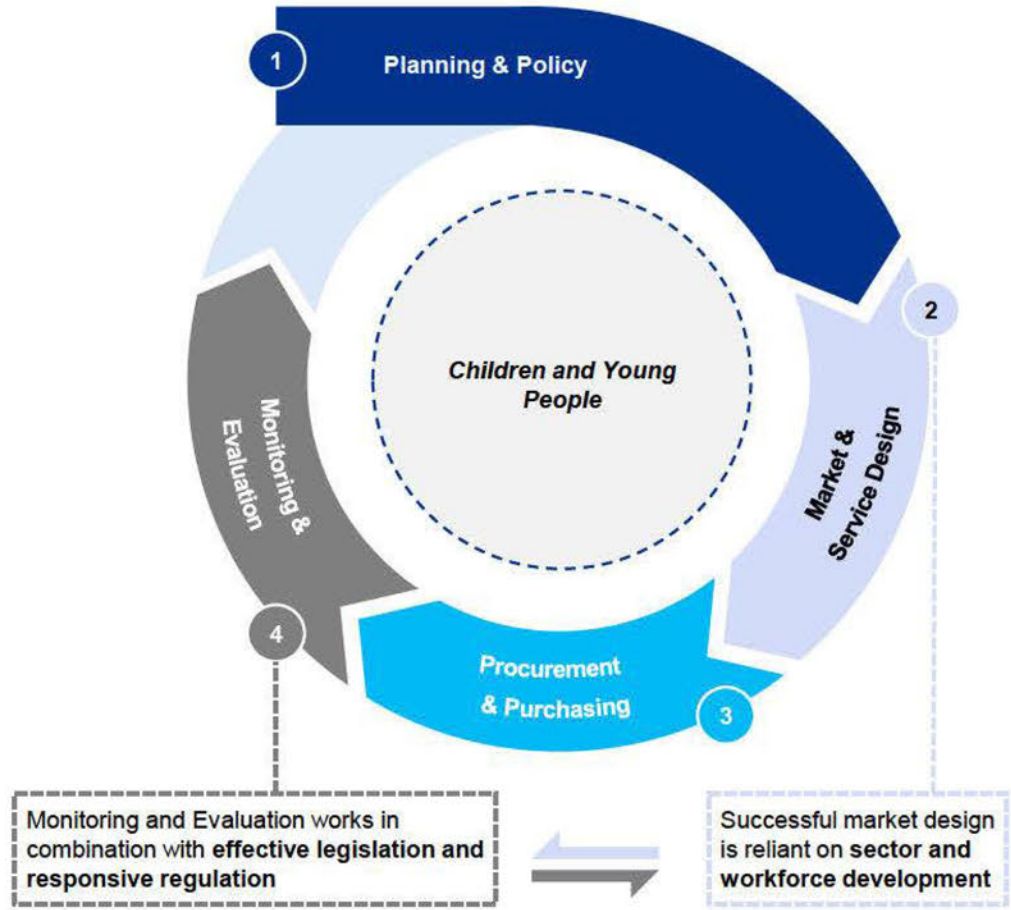
Procurement and purchasing

- Procuring services from public, private or non-government organisations and establishing contractual arrangements;
- Ensuring a consistent contracting approach with clear KPIs and outcomes; and
- Developing robust compliance and oversight processes.

Monitoring and evaluation

- Assessing provider and system performance on a continuous basis;
- Evaluating service interventions; and
- Reviewing and adjusting services, using feedback to inform the planning and policy stage.

Figure A.28: High-level commissioning model for residential care services



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04

Provider financial analysis



Part B. Scope of Work & Purpose

Scope of work

The purpose of Part B is to analyse the profit margins generated by 20 Providers selected by the Commission of Inquiry as a representative cross-section of suppliers and comment on the reasonableness of those margins, having regard to:

a. The input costs incurred by Providers (including labour and overheads);

b. The different models of care offered by residential care Providers;

c. The procurement practices of the Department;

d. The availability of alternative suppliers in the market (covered in Part A); and

e. Any other factors deemed relevant.

Suppliers were selected by reference to the following criteria: for-profit v not-profit; licensed v not licensed; large Providers v small Providers; Providers in different regions; and Providers with different focus areas or models of care.

Confidentiality

While we have anonymised the Providers, the level of detail contained in this report means that individual Providers—and broader sector performance—could still be inferred. Accordingly, this detailed section of our report has been provided to the Commission on a confidential basis to preserve Provider confidentiality.

Purpose

Part B presents the financial analysis of a sample of 20 non-family-based residential care Providers, drawing on information submitted to the Commission, including financial statements, IPS Pricing Schedules, payroll data and Provider Witness Statements. The work focuses on identifying and comparing key profitability indicators, such as youth worker margins, IPS contract margins and funding per placement per day.

The purpose of this analysis is to determine definitive Provider-specific profitability and identify sector-level patterns, risks and explanatory themes relevant to the Commission.

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Part B. Limitations

Limitations

Our financial analysis has been performed using information submitted to the Inquiry by 20 Services Providers (the "Providers"). While we have applied appropriate professional judgement, the scope and reliability of our findings are limited by the completeness, consistency and granularity of the information submitted by those Providers.

The absence of granular financial information limited our ability to reconcile financial performance to the operational activity in the payroll report, IPS Pricing Schedules or the rosters where they were provided. **As a result, our work focused on identifying broad themes rather than validating Provider-specific profitability or efficiency on a bottom-up basis.**

Information requests

Our review of the Provider information is limited to the assessment of 20 Providers that complied with the Notice to Produce Documents and Provide Information dated 19 December 2025. While we sought additional financial information to supplement and improve our findings it was received on 9 March 2026 and, due to the limited time available to complete the report, it could not be incorporated into the analysis.

Financial information limitations

The financial information provided was not sufficient to support a detailed assessment of Provider input costs, particularly labour and overhead costs to determine the underlying drivers of profitability. The data submitted was largely limited to high-level financial statements, with minimal supporting disclosures in the notes to the financial statements.

Specific detail on the limitations of the financial information is included in the confidential annexure provided to the Commission.

Consolidated reporting

Several Providers submitted financial information on a consolidated basis, reporting the performance of more than one service.

Where consolidated data was provided, it was not possible to reliably disaggregate revenues, costs or margins attributable to either IPS or OSD. This has limited our ability to accurately compare the financial results across Providers and has constrained our conclusions.

Alignment of Witness Statements and financial data

There are instances of the Witness Statements not aligning to the financial information provided and, in some instances, not all questions posed were addressed or fully answered. Of note, information relating to salaries and wages was not submitted by all Providers reducing the precision of our conclusions regarding the adequacy of input costs and margin reasonableness.

IPS Pricing Schedule sample size

Each Provider submitted five IPS Pricing Schedules, as requested by the Commission; however, we consider the sample to be small to support a robust or representative comparison.

Our analysis of the Pricing Schedules showed mean price per placement per day of $1.9k and $1.4k for-profit and not-for-profit Providers respectively. In comparison the [redacted] had a significantly larger dataset, [redacted], and reported a mean price of $1.2k for for-profit Providers and $0.9k for not-for-profit Providers [1].

Rosters, payroll and pricing data

To analyse the Residential Youth Worker margins, we reviewed the IPS Pricing Schedules, payroll reports and rosters submitted to the Commission. However, the underlying time frame did not align to enable comparison; the Pricing Schedules were FY26 while the payroll and roster information related to 30 June to 7 July 2025.

The different financial years result in different pay rates due to annual pay uplifts, while the Pricing Schedules could not be linked to the payroll or rosters. For many Providers, the payroll lacked sufficient detail to determine pay rates or hours worked.

As an alternative, we compared the amounts claimed by the Providers in the IPS Pricing Schedules to the average wage bands detailed in the Witness Statements. However, this analysis was limited by the need to average the pay rates which could not be weighted due to a lack of information on workforce composition.

Implications for interpretation

Taken together, these limitations mean that our findings should be interpreted as themes and observations rather than definitive assessments of individual Provider profitability or appropriate pricing. Where corroboration was not possible, we have avoided drawing conclusions beyond what the evidence reasonably supports.

Notwithstanding these constraints, the limitations themselves highlight material issues relating to data transparency, financial reporting and consistency, which are directly relevant to the Commission's consideration of funding adequacy, value for money and system governance.

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Part 4.1

Key Findings

Part B. Key Findings

The detailed findings from the provider-level review are set out in a separate confidential annexure due to the commercially sensitive nature of the information and to preserve provider confidentiality. This section presents the key findings of the analysis and excludes the underlying detailed financial data.

	Findings
1	**Procurement processes provide limited assurance on the reasonableness of IPS Pricing Schedules.** **IPS Pricing Schedules routinely exceed benchmark rates, particularly for labour. Percentage-based overhead allowances can amplify margins, while limited validation of tenders reduces confidence that pricing reflects efficient costs.** • Our assessment of the IPS Pricing Schedules submitted to the Commission found that Providers regularly exceed the benchmark amounts detailed in the Individualised Placement Support (IPS) Business Rules. • Benchmarks are exceeded across all cost categories; however, the most material differences relate to salaries and wages. Of the 95 IPS Pricing Schedules submitted to the Commission, all were above the staff cost benchmarks. Providers state there is a need to cover additional costs, including unforeseen overtime, Workcover claims and premium increases, and vacant rental properties [2]; working capital pressures that arise from delays in departmental invoice payments [3] and the need to factor in CPI and inflationary increases. We note that the IPS Business Rules suggest that operating cost benchmarks have been applicable since August 2020 and December 2020 for salaries and wages [4]; the Commission has sought an explanation from the Department as to why this is the case but has not received an explanation. However, we have used the current SCHADS SaCS 3.4 Award benchmark for staff margin calculations. • It has not been possible to determine whether theses costs flow through to Providers' profit and loss statements, as the financial information submitted is high-level and cannot be reconciled to the assumptions in the Pricing Schedules. • However, we observed that labour input costs recorded in the IPS Pricing Schedules are higher than amounts paid to staff. This has the effect of increasing margins in two ways, as organisation and administration costs are calculated as a fixed percentage (14%) of staff costs [4]. As a result, higher staff cost assumptions automatically increase both staff cost recovery and the associated organisation and administration allowance. • We were unable to establish what level of scrutiny or validation is applied to IPS Pricing Schedules once submitted for tender, or whether Providers are meaningfully challenged on their cost assumptions. We also observed that once staff cost assumptions appear to have been accepted, they are not revised in later submissions, as staff cost inputs remain identical across multiple Pricing Schedules. Consequently, the current procurement process provides limited assurance that IPS Pricing reflects efficient and reasonable costs.

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Part B. Key Findings

	Findings
2	**Reported net profit is not a reliable indicator of a Provider's financial performance.** **Financial statements are provided at a high-level and aggregate key cost categories, making it difficult to analyse service delivery. Economic returns are frequently realised through owner salaries, related-party transactions, acquisitions of non-core assets and dividend payments rather than reported profit.** • Provider profit and loss statements submitted to the Inquiry are a high-level view of the input costs and do not offer sufficient detail to assess the reasonableness of direct service delivery costs. Labour and overheads were often reported in aggregated categories, with no clear separation between direct care costs and indirect or discretionary expenditure. As a result, the financial information received by the Commission does not enable an accurate assessment of whether reported margins reflect efficient service delivery. • In addition, we found that net profit is not an accurate indicator of Provider performance as the analysis shows owners and related parties extract value through various mechanism, which allows cash to be withdrawn from the business irrespective of reported profitability. These transactions are concentrated among the IPS-only Providers in our sample (with one exception noted below) and include the following: o Above-market remuneration; including instances of CEOs being paid salaries of up to and between $400k to $679k, In one instance the salary represents 21% of revenue; o Related party charges, including B.15's (a not-for-profit Provider delivering IPS and OSD services) $4.1m management fee for intellectual property and systems fees (12% of revenue); o Acquisitions of non-core assets including B.7 holding investments in gold and cryptocurrency, stated on the FY25 balance sheet at $242k and $100k respectively. The company also has 2 Mercedes Benz cars, and the owners were paid a dividend of $140k in FY25; o Director and related party loans, including B.10, an IPS-only Provider having 5 different loans for a total of $5.2m at FY25 (25% of revenue), which increased to $8.2m in December 2026; and o Dividend payments, included a $5m payment by B.3, which represents 12% of FY25 revenue. Accordingly, low or modest net profit outcomes do not necessarily indicate weak financial performance or limited capacity to generate surplus cash.
3	**Labour and contract-level margins provide insight to Provider profitability.** **Youth worker margins and IPS arrangement margins are informative indicators of underlying performance.** • IPS contract margins have been prepared using actual wage rates and the Business Rules Benchmarks, and provide an informative measure of a Provider's underlying performance. However, they do not capture the Provider's central corporate overheads, governance costs or group-level allocations meaning they reflect profitability at the arrangement level only. • Our analysis shows that funding per placement per day varies materially and there is not a strong correlation between high funding per day and contract margins. IPS-only Providers generally show stronger revenue growth than Providers operating across both IPS and OSD.

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Part B. Key Findings

	Findings
4	**IPS Providers are more profitable compared to IPS and OSD Providers.** **IPS businesses demonstrate rapid revenue growth over short periods, often without significant working capital or business investment. Growth appears driven by placement access and pricing schedules rather than demonstrated efficiency or service maturity.** • The financial information submitted to the Inquiry shows IPS businesses exhibit higher IPS contract margins, whilst not-for-profit Providers (which are typically IPS and OSD providers) have lower IPS contract margins. The lower contract margins for IPS and OSD Providers may be associated with a better understanding of contracting requirements and having access to a fixed term workforce, given that 50% of IPS Providers in our sample utilise a flexible workforce of labour hire or casual staff rather than fixed term employment. • IPS funding per placement per day varies significantly in our sample, with a ~450% difference between the lowest and highest. We observed that for-profit Providers receive materially higher IPS funding per placement, an increase of 34.7% compared to not-for-profit Providers which equates to ~$182k per placement per annum. Drivers of the difference could be the use of labour hire staff amongst for-profit Providers. • Using the model of care and staff training information detailed in the Provider Witness statements, there is no clear relationship between the stated models of care or training levels and the funding per placement per day. From our sample, Providers with strong models of care have a range of funding levels which may demonstrate Providers are adept at articulating a desired training suite and model of care but are not yet delivering it. • The higher margins for IPS contracts are generally driven by labour input costs. Our analysis found that for-profit providers (primarily IPS-only Providers) claim an average hourly rate that is 16.5% higher than the not-for-profit sample average.

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Part B. Key Findings

	Findings
5	**Financial transparency and consistency of information provided to the Commission is limited.** **Financial statements, payroll data and Witness Statements could not be reliably reconciled, limiting Provider-specific conclusions. However, high salaries, dividends, acquisitions of non-core assets and related party loans suggest many of the underlying businesses are highly profitable.** • The financial information submitted by a number of Providers lacked sufficient transparency and consistency to support reliable reconciliation to their Witness Statements and in several cases, assertions made could not be reliably validated or conclusions drawn. For example: o **B.3** declared a $5.0m dividend in FY25 yet we calculated comparatively low youth-worker margins for the same period, an outcome that could not be reconciled to the profit and loss statements; o **B.9** provided workforce and organisational information in its Witness Statement that did not align to the financial and payroll data, including inconsistencies in reported staffing structures; o **B.10** did not submit IPS Pricing Schedules despite reporting significant IPS revenue, preventing any assessment of whether funding levels, labour costs and reported financial outcomes were aligned; and o **B.18** reported substantial related-party loans or balances in their financial statements that were not clearly explained in Witness Statements. • Across the sample, labour, overheads and related-party transactions were frequently aggregated into high-level expense categories, meaning claims made in Witness Statements regarding cost pressures, staffing intensity or funding adequacy could not be reconciled to underlying financial performance.

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Part B. Key Findings

	Findings
6	**Appetite for procurement under OSD rather than IPS agreements.** **The summary of key financial information shows that IPS-only Providers generate stronger staff and total margins than Providers who deliver OSD agreements, offering little incentive to transition from IPS delivery. Consistent with this, not-for-profit Providers—typically operating across both IPS and OSD—record lower margin outcomes than smaller IPS-only Providers.** • Witness Statements from IPS Providers indicate that, while Providers generally acknowledge OSD as a policy objective, their stated appetite to procure OSD agreements is consistently conditional rather than an active intention to transition under current settings. • Across the cohort, Providers describe a willingness to consider procuring OSD agreements in principle, but only where commercial viability and regulatory requirements could be satisfied. For example: o **B.4** confirmed that no IPS agreements have been converted and that any consideration of conversion would only occur after licensing is obtained [5]; o **B.6** indicated that conversion has not been contemplated within its current operating model [6]; and o **B.20** explicitly linked its position to financial viability, stating that its cost structure relies on IPS funding and that conversion to OSD is not commercially sustainable under current conditions [7]. • Other IPS Providers similarly framed OSD conversion as contingent on changes to funding, cost recovery or regulatory settings, rather than as an immediate or planned transition pathway. • Across the IPS cohort, Providers confirmed that no IPS agreements have been converted in practice, with the exception of B.13, which converted 16 IPS agreements to OSD. Even in this case, B.13 stated that further conversion was constrained by unresolved compliance matters and the closure of the relevant procurement process, rather than by lack of interest.

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05

Demand and cost modelling analysis



Part 5.1

Overview

Part C. Scope of Work & Purpose

Scope

The Commission identified projected demand and cost models for non-family-based care (NFBC) through to 2030 for KPMG to review. Part C assesses the robustness of these existing projections based on their documented methodology, assumptions and stated use. It examines underlying model methodology, identifies opportunities for further sensitivity testing of key demand and cost drivers to strengthen forecasts, and provides reasoned commentary on the reliability of projections, including key uncertainties and risks.

In addition, Part C summarises the context, purpose and intended use of each model as presented in the source reports, including how the models are positioned within broader reform objectives and decision-making processes. This is intended to support appropriate interpretation of the modelling results prior to detailed methodological assessment.

Purpose

Part C assesses the extent to which the projections can be relied upon for their stated purposes, and identifies material limitations, uncertainties and risks. This is achieved by testing whether the existing models and forecasts to 2030 are sufficiently robust, transparent and credible, and by identifying where assumptions, data sources or sensitivities may materially affect projected outcomes.

Part C also seeks to clarify how the models are intended to be read and used, including the distinction between illustrative planning tools and projections relied upon for funding, policy or reform decisions. It clarifies the level of uncertainty and risk inherent in the projections and highlights opportunities to strengthen forecasts where they are relied upon to inform such decisions.

Limitations

This review was undertaken without direct access to live or executable versions of the models, and without the ability to run alternative scenarios or sensitivities. Accordingly, the review does not validate model outputs or independently confirm model logic or parameter interactions. Instead, it assesses whether the methodologies and stated assumptions, as documented in the source reports, support the level of reliance implied for the projections. Findings should therefore be interpreted as commentary on credibility, limitations and sources of uncertainty, rather than as a re-modelling, calibration or assurance exercise.

Model Introduction and Review Framework

The Part C Review considers several models, which are therefore defined, grouped and referenced throughout this report as:

a. **Rennie Advisory Models – Demand (1.A) and Cost (1.B)**
Buyer Beware report authored by Queensland Family and Child Commission and prepared by Rennie Advisory included a demand and cost model. The demand and cost models are grouped because they are presented within the same report and are designed to operate sequentially. The demand model provides an estimate of future placement volumes, and the cost model translates these volumes into expenditure under stated assumptions;

b. **The Demographics Group – Demand model (2)**
Authored by The Demographics Group for PeakCare, this model is used within a workforce analysis context to illustrate potential future NFBC demand;

c. **PeakCare / Social Vantage Advisory – Demand model (3)**
Authored by Social Vantage Advisory for PeakCare, this model is used to support residential care workforce strategy development. It provides indicative demand pathways to illustrate the scale of adjustment implied by policy targets and observed trends; and

d. **SAM-to-PBFM model system – Demand (4.A) and Cost (4.B)**
The SAM (authored by Insight Acumen) and PBFM (used by DFSDSCS and Queensland Treasury) are reviewed separately due to their complexity and central role. However, they are referenced collectively as the SAM-to-PBFM model system, (4.A) and (4.B), because SAM outputs are used directly by PBFM to translate demand into funding estimates.

An overview of each model's existing projected FY30 outputs, together with its limitations and the context in which it should be read, is provided on the following page.

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Part C. Interpreting the existing model outputs

The existing models point in a broadly similar direction when projecting future NFBC demand and cost growth. Under their respective assumptions, each indicates continued growth in OOHC demand, NFBC demand and associated costs to FY30 or the nearest available projection year. However, the models were developed for different purposes, apply different methods and assumptions, and should therefore be interpreted with appropriate caution.

Rennie Advisory Models – Demand (1.A) and Cost (1.B)

Projects the highest demand and cost growth of the models reviewed, with FY30 outputs of:

a. **5,747 NFBC** placements, **17,051 total OOHC** placements; and

b. **Costs of $7.06 billion** in FY30 alone.

This output is best interpreted as a whole-of-state, unchanged-system pressure scenario that illustrates the scale of risk if OOHC demand continues to grow and FBC supply remains constrained.

It is useful as contextual signalling but should not be treated as a precise estimate. Rather the model is likely to represent an upper limit to future demand and cost. Results are highly sensitive to key assumptions, particularly placement mix. For example, holding other assumptions constant and keeping placement mix at the FY24 level (rather than modelling a decline in foster care as a share of total OOHC placements) would reduce the FY30 cost to approximately **$4.5 billion**.

The Demographics Group – Demand model (2)

An intentionally illustrative, trend-based projection of FY30 NFBC placement demand, using simple linear and exponential extensions of observed data:

a. Linear **NFBC** demand of **3,090** vs Exponential demand of **3,450.**

PeakCare / Social Vantage Advisory – Demand model (3)

Projects NFBC and total OOHC demand to FY29 by extending recent historical growth trends, while also illustrating how NFBC demand would differ under the target policy setting. A KPMG extension to FY30, using the existing model's assumptions, is included for comparison:

a. Trend-based projection: **NFBC** of **4,208** and **OOHC** of **14,841 (FY29);**

b. Policy-aligned scenario: **NFBC** of **1,039 (FY29)** (i.e. reflecting target / desired placement mix);

c. KPMG extrapolation of the trend-based projection (using existing model assumptions) for comparison: **NFBC** of **4,880** and **OOHC** of **15,494** (**FY30**) (i.e. producing an FY30 projection that falls within the range of demand outcomes forecasted by models (1.A) and (2).

SAM-to-PBFM model system – Demand (4.A) and Cost (4.B)

The current presented outputs from both SAM (4.A) and PBFM (4.B) are conditional on specified settings and assumptions, with their limitations considered further in the subsequent pages of this analysis. The latest available outputs are:

a. SAM **total OOHC** demand: **15,628** in FY30. [10] However, this projection is based on a model output from FY19, with more recent projections not provided to the Commission;

b. PBFM funding required (policy-aligned placement mix): **$2.066 billion** in FY29, based on an FY25 model output; [11]

c. PBFM funding required (placement mix adjusted to reflect observed figures from FY25): **$2.781** billion in FY29, based on an FY25 model output;

d. The PBFM funding projection implies a more moderate growth in NFBC compared to other demand models.

Overall Commentary

Taken together, the existing models are directionally consistent in indicating strong growth in demand and cost if current pressures persist. At the same time, each model has important limitations, and none should be read in isolation as a definitive view of future demand or funding.

The remainder of this report sets out the review findings and targeted enhancements recommended to support a clearer and more decision-useful view of future demand and cost. In turn, this is intended to provide decision-makers with a more transparent basis for assessing the direction and potential effectiveness of further intervention in Queensland's child protection and OOHC system, and for better estimating the potential cost implications and savings associated with those interventions.

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Part C. Summary Findings

Previous modelling included work undertaken for a specific purpose, with the methodology adopted and results produced relevant to that context and point in time. As such, these models are not suitable for ongoing system management and planning.

The modelling developed to inform the *Buyer Beware* report and the work undertaken and commissioned by PeakCare represent useful agenda-setting baselines. They help quantify the potential scale of future NFBC demand (at a statewide level) and resulting cost pressures if recent trends persist, and they clearly signal that the system trajectory is challenging under an unchanged system.

However, these baselines are not designed to explain why outcomes change or how results would respond if conditions shift. Their reliance on trend extrapolation, fixed assumptions and single-point estimates limits their suitability for:

a. diagnosing key demand and cost drivers;

b. understanding constraints and substitution effects, particularly placement supply mix;

c. understanding demand and placement supply mix at a local level; and

d. supporting funding, workforce or reform decisions that require scenario testing and uncertainty ranges.

Despite its current limitations, the Part C Review concluded that a strengthened SAM-to-PBFM model system offers the most credible pathway to decision-useful analysis among the models reviewed.

The SAM simulates system pathways and demand, while PBFM translates demand into funding requirements for different services under defined assumptions. The Part C Review considers that, with targeted enhancements, the combined model system could support:

a. a defensible reference forecast of demand (by location, service type, client cohort) and required funding to meet this demand within existing system parameters (supply mix, service availability and cost);

b. intervention testing to understand the impact of policy levers within influence; and

c. sensitivity testing to understand the impact of external risks and uncertainty.

To achieve these outcomes, the Part C Review identified a range of targeted enhancements to strengthen the SAM-to-PBFM model system and better meet the varying needs of key Queensland Government stakeholders.

The recommendations below focus on the minimum enhancements required to strengthen the SAM-to-PBFM as a tool for ongoing system management and planning:

a. Include a **driver-based intake module** that links intake volumes to observable drivers, reducing the reliance on trend-only inflows;

b. Establish **formal governance over probability distributions** to ensure pathways within the SAM remain representative of system behaviour;

c. Include a **supply/capacity module** to make placement mix and substitution dynamics explicit within the model;

d. Expand PBFM reporting to include a **standard set of sensitivity ranges** for materially significant parameters;

e. Implement **two standard PBFM reporting outputs**: a “base case” used for control and acquittal, reflecting approved target-driven parameter settings; and a “reference case” used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model; and

f. Establish **formal governance over cost escalation assumptions** to ensure cost parameters remain reflective of reality.

The SAM and PBFM are already embedded in the Department’s forecasting and budget processes, with SAM providing a structured simulation of system pathways and PBFM translating demand into funding under defined parameters. The key limitations identified in this review relate less to the existence of these models and more to the current treatment of critical drivers and constraints, notably future intake drivers and placement supply mix.

Targeted enhancements to inputs, governance and supply-side representation would allow the existing model system to provide a defensible reference case and a practical platform for intervention and sensitivity testing, without requiring wholesale replacement of the modelling architecture.

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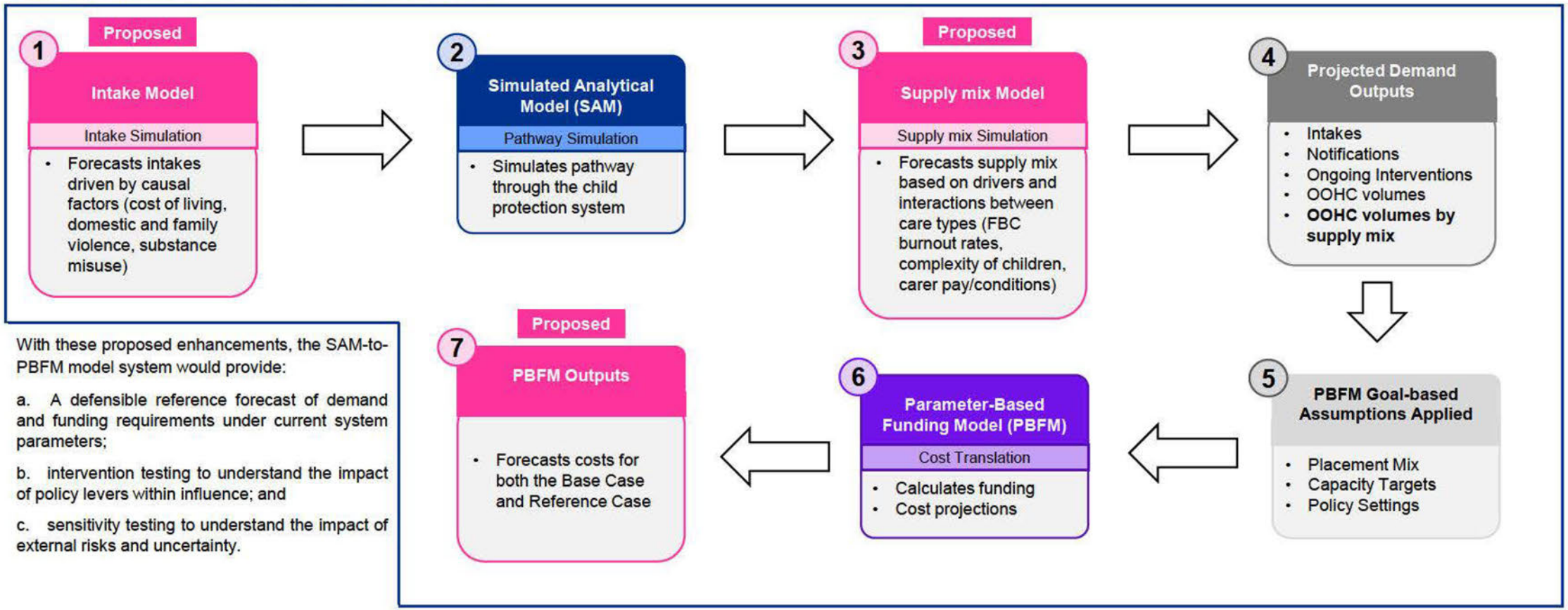
Part C. Key Findings

#	Finding	Model
1	The Rennie Advisory demand and cost models extrapolate recent trends into medium-range forecasts, but their reliance on fixed, highly sensitive assumptions, single-point estimates and forecast outputs that do not clearly reconcile to the stated assumptions materially limits its suitability for forecasting future demand or costs beyond high-level strategic signalling.	(1.A) (1.B)
2	The Demographics Group demand model is intentionally illustrative and trend-based, designed to frame discussion about NFBC workforce sustainability rather than to operate as a technical forecasting tool. However, its reliance on simple historical extrapolation, fixed assumptions and single-path projections, without causal modelling or validation, materially limits its ability to explain or anticipate future changes in demand. Accordingly, this review finds that the model is not fit for purpose for sustained forecasting or decision-making beyond high-level strategic signalling.	(2)
3	The PeakCare / Social Vantage Advisory model provides a point-in-time illustration of future OOHC and NFBC demand under extrapolated recent trend growth and an alternative policy-target scenario. Its methodological simplicity, including trend extension without behavioural, demographic or system-constraint modelling, means it does not capture the drivers or uncertainties shaping future demand. As a result, this review concludes that the model does not constitute a durable or sustainable demand forecasting model for long-term planning or decision-making.	(3)
4	The SAM relies on externally specified future intake inputs that are generated using population growth-based assumptions rather than a driver-based intake forecast, meaning its outputs are conditional on a simplistic trend continuation and are not robust to changes in economic, policy or system drivers. It is recommended that future intake inputs to SAM should be replaced or supplemented with a defensible driver-based intake forecasting module, with those forecasts then used as the inflow to the existing simulation.	(4.A)
5	The SAM's probability distributions (likelihoods of a child passing through each stage of the child protection system) are derived largely from historical system behaviour and may not remain representative if system dynamics have materially changed. A formal review and governance process should therefore be applied to material PD inputs used for forward projections.	(4.A)
6	The SAM-to-PBFM model system does not explicitly represent how factors within the SAM influence placement capacity (including the availability of carers). In particular, there is no explicit representation of dynamics such as carer recruitment, retention or burnout, limiting confidence in cost projections where supply constraints materially influence outcomes. While the SAM contains information relevant to these dynamics, this information is not currently used to forecast carer availability. It is recommended that a driver-based supply mix, capacity and carer availability module should therefore be developed and integrated into the SAM-to-PBFM process. This module should draw on existing SAM inputs to model the underlying factors influencing placement availability and substitution, including testing scenarios such as changes in carer payment levels and their potential impacts.	(4.A) (4.B)
7	PBFM outputs are often reported as single point estimates, which can obscure how much funding results would change even if key assumptions were adjusted within reasonable bounds. It is recommended that PBFM reporting should include a standard set of sensitivity ranges (including alternative cost escalation assumptions for major cost components) and present outputs as funding ranges rather than single figures.	(4.B)
8	There is a governance and interpretation risk that the PBFM outputs are misread as forecasts of funding required to meet real-world demand, rather than as funding benchmarks produced under target-driven parameter settings. This risk is heightened where supply mix assumptions are manually specified and not fully constraint-aware, limiting transparency over how capacity and substitution dynamics influence outcomes. To mitigate this risk, this review suggests that routine reporting should clearly separate two outputs: a "base case" for control and acquittal, reflecting approved target settings, and a "reference case" that draws on the enhanced intake model and forecasted, driver-based, constraint-aware supply mix and capacity model. Both outputs should be supported by a standard interpretation statement clarifying their conditional nature and preventing misplaced reliance.	(4.B)
9	The PBFM escalates base-year costs using indexation settings that are embedded as parameters rather than regularly tested assumptions. This creates a governance risk that escalation settings persist without systematic reassessment, even where placement-specific cost pressures diverge materially from indexation. This review recommends that escalation assumptions should be subject to periodic governance review and explicitly tested through escalation sensitivity analysis.	(4.B)

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Proposed Enhanced SAM-to-PBFM Flow

Figure C.1 Proposed enhanced SAM-to-PBFM model system



"Reference case" refers to a causal-model driven cost forecast; "Base case" refers to a goal-based cost forecast. Both cases are conditional on stated assumptions; neither is an unconditional 'funding required' forecast. This is an illustrative schematic only. It shows one practical pathway to address the limitations identified in Part C; it is not itself a validated model design.

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Part 5.2

Model Context & Reviews

(1.A) Rennie Advisory – Demand Model (*Buyer Beware* Report)

(1.B) Rennie Advisory – Cost Model (*Buyer Beware* Report)

(2) The Demographics Group – Demand Model (The Future Residential Care Workforce – Demographics Analysis Report)

(3) PeakCare / Social Vantage Advisory – Demand Model (Insights and Opportunities – Queensland Residential Care Workforce Report)

(4.A) Insight Acumen – Demand Model (Simulated Analytical Model SAM)

(4.B) DFSDSCS – Cost Model (Parameter-Based Funding Model PBFM)

(1. A) Rennie Advisory – Demand Model

Context

C.1. The *Buyer Beware* report includes a simple, point-in-time, trend-based demand model designed to provide a forward-looking estimate of how many children are likely to require Out of Home Care (OOHC), and how those children may be distributed across placement types, through to FY30, in Queensland as a whole. The model is intended to move beyond retrospective reporting and support consideration of future system pressures, capacity requirements and risks. [1]

C.2. The projected increase in NFBC demand arises from the interaction of several trend-based trajectories embedded in the model assumptions. These stated assumptions include continued overall growth in the OOHC population (3.5% p.a), factoring in forecasted population growth, assumed ongoing decline in foster care availability (-5% p.a), and growth in kinship care placements (2% p.a).

C.3. Under these assumptions, the model implicitly requires NFBC to expand to absorb unmet demand where FBC options are constrained. The projected growth in NFBC therefore reflects pressure within the placement system rather than an explicit forecast of increased suitability or preference for NFBC placements. [1]

Purpose and framing

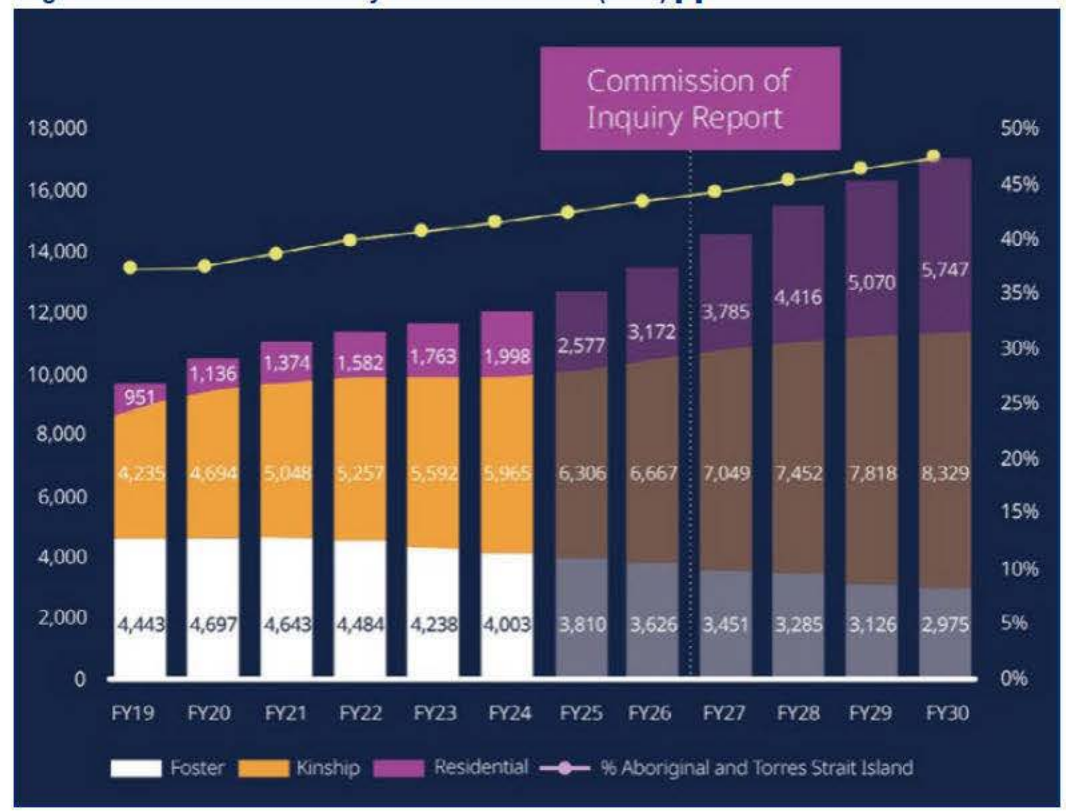
C.4. The demand model is best understood as illustrating the projected trajectory of OOHC demand under current system settings. It is not designed to model the effects of reform or alternative policy interventions, but rather to demonstrate how demand may evolve if the system continues to operate broadly as it has to date. In this sense, the model functions as a baseline or "unchanged system" scenario, providing a reference point for understanding future demand pressures and associated risks. [1]

Forecast findings:

- NFBC demand is projected to reach 5,747 children by FY30 as per Figure 1 from the *Buyer Beware* report, with total OOHC reaching 17,051 by the same period.
- Aboriginal and Torres Strait Islander representation is projected to reach 47% by FY30. [1]

C.5. The model is applied at a whole-of-state level and does not account for geographic variation in placement availability or constraints. In practice, the availability of FBC differs significantly across regions, which are not visible in the whole-of-state projections.

Figure C.2 The Rennie Advisory Demand Forecast (2025) [1]



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(1. B) Rennie Advisory – Cost Model

Context

C.6. The *Buyer Beware* report identifies NFBC as the most resource-intensive form of OOHC, accounting for a disproportionate share of total child protection expenditure relative to the number of children placed in that setting. Expenditure on NFBC has increased significantly over time, reflecting both growth in placement numbers and rising average costs per placement. [1]

C.7. The cost model has been developed to translate projected demand into projected expenditure under existing funding and pricing arrangements. It applies assumptions regarding average costs per placement, growth in unit costs over time, and the interaction between placement mix and total expenditure. Its purpose is not only to estimate future spending, but to illustrate the budgetary consequences of maintaining current system settings in the context of rising demand and constrained alternatives. [1]

C.8. The cost model therefore provides a link between projected demand, service configuration and public expenditure, enabling consideration of financial sustainability under set assumptions and scenarios.

Purpose and framing

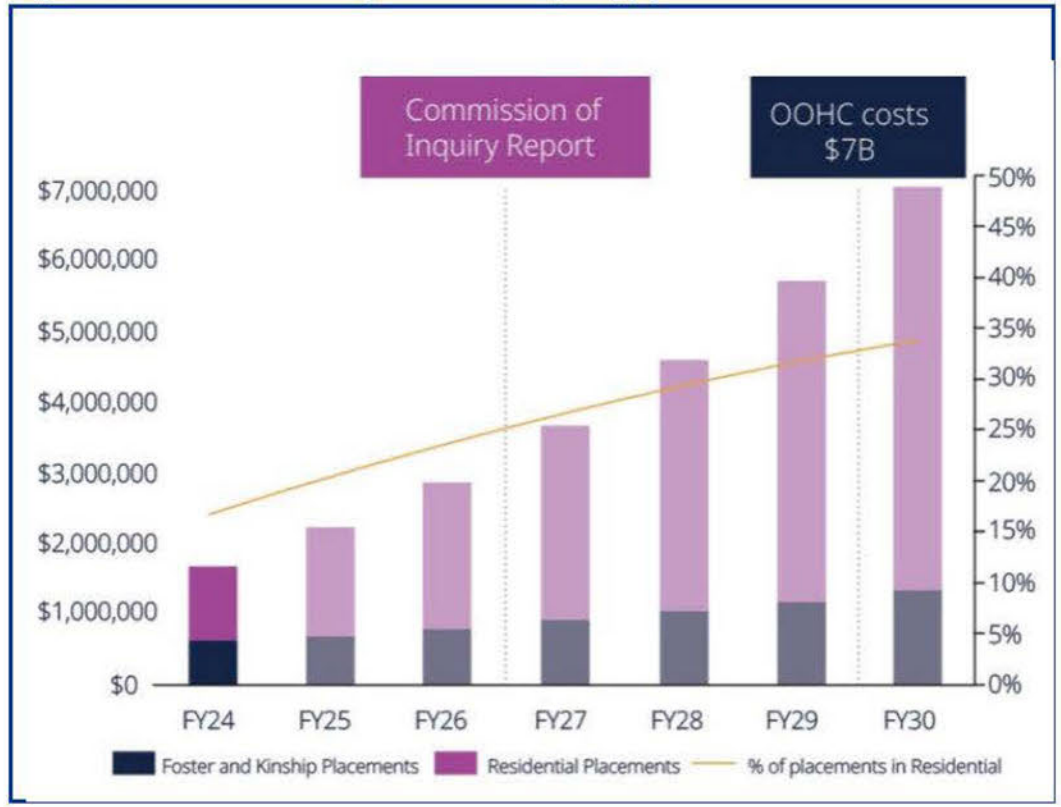
C.9. The cost model is intended to demonstrate the financial consequences of projected demand under an unchanged system. It does not estimate the cost of an improved or reformed system, but rather illustrates the expenditure trajectory that may arise if current funding, pricing and procurement arrangements remain in place. Accordingly, the model serves as a baseline view of fiscal exposure and sustainability risk, against which the potential impacts of future reforms could be assessed.

Forecast findings:

- OOHC system costs are forecast to rise by approximately 289% from current levels in FY24 to around $7 billion per year by FY30 as per Figure 1 from the *Buyer Beware report*.
- Cost growth is driven by continued increases in overall OOHC demand, constrained growth in FBC options, and the resulting expansion of NFBC placements, which carry significantly higher unit costs and are required to scale to meet residual demand. [1]

C.10. These cost outcomes are mechanically driven by the demand trajectories described in Section (1.A), rather than by independent cost modelling.

Figure C.3 The Rennie Advisory Cost Forecast (2025) [1]



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(2) The Demographics Group – Demand Model

Context

C.11. *The Future Residential Care Workforce – Demographics Analysis Report* was prepared by PeakCare, with demographic analysis undertaken by The Demographics Group, to inform discussion about the sustainability of Queensland's **NFBC system**. The report is primarily concerned with whether the NFBC workforce can realistically expand to meet future demand, and the cost and feasibility implications of doing so. [2]

C.12. Within this report, a very simple, illustrative NFBC demand model is included to provide high-level context. The modelling is intentionally basic, relying on straightforward trend extrapolation rather than detailed forecasting, and is used to indicate the potential order of magnitude of future NFBC demand as an input to discussion about future workforce requirements in Queensland. [2]

Purpose and framing

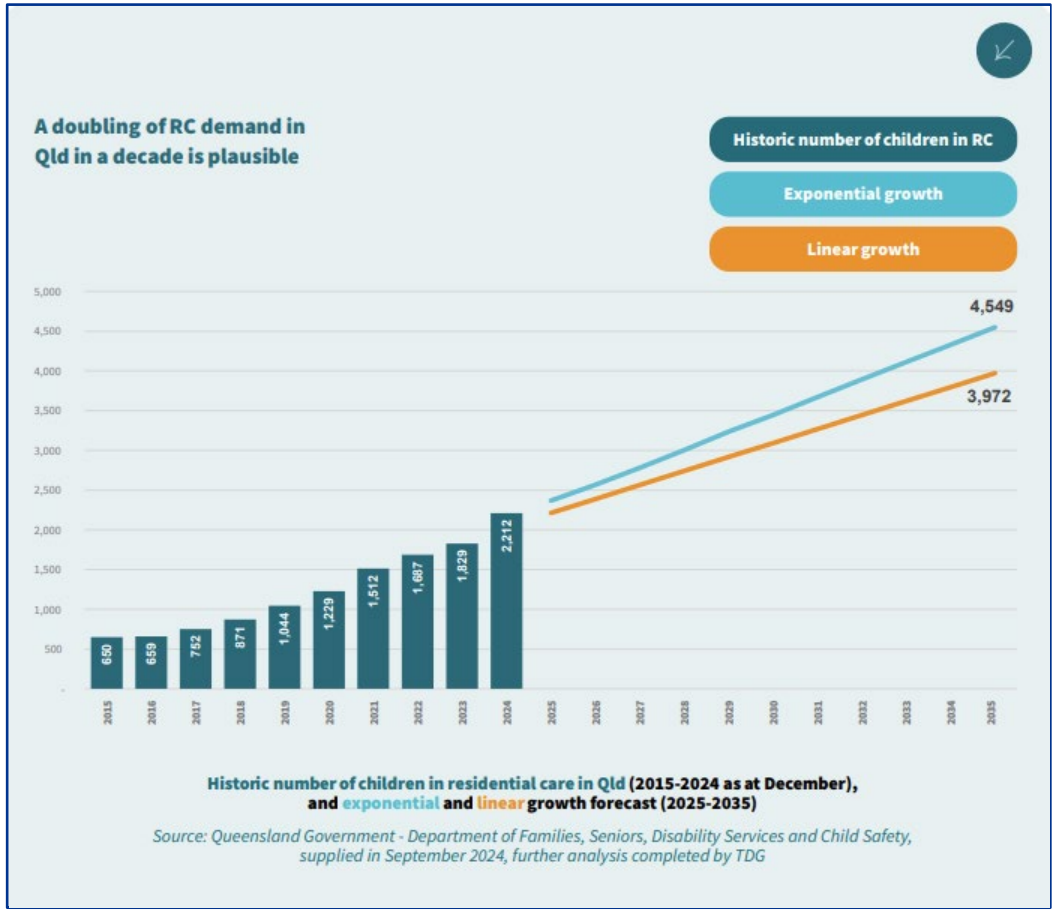
C.13. The NFBC model is included as a contextual tool rather than a technical forecasting exercise. Its role is to provide a simple baseline against which the report examines the scale of workforce growth that would be required if NFBC demand continues to increase broadly in line with recent trends. [2]

C.14. The model is not intended to inform operational planning or policy design, and it does not account for future reforms, behavioural change, future placement mix constraints, or preventative investment. Instead, it is used to frame the report's core analysis of workforce availability, recruitment challenges, and financial sustainability risks associated with continued reliance on NFBC within the OOHC system. [2]

Forecast findings:

- NFBC demand is expected to increase by 40-59% in FY30 under the model's linear and exponential growth scenarios, to reach between 3,090-3,450 by FY30, approximately.
- Workforce requirements increase disproportionately relative to child numbers due to the high-touch nature of NFBC, including 24/7 staffing and an assumed 2.5 carers per placement. [2]

Figure C.4 The Demographics Group Demand Forecast (Sep 2025) [2]



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(3) Peak Care/Social Vantage Advisory – Demand Model

Context

C.15. The *Insights and Opportunities – Queensland Residential Care Workforce* report was prepared by PeakCare under the Catalyst for Care program, with consultation and development led by Social Vantage Advisory, and commissioned by the Queensland Department of Families, Seniors, Disability Services and Child Safety. The report is intended to inform the development of a Residential Care Workforce Strategy by providing an evidence-based picture of current conditions and future pressures facing the workforce. [3]

C.16. Within this report, a high-level demand projection is included to provide context for workforce planning. The projection is deliberately simple and uses recent historical growth rates in OOHC and NFBC placements to illustrate potential future demand. It is not a standalone forecasting model, but an indicative extrapolation used to frame discussion about whether the NFBC workforce can realistically meet future need, and how current demand trajectories compare with stated reform objectives. [3]

Purpose and framing

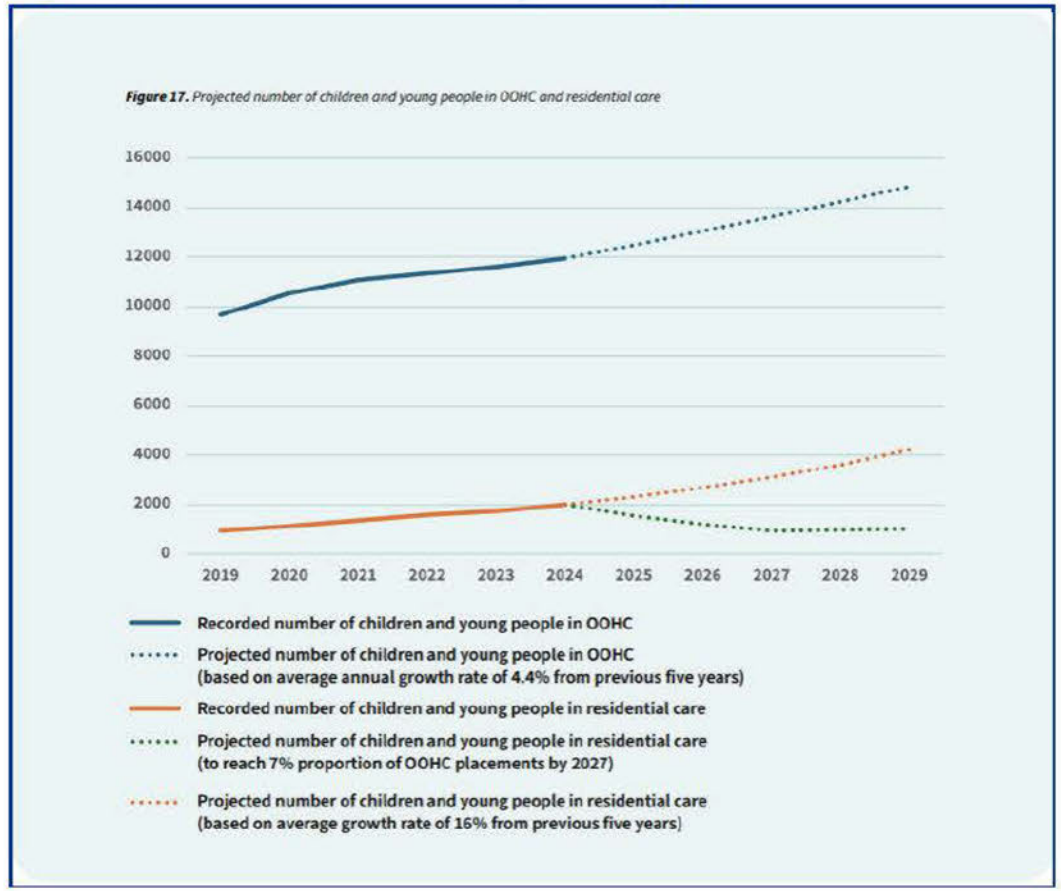
C.17. The demand projection is included as a contextual planning input rather than a detailed forecasting or economic modelling exercise. Its role is to provide a simple baseline that highlights the divergence between policy intent to reduce reliance on NFBC as a proportion of the placement mix, and the actual growth trends observed in NFBC demand in recent years.

C.18. The projection does not attempt to predict outcomes with precision and does not model the effects of future reforms, policy commitments, behavioural change, or preventative investment. Instead, it is used to make visible the scale of adjustment that would be required to achieve reform goals, and to frame the report's core analysis of workforce capacity, skills, and system readiness in the context of current, rather than aspirational, demand trajectories.

Forecast findings:

- Under extrapolated trends, NFBC placements are projected to reach 4,208 by FY29, with total OOHC demand expected to reach 14,841 in the same period.
- Under the policy-target scenario, achieving a reduction of NFBC to 7% of total OOHC by FY27, the model provides a NFBC demand forecast of 1,039 placements by FY29. [3]

Figure C.5 The Peak Care demand Forecast (March 2025) [3]



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(4.A) Simulated Analytical Model (SAM) – Demand Model

Context

C.19. The Simulated Analytical Model (SAM) was originally developed in 2014 for the Queensland Government following the *Queensland Child Protection Commission of Inquiry (Carmody Inquiry)*. It was commissioned to support system-level reform planning by simulating child pathways through the child protection system and testing the impacts of alternative policy and service delivery settings over time. [5]

C.20. Developed by Insight Acumen in collaboration with the Queensland Government using the ExtendSim platform, the role of the SAM has evolved. While initially used as a reform and scenario-testing model, it is now the primary demand input to the parameter-based funding model (PBFM). Its outputs therefore form the core quantitative basis for estimating future service demand and informing funding allocations across the child protection system. [4][5]

Purpose and framing

C.21. In its current application, the SAM functions as the primary demand input currently used for funding estimates, conditional on externally specified intakes, PD tables, and other stated assumptions. [4][5]

C.22. However, the model remains a simulation-based representation of a complex system rather than a deterministic demand forecast. Its outputs are shaped by model structure, embedded assumptions and administrative data. While point estimates are relied upon for funding decisions, they remain contingent on assumptions about system behaviour, policy settings and external inputs affecting future demand. [4]

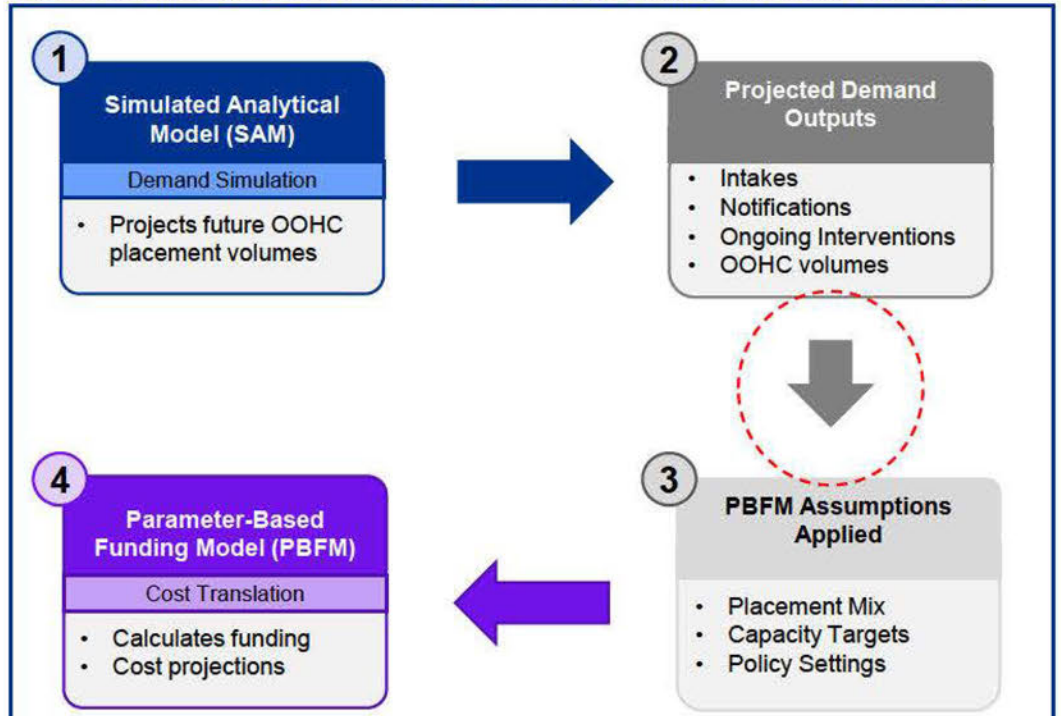
C.23. Accordingly, the SAM provides a structured and internally consistent conditional estimate of future demand for funding purposes, subject to externally specified inputs and stated assumptions. Given its central role in the PBFM framework, this underscores the importance of transparency around assumptions, limitations and sensitivities, and careful interpretation where outputs are used to inform long-term budgetary or reform decisions.

Model Outputs:

- The SAM produces projected child volumes and flows at each stage of the Queensland child protection system, including intake, notification, intervention and OOHC, which are used as demand inputs to downstream funding and planning models. [4]

C.24. Figure C.6 provides an illustrative, high-level schematic of the SAM-to-PBFM linkage, illustrating how simulated demand outputs from SAM are translated into funding estimates within the PBFM (highlighted within the red dashed outline).

Figure C.6 Existing High-level SAM-to-PBFM model system (KPMG derived from [10])



SAM projects demand volumes; PBFM translates those volumes into funding estimates.

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(4.B) Parameter-Based Funding Model (PBFM) – Cost Model

Context

C.25. The PBFM is used by the Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS) and Queensland Treasury to translate projected child protection service demand into funding requirements. It allocates funding based on expected volumes of activity across the child protection system, rather than historical expenditure or incremental budget adjustments. [8][9]

C.26. The PBFM draws its primary demand inputs from the SAM (as shown in Figure 1 of the previous page), applying cost and resourcing parameters to projected numbers of children at different stages of the child protection system. In doing so, it operates as the financial translation of the demand dynamics modelled in the SAM, converting projected demand into budget estimates for service delivery. [8]

Purpose and framing

C.27. The PBFM provides a structured, transparent and repeatable method for producing funding benchmarks under approved demand, supply-mix and cost parameters, to support budget setting, control and acquittal. [9]

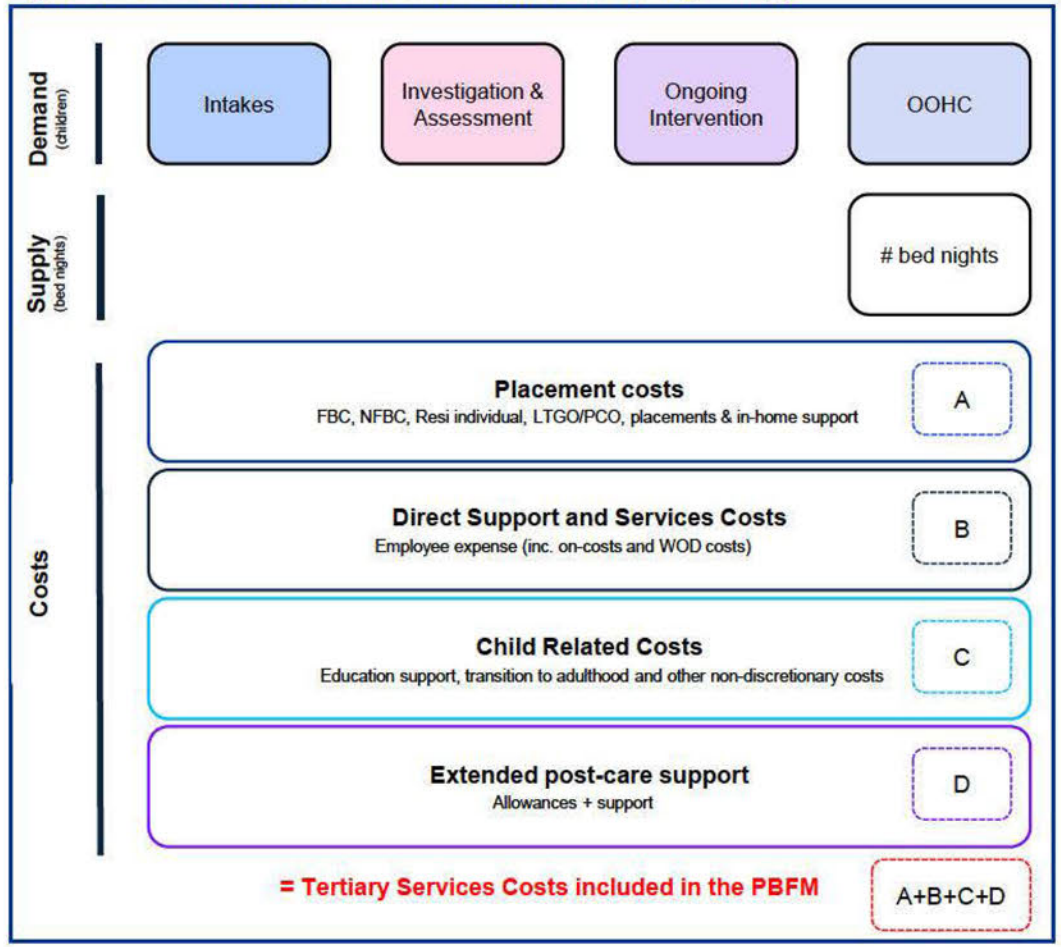
C.28. In practice, the PBFM operates primarily as a budget management and control tool rather than as a predictive funding forecasting model. [8] Funding outcomes are generated under approved policy, supply-mix and cost assumptions and are relied upon for budget setting, acquittal and forward planning. Outputs should therefore be interpreted as conditional funding benchmarks, not as unbiased projections of funding required under real-world constraints.

C.29. Given its central role in informing budgetary decisions, this underscores the importance of transparency around parameter assumptions, sensitivity to changes in demand and cost drivers, and careful interpretation where outputs are used to inform long-term funding.

Model Outputs:

- The PBFM converts projected demand into funding estimates across defined tertiary cost categories, including OOHC placement costs, direct support and services costs, child-related costs and extended post-care support, as specified in the model scope. [9]

Figure C.7 The focus of the PBFM on the Child Protection System [9]



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Part 5.3

Model Issues Identification

Models (1)-(3) Specific Limitations

Table C.1 Detailed commentary of models (1)-(3)

Finding	Issue	Commentary
1	Rennie Advisory model is a deterministic trend-extrapolation baseline (CAGR) that produces single point estimates & unclear model output replicability	The approach is described as a simple, point-in-time, whole-of-state, trend-based forecast to FY30 intended to illustrate future system pressure under an unchanged scenario. It projects future placement volumes using assumptions about entry rates, placement mix, population growth and system behaviour continuing broadly in line with recent trends, and then applies assumptions on average costs per placement and unit cost growth to translate demand into expenditure, producing deterministic outputs. As documented in the source report, the method is not designed to model reform effects. Its reliance on point-in-time trend extrapolation, without causal structure or quantified uncertainty, means it is suitable only for high-level directional signalling rather than robust forecasting. The demand forecast shown in the *Buyer Beware* report could not be reproduced from the assumptions stated in the accompanying methodology note. To the extent that the published cost outputs are derived from that demand forecast, those outputs also could not be reconciled to the disclosed assumptions. The published series implies materially different growth in total OOHC and kinship placements than is disclosed in the note, reducing transparency and reproducibility. The illustration used in *Buyer* Beware to forecast **NFBC demand reaches 5,747 placements by FY30**, with total **OOHC reaching 17,051** in the same period. OOHC system costs are forecast to rise to around $7 billion per year by FY30.
2	Demographics Group model is an illustrative linear/exponential extension of past NFBC counts with a fixed workforce multiplier	The model is explicitly framed as intentionally illustrative and trend-based, included to support discussion about workforce sustainability rather than operate as a technical forecasting tool. Methodologically, it extends historical whole-of-state NFBC population counts (2015–2024) using simple linear and exponential curves to 2035, then converts projected children to workforce needs using a fixed 2.5 carers per placement ratio. It does not incorporate behavioural, demographic, policy or system-constraint modelling, consistent with the presentation that the model is a contextual tool rather than decision-grade forecasting. This models forecasts **NFBC demand is expected to reach between 3,090-3,450 by FY30**, approximately.
3	PeakCare / Social Vantage Advisory projection uses simple trend growth rates plus a policy target pathway, without modelling drivers or constraints	The projection is described as a deliberately simple whole-of-state trend extension to FY29 to provide context for workforce strategy, rather than a standalone forecasting model. It extrapolates OOHC and NFBC demand using observed FY19–24 headcount data, applying five-year average annual growth rates to produce a 'historical trend continuation' trajectory, alongside a second pathway that computes the NFBC cohort implied by achieving a 7% of OOHC target by FY27 and a smoothed reduction path. The method is transparent but does not model drivers, behavioural responses or constraints, aligning with the broader Part C framing that such models are suitable for directional signalling under trend continuation rather than durable forecasting. This model forecasts **NFBC placements are to reach 4,208 by FY29**, with total **OOHC reaching 14,841** in the same period, under the trend-based extrapolation. *If extrapolating using noted methodology to FY30, NFBC placements reach 4,880, with total OOHC reaching 15,494 (KPMG-derived).

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Models (1)-(3) Recommendations and Conclusions

Table C.2 Detailed review of models (1)-(3)

Finding	Issue	Recommendation
1	Rennie Advisory model is a deterministic trend-extrapolation baseline (CAGR) that produces single point estimates & unclear model output replicability	Treat this model as an illustrative baseline for signalling direction of travel only. It should not be relied upon as a robust estimate of the magnitude of future demand or costs, particularly where the forecast outputs cannot be readily reproduced from the stated assumptions.
2	Demographics Group model is an illustrative linear/exponential extension of past NFBC counts with a fixed workforce multiplier	Use this projection only as an illustrative 'do-nothing' trend range to indicate direction of travel and the approximate order of magnitude of NFBC and workforce pressures under an unchanged-system assumption. Do not rely on it to quantify the magnitude of future demand or workforce requirements, nor as a basis for operational planning, funding decisions, or performance targets.
3	PeakCare / Social Vantage projection uses simple trend growth rates plus a policy target pathway, without modelling drivers or constraints	Treat this projection as an indicative trend and gap-to-target framing tool under a "current trends persist" assumption. It should not be relied upon for quantifying future demand levels, or for forecasting OOHC or NFBC caseload.

Conclusion for models (1)-(3)

C.30. Taken together, the limitations of the three models mean they should be treated as illustrative, point-in-time trend baselines only. Their shared reliance on extrapolating recent trends, the lack of an explicit causal structure, and the absence of quantified uncertainty materially constrain their capacity to produce reliable estimates of future demand or costs for funding allocation or long-term planning.

C.31. For these reasons, the role of models (1)–(3) should be limited to agenda-setting and signalling, while decision support would more appropriately rely on the SAM-to-PBFM model system, once enhanced, to enable driver-based forecasting, constraint-aware supply mix, and routine scenario and sensitivity testing.

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Simulated Analytical Model (SAM) – Methodology Overview

This section summarises, at a high level, how the current SAM converts inputs into system-wide outputs through probabilistic simulation.

Inputs

C.32. The model uses structured input datasets (primarily Excel workbooks) which establish initial conditions and parameters for each run. [4]

C.33. Inputs comprise: [4][5]

a. historical "actuals" for completed financial years (child-level intake and pathway records);

b. Ongoing Intervention (OI) records to pre-populate the model at the run start date;

c. probability distributions (PDs) that define transition likelihoods by financial year, region, age, Indigenous status and entry status;

d. "future demand" intake volumes used where actuals are unavailable; and

e. scenario levers and work packages that apply user-specified adjustments to baseline parameters.

Simulation

C.34. SAM is a discrete-event Monte Carlo simulation implemented in ExtendSim, representing system pathways as connected process flows. [4]

C.35. Each child or young person is represented as an entity with attributes (for example age, region, Indigenous status and entry status) which determine PD look-ups and transitions. [4]

C.36. Actuals, future demand and OI cohorts are merged and filtered for run settings (for example region), then progressed through pathways using PDs and timing assumptions. [4]

Outputs

C.37. The model produces counts of children and young people at key system stages, disaggregated by year, region, pathway and cohort, and exports summary outputs to Excel. [4][5]

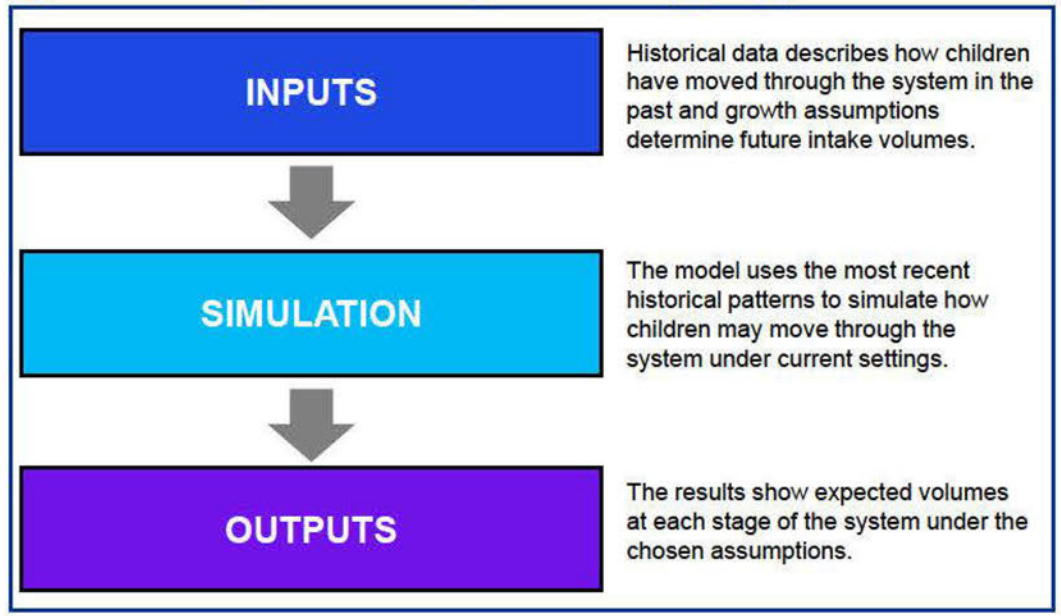
C.38. Output files also record scenario/work package configuration for traceability. [6][7]

C.39. Outputs are presented as indicative model results under the specified assumptions and configuration. [4]

Conceptual view

C.40. The SAM is a system-level model that uses past patterns of movement through the child protection system to estimate how volumes may evolve under current settings. [4][5] Figure C.7 below summarises this logic at a high level.

Figure C.7 The three phases of the SAM (KPMG based on [4] and [5])



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Simulated Analytical Model (SAM) – Demand Model Review

Table C.3 Detailed review of the SAM (4.A)

Finding	Issue	Model Area	Commentary	Recommendation	Severity
4	Future intakes are externally specified, not driver-based	Input	The SAM does not generate future intakes endogenously from causal drivers within the model. Instead, future intake volumes are specified externally using growth-based assumptions (for example, population growth or historical trend extrapolation) and then injected into the simulation. This means that SAM does not explain why intakes change, nor can it test how changes in policy settings, practice reforms, economic conditions or social drivers would alter intake demand. As a consequence, SAM outputs are inherently conditional on the continued validity of externally imposed assumptions, and forecast results cannot be interpreted as an independent or self-contained demand forecast. This limits transparency, weakens causal interpretation, and reduces confidence when forecasts are used to inform downstream funding or service planning decisions.	*Develop a driver-based intake forecasting capability, either within SAM or as a formally integrated upstream module, that links intake volumes to observable drivers (such as economic stress, demographic change, reporting behaviour, policy thresholds or diversion pathways). At a minimum, clearly delineate and document SAM's reliance on externally specified intakes and restrict its use to conditional scenario testing rather than independent demand forecasting	High
5	Probability distribution tables embed historical system behaviour	Simulation	SAM currently relies on extensive PD tables derived from historical system behaviour to determine how children transition through the system. While this approach reproduces past pathways, PDs are largely carried forward into future years without systematic reassessment or adjustment for structural change. This creates a risk that historic dynamics, decision thresholds or service availability patterns are implicitly assumed to persist, even where reforms, practice changes or external shocks have materially altered system behaviour. Without explicit governance, validation or recalibration, PDs may embed outdated assumptions, mask emerging trends, and give a false sense of precision in future projections.	In the absence of a detailed view of the makeup of the PD tables, it is recommended to establish a formal governance framework for PDs, including regular review cycles, explicit tests for structural breaks, documented rationale for carry-forward assumptions, and transparent sign-off processes. Where material system change has occurred, PDs should be recalibrated or stress-tested rather than automatically extended into future years.	Medium
6	SAM does not represent placement supply or capacity constraints	Output	SAM simulates demand flows through the child protection system but does not explicitly model placement supply, workforce capacity or market constraints. Instead, supply mix outcomes and capacity limits are imposed outside the model through static targets or manual adjustments in downstream processes. As a result, SAM cannot capture how supply shortages, shifts between placement types, or capacity bottlenecks create price pressure, trigger cost escalation, or increase the risk of overspends. As a result, the translation of SAM demand outputs into funding and cost projections relies on additional assumptions and does not systematically surface early indicators arising from supply constraints or emerging market conditions. This creates a risk of misalignment between projected demand, feasible system capacity and funding outcomes.	*Extend SAM, or the SAM-to-funding interface, to include an explicit representation of placement supply, capacity constraints and substitution dynamics. This could include modelling limits on placement availability, workforce growth rates and substitution rules, enabling demand forecasts to reflect operational feasibility and improving the robustness of downstream cost and funding estimates.	High

*The proposed enhancements to the SAM-to-PBFM interface have been visualised in Figure C.1.

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Parameter-Based Funding Model (PBFM) – Methodology Overview

This section describes, at a high level, the manner in which the current PBFM converts inputs into cost outputs through parameter setting and escalation.

Inputs

C.41. The model ingests structured financial, demand and policy parameters, primarily through a central Excel model, to establish the funding baseline for each run. [9]

C.42. Inputs comprise: [9][10]

a. demand forecasts for children at key system points (intakes, notifications, ongoing intervention and out-of-home care), sourced from SAM;

b. supply parameters, including forecast out-of-home care bednights and placement mix targets by region;

c. base-year cost data for placements, frontline staffing and child-related costs, drawn from financial and contract records;

d. indexation parameters for price escalation; volume settings derived from demand forecasts and policy settings (for example population growth, wage and CPI-based indices); and

e. policy-set assumptions, including locked-in placement mix targets and unit cost assumptions.

Processing

C.43. PBFM is a deterministic, parameter-based funding model implemented in Excel. [9]

C.44. Forecast demand volumes are used to index base-year costs through predefined volume and price escalation rules. [9]

C.45. Placement costs are calculated by applying forecast bednights to an assumed supply mix and escalated unit costs. [9][10]

C.46. Non-placement costs (including frontline staffing and child-related costs) are escalated using demand-linked or policy-specified indexation rates. [9]

C.47. Selected parameters are subject to annual acquittal, whereby forecast parameters are compared to actuals and funding adjustments calculated. [8]

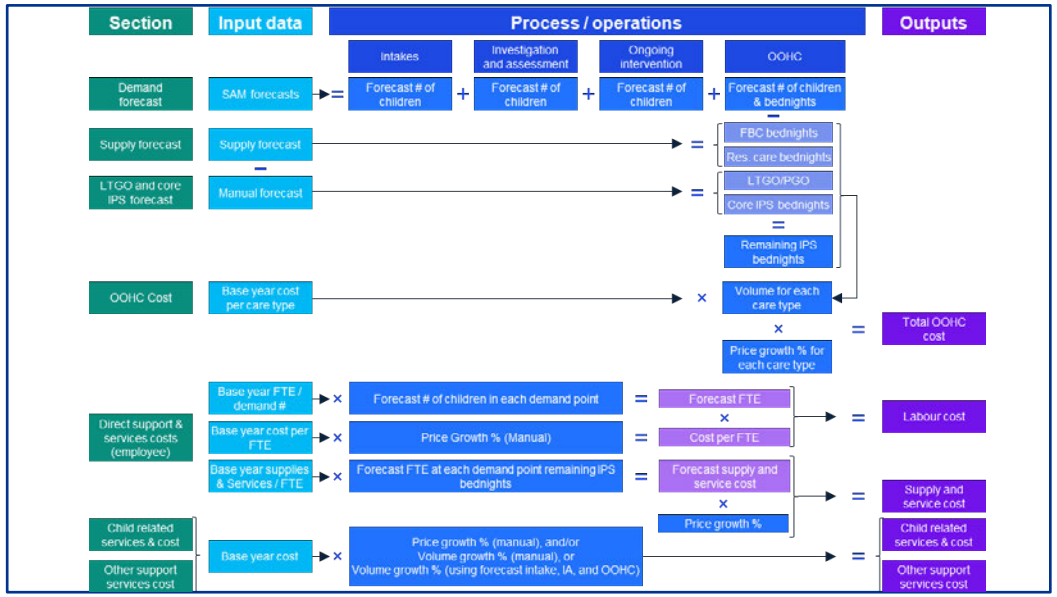
Outputs

C.48. The model produces forecast funding requirements for tertiary child protection services, disaggregated by major cost category and financial year. [9]

C.49. Summary outputs include total placement costs, non-placement costs, workforce funding and aggregate funding impacts across the forward estimates. [9][10]

C.50. Outputs also support annual acquittal and end-of-year reconciliation processes, identifying funding variances attributable to parameter movements. [8]

Figure C.8 KPMG flow chart summarising steps described in [9]



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Parameter-Based Funding Model (PBFM) – Cost Model Review

Table C.4 Detailed review of the PBFM (4.B)

Finding	Issue	Area	Commentary	Recommendation	Severity
7	Single-point reporting obscures sensitivity to key assumptions	Output	PBFM outputs are typically reported as single point estimates derived from applying cost and resourcing parameters to SAM demand volumes. This approach obscures how materially funding results can change under plausible variation in key parameters and assumptions, including demand drivers, supply mix settings and cost escalation rates. As a result, decision-makers have limited visibility of uncertainty and downside risk, particularly where model processing is intentionally aligned to target or policy settings, which may understate funding pressures, rather than a best-estimate representation of system behaviour.	Require PBFM reporting to include a standard set of sensitivity ranges for materially significant parameters, including alternative cost escalation assumptions for major cost components. Outputs should be presented as funding ranges rather than single figures to better reflect uncertainty and support informed decision-making.	Medium
8	PBFM outputs may be misinterpreted as forecasts of funding required	Governance, Output interpretation	There is a governance and interpretation risk that PBFM outputs are misread as forecasts of funding required to meet demand, rather than as funding benchmarks produced under approved, target-driven parameter settings. This risk is heightened where supply-mix assumptions are manually specified and not fully constraint-aware (which is the case with the current model), limiting transparency over how capacity constraints and substitution dynamics influence outcomes. PBFM outputs are also conditional on demand and pathway inputs sourced from the SAM, and therefore inherit the SAM's current limitations by design. In practice, this can lead to misplaced reliance on PBFM outputs for planning and decision-making beyond their intended purpose.	*Explicitly separate and label two standard reporting outputs: a "base case" used for control and acquittal, reflecting approved target-driven parameter settings; and a "reference case" used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model. This separation improves transparency. It makes clear which demand, supply and policy drivers explain differences between "base" settings and "reference case" outcomes, and better supports decisions about potential interventions, such as workforce expansion or provider and carer incentives. Both outputs should be accompanied by a standard interpretation statement. This statement should clearly explain the conditional nature of the results and prevent misinterpretation as unconstrained forecasts.	High
9	Cost escalation is indexation-driven and conditional	Processing, Parameter governance	The PBFM escalates base-year costs using indexation settings embedded within the model. As a result, projected funding outcomes are conditional on the ongoing appropriateness of these escalation assumptions. Where placement-specific price pressures, workforce shortages or market conditions cause costs to move materially above indexation, funding projections may no longer reflect underlying cost drivers. In the absence of a structured governance process, escalation settings risk persisting by default rather than being actively reviewed, challenged and updated in response to observed system behaviour.	Establish formal governance over cost escalation assumptions, including defined ownership, periodic review and explicit decision points for updating indexation settings. Escalation assumptions should be treated as conditional parameters and supported by targeted escalation sensitivity testing for materially uncertain cost components, with impacts clearly documented to inform funding and policy decisions.	Medium

*The proposed enhancements to the SAM-to-PBFM interface have been visualised in Figure C.1.

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06
Appendices



Appendix. Part A

Part A Data limitations

#	Finding	Data source reference
1	The main source of data used for the market scan analysis includes data between July 2021 and December 2025 (i.e. four and a half financial years' worth of data). As only half of FY2025-26 is covered, this year has been excluded from analysis.	[redacted]
2	There was limited opportunity to validate categorisations and definitions with data owners. Noting the complexity of categorising service groupings and that particular services may cross multiple service types, analysis has aligned with Departmental-provided categorisations.	
3	Many data categories within Departmental-provided data were incomplete and displayed partial overlap ([redacted]). Where this occurred, the categories with the most non-blank values were selected, noting that there may be discrepancies with other overlapping categories. For this analysis, classification into 'Residential Care' was selected based on 'Placement and Support Classification'.	[redacted]
4	For calculation of median daily cost, the category [redacted]' from the Departmental-provided data was used. Zero and blank values were excluded from the median calculation. The Department advised that for this category, the median is a more appropriate measure for analysis than the mean due to the wide variation in placement costs.	[redacted]
5	Volume measures were complex to calculate given differences in IPS and OSD contract output measurements; as a result, placement nights were used as a proxy for volume, as advised by the Department.	[redacted]
6	Figures and charts within the supply and demand sections, where based on alternate sources e.g. ABS, ROGs etc. may define periods differently (e.g. point-in-time calculations as at June of each year, rather than full financial year figures as per the Departmental dataset). Comparability may be limited.	Various
7	This review was undertaken without consulting providers. As a result, while patterns are identified in terms of net increases and decreases, there is limited data on the rationale for these changes. Additionally, the quantitative data provided does not support analysis of attribution or causality.	Various

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Appendix: Part A References (Continued overleaf)

Ref #	Reference
1	[redacted]
2	Queensland Government. (2024, December). Media statement: Investing in Queensland's child safety system. https://statements.qld.gov.au/statements/101703
3	Queensland Family and Child Commission. (2025). Buyer beware: How economic forces are shaping Queensland's residential care market. QFCC. https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Paper-Buyer-Beware-How-economic-forces-are-shaping-Queenslands-residential-care-market.pdf
4	Department of Families, Seniors, Disability Services and Child Safety. (2025, June 17). Human services quality framework. Queensland Government. Retrieved March 20, 2026, from https://www.families.qld.gov.au/our-work/human-services-quality-framework
5	[redacted]
6	Gillespie, E. (2023, July 6). Queensland failing children in residential care as key provider shuts its doors, peak body says. The Guardian. Retrieved March 20, 2026, from https://www.theguardian.com/australia-news/2023/jul/06/queensland-failing-children-in-residential-care-as-churches-of-christ-shuts-its-doors-peak-body-says
7	Queensland Parliament, Community Support and Services Committee. (2024). Estimates pre-hearing: Questions on notice and responses - Minister for Child Safety, Minister for Seniors and Disability Services and Minister for Multicultural Affairs. https://documents.parliament.qld.gov.au/com/CSSC-0A12/C20242025-CB35/on%20Notice%20from%20the%20committee%20and%20responses,%20Minister%20for%20Child%20Safety,%20Minister%20for%20Seniors%20and%20Disability%20Services%20and%20Minister%20for%20Multicultural%20Affairs.pdf
8	Leigh, A. (2024, March 8). Interview - Mornings ABC Brisbane with Steve Austin. Ministers' Media Centre. https://ministers.dewr.gov.au/leigh/interview-mornings-abc-brisbane-steve-austin
9	[redacted]
10	Department of Families, Seniors, Disability Services and Child Safety. (n.d.). Queensland care services outcomes framework. https://www.families.qld.gov.au/_media/documents/about-us/partners/child-family/qld-careservices-outcomes-framework.pdf
11	Victorian Government. (2026, February 23). Social Services Regulator. https://www.vic.gov.au/social-services-regulator
12	Queensland Family and Child Commission. (n.d.). Our role. Retrieved March 20, 2026, from https://www.qfcc.qld.gov.au/about-us/our-work/our-role
13	NSW Government, Office of the Children's Guardian. (n.d.). Our legislation. https://ocg.nsw.gov.au/our-legislation
14	Queensland Government. (n.d.). Centralised register for regulated home-based care services: User access and management procedure [Fact sheet]. https://www.families.qld.gov.au/_media/documents/about-us/partners/licensing/hsqf-licensing-fact-sheet.pdf
15	Victorian Government. (2026, March 16). Social Services Regulator registration. https://www.vic.gov.au/social-services-regulator-registration

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Appendix: Part A References (Continued)

Ref #	Reference
16	Australian Government, Australian Business Licence and Information Service. (n.d.). Specialised substitute residential care provider - New South Wales. Retrieved March 20, 2026, from https://ablis.business.gov.au/service/nsw/specialised-substitute-residential-care-provider/47374
17	Queensland Government. (2025, November 11). Compliance and enforcement under the blue card system. https://www.qld.gov.au/law/laws-regulated-industries-and-accountability/queensland-laws-and-regulations/regulated-industries-and-licensing/blue-card/system/compliance
18	Victorian Government. (2026, February 20). About the Social Services Regulator. https://www.vic.gov.au/about-social-services-regulator
19	NSW Government, Office of the Children's Guardian. (2025, July 2). Frequently asked questions about the Working with Children Check (WWCC). https://ocg.nsw.gov.au/working-children-check/apply-wwcc/frequently-asked-questions-about-wwcc
20	Productivity Commission. (2026). Child protection services (Report on Government Services 2026). Australian Government. https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/
21	PeakCare Queensland. (2025). Insights and opportunities - Residential care workforce. PeakCare Queensland. https://peakcare.org.au/wp-content/uploads/2025/11/PeakCare-Insights-and-Opportunities-Detailed-Report-Final.pdf
22	James, S. (2011). What works in group care? A structured review of treatment models for group homes and residential care. Children and Youth Services Review, 33(2), 308–321. https://doi.org/10.1016/j.childyouth.2010.09.014
23	Australian Institute of Health and Welfare. (2024). Child protection Australia 2023–24. AIHW. https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2023-24/contents/about
24	Department of Child Safety, Seniors and Disability Services. (n.d.). Types of care arrangements. Child Safety Practice Manual. https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements
25	Department of Child Safety, Youth and Women, PeakCare Queensland, Encompass Family and Community, & Testro, P. (2015). Hope and Healing framework for working with children and young people living in residential care. Queensland Government. Retrieved March 20, 2026, from https://peakcare.org.au/hopehealing/hopehealing-residential-care/
26	Winokur, M., Holtan, A., & Batchelder, K. E. (2014). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. Cochrane Database of Systematic Reviews, 2014(1), CD006546. https://doi.org/10.1002/14651858.CD006546.pub3
27	Farrugia, C., & Joss, N. (2021). What contributes to placement moves in out-of-home care? (CFCA Paper No. 61). Australian Institute of Family Studies. https://aifs.gov.au/resources/policy-and-practice-papers/what-contributes-placement-moves-out-home-care
28	Macdonald, G., & Turner, W. (2008). Treatment foster care for improving outcomes in children and young people. Cochrane Database of Systematic Reviews, 2008(1), CD005649. https://doi.org/10.1002/14651858.CD005649.pub2
29	Octoman, O., & McLean, S. (2014). Challenging behaviour in foster care: What supports do foster carers want? Adoption & Fostering, 38(2), 149–163. https://doi.org/10.1177/0308575914532404
30	Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. Annual Review of Psychology, 62, 189–214. https://doi.org/10.1146/annurev.psych.093008.100412

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Appendix: Part A References (Continued)

Ref #	Reference
31	SNAICC - National Voice for our Children. (2017). Understanding and applying the Aboriginal and Torres Strait Islander Child Placement Principle. SNAICC. https://www.snaicc.org.au/wp-content/uploads/2017/07/Understanding_applying_ATSICCP.pdf
32	McDowall, J. J. (2015). Sibling placement and contact in out-of-home care. CREATE Foundation. https://create.org.au/
33	Australian Institute of Health and Welfare. (2025). Child protection glossary (v55.0). AIHW. https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/glossary
34	McLean, S. (2018). Therapeutic residential care in Australia: Taking stock and looking forward (CFCA Paper No. 49). Australian Institute of Family Studies. https://aifs.gov.au/resources/policy-and-practice-papers/therapeutic-residential-care-update-current-issues-australia
35	Queensland Department of Child Safety, Seniors and Disability Services. (n.d.). Minimum qualification standards information sheet. Queensland Government. https://www.families.qld.gov.au/_media/documents/about-us/partners/licensing/minimum-qualification-standard-information-sheet.pdf
36	Donkoh, C., Underhill, K., & Montgomery, P. (2006). Independent living programmes for improving outcomes for young people leaving the care system. Cochrane Database of Systematic Reviews, CD005558. https://doi.org/10.1002/14651858.CD005558.pub2
37	SNAICC - National Voice for our Children. (2025). Family Matters report 2025 (10th ed.). SNAICC. https://www.snaicc.org.au/wp-content/uploads/2025/12/Family-Matters-Report-2025.pdf
38	Gatwiri, K., McPherson, L., Parmenter, N., Cameron, N., & Rotumah, D. (2021). Indigenous children and young people in residential care: A systematic scoping review. Trauma, Violence, & Abuse, 22(4), 829–842. https://doi.org/10.1177/1524838019881707
39	Child Protection Act 1999 (Qld). https://www.legislation.qld.gov.au/view/whole/html/current/act-1999-010
40	National Disability Services. (2025). State of the disability sector report 2025. https://nds.org.au/images/State_of_the_Disability_Sector_Reports/NDS8221%20NDS%20State%20of%20the%20Disability%20Sector%20Report%202025_FINAL.pdf
41	Lin, J., Malady, L., Ma, N., Yang, J. S., Sutton, N., Woods, M., Carnemolla, P., & Lorber-Kasunic, J. (2025). Australia's aged care sector: Full-year report 2024–2025 (Version 1). University of Technology Sydney. https://doi.org/10.71741/4pyxmbnjaq.30816452.v1
42	[redacted]
43	Queensland Family and Child Commission. (2023). Annual report on the performance of the Queensland child protection system 2022–23. https://www.qfcc.qld.gov.au/sites/default/files/2025-09/Annual-report-Performance-of-the-child-protection-system-2022-2023.pdf
44	Queensland Family and Child Commission. (2025). Annual report 2024–25. https://www.qfcc.qld.gov.au/sites/default/files/2025-09/Annual-report-2024-25.pdf
45	[redacted]

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Appendix: Part A References (Continued)

Ref #	Reference
46	Department of Child Safety, Seniors and Disability Services. (2026). Our performance: Carer families. DCSSDS. https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/who-we-work-with/carer-families
47	[redacted]
48	Queensland Government. (n.d.). Care arrangements. Our performance: Operational data. Retrieved March 26, 2026, from https://performance.dcssds.qld.gov.au/our-performance/operational-data/care-arrangements
49	Queensland Government. (n.d.). Living arrangements of children. Improving care and post-care support: What we do. Retrieved March 26, 2026, from https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/what-we-do/living-arrangements-of-children
50	[redacted]
51	Ainsworth, F. (2017). For the few not the many: An Australian perspective on the use of therapeutic residential care for children and young people. Residential Treatment for Children & Youth, 34(3–4), 325–338. https://doi.org/10.1080/0886571X.2017.1383868
52	Victorian Government, Department of Families, Fairness and Housing. (2024, August 13). Residential care therapeutic uplift. https://fac.dffh.vic.gov.au/news/residential-care-therapeutic-uplift
53	Centre for Excellence in Child and Family Welfare. (2025). Residential care learning and development strategy (RCLDS). Retrieved March 20, 2026, from https://cfecfw.org.au/learning-development/residential-care-learning-and-development-strategy-rclds/
54	[redacted]
55	[redacted]
56	Fair Work Ombudsman. (n.d.). Social and community services industry pay rates. Australian Government. https://www.fairwork.gov.au/pay-and-wages/minimum-wages/social-and-community-services-industry-pay-rates
57	National Disability Services. (2025). NDS workforce census report 2025. NDS. https://nds.org.au/images/workforce/NDS8096%20Workforce%20Census%20Report%202025%20web.pdf
58	Western Australian Council of Social Service. (2025, November). Sustainable funding report 2025. https://wacoss.org.au/wp-content/uploads/2025/12/Sustainable-funding-Report-2025-Final.pdf
59	Child and Family Focus SA. (2023, May). Final workforce development report. https://www.childandfamily-sa.org.au/wp-content/uploads/2024/06/Final-Workforce-Development-Report.pdf
60	Queensland Family and Child Commission. (2024, December). Too little too late: The progress made against the Queensland Residential Care Roadmap. QFCC. https://www.qfcc.qld.gov.au/sites/default/files/2024-12/Too%20little%20too%20late%20-%20The%20progress%20made%20against%20the%20Queensland%20Residential%20Care%20Roadmap.pdf

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Appendix: Part A References (Continued)

Ref #	Reference
61	Queensland Family and Child Commission. (2025). Treated as broken: Residential Care Expert Advisory Council Kingaroy workshop report. https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Report-Treated-as-broken-Residential-Care-Expert-Advisory-Council.pdf
62	Association of Children's Welfare Agencies. (2024, August 19). Cost pressures in out of home care FY 2023–2024. ACWA. https://www.acwa.asn.au/wp-content/uploads/2024/08/ACWA-Cost-Pressure-Report-19-Aug-2024-FINAL.pdf
63	WorkCover Queensland. (2025). WorkCover Queensland notice (No. 1 of 2025). Queensland Government Gazette. https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0025/146374/Queensland-Government-Gazette.pdf
64	[redacted]
65	Australian Bureau of Statistics. (2026, February 25). Consumer Price Index, Australia, January 2026. ABS. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/jan-2026
66	Real Estate Institute of Queensland. (2025, July 31). No room to move: Queensland's rental market is holding tight. https://www.reiq.com/resources/media-releases/no-room-to-move-queenslands-rental-market-is-holding-tight
67	NDIS Review. (2023). Working together: NDIS review final report. https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf
68	[redacted]
69	Australian Institute of Family Studies. (2016, November 14). Australia is failing to safeguard cultural connections for Aboriginal children in out-of-home care. https://aifs.gov.au/resources/short-articles/australia-failing-safeguard-cultural-connections-aboriginal-children-out
70	NSW Government. (2025, June 24). Rebuilding services for young people in out-of-home care [Media release]. https://www.nsw.gov.au/ministerial-releases/rebuilding-services-for-young-people-out-of-home-care
71	Queensland Government. (2025, May 18). Joint media statement: Commission of Inquiry into Queensland's broken child safety system. https://statements.qld.gov.au/statements/102583
72	Weatherill, J., & White, P. (2025, August 15). Rapid child safety review. Victorian Government. Retrieved March 20, 2026, from https://www.vic.gov.au/rapid-child-safety-review
73	NSW Department of Communities and Justice. (2026, March 2). Accountability and transparency: Historic reforms to foster care [Ministerial release]. NSW Government. https://www.nsw.gov.au/ministerial-releases/accountability-and-transparency-historic-reforms-to-foster-care
74	New South Wales Government. (2024, December 2). Major review released: NSW Government's roadmap to reform foster care. https://www.nsw.gov.au/media-releases/major-review-released-nsw-governments-roadmap-to-reform-foster-care

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Appendix. Part B

B. Appendix: References

Ref #	Document ID
1	[redacted]
2	[redacted]
3	[redacted]
4	[redacted]
5	[redacted]
6	[redacted]
7	[redacted]

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Appendix. Part C

Appendix: Part C References

Ref #	Reference
1	Queensland Family & Child Commission. (2025) Buyer Beware. How economic forces are shaping Queensland's residential care market. https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Paper-Buyer-Beware-How-economic-forces-are-shaping-Queenslands-residential-care-market.pdf
2	The Demographics Group. (September 2025). The future residential care workforce. Demographic analysis. [redacted]
3	PeakCare. (March 2025). Insights and opportunities. Queensland Residential Care Workforce. PeakCare-Insights-and-Opportunities-Detailed-Report-Final.pdf
4	[redacted]
5	[redacted]
6	[redacted]
7	[redacted]
8	[redacted]
9	[redacted]
10	[redacted]
11	[redacted]

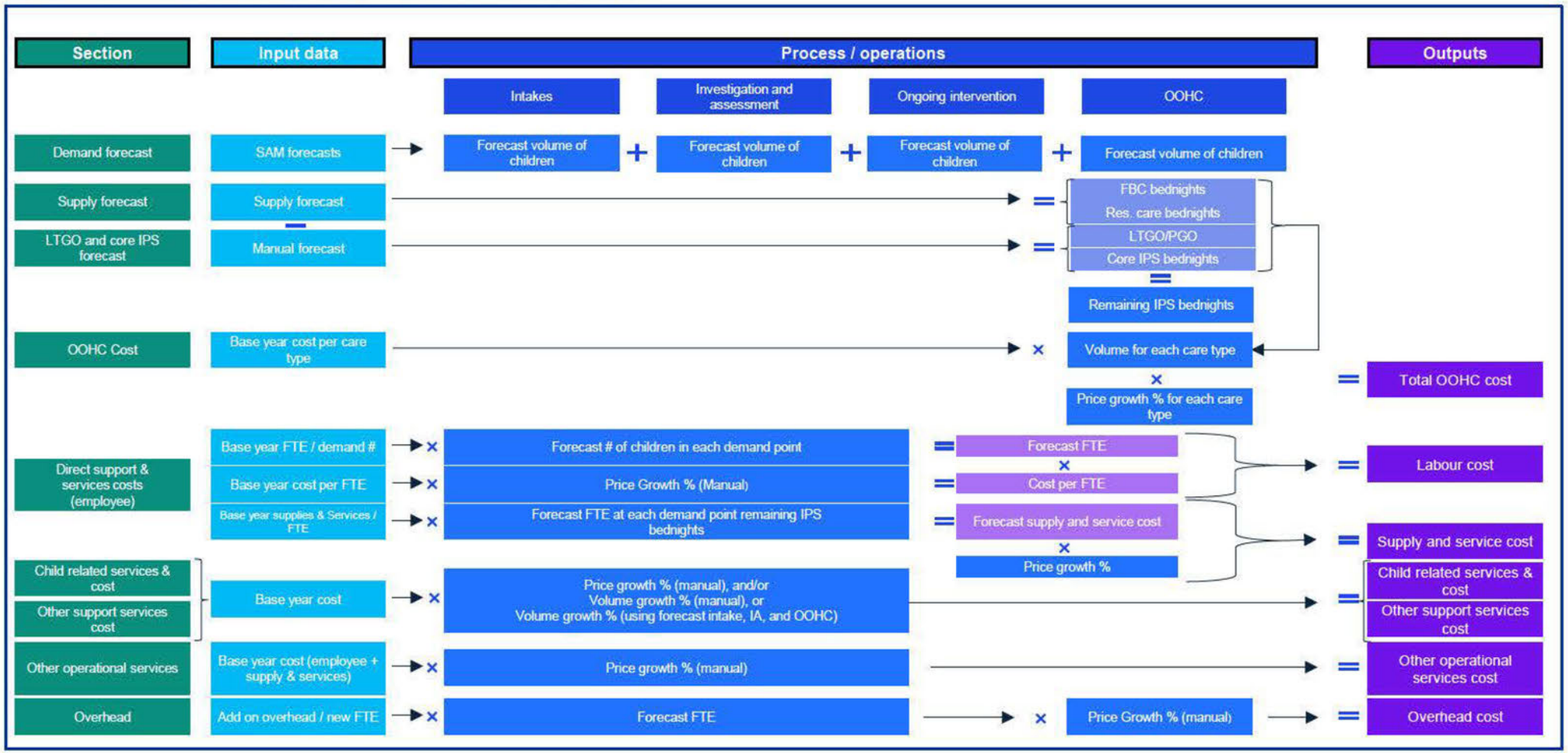
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Appendix: Enlarged figure

Figure C.8 KPMG flow chart summarising steps described in [9] - Enlarged



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Appendix: Comparison of existing FY30 outputs and key limitations

These are the principal outputs reviewed in Part C. They point in a similar broad direction, but are derived differently, serve different purposes, and carry material limitations. For that reason, no single existing output can presently be endorsed as the most accurate forecast of future demand or cost.

Table C.5 Interpreting the existing model outputs to FY30

Model	Forecast to FY30		Limitations / Notes
(1.A) Rennie Advisory Demand and (1.B) Cost	**(1.A) Demand:** • NFBC - 5,747 • OOHC – 17,051	**(1.B) Cost:** • $7.06 billion	Whole-of-state, unchanged-system trend baseline only. Uses deterministic trend extrapolation, fixed assumptions and single-point estimates, without causal modelling or uncertainty analysis. Results should therefore be treated as high-level directional signalling rather than robust estimates of future demand or cost magnitude. The forecast outputs could not be readily replicated from the assumptions stated in the methodology note, suggesting that some underlying assumptions or calculation steps were not clearly disclosed. These projections are based on a FY24 model.
(2) The Demographics Group – Demand Model	**Demand: (FY30)** • NFBC (linear) – 3,090 • NFBC (exponential) – 3,450		Intentionally illustrative only. Extends historical whole-of-state NFBC counts using simple linear and exponential trends and a fixed workforce multiplier, without behavioural, demographic, policy or system-constraint modelling, so it is suitable only for indicating broad order-of-magnitude pressure, not forecasting. These are based on a FY24 model.
(3) PeakCare – Demand Model	**Demand:** • NFBC – 4,208 (FY29) • OOHC – 14,841(FY29) --- • NFBC – 4,880 (Extrapolated to FY30) • OOHC – 15,494 (Extrapolated to FY30)		Simple trend extension for workforce strategy context, not a standalone forecasting model. Does not model drivers, behavioural responses or constraints, and the source projection is to FY29, so any FY30 extrapolation should be treated as indicative only. These are based on a FY24 model.
(4.A) Insight Acumen – SAM Demand Model	**Demand:** • OOHC – 15,628 (FY30 based on FY19 model outputs)		SAM provides conditional demand estimates based on externally specified intakes, historical pathway assumptions and stated settings; it does not currently model key drivers endogenously or explicitly represent supply and capacity constraints. This forecast is based on model outputs from FY19 *(QTC 2020 Review of OOHC Placement Services).* Since then, the model has been updated. As a result, a current-day reprojection would be expected to produce different results.
(4.B) DFSDSCS – PBFM Cost Model	**Cost: (2028-29)** • Funding - $2.066 billion (supply mix target) --- • Funding - $2.781 billion (adjusted supply mix)		Outputs are funding benchmarks under specific demand, supply-mix and cost assumptions, not unconstrained forecasts of funding required. Results are sensitive to supply-mix settings and escalation assumptions, and single-point reporting may understate uncertainty. Adjusted supply mix forecast based on proposed adjustment of supply mix to actual share mix observed – from *the "Budget 2025-26 – New – Sought".* These are based on outputs from a FY24-25 model.

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This deliverable has been prepared as outlined with the Department of Justice in the Scope Section of the engagement contract dated 30 January 2026. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this deliverable are based on a review of data and documentation provided by the Department and the Commission of Inquiry, and publicly available information. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by the Department of Justice as part of the process.

KPMG have indicated within this deliverable the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this deliverable, in either oral or written form, for events occurring after the report has been issued in final form.

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Appendix F

CA40

Issues Arising from CSO Interviews

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

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ISSUES ARISING FROM INTERVIEWS WITH DEPARTMENTAL STAFF IN FAR NORTH QUEENSLAND

Over the course of several weeks across October and November 2025, the Commission conducted a series of interviews with Department staff across the Far North Queensland Child Safety Region. The purpose of the interviews was to gain an understanding of the realities of frontline child safety work, the challenges that are being encountered in the delivery of child safety services and any suggestions to improve child safety practice and outcomes for children in care.

From these interviews, the Commission was able to distil common issues, concerns and suggestions. These are set out below.

Training and onboarding:

1. The GRO training is basic and lacks depth. It is very focused on the legislative and policy framework within which a Child Safety Officer (**CSO**) operates, rather than practical application. On-the-job learning is more helpful. Whilst having a break between the first and second block of GRO is helpful as it allows CSOs to experience the context of the training, waiting six months may be too long.

2. A university degree (in social work or human services) can be of some assistance with providing background knowledge, however it does not necessarily prepare a CSO for the role. On the job training and prior relevant professional experience is of great value in undertaking the CSO role.

3. In-field training (buddying or shadowing) is a highly valuable learning tool, however there is no structured in-field training offered by the Department. Some offices have informal mentoring/shadowing arrangements, but these are often put aside as mentors/supervisors have their own workload which can be overwhelming. The support offered by Senior Learning Advisers is of value, however access to them is too limited.

4. New CSOs are allocated cases before they complete GRO training due to staffing shortages. Some CSOs are allocated a full caseload (~15 and above) immediately after completing the first block of GRO training. Combined with a lack of infield training, new CSOs are unprepared for a full-time caseload.

5. There is a lack of, or too little emphasis on, personal safety training for new CSOs.

6. The GRO training program does not spend enough time on the different divisions of work within the Department (e.g. investigations and assessment, ongoing intervention or placements). A new CSO does not receive specific in depth training for the role they are about to commence, leaving them unprepared for their role.

7. There is inadequate training on the preparation of case notes. This leads to inconsistent case noting across files, which can create difficulties when new CSOs take over a file and need to gain an understanding of the history of a matter.

8. It is difficult for staff to fit ongoing training around work commitments.

9. Having access to online training modules is not a substitute for face-to-face training. Online modules are not as effective at conveying information to Department staff, who may not learn as effectively through this medium, may be distracted by other tasks while completing the training, or may simply click through the online modules so they can be quickly completed.

10. There is a negative perception in the public and universities of the role of a CSO which may be contributing to the lack of new staff entering the Department.

11. There is a lack of transparency as to what the CSO role actually involves. New CSOs believe they will be working with children and families and performing traditional social work activities. This is not the reality of the role, which is mostly administrative with social work being outsourced to external providers. This contributes to new staff leaving the role shortly after commencement.

12. There is a lack of flexible working arrangements, such as part-time work. This could be limiting the number of potential staff.

13. Historically, the Department would sponsor foreign workers who reside in Australia on a working visa. This has since ceased, leading to Department staff having to leave the role to find an employer who would sponsor their visa, including interstate child safety departments.

14. There is no mandatory training for Senior Team Leaders (**STL**). The role of an STL is quite different to that of a CSO. It includes managing a team, human resources issues, delegated decision-making and other management responsibilities. In the absence of mandatory training, STLs are working things out as they go or needing to access non-mandatory training when it is available.

15. There is inadequate training regarding the court requirements of the role of the CSO to properly prepare them for the volume of court related work to be completed. There is a lack of transparency as to how much of the role of the CSO, particularly in Ongoing Intervention, will be spent dedicated to court related work.

16. The current pathways to become a CSO are too restrictive. There are talented workers, both within and external to the Department, who are unable to be employed as a CSO due to the restrictions upon eligible tertiary qualifications. Applicants with relevant professional experience should be eligible to be employed as a CSO, with the possibility of additional training to support their employment in the role.

17. There is inadequate training and procedures on how to manage children who are absent from placement, leading to inconsistent approaches taken across the Department

Workload:

18. Caseloads are above the recommended level (often considerably so), including for new staff. Staff are overwhelmed and unable to perform proper casework. The work is crisis driven, resulting in constant attention to urgent matters, with less urgent matters being significantly delayed or simply not completed.

19. High staff turnover is contributing to high caseloads. STLs are also regularly having to carry their own caseload which gives them insufficient time to attend to their managerial duties. Child Safety Support Officers (**CSSO**) are also carrying de facto caseloads to help manage the burden, taking them away from their key responsibilities in supporting CSOs.

20. The workload management tool does not factor in travel time, which is an acute issue for children placed, or staying with family, in remote/regional areas. Given staff shortages, there is limited practical application of any insights from the workload management tool. Some staff simply do not use the tool as it has no bearing on their caseload. STLs also observe that no changes are made from the data collected from the workload management tool.

21. The amount of administrative work undertaken by a CSO has dramatically increased over time. Administrative work now comprises the vast majority of the work of a CSO, resulting in minimal time being spent working with children and families. Much more time is spent on paperwork than engaging with families and children.

22. The heavy caseload prevents proper and deep engagement with families and children. The requirement to visit children weekly (when under an Intervention with Parental Agreement) or monthly is very difficult to adhere to, especially for school-age children who can only be visited after 3:30pm.

23. The limited time available to spend time with children and families means that relationships are not able to be formed, and the time is spent concentrating on the referrals that need to be made, reacting to an issue that has arisen or other formal tasks that need completion. There is not enough time to ‘listen to’ the concerns and experiences of the children and families to form trusting relationships.

24. It is not possible for a CSO to complete all of the tasks associated with their role. This is amplified when carrying a high caseload.

25. The ability to work flexible hours (i.e. outside of normal business hours) may alleviate some of the time pressures associated with visiting children in care.

26. Detailed case notes are important to proper case work; however, a considerable amount of time is spent inputting case notes into the system file. Consideration should be given

to a more efficient method of recording case notes in the system to reduce administrative burden.

27. It is widely reported that the Department is under resourced. This is partly due to vacancies, but more fundamentally an inadequate number of positions to meet the growing demand on the Department. This applies both to professional and support staff. Inadequate staffing results in unmanageable caseloads being experienced across the Department, with support staff and STLs having to take on duties outside their roles to meet the demand.

28. There is a sense amongst CSOs and STLs that they are required to 'wear many hats' in order to perform their roles, needing to understand various topics/issues such as health, education, disability, cultural competency, etc. Specialist support roles within Child Safety or liaisons with other agencies, such as the NDIS, may alleviate the burden.

29. The inability to share casework responsibilities among service centres, particularly when a child is located a long distance away, increases workload.

Court work:

30. Affidavit preparation is a significant and time consuming task. Preparing affidavits takes CSOs away from time working with children and families, often having to cancel important matters on short notice to meet court deadlines.

31. CSOs regularly encounter challenges working with the Director of Child Protection Litigation (**DCPL**). This includes being required to amend affidavits on very short notice after having been received back from the DCPL, an inability to contact the DCPL regarding queries, a feeling the DCPL is isolated from the realities of child protection practice given their location in Brisbane, and a general disconnect between the legal and child protection views of a case.

32. Service of documents on parents can also be a time-consuming task and the cause of adjournments, especially where parents are transient, difficult to contact or reside in remote areas.

33. Some CSOs are intimidated by court work given their lack of familiarity or experience with the legal system. Fear of court work is also due to the perceived burden and high stakes.

34. There is a common view that everything has to be documented in anticipation the case has to go to court, such that the role of the CSO is focused on potential court proceedings, rather than working with children and families.

35. The present training on court work is inadequate and does not adequately prepare CSOs for the frequency and volume of court related work.

36. There is regular double handling of work between the Office of the Child and Family Official Solicitor (**OCFOS**) and DCPL. This means affidavits are passing through multiple hands before they are finalised, leading to extended delays in finalisation.

37. Due to its adversarial nature, lengthy interim litigation can cause parents to focus on contesting the court proceedings, rather than addressing the underlying concerns or behaviours. This inhibits efforts toward reunification.

38. The amount of court work involved in the role of a CSO is not adequately disclosed during the recruitment and training process.

39. CSOs are generally frustrated and stressed with the amount of court work required in the role, particularly as it takes away from work with children and families.

Support staff:

40. A significant proportion of the administrative work a CSO has to do could be delegated to support staff.

41. Case Support Workers (**CSW**) can free up hours of a CSO's time as they can complete tasks such as referrals, information requests and other administrative tasks that do not require a CSO's skillset.

42. CSSOs are of great value when they are able to perform the role of a CSSO. However, they are often required to carry their own caseloads due to staff shortages. Given their experience, CSSOs are often able to complete CSO tasks with high competency.

43. Paralegals are of great assistance with preparing court materials but they are not consistently available across the region. The use of paralegals can save days of work for a CSO as they can compile exhibits and draft affidavits using templates and information accessible from the case file.

44. Cultural Practice Advisors (**CPA)** are very helpful but also sometimes are tasked with CSO tasks due to staff shortages, taking them away from their key responsibilities.

45. There is a widely reported lack of support staff available to assist CSOs, resulting in an unmanageable administrative burden. There are insufficient support positions created to meet the support work needs.

46. A remote 'pool' of CSWs or paralegals could be a manageable solution to providing support services to those service centres without appropriate support staff. The work that is primarily given to CSWs and paralegals could be completed by a support officer offsite.

Unify:

47. The Unify system is widely seen as a failure. It is an inefficient system which takes a considerable amount of time to navigate, does not intuitively display key case file information and is replete with incorrect or outdated information. The system is also volatile and has been known to 'crash' regularly, resulting in unsaved/incomplete work being lost.

48. The Unify system has resulted in decreased productivity and an increase in the workload and time associated in conducting the role of a CSO and all other roles in the Department. This is across all divisions of the Department.

49. There has been inadequate training on how to properly use Unify. Those who have undertaken the training still remain unable to effectively navigate the system.

50. The problems with Unify are such that Department staff are routinely accessing information on ICMS as this tool is faster and has accurate information.

51. The design of Unify does not meet the needs of child protection practice.

52. Allowing carer agencies to access and input limited information directly into Unify could reduce administrative burden for placement services.

Support services and other government agencies:

53. There is inconsistency amongst agencies as to the quality of record keeping. Some agencies rely on the Department to get information such as application renewal or expiry dates and BlueCard details, which increases administrative burden.

54. Communication between the Department and support agencies is often through emails and phone calls, which can take time to respond to and means things can get missed.

55. There is sometimes a sense that other government agencies make notifications to the Department in order to absolve themselves of responsibility for the underlying issues which may lead to a child entering care, despite not holding genuine concerns for a child's safety.

56. There are many systemic issues which lead to children being at risk of harm, which are outside the control of the Department. For example, homelessness, domestic and family violence, lack of healthcare, and substance misuse. There are inadequate services available to service the identified needs of families with children in care.

57. The lack of services in remote and regional areas inhibits the ability of Child Safety staff to meaningfully support families and work towards reunification, often setting families up for failure.

58. The inability to access the necessary services to address identified concerns that a family is experiencing leads to a feeling of hopelessness for CSOs working with those families.

Kinship carers:

59. BlueCard delays and approval issues are a significant – and sometimes the only – barrier to sourcing kinship placements, especially in remote/rural communities. The delays may span several months while an application is being considered. The period of delay can extend well beyond this if a negative notice is issued, and a submission is required to be made to BlueCard seeking the negative notice be withdrawn.

60. There is no direct liaison for the Department within BlueCard. This results in the Department having limited ability to communicate with BlueCard services or to escalate a BlueCard application.

61. The BlueCard requirement to be a kin carer often prevents the approval of a carer who would otherwise be deemed safe and appropriate by the Department. This is commonly the result of historical criminal convictions which have no bearing on a carer's present ability to care for a child.

62. BlueCard processes are also less accessible and sometimes entirely inaccessible for people living in remote/rural communities with limited access to technology and the presence of language barriers (for some).

63. Having a kin carer's approval sit with an external agency inhibits the Department's ability to approve carers in a timely manner as it removes the discretion of the Department in the approval process.

64. There are often other practical safety concerns which get in the way of people being approved as kinship carers, which are more prevalent in remote and rural locations. For example, lack of hot water and building compliance certification.

65. Involving the Finding Kin team in care team meetings would facilitate more prompt and targeted efforts to find kin.

Placement supply and foster carers:

66. There is a scarcity of foster carers and respite care capacity which is pushing children, including young children, into residential care.

67. There is a spike in the demand for respite care around school holidays which can take away the capacity of emergency carers.

68. The Ready Response pilot has been positive, especially as it has been able to recruit some new carers. Some people may be able to act as Ready Response carers but not as long-term carers.

69. Professional foster care is a model that should be explored to expand the pool of foster carers.

70. Part-time/casual foster carers who may be available for short periods (but are unable to commit to ongoing care) is a model that should be explored to expand the pool of foster carers.

71. The current application process is such that an applicant carer has a 'right' to be assessed. This remains so even if it becomes apparent at the outset of the application process that a carer will not be approved. Having to progress applications that are doomed to fail is an unnecessary drain on resources.

72. There is a considerable amount of work and administration involved in a carer assessment. More of this could be outsourced to the carer support agencies to streamline the application process and free up Department resources.

Regional/removal challenges:

73. There is limited availability of support services available in Far North Queensland, especially in remote communities.

74. There is a practice of placing children long-term in safehouses despite them being not fit for that purpose. This appears to be a compromise position as finding approved carers in remote communities is difficult. This is problematic as the workers in the safehouses are not trained and the safehouses are not setup to provide traditional residential care.

75. Some remote communities do not have a safehouse. Other remote communities have safehouses at capacity. This limits the options available to a CSO who has case management of children within these communities.

76. Removing a child from a remote community is undesirable, however due to limited services and resources in those communities it is often necessary. The prospects of a child being successfully returned to the community after removal are very low.

Domestic and Family Violence:

77. There is limited availability of support services to address perpetrator behaviour. Possibly as a consequence, there is over-focus on victim-survivors in case plans and the steps they can take to reduce risk.

78. The support services that are available to address perpetrator behaviour are ineffective.

79. Information sharing restrictions also mean that Department staff cannot pass-on helpful information to police about perpetrators. For example, a respondent calling Child Safety and informing them that the aggrieved has people over at their house – this indicates that the respondent is watching the house and could be in breach of DVO conditions.

Children absent from placement:

80. Children who are absent from placement are at higher risk of sexual and criminal exploitation and substance abuse. Placements are viewed by the Department as a solution to risks and behaviours in the absence of adequate supports. A placement alone is not a solution to these risk factors, rather there is specific support required.

81. CSOs may try to offer placements to the child at every interaction with them, but the steps they can take to address the issue are limited. There is limited to no training around engaging with children who are absent from placement.

82. CSOs are very limited in their ability to support children who are away from placement.

Career progression

83. There is a general lack of career progression available to staff within the Department. This impacts on staff retention.

84. CSSOs have no ability to become a CSO unless they complete a tertiary degree, which involves great time and expense. CSSOs leave the Department because there is no avenue for them to progress past an AO3 level.

85. CSOs now commence as a PO3. However, there is no progression to PO4 (as there was previously from PO2 to PO3). The only way to become a PO4 is for a position to become available and then to apply for the role, going through an extensive recruitment process. During this recruitment process, there is no formal engagement by the panel with the STL who supervises the CSO to obtain their assessment of the candidates' work (unless the STL is listed as a referee). It is felt that the PO4 roles go to those who interview well, rather than those who have demonstrated their capacity through the quality of their work. The time and effort involved in applying for a PO4 position can deter staff from seeking promotion.

86. There are insufficient PO4 roles available, such that those in a PO3 position have an effective ceiling on their progression for extended periods of time.

87. The role of a PO4 is intended to be more officer based and to provide mentorship, while holding a lower caseload. This is not being experienced in practice as PO4s routinely

hold full or excess caseloads. It is unclear why PO4 positions are not created for more experienced CSOs to recognise their experience and carry a more complex caseload.

Specific issues

88. Having guardianship sit with a CSO/STL, rather than the Department makes it difficult to liaise with external entities, particularly the NDIS, as they will only communicate with the nominated person. This creates issues if the person is not available or there has been a change in CSO. This leads to delays in obtaining key services or information.

89. CSOs are limited in their options to manage high risk children. Children suffering from drug abuse and sexual exploitation are highly vulnerable and CSOs have limited capacity to provide meaningful intervention. Options such as a secure facility or relocations should be explored.

90. There is a lack of suitable education options for children who require alternatives to traditional education.

91. There is inconsistency in approaches taken by different service centres as to the approval of funding and allowances, leading to frustration from carers.

92. The Department should be able to provide consent for medical matters when children are on a Custody Order. The requirement to obtain parental consent results in significant delays in obtaining medical treatment and assessments, including with the NDIS.

93. The new intake approach, implemented earlier in 2025, was intended to reduce the number of priority referrals. It has had the opposite effect. There are now more priority referrals being received by Investigations and Assessment. This means that standard referrals are constantly having to be deprioritised and routinely delayed. Some standard referrals are simply not reached and are closed without having commenced.

94. There is a sense of a lack of recognition of the work of CSOs by higher management. It is felt that higher management are concerned with KPIs, without recognising the difficulties in performing the work. This impacts staff wellbeing.



Appendix G

Guide: A Self-Regulating Child Protection System

Guide: A self-regulating child protection system

Embedding objectives, outcomes, indicators, feedback loops and learning cycles

> The aim is a legacy where the system is better equipped to continuously learn and improve.[1]

1. Introduction

A significant shortcoming of the Queensland child protection system (including early intervention programs) is the absence of systematic data[2] collection and analysis to evaluate and taken action to improve the operation, efficiency and, most important, the effectiveness of the system. Five years ago the Queensland Family and Child Commission (QFCC)[3] concluded that the abundant data collected about the Queensland child protection system[4]

> does not tell us how each part of the system affected children and young people — for example, if they were kept safe; if their basic needs were met; if their health, wellbeing and education were affected; or if they were reunited with their families. It also doesn't tell us what children, young people and their families thought about their experience in the system and the effect they believe it had on them.[5]
>
> We also found that the data is not joined up at a system level, meaning we lack an understanding of each family's outcomes and experience of the system as a whole.

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[1] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis*, UK, 2010, 10.

[2] In this Guide, the term 'data' refers to raw, unorganised and unstructured facts or figures (inputs), whereas 'information' refers to processed, analysed, structured, contextualised and organised data that is useful for decision making (outputs). Primary data are data collected by the user; and secondary data are obtained from another source.

[3] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014-2020)*, QFCC, Brisbane, 2021, vi; and see also Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024, 29; and Luke Twyford, 'Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System', Submission to Child Safety Commission of Inquiry, Queensland (27 March 2026), 38, 59, 69, 80-81, 85.

[4] See, for example the data available at https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/who-we-work-with/children-requiring-care-and-ongoing-support. See also the data collected by the Australian Institute of Health and Welfare and the Productivity Commission, which is noted later in this Guide.

[5] Until 2013 the Queensland Family and Children Commission used to publish results of surveys of children in care. From 2022 to 2024 the Department conducted a *My Life in Care* survey, but this was stopped in 2025 (see the detailed discussion later in this Guide). In 2024, the Department also published the results of *the Children in Care Census*: see 2024 Children in Care Census - Full Report for publication. This is also discussed later in the Guide.

Similarly, the submission of the Together union, the largest representative voice of child protection workers, argued that the Department does not measure quality – only quantity, so that the system rewards 'surface level' work.[6]

> The system currently counts what is easy to count. Cases closed. KPIs met. Timeframes hit. It does not measure whether children feel safe, whether families are supported, whether relationships are being built, or whether reunification is being actively worked toward.[7]

The importance of data collection and sharing is acknowledged in the second, and current, *National Framework for Protecting Australia's Children 2021-2031: Safe and Supported*.[8] One of its foci (the third 'key focus area' for 'collective effort')[9] is on improving information sharing, data development and analysis to better 'measure progress and the effectiveness of policies, identify areas of concern faster and tailor … responses to prevent children, young people and families entering child protection systems'.[10] The *Framework*, crucially, aims to enable a better understanding of 'the experiences of children in out-of-home care and other systems (such as education, justice and health).' Ongoing monitoring and evaluation will enable progress towards *National Framework* goals to be tracked.[11] The National Framework's *First Action Plan* reiterates that there 'will be a strong focus on measuring progress towards the outcomes under Safe and Supported. … A mixed methods approach to measurement and evaluation will be used, in recognition of the complexity of the outcomes.'[12] The *First Action Plan*[13] also states that 'This approach would include quantitative trend data supported by more detailed qualitative analysis and storytelling. The indicators will be included in the Monitoring and Evaluation Strategy. They will be chosen with regards to what we are aiming to measure and how best this can be achieved.'

The *Framework* and *First Action Plan* do not, however, provide further assistance as to the use of data in an overall system of performance improvement; more specifically, they do not examine *how* processes of learning about the effectiveness of the system and the institutions within it can be fostered and harnessed to enable the system, and

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[6] Together, 'Raising Voices, Reforming the System', Submission to Child Safety Commission of Inquiry, Queensland (15 March 2026) 37.

[7] Together, 'Raising Voices, Reforming the System', Submission to Child Safety Commission of Inquiry, Queensland (15 March 2026) 37.

[8] Council of Australian Governments, *The National Framework for Protecting Australia's Children 1021-2031*, Commonwealth of Australia, Canberra, 2021.

[9] Council of Australian Governments, *The National Framework for Protecting Australia's Children 1021-2031*, Commonwealth of Australia, Canberra, 2021, 20

[10] Council of Australian Governments, *The National Framework for Protecting Australia's Children 1021-2031*, Commonwealth of Australia, Canberra, 2021, 32.

[11] Council of Australian Governments, *The National Framework for Protecting Australia's Children 1021-2031*, Commonwealth of Australia, Canberra, 2021, 36.

[12] Commonwealth of Australia, *Safe and Supported: First Action Plan 2023-2026*, Commonwealth of Australia, 2022, 20.

[13] Commonwealth of Australia, *Safe and Supported: First Action Plan 2023-2026*, Commonwealth of Australia, 2022, 20.

its key institutions, to 'self-regulate' to better improve the health, safety, well-being and future prospects of children and young people within the system.

There is already a lot of data about the operation of the child protection system. At a state and systems level, data is and should be collected and analysed to monitor the support provided to families, young people and children; the number of children entering the out-of-home care system; the length of time they stay in that system; and the number leaving the system, with a view to monitoring whether reforms to the child protection system as a whole are reducing the number of children in the system, and/or reducing the time children spend in the system. For example, the Department's current performance indicators[14] are:

- increased proportion of children and young people whose needs were met by an Intensive Family Support or Aboriginal and Torres Strait Islander Family Wellbeing Service;
- reduction in the proportion of children and young people and families escalating to the tertiary child protection system;
- reduction in the disproportionate rate of representation of Aboriginal and Torres Strait Islander children and young people in the child protection system;
- reduction in the proportion of children and young people in residential care;
- increased proportion of children and young people in family based and kinship care; and
- increased focus on retention and attraction of foster and kinship carers.

A number of sources provide information that enables progress in meeting these indicators to be assessed. For each state and territory the Australian Institute of Health and Welfare publishes annual statistics[15] on child abuse and neglect notifications, investigations, and substantiations. It also publishes information on children under care and protection orders and those in out-of-home care, including demographic information, information on carer households, and information related to the National Out-of-Home Care Standard. Similarly, for each state and territory the Productivity Commission publishes information on child protection in its annual Report on Government Services (RoGS),[16] which includes statistics on notifications, investigations, substantiations of child abuse or neglect, children on care and protection orders, and children in out-of-home care. Additional information is available in other reports, such as the *Closing the Gap Annual Data Compilation Report*, which includes information on the disproportionate rates of contact of Aboriginal and Torres Strait Islander children with the child protection system. The Family and Child Commission maintains a register of all child deaths in Queensland, and publishes

[14] Department of Families, Seniors, Disability Services and Child Safety, *Strategic Plan 2025–2029,* Queensland Government, Brisbane, 2025, 3.

[15] https://www.aihw.gov.au/getmedia/558c05da-13a9-4a2f-9afb-86a158318290/child-protection-australia-2023-24.pdf.

[16] https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/.

information for Queensland on key performance indicators, such as investigation response times, substantiation rates, and placement stability for children in out-of-home care.

The Department's website provides information showing how Queensland compares to the Australian national average on key measures in relation to family support services, child protection services and Aboriginal and Torres Strait Islander children.[17] The Department's website also provides regional information on these matters.

In recent years the Queensland Department of Families, Seniors, Disability Services and Child Safety (the Department) has begun to develop and collect data that can be used to build feedback systems for performance improvement.[18] Notably, in 2024 it produced the *2024 Census of children in care*,[19] which reported on data collected by child safety officers (CSOs) in surveys of a sample of children and young people who had been living away from home for more than three years. The collected data enabled the Department to compile a profile — a snapshot — of these children and young people to inform policy and practice. The census information includes:

- the pre-care experience of children and young people of abuse and neglect;
- information on the safety, security and stability of their placements and transition to adulthood;
- information on their health (delay in development, intellectual functioning, suspected or diagnosed mental illness, extreme instability and/or emotional responses that limit functioning, suicide attempts, and self-harm);
- some information on their experiences in education (whether they have been expelled or suspended in the past) and employment;
- information on whether they had experienced attempts at reunification; and
- information on their relationship with their original family, their social skills, and their participation in cultural support plan development and activities.

In another important development, in 2022 the Department took over, from the Commissioner for Children and Young People and Child Guardian, the conduct of the *My Life in Care* survey of children and young adults in care. The Department carried out the survey in 2022, 2023 and 2024, but there was no survey in 2025. The survey is discussed later in this Guide.

Finally, the Queensland Government's *Human Services Quality Standards* and the Department's Investment Specifications,[20] which play a part in the governance of arrangements between the Department and parties providing family support services and care for children and young people in the child protection system, also provide potentially useful information on the child protection system. The *Human Services*

[17] See https://performance.dcssds.qld.gov.au/our-performance/national-data/family-support-services.
[18] For more detail, see Appendix 2.
[19] https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/who-we-work-with/2024-census-of-children-in-care.
[20] Most notably, the Investment Specifications for *Families* and for *Family Based Care Services*.

Quality Standards require providers of human services to address standards relating to governance and management; service access; responding to individual need; safety wellbeing and rights; feedback, complaints and appeals, and human resources. The Investment Specifications include output and outcome measures and indicators for service providers.[21] Both are potentially useful in developing feedback loops and output and outcome indicators, and will be briefly discussed later in the Guide.

This Guide is intended as a conceptual and practical resource to support future design and implementation of performance indicators, feedback loops and learning cycles in the Queensland child protection system. It does not make findings of fact or recommendations, but rather it synthesises evidence and frameworks to support ongoing reform.

The Guide provides a framework to generate and use data in an overall system of performance improvement in the child protection system. More specifically, it explains *how* processes of learning about the effectiveness of the system and the institutions within it can be fostered and harnessed to enable the system, and its key institutions, to 'self-regulate' to better improve the health, safety, well-being and future prospects of children within the system, and of young adults upon leaving the system. The Guide draws on other sources to explore these issues. It does so by examining the kinds of data that could usefully inform those in the system as to whether or not the purpose and objectives of the system, or of parts of the system, are being met, and, in particular, whether or not families, children and young adults are benefitting from early intervention and care. This entails:

- outlining *objectives* for the child protection system, and for institutions within the system, to ensure optimal support for families and support and care for individual children and young adults within the system;
- building *performance measurement* systems for the system, for family support providers and for carers within the system;
- developing indicators to track the *experiences and well-being* of individual children within the system, and young adults leaving the system;
- constructing *feedback mechanisms and loops* in the system to monitor and/or examine the quality of direct work with, and affecting, children, and its impact upon their health, safety and wellbeing;[22] and
- nurturing a learning culture in which every part of the system is focused on considering feedback data and engaging in an open and honest dialogue with others about how to improve the system.

The Guide also briefly raises issues about the time and resources required to develop and implement the proposed data collection procedures in the system, and suggests key criteria for future data creation and collection processes, and for the development

[21] For more detail, see Appendix 2.

[22] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis*, UK, 2010, 9; Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, ch 8, especially 195-202.

of meaningful indicators. A key focus of the Guide is on the need for *longitudinal information* showing the progress of individual children, and in particular, their safety, health and well-being, and education and other living conditions.

2. The Purpose of the Child Protection System

This Guide begins from the position that the **purpose** of the child protection system is to aim to give every child and young person who comes within any part of the system support and care that suits their particular circumstances; and to provide stability, permanency and a state of belonging in a place and a community that 'feels like home' and where they feel safe, valued and accepted, with an ongoing, loving and nurturing attachment to at least one adult, that enables them to 'achieve developmental, physical, cognitive, social and emotional milestones.'[23] The system must support children to flourish and thrive, build increasing levels of competence, develop their sense of autonomy and 'reach their full potential by growing up safe and supported, free from harm and neglect.'[24]

On a broad level, this stated purpose (or objectives) can be translated into measurable qualitative and/or quantitative standards,[25] and then data about the performance of the system can be gathered to assess whether it is *achieving its purpose* (that is, whether it is 'effective').

3. Assessing outcomes

The information that will be most relevant as to whether individual children and young people are benefitting from the child protection system as a whole, and whether the system is effective in meeting its specified purpose, will be information reporting on 'outcomes'. *Outcomes* should be distinguished from the *elements* or *processes* that constitute the system, or more accurately, the *outputs* of the elements or processes within the system.[26]

3.1 *Distinguishing 'outcomes' from 'outputs'*

In this Guide an *outcome* is an assessment of the safety, health and well-being, and education and other living conditions of children and young people and of

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[23] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 33.

[24] Council of Australian Governments, *The National Framework for Protecting Australia's Children 1021-2031*, Commonwealth of Australia, Canberra, 2021, 8.

[25] Section 122 of the *Child Protection Act 1999* (Qld) sets out a 'statement of standards', which outline 'standards of care' for foster and kinship carers.

[26] Mark Friedman, *A Guide to Developing and Using Performance Measures in Results-based Budgeting*, Finance Project, Washington DC, 1997; Mark Friedman, 'The Results and Performance Accountability Implementation Guide', 2001, available at www.raguide.org; Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574-581. Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 7 refer to these as 'intermediate outcomes'.

enhancements in family functioning.[27] Outcomes can be assessments by a third party (for example, a child safety officer (CSO), a medical practitioner or a schoolteacher) of a process's impact on, or a change in, the behaviour, status, health, safety, well-being and welfare of children or young people, and/or the effective functioning of their families.[28] Or, as will be discussed later in this Guide, an outcome can be a child's or a family's' view and report of their experiences of these impacts and changes.

The *elements* or *processes* in the system are the various institutions and activities designed and implemented to support families to address the needs of children in early intervention, and to protect children and young people in the tertiary statutory system. The *outputs* of an *element* or *process* are the direct, tangible products and/or services provided ('what is done'): for example, whether service providers 'reach the children and families who need their help, appropriately assess their needs and provide the level of support they need and are entitled to';[29] the orders made by a court in the tertiary system; the number of visits made by a CSO; and the care and other services provided by a kin or foster carer or a non-family-based residential care facility.

To illustrate the difference between information relevant for an *outcome* and information relevant for an *output*, La Valle et al[30] suggest that the kinds of data that need to be collected to understand the performance and effectiveness of the whole child protection system should include, first, data on the organisation overseeing the system (in Queensland, the Department), its workforce and frontline practice to 'establish if there are the right conditions and culture for services to make a positive difference to the lives of children and their families'.[31] Second, it should also include 'snapshot' data at a particular point in time (and updated at later points in time) to assess whether the organisation, and agencies engaged by it, reach 'the children and their families who need their help, adequately assess their needs and the level of involvement they require'.[32] Third, there needs to be data on the views of children and families who experience care and use the services to find out whether they feel valued and empowered, and whether the support they receive meets their needs and makes a difference to their lives. Finally, and most importantly, there needs to be *longitudinal data* showing the progress of individual children, and in particular, their safety, health

[27] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 574; Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583, 593.

[28] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 232.

[29] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 7.

[30] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 35-37, 27-29 and 31-33.

[31] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 36.

[32] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 36.

and well-being, and education and other living conditions. The first three sets of data are for *output* indicators; and the fourth set is for *outcome* indicators.

3.2 The challenges in assessing outcomes for children and young people

Assessing outcomes for children and young people is not at all straightforward. One challenge is that, as Dickens at al note,[33] there is 'ambiguity' about the concept of children's 'well-being' and ways of assessing it. For example, they suggest that it could be assessed by using

> a "hard" [criterion], such as placement stability, school exam results or further court proceedings; or a subjective [criterion], such as the child's own views about their wellbeing. A third option is to use social work records of the child's progress, behaviour, and emotional well-being.[34] Stability of placement is often taken as a key [criterion], but does not itself guarantee emotional, social or physical wellbeing. There are further questions about correlation and causality, the impact of wider social and economic factors, and the point at which outcomes should be assessed — perhaps they are not truly known until adulthood?

Dickens et al[35] also identify other complexities in assessing children's well-being. Faced with more than one specific, identifiable problem (for example, emotional abuse, neglect, parental mental health etc), many, if not most, children are likely to respond by experiencing poor mental health and/or engaging in challenging behaviours. For younger children, initially mental health and behavioural difficulties may not be apparent but will emerge later. Furthermore, children's and young people's circumstances will change over time, leading to variations in the challenges they face, and, consequently, in their health, well-being and behaviour. Some health and well-being issues that they experience will be attributable to 'normal' child developments: for example, difficult periods during adolescence; and others will be in response to the challenges they face. Consequently, it may be difficult to untangle exactly what has caused each health and well-being issue that children experience. It will also be likely that 'outcomes' will fluctuate — getting better or worse — over time, so that the assessment of children's well-being will vary depending on *when* the assessment is made: 'Assessing well-being at any point is only a snapshot of a particular moment'.[36]

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[33] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 574.

[34] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 574. As the discussion later in this Guide suggests, other relevant assessments and judgments include those made by medical practitioners (including therapists), counsellors, schoolteachers, and the like.

[35] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 577-599.

[36] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 578.

Further, progress 'in the different dimensions of well-being can be ambiguous':[37] For example, family contact for a child in care can reassure the child that their parents and siblings are well and are thinking of them, but can, at the same time, be disturbing and disruptive.

In sum, outcomes evaluating children's well-being will need to be assessed on a regular basis, interpreted taking into account all of the child's circumstances, and triangulated with other data sources.[38]

3.3 Three levels of outcomes in out-of-home care

Outcomes for children and young people in family-based and non-family-based out-of-home care are assessable at at least three levels[39] — outcomes for the individual child or young person, outcomes for all children and young people in the care of a particular carer or institution (institutional outcomes), and outcomes for *all* children and young people in care within the system (system outcomes).

The most important level is that of the individual child or young person. A system of benchmarking the needs of individual children upon their entry to care and then collecting data on improvement or regression against those benchmarks, will enable care providers to better design and adjust interventions to ensure that all the child's needs are met at the right time. Also important is data gathered from young people leaving care, which reflects on their overall experience of care — indeed, in order to generate the most helpful data to assess the effectiveness of a care system, data might be gathered every five years until the care leaver has been out of the system for a significant period of time.[40]

At an institutional (that is, the care provider) level, objectives can also be used to develop key benchmarks against which providers can evaluate whether they have been effective. Most likely, outcomes for each child in the care of the provider will be aggregated to determine the outcomes for the provider; or where providers provide more than one residential care house, for example, outcomes can be measured for each house, and then for the provider generally.[41] For example, the Verso Consulting

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[37] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 577.

[38] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 17.

[39] Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024, 29-30; Luke Twyford, 'Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System', Submission to Child Safety Commission of Inquiry, Queensland (27 March 2026), 69.

[40] Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024, 29-36.

[41] Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024, 29.

evaluation of the 2009 pilot study of therapeutic residential care (TRC) in Victoria evaluated the outcomes of each of twelve pilot therapeutic residential care sites against the goals outlined in the Victorian Child Protection and Family Services *Outcomes Framework* over time.[42] In each site the outcomes for each child or young person were aggregated to determine the outcome for the site. Another example is the evaluation of the Mulberry Bush School in Oxfordshire, England, where the effectiveness of the therapeutic approach within the school was evaluated by assessing changes in the socio-emotional, behavioural and academic development of four cohorts of children as well as changes in their level of attachment to staff, and then aggregating the individual data to determine overall outcomes.[43]

At the level of the system, outcomes are most likely to be the aggregated outcomes generated at the two lower levels — the care provider level and the individual child level[44] – although, as discussed later in this Guide, where highly qualitative outcomes measures for children and young people are used, it may be difficult to aggregate outcomes in any meaningful way. Further, Dickens et al's reflections, noted above, on the ambiguity of well-being measures also suggest that aggregation will often be difficult.[45]

The remainder of this Guide focuses on gathering information to understand the experiences of families with early intervention, and children in out-of-home care and other systems, such as education, health and justice. It examines the possibility of developing *feedback loops* to enable the system to self-regulate for improvement, at least to a small degree. A key aim is to examine:

> … how the system can become better at monitoring how it is performing, learning about emerging difficulties, and responding creatively and adaptively to tackle them.[46]

4. Developing a self-regulating child protection system

4.1 Feedback loops for a learning culture in the child protection system

Systems thinking emphasises the importance of mechanisms to detect malfunctioning parts or imbalances in the child protection system which result in

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[42] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011.

[43] Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409-421.

[44] Verso Consulting Pty Ltd, *Therapeutic Residential Care System Development: Outcomes Measurement Framework*, Family and Community Services NSW, 2016 accessible at https://dcj.nsw.gov.au/documents/about-us/facsiar/past-research-reports/oohc/verso-outcome-measurement-framework-june-2016.pdf, 4; but see Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024,, 29-36.

[45] Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574.

[46] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis*, UK, 2010, 10.

'unintended consequences', so that corrective action can be taken.[47] Feedback loops are such a mechanism. Feedback is defined as information gathered about the performance of a process or system to assess whether the process or system is performing as required, and whether measures need to be taken to improve its performance. It also introduced the notion of 'loops' of learning, which enable corrective action to redress malfunctioning parts of, or imbalances or problems in, the system.

This Guide is focused on the use of feedback to enable the Queensland child protection system to self-regulate to improve children's and young persons' experience of care.[48] Embedding feedback loops in the child protection system has the potential to transform the way that the system operates. For example, the use of feedback and loops of learning can make an important contribution to transforming the child protection system from a 'compliance' culture into a 'learning' culture.[49] A compliance culture is a culture in which staff follow detailed bureaucratic procedures when engaging with families and children, and when making decisions. A 'learning culture', on the other hand, is one in which staff are encouraged to exercise professional judgement within a framework of broad guiding principles. In a compliance culture, the performance of staff is assessed by whether they comply with procedures; in a learning culture, feedback loops provide data about the experience of children and young people in the system, and enable staff and their managers to find out whether they are providing a good service and contributing to better outcomes for children and young people.

One aim of developing feedback loops is to check that the key parts of the overall system are behaving as specified; that is, to check whether the *outputs* of CSOs, carers and other agencies in the primary prevention, early intervention and tertiary systems are as planned and, more importantly, whether the required *outcomes* for children, young people and families have been achieved;[50] and to facilitate corrective action if there is a gap between the required and actual performance and outcomes. The information in the feedback loop can be used to *learn* about the operation (outputs) and effectiveness (outcomes) *of* a process or program, or the system itself. *'Single loop' learning* takes place when those involved in the feedback process examine whether the operation of the system has complied with a target that has been set for it: If the feedback indicates that the system has done what it is supposed to do,

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[47] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 72.

[48] There are already multiple feedback loops in the Queensland child safety system, including foster carer surveys, town hall meetings conducted by the peak bodies, children in care reports by CREATE, and public service surveys.

[49] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011,129; Luke Twyford, 'Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System', Submission to Child Safety Commission of Inquiry, Queensland (27 March 2026), 69.

[50] 'Quality indicators should sit alongside, and ultimately take precedence over, throughput indicators': Together, 'Raising Voices, Reforming the System', Submission to Child Safety Commission of Inquiry, Queensland (15 March 2026), 38.

it has 'done things right'; if not, the feedback specifies what has to be done to close the gap. One of the challenges to enabling informative feedback loops in the child protection system is that very young children have little or no ability to provide feedback, and so single loop feedback will most likely be generated by using other sources of information: for example, the observations of CSOs or carers; or the assessments of medical practitioners or schoolteachers.

Another use of feedback loops is to reflect on the *design* of the child protection system, which involves complex interactions between people, technology and other factors in a complex environment.[51] If key participants in the child protection system, for example CSOs, legal officers and their managers, were to operate in a less hierarchical framework that conceived of them as highly skilled professionals who were encouraged to exercise professional judgment, they would be able to engage *'double loop' learning* — the chance to exercise professional judgment about whether the target that has not been achieved was in fact the right target: was the target 'the right thing' to be aiming for? Double loop learning involves reflecting on causal assumptions, and organisational norms, practices, processes and policies, and 'allows the target itself to be changed, or updated as the system "learns" more about what a sensible target might be'.[52]

The Commission recommends that feedback loops and learning cycles be embedded within the whole child protection system. As MacAlister[53] has counselled, for the proposed objectives and outcome measures

> to be a genuine means of improving outcomes for children and families, it needs to form part of a new pattern where every part of the system is focused on considering feedback, data and information and participating in an open and honest dialogue with others about how to improve.

The Commission envisions that at both system and institution or program level all parties involved in the system engage in candid reflection and discussion about what the information and feedback is telling them and their partners about the quality of their

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[51] Child protection systems are 'socio-technical' systems: there is a close interrelationship between social aspects (the interaction of people) and technical aspects (organizational structure, tools, and processes) in the system. The technology and human social systems interact in a complex, interdependent system, and each cannot be understood in isolation. See Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis*, UK, 2010, 16-18.

[52] Eileen Munro, *The Munro Review of Child Protection: Final Report — Part One: A Systems Analysis*, UK, 2010, 15. *'Triple loop' learning* is an even deeper form of learning, over a longer timeframe, and encourages reflection on 'What is right?', 'How do we decide what is right?', and 'Why do we want to achieve the things we are trying to achieve?' Those analysing the system question its fundamental purpose, vision, and mission, as well as the assumptions (norms, values, mental models, policies, interests, deep beliefs, worldviews and philosophies) underpinning the system, in order to get a deeper understanding of the evolving needs of the various stakeholders in the complex environment in which the system functions.

[53] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 200; and see also Luke Twyford, 'Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System', Submission to Child Safety Commission of Inquiry, Queensland (27 March 2026), 69, 80-83.

work, and then work together to modify the system to ensure that the objectives of the system are met when normal services are carried out in a coordinated fashion.

For the child protection system to be effective, a key institution at State level should be responsible for coordinating all agencies and other parties in the system to respond to feedback as it emerges, engage in collegial and constructive discussions about the operation of the system, and to reform the relevant elements of the system. It should also be responsible for overseeing implementation of the resulting reforms, including examining feedback and intelligence on the success of implementation, and how this is flowing through the system into improvements for children and families.[54] Of the existing Queensland child protection institutions, the Family and Child Commission would appear to be best equipped to carry out this coordinating role.

The success of these reflective processes depends on how well these feedback loops and learning cycles are implemented. It also depends on gathering the *right data* and then developing insightful information about process outputs and outcomes.

4.2 *A mix of performance-based and evidence-based indicators, and the views and experiences of children*

As noted above, the process of assessing or evaluating outcomes, especially in a complex social and technical system such as the Queensland child protection system, is not straightforward. Many commentators have pointed out that the question of 'what to assess' is not a neutral question, or even just a technocratic question, but reflects hotly contested debates about the purpose (economic, regulatory and/or political) of the assessment or evaluation, who decides who should receive a service, what kinds of services should be delivered, how they should be delivered, and what the outcome of the service should be.[55] As Tilbury observes, 'performance indicators must be assessed, not just with reference to how they fulfil the management role, but how they are used politically and organisationally'.[56] Indicators communicate 'policy intent', shape 'the way we think and talk about child protection', and define 'notions of outcomes, effectiveness, and quality'.[57]

If the wrong things are assessed or evaluated, or the assessment approaches do not accurately reflect the phenomena they are supposed to be assessing, the system runs the risk of being changed as a result of the unintended consequences flowing from

[54] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 200. For examples of relevant powers, see Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 46, [3.21].

[55] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157; Tilbury (n 36) 226-231; Clare Tilbury, 'Accountability via Performance Measurement: The Case of Child Protection Services' (2006) 65(3) *Australian Journal of Public Administration* 48, 50; Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583, 583-584

[56] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 226.

[57] Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583, 584.

inadequate or inaccurate indicators. Or to put it bluntly: 'Measuring the wrong things produces the wrong outcomes.'[58] A classic example is Munro's conclusion (noted earlier in this Guide) that the performance audit process in the child protection system in England before 2010 changed the culture from being a conversation about social work practice to one of proceduralisation, blaming and deprofessionalisation.[59] The Together union's submission to this Inquiry argued that in the Queensland child protection system

> The measurement of the system's performance is itself a structural failure … KPIs measure speed and volume – how many assessments are closed per month, how quickly matters move through intake – while quality, safety, cultural appropriateness and children's lived experience go unmeasured. Workers who slow down to do thorough assessments face performance management. Cultural obligations are performed on paper but not in practice. The system does not know whether the children in its care feel safe, connected or heard, because it is never built into the infrastructure to ask.[60]

Drawing on Hood's[61] helpful framework for analysing performance indicators from the perspectives of performance-based accountability, evidence-based services and outcomes, and socio-technical systems design,[62] the next section examines the considerations underpinning the drafting of indicators[63] that could both be used to monitor the performance of the child protection system, and to build a series of feedback loops to enable the system to self-regulate to ensure that children and families are supported in the secondary prevention (early intervention) system, the tertiary statutory system, and in the processes of children and young people leaving the tertiary system to return to their family or to commence independent adult life. A first draft of possible indicators for the Queensland child protection system is included in Appendix 1.

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[58] Together, 'Raising Voices, Reforming the System', Submission to Child Safety Commission of Inquiry, Queensland (15 March 2026), 37.

[59] Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583, 585; June Thoburn, 'Child Welfare and Child Protection Services in England' in Jill Berrick, Neil Gilbert and Marit Skivenes, *Oxford Handbook of Child Protection Systems*, Oxford University Press, 2023.

[60] Together, 'Raising Voices, Reforming the System', Submission to Child Safety Commission of Inquiry, Queensland (15 March 2026), 77, and see also 38.

[61] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157.

[62] See note 51 for a brief description of socio-technical systems.

[63] In this Guide, the term 'indicator' includes 'measures'. Strictly speaking *a* 'measure' *measures* something using an accepted standard (such as a metre, gram, or a quantitative measure of performance) — for example, a carpenter making a table 1.2 metres in height, 2 metres in width and 4 metres in length; or a pH meter measuring the level of acidity or alkalinity of a substance. Similarly, an 'indicator' *indicates* something — for example, it approximates qualities of performance or an outcome, but not by using an agreed standard: for example, an indicator of the suitability of the table is that it can comfortably seat six people; litmus paper indicates generally the acidity or alkalinity of the substance. Distinguishing 'indicators' from 'measures' when assessing human activities, performance and experiences is very difficult, and of little significance for this discussion, so in this Guide the term indicator includes 'measure'.

4.2.1 Performance-based accountability

Performance-based accountability (PBA) (also known as outcomes-based or results-based accountability) establishes a framework for managers to monitor effectiveness, control costs and hold front-line staff such as CSOs to account by setting explicit standards, assessing performance empirically, and then determining whether the performance meets the standards.[64] Governments can then establish independent inspectorates to carry out regulatory and political oversight, by collecting, or receiving already collected and aggregated, performance information from government entities.[65]

As previously discussed, the most useful, and important, child protection system information is about the quality of outcomes for children and young people in the system (whether they are effectively helped and kept safe), short-term and especially long term — but most child protection services rarely carry out this type of information.[66] Indeed, information about long term outcomes for children is unlikely to be gathered simply because children who are well and flourishing will no longer be in the child protection system, and relevant data will need to be collected from universal services such as schools and hospitals,[67] or by independently surveying young people when they leave the system.[68]

Even a cursory review of the literature and of the Department's documentation of its processes reveals a range of possible performance indicators. Tilbury's survey of child welfare 'performance indicators' in England, the USA and Australia examined and listed three kinds of indicators.[69] The first type is 'effectiveness' indicators, such as positive, or the absence of negative, child or family *outcomes*, both in the short term (during the time that the child was in care or otherwise receiving services) and long

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[64] Lisbeth Schorr, *The Case for Shifting to Results-Based Accountability with a Start-Up List of Accountability Measures*, Centre for the Study of Social Policy, Washington, DC,1995, discussed in Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157, 468.

[65] See, for example, Rick Hood et al, R, 'Exploring demand and provision in English child protection services' (2016) 46(4) *British Journal of Social Work* 923-941.

[66] See Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157; Rick Hood et al 'A study of performance indicators and Ofsted ratings in English child protection services' (2016) 67 C*hildren and Youth Services Review* 50-56; Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225; Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583 Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014-2020)*, QFCC, Brisbane, 2021, vi.

[67] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 470

[68] See the discussion later in this section, and Queensland Family and Child Commission (2024) (n 2) 29-36 for a brief discussion of cohort life outcome indicators.

[69] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 233.

term (their future prospects after they had experienced services, in comparison with other children). In Tilbury's survey, the outcome indicators for children and young people included whether they had been re-abused, or had re-entered the statutory child protection system; their health while in care; whether they had been convicted of a criminal offence while in care; their 'educational attainment' while in care; and whether they had been employed, educated or had received training when they left care.

In their highly regarded study of children returning home from care, Farmer and Lutman developed 'researcher ratings' of children's well-being, which included: the child's health, educational progress, emotional or behavioural difficulties, peer relationships, relationships with current carers, relationship and contact with parent(s) if the child was not living with their parents, family and social relationships, social skills and social interaction, and a rating for their overall wellbeing.[70] MacAlister[71] suggested four sets of 'draft outcomes' for (i) family help (parent outcomes), (ii) family help (child outcomes), (iii) children in care, and (iv) adults who had been in care, as follows:

- good quality lifelong relationships;
- safe from abuse, neglect or exploitation;[72]
- a stable loving home;
- a good education;[73]
- improved physical and mental health;
- diverted from crime;
- stable employment;[74]
- avoiding drug and alcohol misuse;
- financial stability;
- safe from domestic abuse; and
- good experiences of children's social care services.[75]

The second type of indicator is for 'outputs'. These indicators assess whether and how change is achieved through the *quality outputs* of services as assessed by adherence to standards, and client feedback.[76] In Tilbury's study, output or 'quality' of process indicators included:

- participation in education while in care;
- entering permanent care, or being reunified;

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[70] Eleanor Farmer and Elaine Lutman, *Effective working with neglected children and their families: Linking interventions to long term outcomes*, Jessica Kingsley Publishers, London, 2012, and see Jonathan Dickens et al 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574, 576-577.

[71] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 197-198.

[72] Family help (child outcomes), children in care and adults who had been in care only.

[73] Family help (child outcomes), children in care and adults who had been in care only.

[74] Family help (adult outcomes) and adults who had been in care only.

[75] Family help (adult outcomes) and adults who had been in care only.

[76] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 233.

- being adopted;
- whether children had been abused in out-of-home care;
- the stability of their placement;
- whether their placement was local;
- whether it was culturally appropriate;
- whether their care home had been inspected;
- timeliness of investigations;
- their feedback, including whether they were satisfied with their care;
- the continuity of their case worker;
- whether they had regular case reviews; and
- whether they had regular contact with their caseworker.[77]

The third type of indicator is for 'access' to the processes in the child protection system.[78] Access indicators include the ethnicity of children in need, and the relative spending on family support. These data are useful to track whether, for example, children from minority racial or ethnic groups are over-represented in any part of the child protection system, or to track whether families in regional or remote locations are receiving the same levels of family services as those families living in the larger cities.[79]

> Given that performance-based accountability indicators are usually used to enable political or regulatory oversight of a process, how can they be used to enable parties in the child protection system to engage in candid reflection and discussion about what the data, information and feedback is telling them and their partners about the quality of their work, and then work together to modify the system to ensure that the objectives of the system are met when normal services are carried out in a coordinated fashion?

In performance-based accountability, outcome, output and access indicators each have their place. Outcome indicators are the most important, because they focus on the health, safety and wellbeing of the children in the child protection system. There should be a reasonable number of long-term outcome indicators, even though it is often difficult to gather suitable data once children have left the child protection system. Process or output indicators are important, too, especially for evidence-based

[77] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 232-233.
[78] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 233.
[79] Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34 *British Journal of Social Work* 225, 233-234

programs[80] and/or complex processes[81] which specify the essential conditions for the system to function effectively.[82] These are discussed in the next section.

> Of the (i) outcome and (ii) output indicators discussed so far, which would be suitable to recommend for use in (a) the secondary prevention (early intervention) system and (b) the tertiary out-of-home care system in Queensland?

4.2.2 Evidence-based processes and outcomes

As is the case in most policy areas, policies, programs and other solutions that are based on 'evidence' are favoured because policy makers can be confident that they are likely to be effective if they are carefully implemented. 'Evidence' in this context means findings from scientifically conducted research, as well as systematic knowledge produced by practitioners and service users. There is, of course, a 'hierarchy of evidence': for example, interventions evaluated using large-scale randomised control trials have stronger claims to validity than those based on other kinds of research, such as in qualitative action research projects. The interface between research and practice can be direct or facilitated: for example, social workers are expected to know of research in their area of practice and incorporate it; and they are also expected to follow best-practice guidelines and protocols based on research.[83] From an evidence-based perspective, process/output and outcome indicators *should* have a scientific justification; for example, a proven link between indicators and outcomes for children and young persons.[84]

The elements and indicators for the implementation of the TRC model developed and used by Verso Consulting[85] in Victoria are evidence-based and are a good example of the 'what works' strand of evidence-based policy.[86] For example, the success of the

[80] See 5.2.2 below.
[81] See also 5.2.3 below.
[82] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 276.
[83] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 471-472
[84] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019.
[85] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011.
[86] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 471-472.

TRC model depends 'on the application of a particular range of program elements that underpin the practice of therapeutic residential care'.[87] These elements are[88]

1. The therapeutic specialists attached to each TRC provider (usually through a sub-contracting arrangement) and intrinsically linked to each element of the program. Therapeutic specialists are the custodians of the 'Therapeutic Approach': They develop plans, strategies and approaches, and 'make sure that the values and approach' are 'maintained across all stakeholders'.[89]
2. The theoretical and practical training of residential care workers, to enable them consistently and skilfully to carry out the therapeutic approach.
3. The funding for additional staff, and flexible rostering, that ensures that one-on-one time with children and young people is possible when it is required, and that there is a consistent pattern of staffing, greater program flexibility, more individualised support and supervision, and capacity to react to the children's and young person's needs.
4. That children and young people are encouraged to engage and participate in decision making from before their entry to the TRC.
5. 'Client group matching' in which the therapeutic specialist considers the overall client mix when assessing the suitability of a potential new 'client' for the TRC unit, so as to maximise the opportunities for all young people in the unit.
6. The regular meetings held by the care team, together with other stakeholders (for example, police) that ensure that members of the team take a consistent approach to care and problem solving.
7. The reflective practices uniformly adopted in the TRC units.
8. The organisational congruence and commitment of the TRC unit to the principles, processes and practices of therapeutic care.
9. The physical environment and arrangements of the TRC unit — home-like, purpose built, with private spaces, indoor recreation activities, the opportunity to personalise rooms etc.
10. Exit planning and post exit support for the young people.

For further discussion of these elements, see the excellent work of the Centre for Excellence in Therapeutic Care.[90] The important point here is that process or output indicators can be used to assess whether these essential elements have been implemented, a step which is crucial for the effective implementation of the model.

Other evidence-based indicators can be used to measure outcomes. For example, questionnaires about how a person feels or functions, such as the Strengths and

[87] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 5.
[88] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 5, 9-10, 40-79.
[89] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 41.
[90] Centre for Excellence in Therapeutic Care, *The 10 Essential Elements of Intensive Therapeutic Care in NSW*, CETC, 2019; Lynne McPherson et al, *The evidence base for therapeutic group care: A systematic scoping review – Research brief*, Centre for Excellence in Therapeutic Care, 2019.

Difficulties Questionnaire,[91] are useful to assess mental health in the child protection system, and are usually evidence-based because their psychometric properties have been scientifically tested.[92] Other common instruments[93] used to assess mental health include the K10 questionnaire[94] and the Patient Health Questionnaire-9 (PHQ-9).[95]

MacAlister[96] proposed that the framework of objectives and outcomes (discussed above) should include evidence-based guidance on the best-known *ways of achieving the objectives*. 'As much as possible, practice guides should point to the features of effectiveness from the best interventions currently being used' and 'should be agile, kept up to date based on evolving feedback and evidence, with updates made and effectively disseminated at least annually'.[97]

> Of the evidence-based (i) outcome and (ii) output indicators discussed in this last short section, which would be suitable to recommend for use in Queensland? Should they replace any of the previously chosen performance-based accountability measures?

4.2.3 The views, experiences and subjective well-being of children and young people

A recent, and very important, development in child protection policy making is the argument that the views, experiences and subjective well-being of children and young persons at the centre of the system should be play a major part in processes evaluating the effectiveness of the system.[98] The debate about what should be assessed in the child protection system, and how, has also become more nuanced with the development of the socio-technical systems design framework[99] which, as the Munro Inquiry into the English child protection system demonstrated, is a powerful framework to use to understand, analyse and reform the child protection system. Consequently, performance measures, including outcomes and processes/outputs,

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[91] See https://www.sdqinfo.org/a0.html.

[92] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157, 476.

[93] See also Portfolio Mental Health Assessment Tools for Mental Health Practice at https://www.dualdiagnosis.ie/wp-content/uploads/2011/05/Health-board-assessment-tool-portfolio-10.02.20091.pdf

[94] https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/k10.pdf

[95] https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

[96] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 199-200.

[97] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 199-200.

[98] See, for example, Luke Twyford, 'Fixing the Foundations: Seven reset reforms for Queensland's Child Protection System', Submission to Child Safety Commission of Inquiry, Queensland (27 March 2026), 50-51; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144-157; J Selwyn, M Wood and T Newman, 'Looked after children and young people in England: Developing measures of subjective well-being' (2017) 10(2) *Child Indicators Research* 363; Clare Tilbury, 'Repositioning prevention in child protection using performance indicators' (2016) 37(6) *Policy Studies* 583, 591-592; and Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 23-24.

[99] See note 51 in this Guide.

have been rethought within this framework, and this has included suggestions that more attention should be paid to the views of children and young persons, and families.

For example, the Munro Report accepted that 'timeliness' is important in child protection systems but argued that timeliness must be seen *from the perspective of the child* rather than the organisation.[100] Consequently, Munro recommended that prescribed timescales for individual assessments should be abandoned as being counterproductive because they focus on organisational tasks rather than on what was important to children and families.[101] Rather, timeliness should be measured by the time taken for effective help to be provided to families, or the number of times children are handed over to other social workers etc.

A second example is Seddon's Vanguard Method, which shares many fundamental propositions common to systems thinking.[102] In this framework, a good indicator should reflect the purpose of a service *from the end-user's point of view* and should be a tool used by practitioners doing the work: Instead of using performance data to appraise and control the work of subordinates, managers should work alongside practitioners to understand, and improve, how the system works. Seddon distinguishes what children or families want from a service ('value demand') from services that do not address what children or families want ('failure demand').[103] Again, rather than looking at things like the number of referrals, assessments or child protection plans, the focus should be on how long children have had to wait, or how often they have been re-referred, until they receive effective support.[104] Where high failure demand is identified, managers and practitioners should work together to analyse why the system is not providing what children or families want from the service, and redesign the system to reduce it and to provide what they want.[105] This is a good illustration of the way in which the use of feedback loops can be rethought to use carefully calibrated outcomes to signal where changes to the system need to be made to improve services.

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[100] Eileen Munro, *The Munro Review of Child Protection, Interim Report: The Child's Journey*, The Stationary Office, London, 2011, 63; and Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 7, 37, 45; and see Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 477.

[101] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 10, recommendation1.

[102] John Seddon and Brendan O'Donovan, 'The Vanguard Method: Beyond Command and Control' 2023 (3) *Journal of Systems thinking* DOI:1, 0.54120/jost.000006; Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 477.

[103] Which is, of course, value demand.

[104] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467; Donald Forrester, 'Outcomes in children's social care' (2017) 12 *Journal of Children's Services* 144, 477.

[105] See, for example, Joanne Gibson and Brendan O'Donovan, 'The Vanguard Method as applied to the design and management of English and Welsh Children's Services departments' (2014) 27(1) *Systemic Practice and Action Research* 39, summarised in Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 477; and Organization for Economic Cooperation and Development, *Systems Approaches to Public Sector Challenges: Working with Change*, OECD, 2017, 25-26 and see the example at 92-106.

A third example is the 'balanced scorecard of indicators for learning and improvement', recommended by MacAlister[106] to support system objectives and outcomes. In this framework, indicators are not 'performance targets', because unless performance targets are very well planned, the performance can 'hit the target but miss the point'.[107] Rather, the data that is collected must reflect what matters to children and families and must be accurate and consistent. 'The guiding question should be whether the data' enables 'meaningful learning'.[108] MacAlister suggests that priority areas for developing indicators would include: an indicator of child and family satisfaction with services, gathering data on what children need in order to better understand the support children and families receive, improving data collection about kinship care, and collecting key information about children in care.[109] This approach can bring transparency and clarity to a complex child protection system and contribute to systems learning to improve services for children and families by gaining an understanding of whether services are meeting the needs of children in families, and if not, finding out why this is the case and making adjustments.

Fourth, from 2022 to 2024 the Department conducted an annual survey of children in care in Queensland (*My Life in Care*), with two components — a full survey for 10 to18 year olds, and a short survey for 5 to 9 year olds.[110] The survey was developed in consultation with academic experts, CREATE, the Queensland Family and Child Commission, teachers, and the Queensland Government Statistician's Office.[111] Children and young people over the age of nine years were asked about: their views of the care system; how they felt about their current placement; and their experience of care. Children aged five to nine years responded to a simpler set of questions. Both sets of questions are summarised in Appendix 2.

Finally, recent commissioned research carried out by the Rees Centre at the University of Oxford (codesigned and implemented with a group of young people who had been through the English child protection system) has explored how young people leaving the child protection system themselves defined 'success'.[112] The project team developed 'a success measurement tool' (a survey)[113] to be completed by care leavers

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[106] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 198-199.
[107] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 198.
[108] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 199.
[109] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 198.
[110] For a summary of the results of the three surveys, see https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/what-we-achieve/views-of-children-in-care.
[111] The survey questions were based on questions used in previous surveys and were piloted and tested by children in care. Five hundred children completed the first survey, and 1000 completed the 2024 survey. The survey received ethics approval, and children responded online using survey software without the need for administrators. Participation was voluntary and anonymous, and children received a $50 gift card for completing the survey.
[112] Aine Kelly et al, *Success – whose definition counts. A co-designed framework by and for young people leaving care*, Rees Centre, Department of Education, The University of Oxford, 2025.
[113] The project methodology to develop the survey tool included a literature review of how 'success' is defined by young adults in the general population; a series of interviews with professionals to evaluate

with the assistance of their personal advisors. The overall aim of the project is to develop a conception of 'success' that better reflects the goals, values and progress of young people who had been through the care system.[114]

The key findings of the project included that professionals were aware of the limitations of the current framework in England, and that it did not represent success as understood by young people leaving care: rather, it focused on easily measurable outcomes and not on what 'truly matters', and defined 'success' largely as the absence of failure (for example, not being homeless).[115] As Kelly and colleagues explain:

> There are clear overlaps between care leavers and the general population in the broad domains considered important for success — such as education, employment, financial security, well-being, and relationships. But care leavers often defined success in more contextual and nuanced ways, shaped by experience of systematic disadvantage, stigma and instability. For many, success was not about reaching conventional milestones but about navigating daily challenges and achieving moments of stability, safety and self-acceptance.[116]
>
> [For care leavers, success] means surviving and thriving on their own terms: through resilience, healing, meaningful relationships, emotional safety, and a self-defined future. Their realities are rich, complex, and personal, far beyond the reach of national metrics. … Until the system evolves to reflect these broader definitions of success, it will continue to fall short of supporting the lives it aims to serve.[117]

In conclusion, the examples in this sub-section illustrate the questions that can be asked of children and young people in care, or who have left care, in order to gather information about their experience of care, and of leaving care, so as to understand how better to support and care for children and young people, and to help them prepare for life after care. Some of the examples also illustrate a process of reflection, deliberation and analysis to understand how the child protection system is failing to provide the care and support that children and young people need.

4.2.4 Examples of mixed outcome indicators

The previous sub-sections have explored the questions that can be asked, the data that might be collected, and the performance indicators, evidence-based indicators and information about the experiences of children and young people that might be

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the existing outcome indicators for young people leaving care; and focus groups with 26 young people who had been in care to examine what success meant for them. The tool was refined by further focus groups and two cognitive interviews involving care leavers.

[114] Aine Kelly et al, *Success – whose definition counts. A co-designed framework by and for young people leaving care*, Rees Centre, Department of Education, The University of Oxford, 2025

[115] Aine Kelly et al, *Success – whose definition counts. A co-designed framework by and for young people leaving care*, Rees Centre, Department of Education, The University of Oxford, 2025, 7, 47-48, 6, 13-23

[116] Aine Kelly et al, *Success – whose definition counts. A co-designed framework by and for young people leaving care*, Rees Centre, Department of Education, The University of Oxford, 202543 and see also 7.

[117] I Aine Kelly et al, *Success – whose definition counts. A co-designed framework by and for young people leaving care*, Rees Centre, Department of Education, The University of Oxford, 2025 47-48, and for fuller details of care leavers' conceptions of success, 24-48.

developed in order to understand and diagnose the strengths and weaknesses of the complex child protection system. Of course, the data that best enables an understanding of the effectiveness of the system will likely comprise a carefully selected mix of the different types of outcome indicators, as the following two examples illustrate.

In the Verso Consulting study of a pilot TRC program in Victoria (discussed above) the outcomes for the children and young people resident in the program were evaluated and compared with the outcomes for children and young people from standard residential care practice.[118] More specifically, the evaluation assessed the progress of children and young people in TRC against the goals outlined in the Victorian Child Protection and Family Services *Outcomes Framework* over time.[119] It used three quantitative evaluation tools: the Strength and Difficulties Questionnaire, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)[120] and the Brann Likert Scales, which use information extracted from the child or young person's file.[121] The outcomes that were evaluated included the stability children experienced in the program; the quality of their relationships and contact with their family during their involvement in program; the contact they had with their residential carers over time; their connection with their community in recreational activity or in part-time paid work; risk taking incidents resulting in episodes requiring police involvement; improved mental and emotional health; improvements in their sense of self, which is an indicator of improved mental health; improvements in nine health measures, including medical, dental, nutritional, sleep and hygiene, recreational patterns and improved exercise; and improvements in relationships at school. Two other outcomes, 'safety from injury and harm' and Indigenous children's connection with their communities, could not be evaluated because suitable data was not available.[122]

A second example is the evaluation of the outcomes of the Mulberry Bush School's therapeutic program for children, briefly discussed earlier in this Guide. Each child's social, emotional and mental development was assessed using a well-established tool — the Boxall Profile.[123] Each child's academic achievement was assessed against national curriculum levels; and behavioural development was assessed by counting

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[118] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011.

[119] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 95.

[120] See https://www.rcpsych.ac.uk/improving-care/ccqi/health-of-nation-outcome-scales

[121] See Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 96-98; and Verso Consulting Pty Ltd, *Therapeutic Residential Care System Development: Outcomes Measurement Framework*, Family and Community Services NSW, 2016 accessible at https://dcj.nsw.gov.au/documents/about-us/facsiar/past-research-reports/oohc/verso-outcome-measurement-framework-june-2016.pdf, 14.

[122] Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 126.

[123] Marion Bennathan and Marjorie Boxall, *Effective intervention in primary schools: Nurture groups*, Routledge, New York, 2012; Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 413.

the number of aggressive and antisocial incidents, and physical interventions involving each child. Finally, the strength of each child's attachments was calibrated using another accepted tool, the Story Stem Assessment Profile for measuring mental representation of attachments.[124]

> Of the outcome indicators discussed in these last two sections, which would be suitable to recommend for use in Queensland? Should they replace any of the previously chosen performance-based and/or evidence-based accountability indicators?
>
> Are you aware of any other good outcome indicators in the grey or academic literature?
>
> How can feedback loops be designed and implemented to ensure that there are no unintended consequences, and to enable the system to self-regulate?

5. Generating good indicators

This section of the Guide addresses the questions: What are the characteristics of good indicators, and how they can be generated? La Valle et al suggest that 'in order to measure if outcomes are achieved it is necessary to identify specific, observable, and measurable indicators'.[125] Their project used the 'MVP principles' to draft indicators: Indicators should be 'meaningful' to the parties who will be using them; 'valid' in the sense of 'measuring what it is intended to measure'; 'reliable' in the sense that 'the measures must be based on data collected in a consistent way' (for example, using standardised data collection instruments); and 'pragmatic' in that, so far as is possible, existing indicators should be used (as long as they are meaningful and valid), and new indicators be developed with existing data. As discussed later in this Guide, however, there are good reasons in some instances to collect new data (for example, through surveys), including highly qualitative data that may not meet these criteria.

The related field of governance indicators provides further useful advice, in the form of the 'three golden rules'.[126] The first 'golden rule' is to use a range of indicators, rather than just one, so as to better reflect the full situation. The second is that an indicator should be used as 'a first question – not the last'. The more detailed the indicator is, the more useful it is to 'point towards actions that could lead to an improvement in the result.' The third is to 'understand an indicator before you use it', and in particular understand its underlying methodology and normative assumptions.

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[124] The study's methodology is discussed in detail in Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 412-415.

[125] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 34-35.

[126] United Nations Children's Fund (UNICEF), *Measuring and Monitoring Child Protection Systems: Proposed Core Indicators for the East Asia and Pacific Region*, Strengthening Child Protection Series No 3, UNICEF EAPRO, Bangkok, Thailand, 2012, 10-11.

In short, the data and performance information should not be interpreted as 'absolute indicators of performance'; rather 'data should be treated as information that needs to be carefully and intelligently interrogated in order understand the particular circumstances and pattern of provision'.[127] One aim of this Guide has been to facilitate this understanding by explaining the intellectual frameworks, assumptions and methodologies underpinning various types of indicators.

6. Complexities in aggregating different types of outcome indicators

As discussed earlier in this Guide, a key challenge is how to align individual indicators with institutional indicators and system indicators ('how have we done overall?'). In many cases, where *simpl*e performance indicators are used, they can be aggregated to report on institutional and system performance. Further, as Hood observes, evidence-based clinical guidelines can be linked with appropriate evidence-based process and outcome indicators.[128]

From the perspective of indicators reflecting the views, experiences and perspectives of children, young people and families,[129] one drawback of tailoring indicators to the scientific literature, rather than to the full range of solutions and problems encountered in practice, is that resources and provisions tend to converge on 'a one size fits all' template that frustrates children's and families' efforts to get what they specifically need.[130] Another difficulty is that evidence-based psychometric measures are inflexible. One approach to address these problems is to accept more ideographic types of evidence, such as narrative pen portraits[131] and report scaling tools, in order to understand the nuances in the issues important to service users.[132] Examples include user report tools like Goal Attainment Scaling,[133] the Satisfaction with Life Scale[134] to evaluate child-safeguarding interventions, and the Story Stem Assessment Profile for measuring mental representation of a child's attachment to adult teachers or carers.[135] These are personalised scales, but are less reliable when making

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[127] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 48.

[128] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467, 477-478.

[129] That is, the socio-technical design framework – see note 51.

[130] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467, 478.

[131] These are vivid and brief snapshots that capture a person's story and key traits in a descriptive, holistic way, and making abstract information tangible and relatable. This approach is used in qualitative research to analyse experiences and provide detailed profiles. See, for example, Laura Sheard and Claire Marsh, 'How to analyse longitudinal data from multiple sources in qualitative health research: the pen portrait analytic technique' (2019) 19:16 *BMC Medical Research Methodology*.

[132] Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466-467, 478.

[133] See https://clinicaltoolslibrary.com/goal-attainment-scaling-gas/.

[134] See https://eddiener.com/satisfaction-with-life-scale-swls/.

[135] Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 414; Jill Hodges and Miriam Steele, 'Effects of abuse on attachment representations: Narrative assessments of abused children' (2000) 26(3) *Journal of Child*

comparisons over time and between people. It is also difficult to aggregate these highly qualitative indicators for use at care provider and systems level. A further complexity is that, as explained earlier, primary users of services often have different interests and goals from other parties in the system.[136]

7. Improving outcomes through open and honest dialogue and collaboration, and preventing a 'tick-the-box' paper compliance culture

One of the challenges in developing a system of feedback loops to ensure stronger support for families and better care for children and young people is to ensure that every part of the child protection system is focused on considering the *substance* of the feedback, and that there is an 'open and honest dialogue with others about how to improve'.[137]

As noted earlier in this Guide, the use of feedback loops and learning is an important part of shifting the child protection system from a 'compliance' culture to a 'learning' culture. Rather than a culture in which service providers, carers, and CSOs and their managers see the managing of information from feedback loops as part of a detailed bureaucratic procedure, and take a ritualistic 'tick-the-box' approach to comply with the requirement to act upon the information, a 'learning culture' is one in which service providers, carers, and CSOs and their managers are encouraged to find out whether they are providing a good service and contributing to better outcomes, and to work together to improve the support provided to families and carers and the quality of care provided to children and young people. The Commission's vision is that each party involved in the child protection system should engage in candid reflection and discussion about what the indicators are telling them and the people they work with about the quality of their work and the quality of care and support that they are providing, and then work together to modify the system to ensure that the purpose and objectives of the system (see the discussion of purpose and objectives above) are met when normal services are carried out in a coordinated fashion. Munro reminds us that:

> The complexity of the multi-agency child protection system heightens the need for continual and reliable feedback about how the system is performing. This is in order that organisations can learn about what is working well and identify emerging problems and so adapt accordingly. Such a learning culture is needed both within and between agencies. It needs to include people at all levels in organisations, from the frontline workers engaging with families, to the most senior managers in hierarchies. Mechanisms for generating organisational learning are therefore also valuable forms of multi-agency training. These provide opportunities for people to better understand their relative roles

and Adult Psychotherapy 433-455; Saul Hillman, Richard Cross and Katherine Anderson, 'Exploring Attachment and Internal Representations in Looked-After Children' (2020) 19:110 *Frontiers in Psychology* 464.

[136] See further Rick Hood, 'What to Measure in Child Protection?' (2019) 49 *British Journal of Social Work* 466, 466, 477-478.

[137] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 200.

> and areas of expertise across agencies and how they can best work together and support each other in their common goal of helping children and families.[138]

Leadership and training are important elements in ensuring that a learning culture is embedded. Departmental and agency leaders must show commitment to a learning culture, and to focusing on and measuring what really matters — whether families and children and young people have been helped.[139] Service providers, carers, CSOs and their managers should be provided with guidance in the form of broad principles (and performance indicators consistent with these principles) to encourage, guide and enable careful engagement with issues raised by feedback, and thoughtful dialogue with others to develop solutions to improve family support and care for children and young people. Training and continuing professional development for CSOs and their managers should include a strong focus on the values, attitudes and skills required for a strong learning culture.[140] It should also enable CSOs and managers to develop the appropriate normative motives (to achieve the overall purposes and objectives of the child protection system – as outlined above ─ through dialogue and collaboration) and the capacity to make and implement good decisions.[141] The child protection system also needs to ensure that there are sufficient resources to ensure that service providers, carers, CSOs and their managers have the time for reflective deliberation and that families are supported and children are cared for.[142]

In organisations subject to the Queensland *Human Services Quality Standards*,[143] the standards might be used to embed this process of using outcomes and indicators to assess the effectiveness of the system. For example, the Standards set down 'expected outcomes' and 'indicators' such as:

- 'Sound governance and management systems that maximise outcomes for stakeholders' (Standard 1);
- 'Mechanisms for continuous improvement are demonstrated in organisational management and service delivery processes' (Indicator 1.5);
- 'The assessed needs of the individual are being appropriately addressed and responded to within resource capability' (Standard 3);
- 'The organisation ensures that services to the individual/s are delivered, monitored, reviewed and reassessed in a timely manner' (Indicator 3.3); 'Effective feedback, complaints and appeals processes … lead to improvements in service delivery' (Standard 5);

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[138] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 62.
[139] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 7.
[140] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 116-117.
[141] Christine Parker and Vibeke Lehmann Nielsen, *Explaining Compliance: Business Responses to Regulation*. Edward Elgar, Cheltenham, United Kingdom, 2011, ch 1.
[142] Christine Parker and Vibeke Lehmann Nielsen, *Explaining Compliance: Business Responses to Regulation*. Edward Elgar, Cheltenham, United Kingdom, 2011, ch 1
[143] https://www.families.qld.gov.au/_media/documents/hsqf/standards/standards.pdf.

- and 'The organisation demonstrates that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders' (Indicator 5.4). See Appendix 2.

8. Improving data and technology systems

The effective use of feedback to improve the child protection system will be dependent on improving data and technology systems. Three issues, in particular, will need to be addressed.

8.1 Reducing the time spent with the case management system

Poor case management systems and inefficient data management reduce the time that CSOs have available to spend with families and children in need. All parties in the child protection system need a data system that facilitates entry and retrieval of appropriate, accurate (clean) and fit for purpose data. A key objective of the case management system 'should be to significantly reduce the time spent recording, improve practice and make access to data more automatic'.[144]

8.2 Frictionless information sharing

The data management system needs also to ensure fast and 'frictionless' sharing of information between all key parties in the child protection system.[145]

8.3 Analysis of data

The decision making of CSOs, support agencies and other key parties in the system, and the effectiveness of feedback loops in the child protection system, depend on sound analysis of data, and the ability to turn the data 'into actionable intelligence'.[146] For example, the output measures required of the Department require it to have a system of easy entry of data about support given to families, carers, and children, including facilitating access to health and medical services, recreational activities etc.

9. Conclusion

This Guide has discussed a framework for developing indicators that can be used to assess the effectiveness of early intervention support processes for families and the effectiveness of the care provided for children and young people by their own families or in out-of-home care. Indicators can be used for many uses and purposes to explore ways of developing indicators that provide accurate information about

(i) whether early intervention processes and out-of-home care processes have been properly implemented; and, more importantly,

(ii) whether families and children have benefited from early intervention; and

[144] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 221.
[145] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 221.
[146] Josh MacAlister, *The Independent Review of Children's Social Care, Final Report*, 2022, 221-222.

(iii) the health, safety and welfare of children has been enhanced by out-of-home care.

The primary purposes of these indicators are to assist the Department and agencies and entities involved in the child and family support and child protection systems to

- make properly informed planning decisions and decisions about the delivery of services;
- monitor 'business as usual'[147] and check that it results in improvements in the functioning of families and/or the health, safety and wellbeing of children and young people;
- identify flaws in the overall system, so that the system's processes can be altered and reformed to better achieve their primary purposes; and
- assess whether the improvements themselves are effective and do not result in unintended effects.[148]

Secondary purposes are to generate publicly available data about the operation of the system to ensure full accountability, and to enable benchmarking and comparisons with other systems across Australia by sharing data with the relevant departments and agencies in the other States and the Territories.

The analysis of the data in the indicators must take into account the broader context within which the indicators were selected and the data collected and analysed.[149] This includes the pressures of poverty, homelessness and other disadvantages experienced by families; the possibility that families, carers and children from different socio-cultural backgrounds may receive different responses from CSOs and agencies; the resources allocated by the Department (for example, budget, staff, etc), which play a key part in enabling departmental staff and agencies to work effectively; and the ability of departmental staff and agencies and their staff to work together effectively.

Finally, La Valle et al remind us that in making sense of the data, none of the indicators should be considered in isolation.[150] Indicators from different sources should be triangulated to capture the complexity within which the Department and agencies work, and the support provided to families, carers and children.

The draft indicators set out in Appendix 1 are the first step in developing the appropriate indicators.[151]

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[147] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 14.

[148] Eileen Munro, *The Munro Review of Child Protection: Final Report: A child-centred system,* The Stationary Office, London, 2011, 48.

[149] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 9, 11.

[150] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 9, 11.

[151] See also the draft 'metrics' for residential care developed by the Queensland Family and Child Commission: see Queensland Family and Child Commission, *'A system that cares': Queensland*

Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland', QFCC, Brisbane, April 2024, 29-36.

APPENDIX 1

Draft output and outcome indicators

These draft outputs, outcomes and indicators are a starting point for further discussion, analysis, development and testing. The further discussions should include examination of what sorts of indicators there should be, the number of indicators, and how the data and information gathered for the indicators should be used to ensure that improvements to the child protection system are made.

The draft objectives and corresponding indicators are as follows:

	Secondary prevention (early intervention) system	
	Objective	**Measure or indicator of output or outcome**
Output 1	Overall significant increase in the funding, provision and quality of secondary (early intervention) services.	Government departmental budgets and reports and service provider accounts and reports show clear evidence of increased funding of family supports, and increased provision of family supports; there is an evaluation of the quality, efficiency, targeting and effectiveness of service provision, and there is evidence of improvement for each criterion; there is an improving ratio of expenditure on family support compared with expenditure on tertiary system.
Output 2	Provision of non-stigmatising family help, focusing on supporting the whole family. Ensure the voluntariness of the process; and eliminate a blaming, coercive, controlling and compliance culture.	Evidence of non-stigmatising strategy; lack of complaints about stigmatisation and inadequacy of family support; peak body surveys of provision of supports show that families feel that that they are more supported; correspondence, acknowledgement by the families, etc that they are feeling more supported.
Output 3	All child and family needs are identified early and there is timely access to quality services and supports from skilled and decisive multi-agency sources, including: • Employment • Financial advice and access • Housing • Health • Parenting skills • Counselling, including for the psychological and physiological effects of neglect, abuse and detachment from their family. • Access to education (early childhood to tertiary) • Family law systems, justice services and supports • Disability services and supports.	Data shows that average time between request for assistance and access to and receipt of services is reducing; reports of satisfaction survey data show increased satisfaction with services; peak body surveys of provision of supports show increased satisfaction with services. Overall data provides evidence (eg accounts, provider reports, correspondence, acknowledgement by the family etc) that help and support has been provided in each of the needed areas.
Outcome 1	Child or young person is supported to thrive with their families.	Evidence from child's completion of The Satisfaction with Life Scale.
Outcome 2	Support enables children to grow up in safe, secure and nurturing homes, where they are loved, feel accepted, have a sense of belonging and are supported by strong families and communities.	Adapt out-of-home care indicators set out below.

Outcome 3	Strong multi-agency working means that services and decisions are joined up and focused on what is best for children and families.	Analysis of documents explaining coordination of services shows that services are better coordinated. Survey of parents shows that they have had a positive experience in receiving services.
Outcome 4	Resources are used effectively so that children and families receive the maximum benefits and have their holistic needs fulfilled.	Reports from agencies show that they have made reasonable efforts to provide families with the maximum benefits.
Outcome 5	Support enables: • Stable family employment • Financial independence • Security: communities free from violence and discrimination • Safe and stable housing • Effective advice and support in relation to family law systems, justice services and supports, and disability services and supports • Holistic physiological and mental health, including healing from psychological and physiological effects of neglect, abuse and detachment from their family. • Successful completion of education (early childhood to tertiary).	Survey of parents shows satisfaction with the services that they have sought. Adapt out-of-home care indicators set out below.
Outcome 6	Fewer families experience social, emotional and economic risk factors for child neglect and abuse.	• Future data collected by the Australian Child Maltreatment Study shows a fall in the incidence of the risk factors and in the incidence of the various forms of child maltreatment and abuse.[152] • Queensland Family and Child Commission,[153] Productivity Commission (RoGS),[154] Australian Institute of Health and Welfare,[155] and/or departmental data show a fall in notifications, investigations, substantiations, care and protection orders, out-of-home-care placements. [156]

[152] https://www.acms.au/
[153] https://www.qfcc.qld.gov.au/publication/annual-report-performance-queensland-child-protection-system-2024-25
[154] https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/.
[155] https://www.aihw.gov.au/getmedia/558c05da-13a9-4a2f-9afb-86a158318290/child-protection-australia-2023-24.pdf.
[156] See https://performance.dcssds.qld.gov.au/our-performance/national-data/family-support-services.

	Out-of-Home Care (Family and Non-family)	
	Objectives	**Measure or indicator of output or outcome[157]**
Output 1	A relentless focus on engaging and supporting the child's wider family network to step forward.	Department's records showing steps CSOs took to engage and support wider family network; verified by phone calls to a random sample of extended family members.
Output 2	Child's voice should be heard and prioritised in decisions about what happens to them through reinvigorated advocacy Child receive support from the department throughout the process.	• Department's records showing steps taken to consult the child, and record of child's opinions. • Does the child recollect being consulted? Did the child feel that they were being listened to? • Child's views on the extent to which they have been involved in (i) identifying their needs; (ii) what support they require. • Percentage of children who attended meetings to plan their support. • Percentage of children who have changed their CSO. • Child's views on relationship with their CSO eg based on trust, supportive, empowering. • Child's views on extent to which communication with their CSO has been open and honest.
Output 3	Family and carer receive support from the department throughout the process.	• Department's records showing support given to family and carer – regular case reviews; continuity of CSO, regular contact with CSO, and turnover of CSOs; regularity, timing and quality of investigations of care home. • Percentage of families/carers who have changed their CSO. • Views on the extent to which families/carers have been involved in identifying (i) their needs; and (ii) what support they require. • Views on relationship with their CSO; for example, whether it is based on trust, supportive, empowering. • Views on extent to which communication with their CSO has been open and honest.
Output 4	Care placement that suits the child's particular circumstances (and whether they are placed with their siblings).	Are persuasive reasons given for the placement? Is the child satisfied with the placement? If relevant, was the child placed with their siblings?
Output 5	When needed, the child has prompt access to health and medical services (including dental services and psychological counselling).	Carer's records of requesting services for the child and records of services provided. How long did the carer and the child have to wait before they received the service? If the allegation is that the Department did not support access to services, request to Department to respond.

[157] See also the draft metrics for residential care developed by the Queensland Family and Child Commission: see Queensland Family and Child Commission, *'A system that cares': Queensland Family and Child Commission response to Child Safety's 'A Roadmap for Residential Care in Queensland'*, QFCC, Brisbane, April 2024, 29-36.

Output 6	Secure and stable placement with minimal transfers.	The time the child spent at the placement; the number of other placements; the total number of times the child was handed over to another carer.
Output 7	Placement local – close to family	How long does it take for the family to travel to the carer to visit the child?
Output 8	Attendance at school while in care	How long does it take for the child to get to the school; School's attendance records.
Output 9	Was the placement 'culturally appropriate'?	Was the child placed with a culturally appropriate carer?
Outcome 1	Child and carer feel supported throughout the process The child and the carer think the service is responding to their needs.	• The child's and the carer's views about the support the child and the carer received from CSO(s); how long did the child or carer have to wait before the CSO responded to a request; and whether the child and the carer had a good experience with the CSO(s). • The child's and the carer's views on whether their CSO(s) worked collaboratively with other services to get the support they required. • Percentage of substantiated complaints from children (and from carer). • Percentage of repeat complaints from children (and from carer).
Outcome 2	A sense of security and permanency, and a stable living arrangement.	• Score on the Brann Likert Scales (residential stability of placement). • Case audit confirming that the child's plan has been updated in the past six months. • Case audit confirming that there is evidence of the child's needs are being met at home. • The child has/does not have a long-term plan for how they will be cared for throughout their childhood within two years of coming into care. • Has there been an unplanned placement move in the past 6 months? • Have there been successful/unsuccessful moves to permanence arrangements in the past six months? • The child's views on what is being done to achieve permanence. • The parent's/carer's views on what is being done to achieve permanence.
Outcome 3	A sense of belonging and being happy and settled in a place that 'feels like home' and which is as close as possible to a family environment.	• To what extent does the child feel settled, loved and cared for at home or in the placement? • To what extent do they report that they understand the plans for their future care? • The child's score on the Strengths and Difficulties Questionnaire (behaviour). • Has the child been involved in the youth justice system in the past six months? Compared with previous six months? • Has the child been involved in substance abuse in previous six months? Compared with previous six months? • Has the child been more or less likely to have self-harmed in the previous six months? Compared with previous six months?
Outcome 4	Relationship with carers; an ongoing, loving and nurturing attachment with at least one adult.	Scores on the Story Stem Assessment profile;[158] and/or Brann Likert Scales (connectedness to carers)

[158] Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409-421

Outcome 5	Feel safe, and free from harm, neglect and exploitation.	• To what extent does the child feel safe and supported at home or in placement? • Did the child go missing from home or from a placement in the past six months? • Has the child had more or fewer missing episodes in the past 6 months compared with the previous six months? • Has the child been affected by domestic violence in the previous 6 months? Compared with the previous six months? • Has the child been affected by parental mental ill-health in the previous 6 months? Compared with the previous six months? • Has the child been affected by parental substance abuse in the previous 6 months? Compared with the previous six months?
Outcome 6	Behavioural, emotional and mental development. Emotional and behavioural issues.	• Score on the Boxall Profile;[159] and/or Brann Likert Scales (social and emotional development). • Score and changes in score in the Strengths and Difficulties Questionnaire – emotional development, conduct problems, hyperactivity. • Count the number of aggressive and antisocial incidents, and physical interventions;[160] the child's score in the Health of the Nation Outcomes Scale (disruptive, aggressive, antisocial behaviours); and/or Strengths and Difficulties Questionnaire (emotional symptoms, conduct problems).
Outcome 7	Social development.	• The child's score on the Boxall Profile;[161] and/or Brann Likert Scales (social and emotional development). • The child's score and changes in score in the Strengths and Difficulties Questionnaire – peer relationships; prosocial behaviour (ie positive, helpful, and intended to promote social acceptance and friendship).
Outcome 8	Maintain full physiological health, including dental, sleep, nutrition etc.	Results of the six-monthly check up by local general practitioner; child's score on the Brann Likert Scales (physical health); has the child had positive sleep patterns?
Outcome 9	Maintain mental health and wellbeing.	• Has the child had any identified unmet mental health needs in the past six months? • Has the child had any identified mental health needs supported by a mental health practitioner or the equivalent? • What are the parent's/carer's views on the child's positive sense of their identity; and their hopes for the future? • Score on the Brann Likert Scales (positive sense of self); Strengths and Difficulties Questionnaire (hyperactivity/inattention?); the K10 questionnaire; the PHQ-9 questionnaire.

[159] Marion Bennathan and Marjorie Boxall, *Effective intervention in primary schools: Nurture groups*, Routledge, New York, 2012; Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 413.
[160] Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409-421
[161] Marion Bennathan and Marjorie Boxall, *Effective intervention in primary schools: Nurture groups*, Routledge, New York, 2012; Leslie Gutman et al 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 413.

Outcome 10	Clear progress in healing from the psychological and physiological effects of neglect, abuse and detachment from their family so that they 'can have life outcomes on par with their peers'.	• Regular reports from a therapeutic specialist showing progress; • The child's score on the Trauma Symptom Checklist for Children; • The child's score on the Harm Consequences Assessment; • The child's score on the Strengths and Difficulties Questionnaire; etc
Outcome 11	The child feels valued and accepted; enabled to flourish and thrive, build a level of confidence, and experience excellence in something; able to develop their sense of autonomy and reach their full potential.	• Child's score on the Strengths and Difficulties Questionnaire (Pro-social behaviour?) • Child's score on a completed The Satisfaction with Life Scale.
Outcome 12	Maintain contact and relationships with their parents, siblings and kin.	• Child's score on the Health of the Nation Outcomes Scale (family relationships). • The child is clear about the plans for contact with their family; and feels that their wishes have been taken into account. • Parents/siblings are clear about the plans for contact with their child; and feel that their wishes have been taken into account.
Outcome 13	Social skills and interaction and build quality peer/school relationships.	The child's score on the Health of the Nation Outcomes Scale (peer relationships); and/or the Strengths and Difficulties Questionnaire (peer relationship problems).
Outcome 14	Explore and maintain their identity and values (including cultural, ethnic and religious), and for ATSI children maintain a connection to community and country.	The child's score on the Brann Likert Scales (connection to culture).
Outcome 15	Connections to broader community that meet the child's developmental, educational, emotional, health, intellectual, physical, creative and recreational needs.	The child's score on the Brann Likert Scales (connectedness to school and community.
Outcome 16	Education: Engagement Stable and positive experiences Progress in education.	The child has • been in an appropriate level of education for the previous 6 months. • been excluded from school in the previous six months. • unauthorised absences from school in the previous six months. • had changes of school in the past 12 months. • had good or bad experiences of school: score on the Brann Likert Scales (education and learning); and/or the Health of the Nation Outcomes Scale (school attendance). • had engagement with other activities they enjoy. • had their educational progress measured against national curriculum levels; school reports, perhaps with follow up meetings with their teacher. • aspirations for the future.
Outcome 17	Diverted from crime; risk taking behaviour.	Child's score on the Brann Likert Scales (risk taking).
Outcome 18	Avoid drug and alcohol misuse.	Child's score on the Health of the Nation Outcomes Scale (substance misuse).

	Therapeutic Residential Care Output Indicators	
	Evidence-based minimal critical essential elements and pre-conditions	**Indicator of output**
Output 1	Engagement of therapeutic specialists.	Evidence of appointment of therapeutic specialists with requisite knowledge and experience, and the ability to relate to staff, children, families and other agencies; evidence of evaluation and reflection to ensure ongoing improvement in performance of the role.
Output 2	Theoretical and practical training of residential care workers.	Evidence of implementation of theoretical and practical training of residential care workers:[162] for example, for Residential Care Program Manager, Unit Manager, House Supervisor, and Care Workers; evidence of regular reviews of training, and modules have been revised when gaps have been identified.
Output 3	Funding for additional staff, consistent and predictable pattern of staffing and staff members, and flexible rostering to ensure one-on-one time with children.	Evidence that funding has been provided for additional staff, and that flexible rostering to ensure one-on-one time with children has been implemented; evidence that there is a process of monitoring factors causing staff turnover (through satisfaction surveys) to reduce turnover, ensure a stable team, ensure the team takes a consistent approach and to enable children and young people to build up trust in team members.
Output 4	Children and young people are encouraged to engage and participate in decision making.	Evidence of evaluation interviews with children and young people about whether they feel supported and listened to, and of a quantitative survey on quality of engagement with carers. When processing the results of both, that there has been a comparison of experiences prior to care, on entry to care, and during time in care.[163]
Output 5	There is client group matching – the therapeutic specialist assesses the client mix when selecting new entrants, to maximise the opportunities for all young people in the TRC.	Documented application of matching criteria.
Output 6	There are regular care team meetings to ensure consistency in care.	Evidence that regular meetings have taken place. Minutes of meetings, including actions to be taken.
Output 7	The care team undertakes reflective practices.	Evidence that the care team allocates time in each meeting for group reflective practices.
Output 8	The organisational congruence and commitment of the TRC unit to the agreed principles, processes and practices of therapeutic care; and congruence with interfacing agencies.	Evidence (minutes of meetings, documentation of processes and agreements etc) that all TRC units and interfacing agencies are aware of, and understand, the agreed principles, processes and practices of therapeutic care. Derogation from the agreed principles, processes and practices of therapeutic care have been noted and justified.

[162] For content, see Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 49-51.

[163] For details, see Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, Department of Human Services, Melbourne, 2011, 54-56.

Output 9	Physical environment and arrangements unit — purpose built, with private spaces, indoor recreation activities, opportunity to personalise rooms etc	There is a documented assessment of how the physical environment and arrangements rate against those criteria.
Output 10	Exit planning and post exit support.	Does the child have an exit and post exit support plan? Is the plan satisfactory? What is the child's (and if relevant, the family's) opinion of the plan?

	Leaving out-of-home care Reunification Objectives	**Measure or indicator of output or outcome**
Outcome 1	Returned successfully to family.	• Evidence from child/young person and family that child has settled back with their family. • Attempts by the child to leave the family.
Outcome 2	Has the child/young person self-placed, or returned to the child protection system?	• Ongoing check that the child/young person is still settled with their family • Attempts by the child to leave the family.
Outcome 3	Health, safety and wellbeing.	Outcomes for children in out-of-home care (above), measured occasionally.
	Leaving out-of-home care Transition to adulthood Objectives	**Measure or indicator of output or outcome**
Output 1	Care leavers continue to be supported by their corporate parent.	• Does the young adult feel supported? • What evidence is there of adequate support?
Outcome 1	Care leavers maintain full physiological health, including dental, sleep, nutrition etc; a life expectancy equal to the wider population.	Results of the six-monthly check up by local general practitioner; score on the Brann Likert Scales (physical health).
Outcome 2	Care leavers maintain mental health and wellbeing.	• Has the young adult experienced any identified unmet mental health needs in the past 6 months? • Has the young adult had their identified mental health needs supported by mental health practitioner or equivalent? • What are the parent's/carer's views on the young adult's positive sense of their identity; and their hopes for the future? • The young adult's scores on the Brann Likert Scales (positive sense of self); Strengths and Difficulties Questionnaire (hyperactivity/inattention); the K10 questionnaire; the PHQ-9 questionnaire.
Outcome 3	Care leavers are healed from the psychological and physiological effects of neglect, abuse and detachment from their family so that they 'can have life outcomes on par with their peers'.	Are there regular reports from a therapeutic specialist? Do the regular reports show that the young person is making good enough progress?
Outcome 4	Emotional and behavioural issues.	Young adult's score on the Health of the Nation Outcomes Scale (disruptive, aggressive, antisocial behaviours); and Strengths and Difficulties Questionnaire (emotional symptoms, conduct problems).
Outcome 5	At least two loving relationships.	Does the young adult self-report that they have two loving relationships?
Outcome 6	Safe from harm, abuse and exploitation.	Does the young adult self-report that they are safe from harm, abuse and exploitation?
Outcome 7	A good home.	Is there evidence that the young adult is in stable and satisfactory housing.
Outcome 8	Self-care.	The young adult's score on Health of the Nation Outcomes Scale (self-care).
Outcome 9	Financial stability.	Does the young adult have annual meetings with a financial advisor? Does the young adult have manageable debt?

Outcome 10	Access to well-paid stable work.	Is there evidence of employment?
Outcome 11	Further education and/or training ('double the chance of attending university').	Does the young adult self-report that they are engaged in further education and/or training (evidence of enrolment?)
Outcome 12	Avoid drug and alcohol misuse.	Score on the Health of the Nation Outcomes Scale (substance misuse).
Outcome 13	Diverted from crime.	Has the young person been convicted of a crime?
Outcome 14	Does the young person regard their journey through the child protection system as a 'success'?	The young person's score on completion of a success measurement tool based on the survey developed by the Rees Centre as modified by using the Rees Centre methodology.

	Child Protection System overall Objectives[164]	Measure or indicator of output
Output 1	Effective leadership: State and regional leaders continuously learn and improve, supported by transparent data, effective inspection and accountability	• Is the department committed to Child Safety? • Does Child Safety have clear strategic priorities? • Is Child Safety senior management in touch with frontline CSO practice?
Output 2	Commitment to social work values and ethics	• Is there a statement setting out Child Safety's values? • If there is a statement, does it describe how the values operate?; to what extent are staff able to apply these values in their everyday practice?
Output 3	Culture that supports reflective learning	• To what extent does Child Safety support reflective learning? • To what extent does users' feedback inform (i) service planning; (ii) CSO practice?
Output 4	Effective multi-agency working	• Do representatives from partner agencies routinely attend multi-agency (i) strategic meetings; (ii) operational meetings? • To what extent is there effective multi-agency working? • List factors that support or undermine effective multi-agency working?
Output 5	Shared understanding of what good practice looks like	Survey of CSOs: • Is there a framework underpinning practice?: if so, to what extent are you able to apply it? • Is your practice supported by evidence of its effectiveness? • Are you able to work with the whole network of relevant family members and friends? • To what extent do children and their parents/carers have a meaningful role in determining the support they receive? To what extent are you able to establish relationships with children and their parents/carers which are based on trust? • To what extent do you have appropriate autonomy in decision making for key processes (for example, assessments)?
Output 6	The department's child safety officer workforce has the motivation, knowledge, skills, time, resources, systems and autonomy to support children and families.	Survey of CSOs: • Are you satisfied with the key aspects of your job: do you spend enough time with children in care; do you think your interventions improved child outcomes? • Do you feel valued by your employer? • Are you adequately supervised? • Do you have enough learning and development opportunities? • To what extent is your workload manageable? • Do you think your skills are adequate for you to carry out your work? • Are the skills of your colleagues and managers adequate?

[164] Objectives and indicators for this section are drawn from Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework*, Rees Centre, Oxford, 2019, 41-42.

		• Is the skill mix in your team and in the department adequate? Question for Child Safety management: what have the sickness levels of staff at different levels been in the past year?
Output 7	Adequate support infrastructure	• Survey of CSOs: • To what extent do you have access to adequate: (i) Information about the children and families you work with? (ii) Case management systems that allow efficient access to this information? (iii) Training to effectively use these systems? • Is the physical and psychological work environment safe and without risks to health?
Output 8	Stable workforce at all levels	Questions for Child Safety management: what are the • Turnover and vacancy rates for staff at different levels in the past year? • Lengths of service of staff at different levels in the past year? • Level of use of social work *temporary agency staff* in the past year?

Appendix 2: Examples of the Department's current indicators

Source	Nature	Content of measure or indicator
Investment Specification for *Families* (Department of Families, Seniors, Disability Services and Child Safety 2025b, 42-59).	Outcome	'Number of Service Users that have shown improvements in being safe and/or protected from harm'; 'Number of Service Users with improved life skills'; 'Number of Service Users with improved cultural identity/connectedness'; 'Number of Service Users satisfied with the supports provided'; and 'Number of instances in which family participation support results in lower levels of involvement in the child protection system by the child and families'.
'Measures' in residential care contracts for qualitative milestone reports to enable oversight of the funding of outsourced service delivery contracts for the supply of residential care services (Department of Families, Seniors, Disability Services and Child Safety 2025c).	Outcome	Evidence that children and young people experience: improved safety nurturing environments, improved community connections, achievement of personal goals, and increased health resilience.
Department's Investment Specification for *Families*	Output	'Number of Service Users with cases closed with all or majority of case plan goals achieved' and 'Number of occasions that information, advice and referral services were provided (not provided elsewhere) to Service Users'.
Investment Specification for *Family Based Care Services* (Department of Families, Seniors, Disability Services and Child Safety 2024, 33-44).	Output	'Number of service users who received a service during the reporting period'; and 'Number of individual care arrangement nights provided by kinship (foster) carer households during the reporting period'.
'Measures to track key service metrics' specified in residential care contracts to improve oversight of the funding of outsourced service delivery contracts for the supply of residential care services.	Output	'Unoccupied placement nights, the number of service users under six years, those accommodated with siblings, those who exited upon turning 18, and those who exited as part of a planned change in the care arrangement.' Qualitative milestone reports are to include information about 'staff ratios to children and young people, including sleep shift, awake shift and overlay'; and children and young people with disability.
Annual survey of children in care in Queensland (*My Life in Care*), 2022-2024, with two components — a full survey for 10-18 year olds, and a short survey for 5-9 year olds.	Views of children and young people about the care system, and their experiences with it.	Children and young people over the age of nine years were asked about: • their views of the care system; • how they felt about their current placement; • whether they had been bullied in the previous month, whether they had seen a doctor and dentist in the previous 12 months, how they rated their physical and mental health, and whether they had accessed therapy since entering care; • how often they did recreational activities; • whether they could access essential items such as medication, toiletries, underwear and wi-fi; • whether they had a disability; • whether they used substances;

		• their experience of school; • whether they felt included in decisions about their lives; • whether they were satisfied with how often they saw and talked to their original family; • who they trusted; • whether their rights in care had been explained to them by a child safety officer; • who they would talk to if they were unhappy in care, and whether they could contact their child safety officer if they needed to; • whether they had personal items such as their birth certificate, personal photos, and a memory box and had heard of kicbox;[165] • whether they felt 'the same as their peers who' were not in care; • whether they told their friends they were in care; • their gender identity, sexual orientation and whether they have been discriminated against because of either; • their background, especially whether they are from a culturally and linguistically diverse background, or were Aboriginal an/or Torres Strait Islander; • how much they could follow their culture where they live, and whether they were happy with this; and • from whom they learned about their culture. Young people over the age of 15 transitioning to adulthood were also asked: • whether they felt supported to make decisions about what they will do when they exited care; • how confident they were about caring for themselves in a range of matters, including personal grooming, maintaining their health, finding accommodation, managing money, shopping, preparing meals, learning to drive, finding and keeping a job, and maintaining relationships; and • whether they had a learner driver's license, a tax file number, a Medicare card, and/or a bank account/bank card. Children aged five to nine years responded to a simpler set of questions, including: • 'how much do you think the people you are living with now look after you?'; • 'do you feel safe where you live now?'; • 'do you have a grown up you can talk to when you're scared or worried about something?'; • 'how much do you get to do things you like where you live like watching a movie or playing games or sport'? • 'In the past week have you felt happy?', had fun?, and had a good night's sleep?

[165] https://www.qld.gov.au/youth/support-services/young-people-in-care/kicbox

Queensland *Human Services Quality Standards*	Expected Outcome	Standard 1 'Governance and management': 'Sound governance and management systems that maximise outcomes for stakeholders', Standard 3 'Responding to individual need': 'The assessed needs of the individual are being appropriately addressed and responded to within resource capability'. Standard 5 (Feedback, complaints and appeals) specifies that the expected outcome is 'Effective feedback, complaints and appeals processes that lead to improvements in service delivery'.
Queensland *Human Services Quality Standards*	Indicator	1.5 'Mechanisms for continuous improvement are demonstrated in organisational management and service delivery processes'.[166] 3.3 'The organisation ensures that services to the individual/s are delivered, monitored, reviewed and reassessed in a timely manner.' 5.1 'The organisation has fair, accessible and accountable feedback, complaints and appeals processes' 5.4 'The organisation demonstrates that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders.'

[166] See also Indicators 1.6 and 1.7.



Appendix H

Witness List

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

Appendix H – Hearings

The Commission held 50 days of hearings, with 70 witnesses examined over this time. Below are the key figures for hearings conducted over the Commission's public inquiry.

Place	Hearing Days	Witnesses Examined
Cairns	15	42
Brisbane	29 (including opening and closing hearings)	17
Toowoomba	6	11

Government

Department of Families, Seniors, Disability Services and Child Safety

- Leanne Black – Regional Executive Director, South West
- Bernadette Harvey – Deputy Director-General, Commissioning
- Hanelie Lategan – Chief Procurement Officer
- Clair Martin – Principal Lawyer, Office of the Child and Family Official Solicitor
- Michelle McNamara – Director, Reform Implementation Office
- Deidre Mulkerin – former Director-General
- Arthur O'Brien – Deputy Director-General, Corporate Services
- Corinne Porta – Regional Director Far North Queensland
- Angela Schifilliti – Official Solicitor, Office of the Child and Family Official Solicitor
- Danny Short – Chief Finance Officer
- Victoria Van Houdt – Acting Chief Practitioner
- Natalie Wilson – Acting Senior Executive Director, Investment and Commissioning
- Witness A – Manager, Child Safety Service Centre
- Witness J – First Nations Departmental Employee
- Witness M – Manager, Child Safety Service Centre
- Witness N – First Nations Departmental Employee
- Witness V – First Nations Departmental Employee
- Witness W – Manager, Child Safety Service Centre

- Witness AA – First Nations Departmental Employee
- Witness AD – First Nations Departmental Employee
- Witness AF – Senior Child Safety Officer
- Witness AH – First Nations Departmental Employee

Former Minister for Children, Youth Justice and Multicultural Affairs

- The Honourable Leanne Linard MP

KPMG

- Dan Jefferson – National Lead Partner, Health, Ageing and Human Services

Office of the Director of Child Protection Litigation

- Nigel Miller – Director of Child Protection Litigation

Office of the Public Guardian

- Witness K – Community Visitor

Queensland Family and Child Commission

- Luke Twyford, Principal Commissioner

Queensland Health

- Witness AC – [redacted] Children's Health Queensland Hospital and Health Service
- Dr Marnie Fraser – Staff Specialist Paediatrician, Cairns Base Hospital
- Michelle O'Conner – Director of Midwifery, Torres and Cape Hospital and Health Service

Queensland Police Service

- Renee Garske – Detective Inspector, Darling Downs District Crime Services Group
- Bettina Trenear – Senior Prosecutor, Youth Prosecution Support Unit

Youth Justice and Victim Support

- Michael Drane – Acting Director-General

Non-Government Organisations

Aboriginal and Torres Strait Islander Legal Service

- Julie Go-Sam – Director

Anglicare

- Elizabeth Colahan – Chief Executive Officer

Goolburri

- Elizabeth Adams – Chief Executive Officer
- Trent Adams – Deputy Chief Executive Officer

Kanda Care

- Ken Pyne – Regional Manager

Mookai Rosie Bi-Bayan

- Karen Guivarra – Secretary
- Emily Hapea – Social Worker

Mura Kosker Sorority

- Rachel Bruce – Operations Manager
- Dulcie Cook – Cultural Lead, Delegated Authority
- Alana Mitchell – Practice Lead, Delegated Authority

OzChild

- Lisa Griffiths – Chief Executive Officer

PeakCare

- Thomas Allsop – Chief Executive Officer

Queensland Indigenous Family Violence Legal Service

- Thelma Schwartz – Executive Director Legal

Wuchopperen

- Rachel Ham – Deputy Chief Executive Officer
- Francis Jose – Director of Child Youth and Families Services

Individuals

- Witness B – foster carer
- Witness C – foster carer
- Witness D – former residential care worker
- Witness E – former foster carer
- Witness F – kinship carer
- Witness G – former foster carer
- Witness H – foster carer
- Witness I – foster carer
- Witness L – former foster carer
- Witness O – foster carer
- Witness P – foster carer
- Witness Q – kinship carer
- Witness R – kinship carer
- Witness S – adult with a care experience
- Witness T – mother who had children removed
- Witness U – foster carer
- Witness X – adult with a foster care experience
- Witness Y – retired Manager, Child Safety Service Centre
- Witness Z – foster carer
- Witness AB – foster carer
- Witness AE – former foster carer
- Witness AG – foster carer



Child Safety

Commission of Inquiry



Companion Report 1

Functions of System

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

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Introduction

Companion Report 1

Functions of System

Introduction

This Companion Report examines how Queensland's child safety system operates in practice across the continuum from prevention and early intervention, through to targeted intervention, diversion and longer-term family support following statutory involvement. It focuses on the system's capacity to support families early, to stabilise risk before escalation occurs, and to prevent recurrence where statutory intervention has already taken place. It also focuses on the way in which that system engages with pregnant women and new mothers.

In most cases, children who enter out-of-home care (OOHC) are commonly known to services well before statutory thresholds are met. The period before and at the point families become known to the child safety system is a critical, and often underutilised, point of influence at which families may stabilise or escalate into statutory pathways, depending on the approach taken. For this reason, this companion report begins upstream, examining how prevention, early intervention and targeted intervention function in practice, and why these function matter to system outcomes.

To support clarity and consistency in the analysis that follows, the Commission has developed a synthesised continuum diagram (Figure 1 below) adopting a public health framing that distinguishes between primary prevention, secondary prevention (early intervention), diversion, targeted or intensive intervention, tertiary prevention and statutory involvement. The diagram makes explicit the relationship between family circumstances, system thresholds and the different parts of the service system involved at each stage, including the respective roles of universal systems, the non-government sector and statutory child protection.

The Commission has developed this continuum in response to a consistent theme that has arisen throughout the course of our inquiries: while prevention and early intervention are widely referenced in policy and commissioning documents, their meaning, timing and function are often applied inconsistently in practice. The continuum therefore operates as both a conceptual map and analytical tool for the chapters that follow.

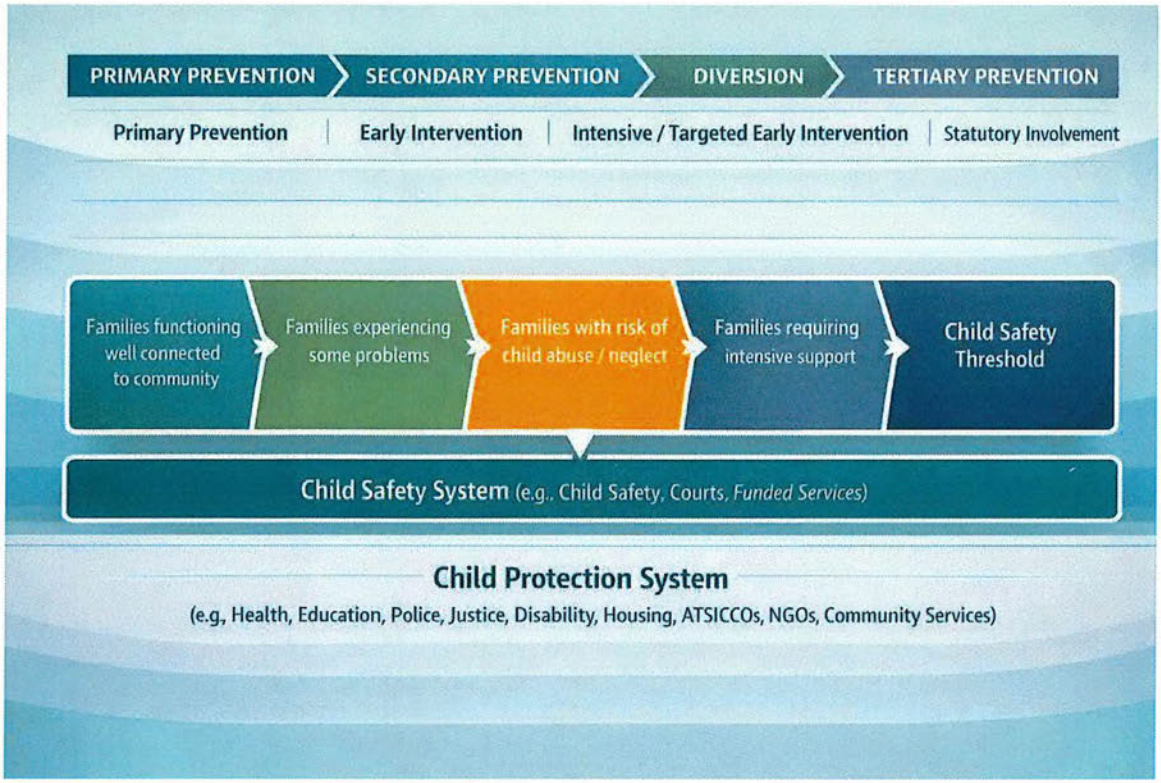


Figure 1: Commission's conceptual map of the continuum

This continuum is consistent with the legislative intent of *the Child Protection Act 1999* (Qld) (the CP Act). The CP Act is not just confined to authorising investigation and coercive statutory intervention after harm has occurred. Its purposes and principles emphasise that children's safety and wellbeing should, wherever possible, be achieved by supporting families and that State action should be proportionate and warranted in the circumstances.[1] Further, the functions of the Chief Executive under the CP Act expressly include:

- Providing, or helping provide, preventative support services to strengthen and support families and reduce the incidence of harm to children;
- Providing or helping provide, services to families to protect their children where a risk of harm has been identified;
- Helping Aboriginal and Torres Strait Islander communities to establish programs for preventing or reducing incidences of harm to children;
- Promoting partnerships between the State, local government, non-government agencies and families; and,

[1] *Child Protection Act 1999* (Qld) ss 4, 5B(a)-(e) (*'CP Act'*).

- Cooperating with other government entities that provide services to children or their families.[2]

These functions reinforce that early intervention and prevention are not peripheral to the child safety system but form part of the legislative framework through which the State is expected to support children's safety and wellbeing.

Importantly, the CP Act also enables early, collaborative action across the broader system, including before a child is born.[3] It also contains specific provisions for unborn children,[4] which makes clear that the purpose of action during pregnancy is preventive, to reduce the likelihood that the child will be a child in need of protection after birth. Read together, these provisions establish a legislative foundation for prevention-oriented, cross-system responses, not only downstream statutory action.

What this Commission means by 'upstream' and 'downstream'

Upstream refers to system activity aimed at assisting families before harm has occurred or escalated, and before families are drawn into statutory pathways. Upstream action is characterised by voluntary engagement, relational practice, low stigma and a focus on strengthening family capability and connection. It includes primary prevention, early intervention and diversion.

Downstream refers to system activity that occurs after harm has been identified, risk thresholds have been met, or statutory authority has been engaged. Downstream responses are necessarily more formal, time-pressured and risk-focussed, and include statutory investigation, court involvement, OOHC and tertiary prevention responses.

The Commission uses these terms descriptively, not judgementally. Downstream responses are essential when children are unsafe. However, when upstream functions are weak, late or poorly implemented and coordinated, the system defaults to downstream responses even where earlier support could have prevented escalation.

The Commission recognises that public health and prevention frameworks are described differently across academic disciplines and policy traditions. The prevention literature describes

[2] Ibid s 7.
[3] Ibid s 159H.
[4] Ibid s 22.

child maltreatment as existing along a continuum of risk and harm and emphasises the needs for population-wide (primary), targeted (secondary) and post-harm (tertiary) responses.[5]

However, the Commission has not adopted Figure 1 as a purist academic taxonomy. Instead, the continuum is used as an evidence-informed, pragmatic organising framework that reflects how systems *actually* operate, how services are commissioned and how families move between supports over time.

In particular, the Commission has adopted the term 'targeted intervention' to describe support provided once families are known to the child safety system, including diversionary responses near statutory thresholds and ongoing family support during statutory involvement. This language is used deliberately to distinguish these functions from both upstream prevention and statutory investigation, and to avoid the ambiguity that arises where post-referral services are described as 'early help' or 'early intervention' despite occurring late in the trajectory of concern.

The way prevention, early intervention and targeted intervention are conceptualised shapes commissioning, thresholds and practice behaviour. When early intervention is defined primarily by referral status rather than timing, the focus and resources of the system shift downstream. Targeted intervention is therefore a core system function, and not a discretionary adjunct, operating as a genuine alternative to escalation.

Departmental Definitions and Investment Language

This chapter is organised by reference to the purpose and timing of services, including what the system is trying to achieve, and when, consistent with a public health prevention framework.

The Department's *Families Investment Specification* describes a "family support continuum", primarily through service categories, service user groupings and funding streams with the child safety investment architecture.[6]

The Commission's analysis differs in three important respects:

- The Commission considers that primary prevention is broader than child safety-funded services. It includes universal systems and platforms (such as health, education and

[5] Debbie Scott, Bob Lonne and Daryl Higgins, 'Public Health Models for Preventing Child Maltreatment: Applications From the Field of Injury Prevention' (2016) 17(4) *Trauma, Violence, & Abuse* 408, 408-419.
[6] Department of Families, Seniors, Disability Services and Child Safety, *Families Investment Specification* (version 8.4, January 2025), 7.

community services) that shift population-level risk before statutory thresholds are reached. Together, these broader services combine to form the 'child protection system'.

- The Commission notes that early intervention is defined by timing, not referral status. There is a risk that describing post-referral services as 'early intervention' can shift early intervention closer to statutory pathways, narrowing its preventative function.
- The Commission considers diversion is a distinct system function. The continuum distinguishes diversion as an active mechanism that redirects moderate and complex concerns away from statutory escalation, rather than as a by-product of service referral.

Definitions shape commissioning, thresholds and practice behaviour. When early intervention is conceptualised primarily as a response to assessed risk, the system's centre of gravity shifts downstream. When prevention and early intervention are protected upstream functions, statutory intervention is more likely to be reserved for situations where coercive action is genuinely required.

A central feature of the continuum is the role of the non-government sector in enabling prevention, early intervention and early help to function as genuine alternatives to statutory escalation. In Queensland, many supports intended to strengthen family capacity and prevent harm are delivered through commissioned non-government organisations (NGOs), rather than directly by the State.

For Aboriginal and Torres Strait Islander children and families, there is potential for Aboriginal and Torres Strait Islander Community-Controlled Organisations (ATSICCOs) to play a particularly critical role across the continuum. This includes culturally informed engagement, early identification of kin and community supports, family-led planning, cultural brokerage and practical stabilisation and navigation functions that strongly influence whether families engage voluntarily and early or disengage from fear, shame and mistrust. The Commission therefore treats ATSICCOs and the broader non-government sector not as adjuncts to the child safety system, but as core system infrastructure that may be able to shape whether prevention and early help operate as intended.

Similarly, services provided during pregnancy offer a distinct and critical prevention and early-help window. As noted earlier, the CP Act explicitly recognises pregnancy as a point at which the State may act to reduce the likelihood that a child will be in need of protection after birth. Decisions made during pregnancy, including those about how concerns are framed, whether support is offered early, and whether engagement is relational or surveillance-oriented can have a significant influence on whether families stabilise or require statutory involvement at the point of birth. The Commission is concerned there is a lack of support offered to women during

pregnancy, which represents a missed opportunity to address child protection concerns, particularly for mothers who have had other children removed.[7] For this reason, pregnancy is given particular focus in this companion report.

This companion report also includes a focused examination of the proximate causes of over-representation, particularly for Aboriginal and Torres Strait Islander children in regions of concentrated disadvantage. This reflects evidence received by the Commission that challenges prevailing explanatory frameworks and calls for more direct engagement with the drivers of harm in children's lives. The Commission includes this analysis because effective prevention and targeted intervention cannot be designed in abstraction from the conditions they are intended to address.

While the terms of reference for the Inquiry, strictly speaking, do not include primary and secondary prevention strategies, apart from targeted intervention and family support (once families become known to the child safety system), what follows are examples of what the Commission heard were preventive ways to provide earlier help for families. The following box describes two examples. The first is a national Community Hubs Australia model, which can be embedded in local schools, with the aim of connecting families to local services and supports tailored to needs of local communities. The second is the Murri School, an independent community school located in Brisbane, which works with Aboriginal and Torres Strait Islander families who may be experiencing vulnerability. The school provides a coordinated mix of services to address the needs of families so that they can safely provide for their children.[8]

[7] Discussed below in Chapter 2 – Intake and Assessment.
[8] The Commission received other submissions on community hub type models. For example: Micah Projects, *Submission to Child Safety Commission of Inquiry* (29 March 2026); QATSICPP, *Submission to Child Safety Commission of Inquiry* (March 2026).

1. About Community Hubs Australia[9]

Community Hubs was established in 2011 to give culturally diverse families, mainly women with pre-school aged children, a safe and low stigma environment to connect with each other and their schools. Hubs can connect families to local services such as social services, health care, education and training and employment opportunities.

In 2025, there were a network of 100 hubs in Queensland, New South Wales, South Australia and Victoria. Community Hubs were first established in Queensland in 2014. There are currently 24 hubs across Queensland: Brisbane (5), Ipswich (5), Logan (5), Rockhampton (3), Toowoomba (3) and Townsville (3).

How they operate

Hubs located in primary schools use existing infrastructure and facilities. Each hub is managed by the school and employs a hub leader. The host school manages services and programs offered, based on what the school and local community may need. Hubs are not service providers but facilitate programs or services. Examples include parenting programs, playgroup, kindergarten and prep transition activities, child health nurses and other developmental supports, and formal training to build work-ready skills.

Benefits of Hubs

- **Economic**

In their submission, Community Hubs Australia notes that in 2023, Deloitte Access Economics undertook a social return on investment evaluation of the National Community Hubs Program, which found that they generated $65.7 million in social benefits – a return of $3.50 for every dollar invested.

- **Helping to address protective factors**

Hubs can provide access to universal supports to support families, such as:

- maternal and family health care
- parenting support to develop parenting skills
- pathways to employment by encouraging volunteering and access to informal and formal training opportunities.

2. The Murri School[10]

The Aboriginal and Islander Independent Community School (the Murri School) is a community controlled Aboriginal and Torres Strait Islander school (prep to Year 12), that was established 40 years ago by Elders and community members who believed that the existing school system was not working for Aboriginal and Torres Strait Islander children.

How it can support prevention and early intervention

The Murri School offers Aboriginal and Torres Strait Islander families who may be experiencing vulnerability a coordinated mix of services to build family and community capacity to safely care for and protect vulnerable children.

Examples of the range of supports offered to students:

- *Family Wellbeing Service* – information and/or referrals or supports (e.g. education, medical/allied health, counselling, housing, Centrelink)
- *Allied Health services* – e. g. speech therapy, occupational therapy, hearing health and psychology
- *Community Engagement* – e.g. food hampers, transport, family camps, community events and behaviour support
- *Medical Centre* – Medical Centre Coordinator who organises paediatrician clinics and other medical appointments for families. Paediatrician clinic at the school two days a week
- *Nutrition Program and Student Support Team*.

[9] Community Hubs Australia, *Submission to Child Safety Commission of Inquiry* (14 January 2026).
[10] PowerPoint presentation provided by the Murri School during the Commission's visit to the school.

Chapter 1

Targeted Intervention

Companion Report 1

Functions of System

Chapter 1: Targeted Intervention

Abstract

This chapter examines the functioning of targeted intervention and family support once families become known to the child safety system. The chapter contends that targeted intervention is one of the system's most decisive leverage points, yet it is poorly defined, inconsistently activated, and weakly integrated with statutory and legal authority. This chapter outlines how late activation, compliance-driven practice, fragmented pathways, and diffuse accountability prevent intervention and diversion from functioning as credible alternatives to escalation. This chapter concludes that targeted intervention and family support must be treated as core child safety system functions, deliberately designed to operate early, relationally, and in direct response to the drivers of harm. Without clear purpose, protected capacity, and firm integration with decision-making, these functions will continue to be deployed too late to prevent escalation, thus weakening family preservation, reunification, and system legitimacy.

1. Introduction

As outlined in the introduction to this companion report, the Commission has adopted a continuum framework to examine how Queensland's broader child safety system operates from prevention and early intervention through to targeted intervention, statutory involvement, and longer-term family support. Children who ultimately enter OOHC are commonly known to services earlier in their lives, at times where families are experiencing emerging stress and before acute crisis. The periods before and at the point families become known to the child safety system represent critical points of influence in shaping whether concerns stabilise, reduce or escalate into statutory pathways. In the current system, families within this critical engagement period are often overlooked due to the disproportionately high number of families reaching acute stress.[11]

[11] See Chapter 2 – Intake and Assessment – figures showing delayed responses to standard and priority responses for notified concerns screened as a Child Protection Notification.

For clarity and consistency, the Commission has taken the approach of referring to services in terms of their function when viewed objectively. The Commission notes that in some cases, this may be different to the way in which a particular service is actually described – for example, in the Department's investment specifications.

- Prevention: refers to universal, population-level actions that strengthen protective factors and reduce the likelihood of harm occurring.
- Early intervention: refers to voluntary, time-limited support provided at the earliest signs of family stress, before statutory thresholds are approached.
- Targeted intervention: refers to more intensive support provided once families are known to the child safety system, including diversionary responses near statutory thresholds and ongoing family support during statutory involvement.
- Statutory intervention: refers to coercive responses authorised under legislation.

Consistently with the Commission's Terms of Reference,[12] this chapter focuses on targeted intervention as a core function of the child safety system. It examines how support operates once families are known to the system, including how and when intervention is activated, how it is experienced by families, how it interacts with statutory decision-making and court processes, and how it contributes to stabilisation, diversion, and reunification. The analysis in this chapter concentrates on targeted intervention and family support in the statutory context.

Targeted intervention is critical to improving outcomes for children and reducing reliance on intrusive statutory responses. Public health prevention frameworks emphasise that once harm and risk have escalated, systems are forced to rely on more formal, costly, and coercive interventions; conversely, timely targeted supports can reduce escalation, strengthen safety, and preserve family functioning when it is safe to do so.[13] In Queensland, these responses are largely delivered through commissioned non-government services operating alongside statutory decision-making and are intended to strengthen family capability and reduce entry into (or further, more intrusive involvement in) the statutory system.[14]

In Queensland, targeted intervention services operate in an environment characterised by heightened scrutiny, compressed timeframes, information asymmetry, and the possibility of

[12] 'Commissions of Inquiry Order (No. 1) 2025' in Queensland, *Queensland Government Gazette – Extraordinary*, Vol. 399 No. 16, 23 May 2025).
[13] Debbie Scott, Bob Lonne and Daryl Higgins, 'Public Health Models for Preventing Child Maltreatment: Applications From the Field of Injury Prevention' (2016) 17(4) *Trauma, Violence, & Abuse* 408, 419.
[14] Department of Families, Seniors, Disability Services and Child Safety, *Families Investment Specification* (version 8.4, January 2025). These specifications describe the intent of investment and service delivery types aimed at strengthening families and reducing entry/re-entry to the statutory system.

coercive intervention. Once a child or family has come to the attention of the Department, the family's experience of the service system – supportive or combative, relational or procedural – may shape whether they engage, disclose concerns, and take up supports that are offered. These dynamics are further shaped by the highly complex Queensland child protection legal system and a bureaucratic approach to service delivery that underly engagement with families once the Department's statutory authority is engaged.

These challenges are not new. Previous reviews in Queensland have long acknowledged that families move up and down a continuum of need, and that effective service systems require support and diversionary pathways that can respond to complexity without defaulting to statutory intervention.[15] This Commission has identified that support continues to be activated late, is often framed in terms of compliance activity, and is disconnected from statutory and legal decision-making, compromising the capacity for interventions to reduce escalation or support reunification.

> *Queensland's child safety system is not failing due to a lack of effort or goodwill. It is being constrained by structural design choices that unintentionally reward activity over impact, history over change, monitoring over intervention, and process over relationships. These design settings increase escalation, workforce churn and system dependency, while undermining early stabilisation and family-based solutions.*
>
> Submission from Kummara Limited[16]

Prevention, early intervention, and the focus of this chapter

Prevention and early intervention are the foundations of an effective, equitable, and sustainable child protection system. Population-level prevention strengthens the conditions in which children grow, and families are supported well before statutory thresholds are reached, while early intervention provides voluntary, relational support at the first signs of family stress. Together, these upstream functions shape whether families are supported to stabilise early or whether concerns escalate into crisis-driven statutory involvement.

Despite longstanding recognition of their importance, prevention and early intervention have not been consistently realised as protected system functions. In practice, they have often remained conceptually endorsed but structurally weak, frequently displaced by downstream statutory

[15] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013) ch 5.
[16] Kummura Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 8.

demand. Ambiguity in definitions and system boundaries has meant that responses described as 'early' frequently occur late in the trajectory of concern, limiting their preventive impact. These dynamics have had dire consequences for Aboriginal and Torres Strait Islander families, where delayed and coercive responses compound harm and contribute to ongoing over-representation in statutory systems.

This context is critical to understanding the focus of this chapter. Targeted intervention—the support provided once families are known to the child safety system—represents a key point of system leverage within the scope of this report. Decisions made at this stage are shaped by timing, posture, integration, and trust and have a disproportionate influence on whether families are diverted from escalation, supported through statutory processes, or disengage altogether.

For this reason, this chapter concentrates on how targeted intervention and family support operate in child safety practice, recognising that their effectiveness is inseparable from broader upstream conditions, while also reflecting that they remain the most immediate and actionable system functions available once the child safety system is engaged.

2. Defining targeted intervention and ongoing family support

> *When a family's already come to the attention of Child Safety and it's determining as to whether or not they're going to intervene or they might refer over to a support service that, to me, isn't early intervention; that, to me, is a preventative for tertiary.*
>
> Elizabeth Colahan, Chief Executive Officer – Anglicare North Queensland[17]

Clear and shared definitions are essential to effective system design, commissioning, and accountability. As noted in the Introduction to this Companion Report, the Commission observed a lack of consistency in the way terms such as prevention, early intervention, targeted intervention, and family support are often used interchangeably across policy, commissioning, and practice, despite referring to responses that operate at different points in the child protection continuum and under very different conditions. This lack of clarity has contributed to inconsistent expectations, fragmented delivery, and confusion for families and practitioners alike.

For the purposes of this chapter, the Commission uses 'targeted intervention' as an umbrella term to describe support provided once families are known to the child safety system and distinguishes between two related but distinct system functions: intervention/diversion and ongoing family support during statutory involvement. Intervention and diversion refer to targeted or intensive support activated once a family is known to the child safety system but before, or at the cusp of, deeper statutory escalation. These responses are typically time-limited and are intended to stabilise families, address emerging or escalating concerns, and avert unnecessary progression to more intrusive statutory action where it is safe to do so.

Once children are placed in the care of the Department, the Department has a statutory duty to take steps that are reasonable and practicable to help the child's family meet the child's protection and care needs.[18] Ongoing family support refers to support provided once statutory child safety involvement is established, including during ongoing intervention, court processes, and efforts towards reunification. Its purpose is to support families to address the issues that led to child protection concerns, strengthen parenting capacity and family functioning, enable safe

[17] Transcript, Evidence of Elizabeth Colahan (19 September 2025) 1350 :23-28.
[18] *CP Act* s 73(2).

reunification or placement stability, and reduce the likelihood of re-entry into the statutory system. Ongoing family support services are a central component in the way the Department achieves this objective, particularly where reunification is the intended outcome. However, many stakeholders observed there is a tension where resources allocated to ongoing family support tend to be at the expense of early intervention. [19]

> *'…Early intervention and family support are often lacking with limited assistance typically provided to families after the removal of their children due to services primarily focused on children once they are in [out of home care]. This practice and lack of support reinforce a reactive rather than preventative approach.'*
>
> Submission from the Queensland Aboriginal and Torres Strait Islander Child Protection Peak[20]

[19] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (11 August 2025) 22.
[20] Ibid.

3. How families enter targeted intervention

> *'The system often responds too late, after cumulative harm has occurred.'*
>
> Submission from the Australian Association of Psychologists[21]

A recurring theme across submissions and hearings was that targeted intervention is frequently activated too late, after risks have already escalated to the point of notification, investigation, or imminent court action.[22] Services described receiving referrals when families were already in crisis, when statutory positions had been taken, or when removal was being seriously contemplated.[23]

> *'Early intervention opportunities are routinely missed, despite schools often identifying concerns first. The threshold to investigate is significantly higher now, placing young people, families and staff at risk due to lack of intervention and mostly delayed intervention'.*
>
> Submission from Townsville Catholic Education [24]

In Queensland, the Department funds a range of programs designed to intervene early and divert families from the statutory system. These include programs such as the Family Wellbeing Service, Intensive Family Support, and Family and Child Connect, who collectively deliver a wide range of service types intended to provide targeted assistance for families along the child protection continuum. However, referral data for these services shows that the Department is the primary referring agency. Figure 2 below shows that as of 30 September 2025, the Department was the largest referrer to Family and Child Connect and to Aboriginal and Torres Strait Islander Family Wellbeing Services.[25]

[21] Australian Association of Psychologists, *Submission to Child Safety Commission of Inquiry* (31 July 2025) 2.
[22] For example, see – Australian Association of Psychologists, *Submission to Child Safety Commission of Inquiry* (31 July 2025) 3. See Chapter 2 – Intake and Assessment regarding delays in responding to Child Protection Notifications.
[23] Transcript of Private Hearing, Evidence of Witness N (25 September 2025) 1803; Transcript, Evidence of Trent Adams (25 February 2026) 4655 :21-34; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (11 August 2025) 8.
[24] Townsville Catholic Education, Submission to Child Safety Commission of Inquiry (11 November 2025) 3-4.
[25] Department of Families, Seniors, Disability Services and Child Safety (Qld), 'Our Performance: Supporting Queensland Families' (Web Page) <https://performance.dcssds.qld.gov.au/supporting-queensland-families/who-family-support-services-work-with/family-and-child-connect-facc>.

	Total referrals	Referrals from Child Safety
Family and Child Connect	24,175	5,826 (24%)
Family Wellbeing Service	5,576	2,245 (40%)

Figure 2: Referrals from Child Safety to Family and Child Connect and Family Wellbeing Service, as of 30 September 2025.

These figures may indicate that one of the Queensland child safety system's primary targeted intervention pathways operates after families have already entered child safety processes, rather than being activated early enough to consistently hold concerns in a stabilising, diversionary way.

> *'There remains a disproportionate focus—and funding—on OOHC, rather than on early intervention and family support programs that could prevent removals in the first place.'*
>
> Submission from the Queensland Aboriginal and Torres Strait Islander Child Protection Peak [26]

The Commission heard that the Department often does not clarify for families how support relates to statutory expectations or legal processes. There is a tendency to talk in generalities about the need to 'engage with support services', without articulating what that engagement needs to look like—or what specific behavioural change needs to be evidenced by the Department as a result of that engagement.[27] The Commission also heard that opportunities for early de-escalation, family-led planning, and mobilisation of kin are missed or subordinated to statutory risk management.[28]

> In the case study of Melanie,[29] an Aboriginal or Torres Strait Islander woman shared her perspective as a parent who had had a number of her children removed pursuant to the CP Act (including a newborn) and her struggles to achieve reunification.
>
> Melanie had undertaken thirteen family and parenting programs to deal with in effect aggressive and violent parenting practices, yet did not, over the years, progress towards reunification with her children.

[26] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (11 August 2025) 28.
[27] See Melanie's case study in Appendix B.
[28] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (11 August 2025) 4; Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 14.
[29] See Melanie's case study in Appendix B.

In this case, the Department was not looking for completion of the course per se. As one Child Safety Service Centre Manager explained:

> *'...within our framework for practice, we're very clearly taught that a program or a certificate never kept a child safe. It's actually the actions of protection of the parent that keep a child safe. So by virtue of a program or a certificate saying that she's done this, it doesn't mean that she's acting in a way by which this training has potentially taught her. So the challenge that we have is that yes, she did engage in these programs, but we're not seeing that reflected in her parenting responses to the children.'*[30]

These patterns reflect current system design constraints rather than individual practice failures. The Department is placed in a very challenging position where it must engage with extremely complex issues in a supportive way, while at the same time carrying responsibility for risk and being accountable to evidence its decisions. The risk in designing and funding a suite of poorly defined or weakly integrated targeted intervention services is that efforts to address serious child protection concerns become tokenistic, coercive, or too late to influence outcomes.[31] Where no endorsed alternative pathway exists, departmental intervention may be the only available response.

The use of authority and accountability mechanisms within intervention and diversionary approaches is not inherently incompatible with supportive, relational practice. In a submission from the Cape York Institute, the Commission heard that the system-level rebalancing towards early intervention and family support that Carmody envisaged has not been fully realised.[32] The Carmody Inquiry recommended the development of community-based intake and diversion pathways that would build on the strengths of this model.[33] In support of this recommendation, the Carmody Inquiry referred to the Family Responsibilities Commission as a model for bringing together conferencing, referral, and monitored support to strengthen responsibility, engagement, and behaviour change alongside assistance.[34]

[30] Transcript, Evidence of Witness W (18 November 2025) 2229:19-22.
[31] Debbie Scott, Bob Lonne and Daryl Higgins, 'Public Health Models for Preventing Child Maltreatment: Applications From the Field of Injury Prevention' (2016) 17(4) Trauma, Violence, & Abuse 408, 408–419.
[32] Cape York Institute for Policy and Leadership, *Submission to Child Safety Commission of Inquiry* (April 2026) 23.
[33] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013), 383–384 (recommendation 11.2).
[34] Ibid 358.

Within the statutory environment, the effectiveness of ongoing family support approaches depends on integration with core system functions, particularly legal processes. Once court proceedings are initiated or contemplated, families must navigate complex legal, procedural, and evidentiary frameworks, often under significant stress and—if not legally represented—with limited understanding of their rights or options. Evidence before the Commission indicates that families engage more constructively where they are supported early to access independent legal advice, understand the implications of orders and case plans, and participate meaningfully in decision-making.[35] Where legal advocacy is delayed or disconnected from broader family support, proceedings are more likely to be experienced as opaque, combative, and disempowering, undermining engagement and the effectiveness of concurrent support.[36] The importance of ongoing family support through the legal process is discussed further in Companion Report 2: Child Protection Litigation.

Early family mapping is another core feature of both effective in-system support and effective intervention/diversion. The identification and mobilisation of kin, extended family, and community supports can serve to reduce immediate risk, enable family-led planning, inform proportionate decision-making, prevent unnecessary placement outside family networks, and ultimately support reunification and long-term stability.[37] Evidence before the Commission indicates that family mapping often occurs late, after decisions have hardened, and is driven by placement needs rather than seen as a targeted intervention/diversionary response to support de-escalation.[38]

A further feature contributing to the effective delivery of ongoing family support is continuity with previous intervention/diversionary responses. Where a service provider has already established a relationship of trust and guidance for a family, the ability to have that service provider continue that support for the family if they tip into the tertiary child safety system is essential.[39] This becomes a purposeful feature of system design in an effective child protection system.

[35] Aboriginal and Torres Strait Islander Legal Service (ATSILS), *Submission to Child Safety Commission of Inquiry* (28 August 2025) 5–7; Transcript of Private Hearing, Evidence of Witness V (24 September 2025) 1735.
[36] Queensland Aboriginal and Torres Strait Islander Child Protection Peak (June 2024), '*Child Protection Litigation Review Project*', 13–14; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 4.
[37] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (11 August 2025) 18; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 3,15.
[38] Aboriginal and Torres Strait Islander Legal Service (ATSILS), *Submission to Child Safety Commission of Inquiry* (28 August 2025) 11.
[39] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 7, 11; Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 11.

4. The experience of families navigating early involvement with the Department

Families' experiences of targeted intervention are shaped by how support is offered, framed, and connected to decision-making once families are known to the child safety system.[40] For many families, particularly those with prior child protection involvement, initial contact with the system is experienced as negative, intrusive, and fear-inducing, triggering defensive, uncooperative responses even where the stated intention is to provide support.[41]

Families have described entering the system at points of acute stress, often following a report, an investigation, or the initiation of court proceedings.[42] At this stage, trust is often fragile. Evidence indicates that these families were often uncertain about the purpose of the engagement, unclear about the consequences of disclosure, and fearful that participation in support services would be interpreted as an admission of wrongdoing, or evidence of risk rather than need. For example, a witness from Mura Kosker Sorority Incorporated told the Commission that families 'don't talk' and will often refuse to engage with the Department and its officers', but are 'more willing to talk to [them] and share their story [only] when [they are] there'.[43] Similarly, Witness AD referred to there being a 'distrust to actually say anything,' as that could result in 'involvement from places such as [the Department] which then means there could be a removal…or an intervention of some sort'.[44]

Submissions described families experiencing early offers of support as surveillance rather than assistance. Families reported confusion about whether engagement was voluntary or compulsory, concern that refusing services would be viewed negatively, and anxiety about 'saying the wrong thing' and worsening their situation. In this context, even well-intended intervention was sometimes met with guarded, defensive, or minimal engagement, limiting its effectiveness.[45]

Once families are known to the child safety system, they are also required to navigate different parts of the overlapping system, including the Department, courts, legal services, and a range of community-based supports, often without clear guidance or continuity.

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[40] Transcript, Evidence of Rachel Bruce (16 September 2025) 904:8-24; Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 11.
[41] Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 11–12, 33; Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (31 March 2026) 66; Transcript, Evidence of Emily Hapea and Karen Guivarra (17 September 2025) 999-1004.
[42] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (31 March 2026) 24.
[43] Transcript, Evidence of Alana Mitchell (16 September 2025) 902:37-41.
[44] Transcript of Private Hearing, Evidence of Witness AD (24 September 2025) 1661.
[45] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 6, 11.

The complexity of this navigation worsened once court proceedings were initiated or anticipated. Legal processes introduced additional power imbalances, technical language, and procedural requirements that many families felt ill-equipped to manage without early and effective support.[46] Evidence indicates that families often enter court processes without timely access to legal advice or advocacy, limiting their capacity to understand the implications of applications, orders, and case plans, or to participate meaningfully in decision-making.[47] A recurring theme in evidence before the Commission is that support to families is frequently offered late in the process, often when statutory intervention is already entrenched, or removal is imminent.[48]

The Commission also heard that support was commonly framed as conditional or compliance-focused, particularly when statutory concerns had already crystallised. Families described experiencing support as something they had to prove themselves worthy of, rather than as a genuine opportunity to stabilise, heal, and strengthen family functioning. This dynamic was reported to reinforce shame, defensiveness, and disengagement, particularly for families affected by trauma, disability, or intergenerational disadvantage.[49]

Delays in family mapping and mobilisation of kin and community supports compounded these experiences. Families reported that extended family members were often identified late or not at all, kinship options were explored after removal rather than as a preventive measure, and family-led solutions were sidelined in favour of system-driven decisions.[50] These delays limited opportunities for de-escalation and contributed to decisions being made without the benefit of knowing the full family and community context.

Evidence before the Commission indicates that Aboriginal and Torres Strait Islander families are more likely to disengage early, or not at all, due to fear of removal, they experience statutory processes as culturally insensitive and believe kinship and cultural supports are overlooked or engaged too late to influence outcomes.[51]

[46] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (25 August 2025) 5.
[47] Transcript, Evidence of Emily Hapea and Karen Guivarra (17 September 2025) 1035–1036; Transcript, Julie Go-Sam (18 September 2025) 1265:29-47; Transcript, Evidence of Thelma Schwartz (22 September 2025) 1508-09; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (June 2024) 13.
[48] Transcript, Evidence of Ralph Laksa (10 September 2025) 310:4-15; Transcript, Evidence of Rachael Ham (17 September 2025) 1094:7-22; In the context of newborns, refer to Chapter 2 – Intake and Assessment.
[49] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (June 2024) 15, 22; Transcript, Evidence of Michelle O'Connor (23 September 2025) 1557-58.
[50] Transcript, Evidence of Witness Y (10 September 2025) 310: 4-15; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 13, 15; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 18.
[51] Transcript, Evidence of Rachael Ham (17 September 2025) 1090:7-23; Transcript, Evidence of Alana Mitchell (16 September 2025) 901-4.

> *'Evidence consistently demonstrates that early intervention and family stabilisation approaches produce significantly better outcomes than institutional care placements. Research shows that late intervention responses such as residential care are substantially more expensive than preventative supports and produce poorer long-term outcomes for children.'*
>
> Submission from Central Queensland Indigenous Development[52]

5. What effective in-system targeted intervention and family support look like

The matters examined in this chapter indicate that the effectiveness of targeted intervention and ongoing family support is not determined by the existence of services alone, but by how, when, and under what conditions support is activated and integrated once families are known to the system.

Across submissions and hearings, a consistent set of features emerged as distinguishing targeted intervention that functions as a genuine stabilisation, preservation, and reunification mechanism from support that is offered too late or too narrowly to prevent escalation.

Effective targeted intervention is activated early enough to shape decision-making, rather than as a response to crisis or imminent removal. When support is engaged as soon as concerns emerge or families first become known to the system, it is more likely to support voluntary disclosure, stabilisation, and de-escalation. When intervention is activated only after statutory positions have been made, its capacity to influence outcomes promptly, such as early reunification, is significantly reduced.[53]

[52] Central Queensland Indigenous Development (CQID), *Submission to Child Safety Commission of Inquiry* (March 2026) 5-6.

[53] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 4.

> *'Queensland's child safety system is not failing due to a lack of effort or goodwill. It is being constrained by structural design choices that unintentionally reward activity over impact, history over change, monitoring over intervention, and process over relationships. These design settings increase escalation, workforce churn and system dependency, while undermining early stabilisation and family-based solutions'.*
>
> Submission from Kummara Limited[54]

Continuity is important. Families are more likely to engage and sustain change where intervention is provided by the same worker or team over time, rather than through a series of short-term, disconnected services and workers. Continuity supports trust, reduces confusion, and enables workers to understand family context, strengths and risks.[55]

Effective targeted intervention is also grounded in relational, strengths-based practice. Families are more likely to engage where concerns and expectations are communicated transparently, engagement is respectful and non-judgemental, and support is experienced as partnering rather than policing. This does not diminish accountability or safety: rather, it strengthens decision quality by enabling meaningful participation and more accurate assessment.

A defining feature of effective targeted intervention is its integration with statutory and legal decision-making, rather than operating alongside or in isolation from it. Where information from family support services is sought, shared, and considered before escalation decisions are made, intervention is more likely to function as a credible alternative to statutory action.[56]

Once court proceedings are anticipated or initiated, effective intervention includes early access to legal advice and advocacy, and coordination between legal and support services. Evidence indicates that families who understand legal processes and expectations are better able to engage constructively, align service participation with decision-making requirements, and focus on practical steps towards safety, preservation, or reunification.[57]

Many submissions emphasised the central importance of early family mapping, and the mobilisation of kin and community supports. [58] When undertaken early and led by those with

[54] Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026).
[55] Ibid 11; Transcript, Evidence of Michelle O'Connor (23 September 2025) 1535:10-35.
[56] Transcript, Evidence of Corinne Porta (20 November 2025) 2424:3-33; Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2870:19-25.
[57] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry* (12 December 2025) 3–4.
[58] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 18; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry*

relational and cultural knowledge, family mapping expands the range of safe options available to support children, enables family-led planning, reduces reliance on non-kin placements, and strengthens pathways to preservation and reunification.[59]

Delayed or perfunctory family mapping significantly reduces its preventive and protective potential and limits the system's ability to respond proportionately.[60]

Effective targeted intervention recognises that child safety concerns often arise in the context of broader family stressors, including housing insecurity, family violence, substance misuse, disability, trauma, and social disconnection. Intervention is more effective where it addresses these drivers directly through coordinated, practical, and sustained support, rather than focusing narrowly on compliance tasks or individual behavioural change.[61]

Targeted intervention is more effective when it is delivered through culturally attuned, community-governed, and relationally accountable pathways, and when families and communities are meaningfully involved in the planning and decision-making that affect their children.[62]

6. Family support as a foundation for reunification

Reunification is widely recognised as the preferred permanency outcome for children in out-of-home care—when it is safe and in the best interests of the child. Queensland's policy and previous reform inquiries have consistently emphasised the importance of supporting families to care for their children at home wherever possible.[63]

Submissions before the Commission suggested that the likelihood of reunification is strongly shaped by the availability, timing, and quality of ongoing family support once statutory

(March 2026) 15; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 2–3.

[59] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 18; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (December 2025) 11; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 19.

[60] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 13; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 13.

[61] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 4, 8; Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (March 2026) 9–10; Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 13.

[62] Transcript, Evidence of Rachel Bruce (16 September 2025) 904:8-24; Kummara Limited, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 32–33.

[63] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013) 407.

involvement has begun.[64] Reunification is not a single decision point, but a process of permanency planning that depends on early engagement, clear expectations, sustained support, and proportionate decision-making across statutory stages.

The Commission heard that reunification is more likely to occur if family support has been activated early, ideally at the point a child enters care, and continues consistently through investigation, court processes, and permanency planning.[65]

Conversely, where support is delayed, fragmented, or framed ambiguously, families reported confusion, disengagement, and diminishing opportunities for restoration. Evidence before the Commission suggests that delayed or inconsistent support contributes to reunification being deprioritised over time, even where safety concerns may have been capable of resolution with earlier intervention.[66]

> *'While reunification may be the right outcome for some families, it cannot be the default outcome for all. Forced reuniting often fails and leads to deeper trauma'.*
>
> Submission from member of the public[67]

Maintaining meaningful, safe contact between children and their families is a critical component of reunification. Evidence before the Commission indicates that contact arrangements that are regular, purposeful, supported, and linked to reunification goals have higher rates of success.[68] Where contact is irregular, poorly supported, or disconnected from reunification planning, it can undermine family relationships, increase distress for children, and reduce the likelihood of reunification.[69]

Effective reunification support also recognises the need for healing and capacity building, particularly for families affected by trauma, disability, substance misuse, family violence, or intergenerational disadvantage. Short-term or compliance-focused interventions are insufficient to address these complexities. Reunification does not (or should not) mark the end of the system's responsibility. Families often require ongoing, tapered support following reunification

[64] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 22.
[65] Ibid 3, 10.
[66] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (25 August 2025) 12; Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 37.
[67] Submission No 329 to Child Safety Commission of Inquiry (17 February 2026) 2.
[68] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 21.
[69] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (25 August 2025) 12.

to adjust to changed family dynamics, support children's emotional and behavioural needs, sustain safety and stability, and prevent re-entry into care.[70]

For Aboriginal and Torres Strait Islander children and families, reunification carries particular significance given the historical and ongoing impacts of child removal. The Commission heard evidence that culturally unsafe processes, delayed kin identification, and inadequate ATSICCO involvement significantly reduce the likelihood of reunification of Aboriginal and Torres Strait Islander children with their families.[71]

The Commission considers that improving reunification outcomes for these children requires system settings that prioritise early family-led planning, cultural continuity, meaningful participation, and sustained support across statutory stages. These issues are examined in greater depth in Companion Report 5: Corporate Parenting and the Youth Justice Interface, which addresses permanency.

6.1. Aboriginal and Torres Strait Islander families and the role of ATSICCOs in targeted intervention

The Commission heard that Aboriginal and Torres Strait Islander children and families experience disproportionate contact with the child safety system, and agrees that this over-representation is neither inevitable nor culturally determined.[72] Rather, QATSICPP suggested that the current over-representation reflects persistent system design flaws and underinvestment in prevention.[73] Within this context, the Commission considers it necessary to examine not only what services exist, but who is best placed to provide prevention and targeted intervention, how support should be structured to address the drivers of harm, and what system conditions must be in place for early help to prevent escalation.

The Commission acknowledges that ATSICCOs may be able to add value across the child protection continuum.

To that end, some of the evidence before the Commission reaffirmed ATSICCOs' important role in delivering targeted intervention approaches (both in terms of intervention/diversion and

[70] Transcript, Evidence of Witness Y (10 September 2025) 338–341; SNAICC: National Voice for our Children, *Family Matters Report 2024* (Report, 2024) 112.
[71] SNAICC: National Voice for our Children, *Submission to Child Safety Commission of Inquiry* (March 2026) 21; SNAICC: National Voice for our Children, *Family Matters Report 2024* (Report, 2024) 18.
[72] YFS, *Submission to Child Safety Commission of Inquiry* (July 2025) 2; Office of the Aboriginal and Torres Strait Islander Children's Commissioner, *Submission to Child Safety Commission of Inquiry* (1 August 2025) 5; Queensland Council of Social Service, *Submission to Child Safety Commission of Inquiry* (August 2025) 4.
[73] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 23-34; Queensland Law Society, *Submission to Child Safety Commission of Inquiry* (September 2025) 2.

ongoing family support). The Commission has been consistently told that families are more likely to engage, disclose concerns, and remain involved when support is delivered by organisations that are 'culturally legitimate, community governed and relationally accountable'.[74] This factor matters most at the intervention/diversion stage, when the system is deciding whether concerns can be addressed through support and planning or whether statutory escalation will occur. Where families disengage because support is perceived as surveillance or a pathway to removal, the reach of intervention and diversion can become limited[75]

Targeted intervention works when it addresses the pressures that drive risk: family violence, housing instability, substance misuse, disability, trauma, mental health, parenting stress, and disconnection from supports. The combined effect of these factors, together with the wider socio-economic environment, all contribute to creating the risks which lead to children being removed. Some factors 'proximate causes' are more closely and directly connected to child harm. The Commission discusses the distinction to be drawn between proximate causes and other contributing factors in Chapter 4 of the Executive Report.

As noted earlier, ATSICCOs described delivering holistic support that addresses the drivers of risk in ways that are relational, practical and whole-of-family, rather than limited to compliance tasks. However, this does not displace or downgrade the important role of other non-Indigenous support providers. The Commission notes that effective targeted intervention depends on a broader ecosystem of services (health, housing, schools, disability, and specialist supports). For Aboriginal and Torres Strait Islander families, however, ATSICCOs may be well positioned to act as the relational anchor that makes wrap-around support coherent and sustained.[76]

The Commission's view is that ATSICCOs' highest value can be realised when they are engaged early, in both prevention and targeted intervention, before statutory escalation becomes entrenched and before families disengage. Targeted intervention is the point where the system has the greatest leverage to prevent escalation, reduce unnecessary statutory involvement, and retain or reinstate an Aboriginal or Torres Strait Islander child's connection to family, kin, community, and Country.

[74] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 24–25.
[75] Transcript, Evidence of Deidre Mulkerin (14 March 2026) 5385; Transcript, Evidence of Thomas Allsop (16 September 2025) 981:16-30.
[76] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 6.

The Commission also notes that the work required in the prevention and targeted intervention spaces is not simply about delivering 'more services earlier'. It requires responses that are legitimate, relational, integrated with decision-making, and capable of addressing the real drivers of harm in the lives of children.[77]

Evidence before the Commission indicates that delays in identifying kin and mobilising family networks contribute directly to escalation, placement decisions, and poor reunification trajectories.[78] ATSICCOs consistently advised the Commission that they are well-positioned to lead early family mapping because this work depends on relational knowledge, cultural context, and local community networks.[79] The Commission considers that early family mapping is not simply a placement function; it is a protective intervention/diversion function that can prevent escalation by activating safe family supports before statutory decisions are set in stone.

Given the evidence presented at hearings regarding families' experiences navigating the court processes, it is the Commission's view that ATSICCOs, while not legal representatives, could help families access legal advice, understand process, and participate meaningfully in planning and decision-making.[80] This function is particularly important where distrust and fear might otherwise drive disengagement from statutory processes.[81]

Within this frame, ATSICCOs can add the most value through:

- providing culturally legitimate engagement that enables families to accept support earlier (including alcohol and drug treatment, DFV supports, and social and wellbeing responses);
- leading early identification of families under pressure (including visible early signs such as chronic truancy, which the Cape York submission describes as an 'early visible sign ignored');
- supporting structured planning for families that combines responsibility with opportunity and clear expectations with practical supports such as stable housing, parenting, coaching, treatment access, and routines; and

[77] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 26-38.
[78] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry* (12 December 2025) 11.
[79] Central Queensland Indigenous Development, *Submission to Child Safety Commission of Inquiry* (March 2026) 6; K.I.N. Care Services, *Submission to Child Safety Commission of Inquiry* (12 November 2025) 10; Institute of Urban Indigenous Health, *Submission to Child Safety Commission of Inquiry* (November 2025) 23; Kummara Limited, *Submission to Child Safety Commission of Inquiry* (19 March 2026) 31–35.
[80] See for example, the Baby Nathan case study in Annexure B of the Executive Report.
[81] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (25 August 2025) 7; REFOCUS, *Submission to Child Safety Commission of Inquiry* (July 2025) 3; SNAICC: National Voice for our Children, *Family Matters Report 2024* (Report, 2024) 50.

- facilitating community-led conferencing approaches that strengthen family responsibility and restore community authority as part of early help, consistent with the Cape York Institute's account of the Family Responsibility Commission model.

As previously highlighted, the Commission does not consider that strengthening the role of ATSICCOs in delivering intervention/diversionary approaches requires diminishing the role of other early help providers. Effective intervention and diversion depend on a broader ecosystem, including the availability of both universal and specialist supports, and that many non-indigenous services provide critical family support functions. Strengthening ATSICCO roles must, however, be understood as system design reform, not a program expansion, requiring clear role definition, capacity building, integration with statutory decision-making, resourcing that recognises relational practice, and accountability settings that measure prevention, preservation, and reunification outcomes over time to demonstrate effectiveness.

7. System interfaces and accountability

The effectiveness of targeted intervention does not depend solely on the quality of individual services or practitioners. Families navigating the child safety system typically engage with multiple systems simultaneously, each exercising different forms of authority and operating under distinct mandates, timeframes, and accountability frameworks. These include statutory decision-making by the Department, judicial oversight through the courts, legal representation and advice, and family support delivered by community organisations.

The Commission heard that families are frequently required to reconcile service advice with statutory directives and court expectations, often without clear guidance as to which requirements were prioritised or how progress would be assessed.[82] This fragmentation undermines trust, creates confusion, and increases the likelihood of disengagement, particularly when families are already experiencing stress, trauma, or prior harm.

A central accountability challenge arises at the interface between targeted intervention and statutory decision-making. While targeted intervention approaches may work intensively with families to build capacity and address concerns, statutory decisions about escalation, removal, or reunification are often made within separate processes, drawing on different information sets and operating under different time pressures. Evidence before the Commission indicates that

[82] Transcript, Evidence of Julie Go-Sam (18 September 2025) 1239–42; Transcript, Evidence of Corinne Porta (21 November 2025) 2488:90.

information held by current targeted intervention services is not always requested or fully considered in statutory decision-making.[83] In some cases, decisions proceed before support pathways have had a reasonable opportunity to take effect, or without transparent explanation of how support outcomes have been weighed alongside risk indicators.[84]

Proximate causes of harm

Earlier, this chapter listed the 'proximate causes' of harm —that is, the factors that may cause entry into the child safety system. The Commission's interest in proximate causes of harm that cause entry into the child safety system required asking the question of not only how services are delivered, but whether the existing prevention and targeted intervention systems are organised around the real drivers of child harm.

The Cape York Institute submission argues that in Cape York the proximate causes of the child safety crisis are 'visible and well documented'— being alcohol, cannabis and methamphetamine epidemics and violence— and deeper structural causes including passive welfare and the breakdown of social norms has entrenched them. The Cape York Institute explicitly rejects the idea that these are merely 'peripheral risk factors', arguing that tolerating substance-abuse epidemics while multiplying services at the margins guarantees downstream system growth and continued removal.

The Commission notes that the Cape York Institute frames its reform principle as:

Responsibility.>.Opportunity.±.Capability

and argues that reforms must deliberately join structured expectations with real supported opportunity if capability is to build.

This evidence is directly relevant to early help in two ways:

1. It supports the view that early help must be organised around drivers of harm, not simply just compliance with referrals

[83] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 15–17.
[84] Ibid.

2. It highlights that in some contexts, voluntary referral-based supports alone may be insufficient, and that community authority structures (such as conferencing and monitored agreements) may be required to achieve behaviour change while keeping children safe.

The Commission does not adopt all elements of the Cape York Institute's proposal as a general statewide template, noting that proximate causes of harm can differ by community and region, and system responses must be capable of local adaptation. However, the Commission accepts that intervention and diversion approaches must be capable of addressing proximate causes directly, including substance misuse and violence, as well as addressing risk factors such as school disengagement, and unaddressed disability; and that these systems must be structured so they do not default to removal as the primary response.

The Commission also heard that accountability mechanisms within the child safety system do not consistently operate in ways that are accessible or meaningful for families. Families described reluctance to question decisions, challenge case planning, or raise concerns, particularly where they remain dependent on the Department for ongoing decisions affecting their children. This dynamic is amplified by power imbalances, legal complexity, and the fear that raising concerns may worsen their situation. This issue will be discussed further in Companion Report 6: Complaint Systems.

The Commission considers that accountability in a support-centred system must extend beyond compliance with procedure. It must include clarity about decision-making criteria and thresholds, transparency about how information from different service providers or agencies is shared and used, and mechanisms that allow families and service providers to influence decisions before escalation is considered.

Submissions to the Commission contend that ATSICCOs often play a bridging role at system interfaces, supporting families to navigate statutory and legal processes, facilitating communication between systems, and bringing cultural authority and relational insight into decision-making.[85] However, the Commission also heard that ATSICCO involvement is frequently delayed, constrained by referral thresholds, or limited to discrete program functions,

[85] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 14; Central Queensland Indigenous Development, *Submission to Child Safety Commission of Inquiry* (March 2026) 3.

reducing their ability to influence outcomes at critical decision points.[86] The Commission considers that targeted intervention will not function well unless ATSICCOs and other family support providers are enabled to engage before decisions are made, and unless system interfaces are designed to support shared accountability for safety and wellbeing.

8. Implications for reform: what a support-centred system would look like

The Commission readily accepts that targeted interventions are not peripheral functions of Queensland's child safety system. They are foundational system functions that can determine whether concerns escalate into statutory intervention or are resolved through support, planning, and strengthened family capability.

The Commission considers, therefore, that reform must move beyond incremental service adjustments and address system design, including how authority is exercised, how early help is activated, and how accountability for outcomes is structured.

It appears that interventions and diversions are often activated too late, framed too narrowly, and insufficiently protected from downstream statutory demand. Reform requires an explicit reframing of targeted intervention (both intervention/diversion and ongoing family support) as core system functions, rather than discretionary or preparatory activities. This includes clear articulation of the purpose of these functions in preventing escalation and supporting family preservation, protection of these functions from being overwhelmed by crisis response, and commissioning and funding settings that recognise relational, preventive work as essential—not ancillary.

The Commission considers that targeted intervention will only prevent escalation if it is activated early enough to influence decisions. This requires system settings that enable family support and ATSICCO involvement as soon as concerns emerge or families first become known to the child safety system, not only after thresholds are reached.

[63] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 14; SNAICC: National Voice for our Children, *Submission to Child Safety Commission of Inquiry* (March 2026) 31; Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (March 2026) 2.

Reform must therefore address:

- referral pathways that delay engagement;
- consent and information-sharing barriers that limit support effectiveness;
- fractured services that reduce consistency for families and increase disengagement; and
- decision-making processes that proceed without meaningful consideration of early-help outcomes.

Additionally, the Commission's focus on proximate causes of harm underscores the need for targeted intervention systems to be organised around the real drivers of risk in children's lives, such as substance misuse and family violence, as well as their companions, housing instability, disability, trauma, and social disconnection. The Commission considers that targeted intervention must be capable of addressing these drivers directly, through coordinated, practical, sustained support. This requires moving beyond compliance-focused interventions towards approaches that deliberately build family capacity by joining responsibility with real opportunity for change.

ATSICCOs are well placed, subject to capacity building. to add value in the targeted intervention space because of cultural connections, community governance, and capacity to engage families early and sustain trust. Reform must, therefore, consider how to enable ATSICCOs to perform targeted intervention functions at scale, clarify their role and authority within the broader child protection system, ensure timely access to information and decision-making processes, and appropriately resource relational, culturally grounded practice. Strengthening ATSICCO roles in targeted intervention should be understood as system reform, not program expansion.

Finally, the Commission considers that targeted intervention cannot function effectively without deliberate reform of system interfaces and accountability mechanisms. This includes clearer integration between family support, statutory casework, and legal processes; transparency about how support outcomes influence decisions; and accountability frameworks that focus on prevention, preservation, and reunification outcomes over time.

Taken together, the matters canvassed in this chapter indicate that a support-centred system is one in which targeted intervention is activated early, integrated with decision-making, oriented towards addressing proximate causes of harm, and delivered through culturally legitimate, relational practice. The Commission considers that reform in these areas is essential to reducing

unnecessary statutory intervention, improving outcomes for children and families, and restoring confidence in Queensland's child safety system.

9. Recommendations

Recommendation 1: Respond to the proximate causes of harm	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 1)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, ensure collaboration between relevant agencies to commission, fund, support and develop evaluation frameworks for intervention responses capable of directly addressing the proximate causes of harm in children's lives. The framework for the evaluation of outcomes must critically examine whether funded activities reduce escalation into more intrusive statutory responses, support family preservation and reunification, and achieve better outcomes than downstream statutory intervention alone.	
CONTEXT: The Commission notes the relevance of evidence describing the needs for sustained, multi-system approaches to address the proximate causes of harm. The Commission considers that targeted intervention will only function as a genuine alternative to escalation if it is designed to engage directly with the drivers of harm and is supported by system settings that enable early, coordinated, and sustained action.	
IMPLEMENTATION NOTES: The Queensland Government should treat this reform as a Tier 1 system reform and assign responsibility for its design, implementation and oversight to the independant implementation and reform assurance taskforce established in response to this Report (see Recommendation 51).	

Recommendation 2: The role of ATSICCOs in intervention and family support	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, through the Targeted Intervention and Family Support business function established in recommendation 45A and within 12 months of the Government's response to this report, commence the process of repositioning and resourcing ATSICCOs to deliver targeted intervention and family support services for Aboriginal and Torres Strait Islander children and families. This should include:

(a) Early and consistent ATSICCO involvement once families become known to the child safety system, including involvement in diversion, family mapping, and support planning.

(b) Clear role definition and authority at system interfaces, including how ATSICCO input is considered in decision-making prior to escalation, while maintaining appropriate boundaries between support and statutory investigation.

(c) Timely information-sharing and participation in planning processes, so ATSICCOs can support families effectively and reduce fragmentation across services, legal processes, and decision-making.

(d) Resourcing models that recognise relational, culturally grounded practice, including outreach, trust-building, cultural brokerage, and coordination across services, rather than narrowly defined service outputs.

(e) Shared accountability for outcomes, with ATSICCOs recognised as accountable for the delivery and effectiveness of culturally led, targeted intervention functions within their role, and government retaining accountability for statutory thresholds, coercive interventions, and legal decisions.

CONTEXT:

Evidence before the Commission highlights the importance of targeted intervention responses that can combine clear expectations, culturally legitimate authority, practical support pathways, and sustained follow-up, particularly in communities experiencing entrenched disadvantage and concentrated drivers of harm. The Commission notes the relevance of evidence describing the needs for sustained, multi-system approaches that enable capability and address the harms produced by the alcohol and drug economy, violence, and institutional settings around children.

The Commission considers that strengthening ATSICCO roles in targeted intervention is a matter of system design and reform, not program expansion, and is central to improving engagement, preventing escalation, and supporting preservation and reunification for Aboriginal and Torres Strait Islander children and families.

The Commission considers that targeted intervention will only function as a genuine alternative to escalation if it is designed to engage directly with the drivers of harm and is supported by system settings that enable early, coordinated, and sustained action.

IMPLEMENTATION NOTES:

In implementing this recommendation, the development and commissioning of targeted intervention and family support responses should be guided by the following features:

(a) early activation and intervention pathways in response to visible indicators of escalating risk, such as chronic truancy, substance-related harm, family violence, housing instability, and untreated disability;

(b) Integrated whole-of-family responses that combine clear expectations with practical support across relevant systems (including health, housing, education, disability, justice, and alcohol and drug services), so that intervention is organised around what is driving harm rather than procedural compliance;

(c) Community-led and culturally legitimate models, including conferencing or monitored-agreement approaches where appropriate, that can combine responsibility, authority, and opportunity without defaulting immediately to statutory escalation;

(d) Early family mapping and mobilisation of kin and community supports as a core stabilisation and diversion function.

Chapter 2

Intake and Assessment

Companion Report 1

Functions of System

Chapter 2: Intake and Assessment

Abstract

This chapter examines how the child safety system delivers its intake and assessment functions by identifying concerns, applying statutory thresholds, and responding once statutory intervention is required. It explores the operation of the Department's current "Enhanced Intake and Assessment Approach" (EIAA), with particular focus on the use of "Safety and Support Responses" and the involvement of non-government agencies within statutory pathways. The chapter raises concerns about whether the Department's intake and assessment processes seek to promote proportionality and early support, as well as the present configuration of the EIAA. The chapter concludes with a recommendation to ensure clarity and alignment with the Department's core statutory function of intake and assessment.

1. Introduction

For children and families, involvement with Queensland's child safety system most often begins at a moment of acute vulnerability. Concerns about a child's safety or wellbeing are reported to the Department, and decisions are made, often rapidly and with limited information, about whether and how the Department will respond. It is through intake and assessment processes within the Department that the State's protective authority is first exercised, shaping whether families experience the system as proportionate and supportive, or as abrupt, confusing, and punitive.

Intake and assessment functions constitute the gateway to statutory intervention. Through intake processes, the Department determines whether information received gives rise to a reasonable suspicion that a child may be "in need of protection".[87] Through assessment activities, the Department gathers information to determine whether that suspicion is substantiated, whether targeted early intervention is sufficient in supporting care and protection needs, or whether ongoing statutory intervention is required. Together, these functions set the direction for all subsequent engagement with the child safety system. Decisions made at this stage may influence whether risk is identified and addressed early, or whether alleged harm is left to accumulate, potentially requiring more intrusive intervention at later points in a child's life.

[87] *CP Act* s 10.

While intake and assessment are often described as discrete operational processes, children and families do not experience them in this way. They experience the child safety system as one continuous encounter with State authority. In that encounter, families and children may feel seen, heard, and supported, or they may not. Delays, errors, or inconsistent practices can have consequences that extend throughout the life of a child and can undermine trust and confidence in statutory decision-making.

This chapter examines how Queensland's intake and assessment functions operate in practice, and how children and families experience the transition from reported concern to statutory involvement. It considers whether these functions have been administered in a manner consistent with the protective purpose of the CP Act, and the Department's fundamental obligation to protect children from significant harm. In doing so, the chapter addresses key aspects of the Commission's Terms of Reference, including whether systemic, procedural and policy failures have impeded the Department's ability to protect children, and whether investigation and assessment practices have been effective, timely, lawful and in the best interests of children.[88]

The chapter first sets out the role of intake and assessment. It considers the operation of targeted intervention responses at the front end of the system including whether there is sufficient accountability to protect children. The chapter concludes with the implications of these findings for system reform and recommendations to restore and preserve intake and assessment as integrated, accountable, and child-centred safeguarding functions.

Before turning to the analysis, the Commission notes the limits of the evidence examined in this chapter. The analysis in this chapter draws primarily on internal Departmental reviews and projects, oversight body reports and statements from senior Departmental officers produced to the Commission pursuant to various Notices to Produce. There was also a limited body of witness evidence. These materials provide critical insight into how intake and assessment decisions are made and experienced, and how early system responses shape children and families' engagement with statutory authority over time.

Given the Commission's truncated schedule, however, it was not possible to test and explore the materials provided to the Commission with witnesses in public hearings. However, the

[88] 'Commissions of Inquiry Order (No. 1) 2025' in Queensland, *Queensland Government Gazette - Extraordinary*, Vol. 399, No. 16, 23 May 2025) 137-138 [3(b)-(c), (e)].

Department's records and its own internal review provides direct evidence which reveal systemic failings as shall be discussed below.

It is not the purpose of this chapter to review individual decision-making or practitioner conduct. It is to examine how the child safety system functions at the point of entry into statutory intervention.

2. Child safety system: early pathways to safety

An effective child safety system operates as a single safeguarding pathway, rather than as a series of disconnected administrative processes. Intake, assessment, and targeted early intervention are best understood as mutually dependent stages of one protective function: namely, receiving information about a child's safety, forming and testing reasonable suspicion, understanding harm and risk over time, and ensuring that action taken (whether statutory or supportive) improves the child's safety. Where any part of this continuum is weakened, for example through inaccurate threshold decisions, delayed assessment, or inappropriate referrals, the system's capacity to prevent harm diminishes, and the likelihood of escalation into more intrusive downstream intervention increases. This is not simply a matter of 'process efficiency'; it goes to whether the State's protective authority is exercised lawfully, fairly and effectively in the lives of children and families.

Understanding the intake and assessment process as a continuum also aligns with what children and families experience. While systems often describe "intake", "assessment" and "referral" as discrete activities performed by discrete teams, families experience an ongoing encounter with State authority, shaped by a series of interconnected decisions made over time. When the continuum works well, families experience proportionate responses, clarity, timely engagement, and support that is coordinated and monitored. When it fails, they experience delay, confusion, and referral pathways that do not resolve risk, often followed by later escalation when harm has become entrenched.

When early system contact points fail, later parts of the statutory journey, namely litigation and ongoing casework, are forced to operate in conditions of heightened risk, urgency, and correspondingly constrained options.[89] The result is a greater likelihood that intervention occurs more intrusively. And, if a residential care placement of any kind is ultimately chosen,[90] intervention is not only very expensive but also potentially exposes the child to harms of a different kind.[91]

3. Intake: the first exercise of statutory power

As noted above, intake is the formal entry point to Queensland's statutory child safety system. The Department's Regional Intake Service (RIS) holds several core functions. It acts as the system's triage point as the first formal point of risk assessment. Its purpose is to: (a) receive information about child safety concerns from community members, professionals and agencies; (b) assess whether there is a reasonable suspicion that a child or unborn child may be in need of protection;[92] and (c) determine, authorise and record an appropriate statutory response in line with legislative thresholds.[93] Intake's triage role is critical in preventing unnecessary statutory involvement where risks can be addressed through support, but also ensuring timely escalation where more intrusive statutory intervention may be required.

During the intake phase, all child safety concerns are assessed against the threshold set out in the *Child Protection Act 1999 (Qld)*.

A concern becomes a **Notification** where there is a *reasonable suspicion* that:

- a child has suffered, is suffering, or is at unacceptable risk of suffering significant harm, and
- there is no parent able and willing to protect the child.

Where this threshold is met, the Department records the matter as a **Notification** and undertakes a statutory response to assess the child's need for protection.

Where concerns do not meet the statutory threshold, they are recorded as a **Child Concern Report (CCR)**.

A CCR recognises that a child or family may need support, but that the concerns can be addressed through information sharing, referral, and family support responses rather than statutory child safety intervention.

[89] See for example: Transcript, Evidence of Luke Twyford (25 February 2026) 4769:1-4771:39.
[90] Australian Institute of Family Studies, *Improving the safety and wellbeing of vulnerable children* (Report, June 2024); Queensland Family and Child Commission, *Annual Report on the Performance of the Queensland Child Protection System* (Report, 2024).
[91] See for example: Transcript, Evidence of Aimee (16 February 2026) 4133:25-40.
[92] Department of Child Safety, Seniors and Disability Services, *Child Safety Practice Manual – Receive and respond at intake* (Policy, 9 July 2025) 11.
[93] Department of Child Safety, Seniors and Disability Services, *Child Safety Practice Manual – Assess the information and decide the response* (Policy, 9 July 2025).

In the Commission's view, the process of child safety intake cannot be viewed as merely an administrative function, but must be seen as a critical exercise of public power with profound implications for children and families and significant downstream consequences.

3.1 What the evidence shows

The materials before the Commission suggest that Queensland's intake function has struggled to operate as an effective triaging mechanism that effectively identifies and responds to statutory thresholds and expectations.

Internal reviews have identified that serious allegations of harm have been incorrectly characterised and recorded as Child Concern Reports (CCR), which do not require further assessment, rather than Child Protection Notifications (CPN), which do. [94]

The Commission has obtained and reviewed internal Departmental documents showing repeated reports concerning the same children and families that have been assessed in isolation, without effective synthesis of Departmental history or recognition of escalating patterns of harm. Intake decisions have often been made without access to, or effective integration of, relevant police, health, education or prior child safety information, resulting in incomplete and unreliable risk assessment. In matters involving cumulative harm or chronic neglect, this has the effect of allowing ongoing exposure to risk and delaying protective intervention until harm had crystallised. In the extreme, sometimes intervention has not occurred before a child has died or been irrevocably harmed. [95]

There is a prevalent narrative to the effect that the Department's intake function is subject to system pressure primarily caused by significant and unnecessary over-reporting of concerns, compounded by mandatory reporting legislation. [96] This narrative was ostensibly accepted by the Carmody Inquiry, which characterised the child safety system as overwhelmed by risk averse reporting and "better safe than sorry" decision-making. [97]

From 2019 onwards, however, a series of internal Departmental projects have challenged the purported explanation that over-reporting is causing system failure. The Department's

[94] Department of Children, Youth Justice and Multicultural Affairs, *Intake Reform Project – End of Phase 2 Project Report* (Report, June 2021) 18-32; Queensland Child Death Review Board, *In Plain Sight* (Report, 2025); Transcript, Evidence of Victoria Van Houdt (26 November 2026) 2833:35-42.
[95] For example: Department of Families, Seniors, Disability Services and Child Safety, *Systems and Practice Review Report Tier 2 Review* (Report, 10 December 2025).
[96] Department of Children, Youth Justice and Multicultural Affairs (Memorandum for Approval No 01923-2023, 9 May 2023) 7.
[97] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013) 116-117.

internally-conducted *Intake Reform Project*, finalised in June 2021, drew on extensive data analysis, stakeholder consultation and the review of more than 4,000 case records.[98] It found no clear evidence that mandatory reporters were reporting matters outside scope.[99] Rather, it identified repeated instances of serious allegations, including chronic neglect, domestic violence and sexual abuse, being recorded as CCRs rather than CPNs;[100] repeated and escalating concerns being assessed episodically rather than cumulatively;[101] and families being diverted to voluntary services in circumstances where statutory assessment and oversight were warranted.[102] The findings of the *Intake Reform Project* support a quite different conclusion, namely, that inaccurate screening and risk assessment, rather than excess reporting, have contributed to the need for later repeat reporting, escalation of harm, and delayed statutory intervention.

Following the conclusion of the *Intake Reform Project*, the Department introduced the use of differential response pathways in intake processes that allow concerns to be responded to through either statutory assessment, or referral to non-statutory family support services. [103] This practice approach is consonant with the Carmody Inquiry by placing towards a greater emphasis on prevention and early intervention, increased diversion of families, and greater reliance on non-government and secondary services to respond to concerns.[104] However, while intended to support proportionate and earlier responses, the Commission has found that this approach has instead placed increasing weight on intake screening decisions, and that those critical assessments have often been erroneous. This is a very significant flaw, as it allows 'false negative' results, not subject to external oversight to go uncorrected, resulting in an obvious risk that children, who, properly assessed, are at risk of harm being left where they are. Those children thus fall into an unprotected lacuna until their risk of harm is properly evaluated. Evidence examined later in this chapter indicates that, in practice, these pathways have not consistently operated with the safeguards required to ensure that risks are assessed and resolved before statutory oversight is withdrawn.

[98] Department of Children, Youth Justice and Multicultural Affairs, *Intake Reform Project – End of Phase 2 Project Report* (June 2021) 8.
[99] Ibid 23.
[100] Ibid 25-26.
[101] Ibid 10, 29.
[102] Ibid.
[103] Statement of [redacted] (18 March 2026) [13]; Transcript, Evidence of Corinne Porta (20 November 2025) 2422:27-37, 2423:35-2424:33; Transcript, Evidence of Witness M (25 November 2025) 2703:1-34; Transcript, Victoria Van Houdt (26 November 2025) 2813:17-25, 2833:42-2834:23, 2863:10-2865:30.
[104] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013).

Where decisions are made at the intake stage to downgrade or divert matters that meet the statutory threshold for assessment, the Department effectively withdraws its protective oversight at the point when it is most needed. Some of the evidence before the Commission reveals that this has contributed to a pattern in which children cycle through intake and non-statutory responses multiple times, only to re-enter the system at a later stage with higher levels of risk, fewer protective options, and greater likelihood of coercive intervention.[105] Concerningly, these failures at the point of entry into the system, are likely to have enduring consequences for children and families, shaping the trajectory of later statutory involvement and contributing to cumulative harm across the life of their involvement with the child safety system.

4. Assessment: Determining whether the State must intervene

Assessment is central to how the child safety understands and responds to risk. It is the statutory phase that follows once a notification has been recorded and is the mechanism through which the Department determines whether a child is, in fact, in need of protection, and whether ongoing statutory intervention is required.[106]

Critically, the assessment stage is often the Department's first direct, face-to-face engagement with a child and their family. It is a vital opportunity for the family – and the child – to develop trust and rapport, and a productive working relationship through which help can be offered. Where the statutory threshold at the intake stage has been met, assessment must occur without delay, and in a manner proportionate to the seriousness and urgency of the concerns.

The Department delivers this assessment function through its assessment teams, which hold key responsibilities. These teams are the system's primary point of understanding safety concerns and the principal mechanism for deciding whether ongoing statutory intervention is required. The purpose of an assessment is to assess a child's immediate safety, determine whether the child has suffered, or is likely to suffer, significant harm; assess whether a parent is willing and able to protect the child, and decide the appropriate outcome, including referral to supports, ongoing intervention, or court.[107]

[105] See for example: Transcript, Evidence of Witness Y (10 September 2025) 392:31-394:15.
[106] *CP Act* s 14; Department of Families, Seniors, Disability Services and Child Safety, *Assess harm and risk of harm* (Practice Guide, April 2025) 1, 4-10.
[107] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual: Respond to a notification* (Practice Guide).

The Commission recognises that the core statutory function undertaken during the assessment phase has profound consequences for children, families, and the exercise of State power. Therefore, the quality and timeliness of assessment decisions is central in shaping a positive child safety outcome. These assessment decisions determine whether families exit the system or become subject to ongoing statutory intervention, and if so, the level of coercive protective action required. As such, the assessment is not merely a midpoint in the child protection process. It is a critical system entry point.

4.1 Timeliness and quality of assessment in Queensland

Timely and high quality assessment is central to the protective purpose of the child safety system. Where statutory assessment is delayed, incomplete, or transferred to alternative responses, children may remain in unsafe or unstable circumstances and the Department risks failing to meet its statutory responsibility to act immediately to protect them from harm. Therefore, assessment delays are not merely administrative in nature. They represent the potential prolonged exposure of children to unresolved risk, contrary to the protective intent and requirements of the CP Act.[108]

Figures 3 and 4 below show the proportion of notifications where the investigation commenced in the required timeframe, and the median days to commence.[109]

	Investigations commenced in time				
	2021-22	2022-23	2023-24	Jul 2024 to Mar 2025	Apr 2025 to Mar 2026
24 hours / Priority Response (24 hours)	96 %	93 %	92 %	91 %	44 %
5 days / Priority Response (72 hours)	38 %	33 %	31 %	30 %	13 %
10 days / Standard Response (7 days)	30 %	25 %	25 %	26 %	6 %

Figure 3: Proportion of investigations commenced in time, by notification timeframe.

[108] *CP Act* ss 5A, 14.
[109] Department of Families, Seniors, Disability Services and Child Safety, Datasheets provided in response to Notice to Produce No. 353 (3 March 2026). The Department's response timeframes were altered in April 2025 alongside the introduction of the Enhanced Intake and Assessment Approach (EIAA). The timeframes under the EIAA are contained within the brackets (24 hours, 72 hours and 7 days).

	Days to commence				
	2021-22	2022-23	2023-24	Jul 2024 to Mar 2025	Apr 2025 to Mar 2026
24 hours / Priority Response (24 hours)	1.4	1.7	2.8	1.6	1.1
5 days / Priority Response (72 hours)	27.7	40.6	43.1	37.9	41.4
10 days / Standard Response (7 days)	40.9	50.9	54.8	44.0	63.4

Figure 4: Median days taken to commence investigations, by notification timeframe.

These figures were provided by the Department pursuant to a Notice to Produce issued by the Commission. They reveal that over five years, there has been a consistent trend of increasing delays in responding. This is shown both by decreased compliance with timeframes each year, and increased days to respond each year. With respect to compliance, the Commission observes:

- Compliance with 24-hour responses has generally been high though has declined each year. In the most recent period however, only 44% of 24-hour Priority Responses were commenced in time taking approximately one to two days;
- Compliance with three, and five-day responses has been consistently poor and has declined each year. In the most recent period, only 13% of 72-hour Priority Responses were commenced in time, taking approximately 41 days; and
- Compliance with seven, and ten-day responses has been consistently very poor, also declining each year. In the most recent period, only 6% of Standard Responses were commenced in time, taking approximately 63 days.

The marked decrease in compliance with investigation timeframes from April 2025 is particularly concerning. This decrease corresponds in time both with the rollout of Unify and with the full implementation of the EIAA. The EIAA is discussed further below. With respect to Unify, the Commission notes that the data provided for the periods between 2021 up to March 2025 were produced from the Department's now-defunct ICMS system. The data provided for the period April 2025 to March 2026 were produced from the Department's current Unify system. As such, the figures are reported with some caution and may be subject to reasonable adjustments.[110]

[110] In particular, the 'days to commence' figures for the period 2021 to March 2025 (ICMS) should be used with caution. For that period, the Commission was provided two median figures – one figure for median days to commence *if the investigation commenced in time*, and another figure for median days to commence *if the investigation did not commence in time*. The figures reported here are aggregated as a weighted average group median. The 'true' median may be different. The median days to commence for 24-hour notifications being greater than one may be a result of this calculation method, with a skew occurring from outlier cases.

The Department has acknowledged that its assessment function has been operating under sustained strain. This has been identified and known internally within the Department since at least April 2020, when its internal *Investigation and Assessment Project* identified that 63% of investigations were not commenced within statutory timeframes.[111] The report stated these delays were "not a new phenomenon", but reflective of a system under strain.[112]

The quality of assessment outcomes generated under these circumstances also warrants attention. The same project identified that some matters finalised as "unsubstantiated" involved children who had suffered harm or were in need of protection, and that 27% of cases reviewed with an unsubstantiated outcome were "considered appropriate for an alternative response".[113] The review found that inaccurate outcomes were frequently associated with limited or unreliable information, failure to synthesise historical child protection involvement, suffered from confirmation bias, or insufficient analysis of parental capacity to protect. The review also raised concerns about the suitability of referrals being made to voluntary services, notwithstanding repeated prior engagement with services that had not resulted in sustained safety improvements.[114] These findings raise serious questions about whether the Department was meeting its statutory duty to meaningfully assess harm and risk when concerns were reported.

In response to escalating backlogs of assessments, and amidst concerns about the quality of assessments that were conducted, the Department began to rely on administrative strategies such as its "Review and Complete" and "Review and Close" processes as the best way forward. These internal Departmental processes were commenced from as early as December 2019 and have, at various times, authorised Department officers to close investigations and assessments without an outcome where matters have exceeded prescribed timeframes.[115] This is self-evidently an unjustifiable approach as it is based upon an arbitrary procedural time limit rather than an evaluative risk assessment.

The risks of adopting such approaches in any child safety system are clear. In a subsequent internal review undertaken in October 2022, the Department identified that a significant proportion of matters closed via the "Review and Complete" process revealed further reported

[111] Department of Children, Youth Justice and Multicultural Affairs, *Investigation and Assessment End of Project Report* (Report, April 2020); Department of Children, Youth Justice and Multicultural Affairs, *Intake Reform Project – End of Phase Report* (Report, June 2021).
[112] Department of Children, Youth Justice and Multicultural Affairs, *Investigation and Assessment End of Project Report* (Report, April 2020) 1.
[113] Ibid 13, 18.
[114] Department of Child Safety, *Investigation and Assessment Project Report* (Report, April 2020).
[115] Department of Children, Youth Justice and Multicultural Affairs, *Investigation and Assessment End of Project Report* (April 2020) 9; Department of Families, Seniors, Disability Services and Child Safety, *Attachment 6 – Review and complete/close strategy authorisations* (Table, January 2026).

and/or repeated concerns, as well as inaccurate risk assessment and subsequent escalation.[116] Despite this, the Department continued to extend this process which has since been used to close a significant number of investigations without assessment.[117] The Commission expresses its disapproval of that practice.

Recently, the New South Wales Ombudsman, investigating a similar practice adopted by the Department of Communities and Justice as the lead agency for child protection in New South Wales, noted that routine closure of reports without investigation based on elapsed time or lack of capacity was incompatible with statutory child protection obligations, particularly where closure occurs without new information to justify reassessment of risk.[118]

In the Commission's view, weaknesses in assessment have not arisen because risk was low or unclear. Rather, the system has for a long time been unable to respond and intervene appropriately. Where these assessments are rushed, delayed, or otherwise constrained by workload pressure, decision-making shifts from careful evaluation of harm and safety to prioritising administrative finalisation. This is an anathema to the core functions of the child safety system. The Commission is concerned that this approach, and the decision-making that has permitted it, has contributed to undermining the core statutory function of assessment and weakening the reliability of decisions about whether children can safely remain at home. That such processes have been known to and accepted, at least tacitly, by senior Departmental officials responsible for the critical protective functions of the Department is a matter of significant concern to the Commission. In the Commission's view, any policy, practice or procedure founded upon such arbitrary and non-evaluative criteria should be clearly revoked.

[116] Department of Families, Seniors, Disability Services and Child Safety, Departmental Briefing Note – *Review and Complete Strategy* provided in response to Notice No 353 (4 October 2022).
[117] For example, between 1 April 2025 and 1 March 2026, 2,234 assessments had a 'review and close' outcome recorded. See: Department of Families, Seniors, Disability Services and Child Safety, *Assessments with a Review and Close outcome recorded from 1 April 2025 to 1 March 2026* (Spreadsheet, March 2026).
[118] New South Wales Ombudsman, *"No Capacity to Allocate" - The Department of Communities and Justice's practice of ROSH (Risk of Significant Harm) reports* (Special Report, 6 February 2026) 7.

5. Enhanced Intake and Assessment Approach: The Intended Solution

The Enhanced Intake and Assessment Approach (EIAA) was introduced by the Department in April 2025 as a response to findings of its internal *Investigation and Assessment End of Project Report*[119] and the *Intake Reform Project*.[120] The approach was intended to strengthen decision-making and assessment, improve differentiation between levels of risk and need, and enable children and families to receive timely and appropriate responses without default escalation to intrusive statutory intervention.[121] In doing so, EIAA was intended to balance two imperatives within child safety systems: ensuring the Department meets its statutory obligations to assess and respond to alleged harm; and reducing unnecessary intervention and better leveraging family support and community-based responses where appropriate.

The EIAA is Queensland's framework for responding to child safety concerns at intake and early assessment. It was designed to strengthen front-end decision-making, improve differentiation between levels of risk and need, and support more proportionate statutory responses.

Key features of EIAA include:

- **Enhanced intake decision-making**, to determine whether concerns meet the threshold for a notification and require a statutory response.
- **Differentiated response pathways** once a notification is recorded, intended to align the level of statutory intervention with assessed risk and safety concerns.

Three response types following a notification:

Priority Response - where concerns indicate a high level of risk and require urgent assessment by the Department (KPI of 24 hours).

Standard Response - where concerns require direct assessment of a child's safety, risk, and family circumstances by the Department (KPI of 72 hours).

Safety and Support Response - a response available *within* the Standard Response pathway. The response is undertaken by an ACS provider to assess child and family support needs and connect them with appropriate support.

Under the EIAA, once concerns are assessed as meeting the threshold for a notification, the Department's statutory functions to assess risk and determine whether a child is in need of

[119] Department of Children, Youth Justice and Multicultural Affairs, *Investigation and Assessment End of Project Report* (Report, April 2020).
[120] Department of Children, Youth Justice and Multicultural Affairs, *Intake Reform Project – End of Phase 2 Project Report* (Report, June 2021).
[121] CL-21, *Enhanced Intake and Assessment Approach*, tendered 20 November 2025; Statement of [redacted] (18 March 2026) [13]; Transcript, Evidence of Corinne Porta (20 November 2025) 2422:27-37, 2423:35-2424:33; Transcript, Evidence of Witness M (25 November 2025) 2703:1-34; Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2813:17-25, 2833:42-2834:23, 2863:10-2865:30.

protection are triggered. When a notification is recorded, the Department may undertake a "Priority Response", where certain criteria indicative of urgency are met, or otherwise, a "Standard Response".[122]

There is also a third option, known as "Safety and Support Responses", which are a subset of "Standard Responses".[123] "Safety and Support Responses" are subject to statutory duties but differ from other notification responses in that they do not involve the Department undertaking an assessment of safety, risk, and reported child safety concerns directly with the child and family at the outset. Instead, a "Safety and Support Response" allows the Department to refer the notification to an Assessment Service Connect (ASC) provider,[124] who independently engages with the family and child, assesses support needs, and connects the family with relevant support services.[125]

Importantly, a referral to an ASC service provider can only be made in limited circumstances, including if the service provider has capacity to engage the child and parents within 10 business days.[126] If an ASC service provider does not have capacity to accept the referral, or the family does not engage with the provider within 10 business days, a "Standard Response" (which is led by the Department) will instead be required.[127]

Referral to an ASC service provider is not suitable and will not be made by the Department if: (a) an immediate harm indicator or danger is present; (b) an authorised officer is using or likely to use certain powers under the Act; (c) a joint investigation with the Queensland Police Service is required; or (d) where the child is already subject to ongoing intervention.[128]

Further, according to the Assessment Service Connect Model and Guidelines, a child may be considered for a Safety and Support Response if: there are identified strengths within the family that could be built on with the help of an early intervention service, to provide for the child's safety or unborn child's safety after their birth; the child is visible within their extended family and

[122] Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 9-11.
[123] Ibid; Statement of Victoria Van Houdt (18 March 2026) [22].
[124] As of March 2025, there were eight non-government organisations across Queensland that were engaged by the Department to provide ASC services (Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 34.
[125] Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 10-13; Statement of Victoria Van Houdt (18 March 2026) [22]-[25].
[126] Statement of Victoria Van Houdt (18 March 2026) [24].
[127] Statement of Victoria Van Houdt (18 March 2026) [25].
[128] Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 14.

community, such as at school; or it is appropriate for the service to engage with the family without the Department assessing the child's immediate safety.[129]

Taken collectively, those criteria suggest that the circumstances in which a child will be referred to an ASC for a "Safety and Support Response" may be reasonably limited and confined to lower risk notifications. However, the Commission did not have in its possession any data that indicated how frequently the Department enlisted the assistance of ASC providers.

The EIAA has now been in operation for more than 12 months and is currently undergoing an evaluation led by Professor Silke Meyer of Griffith University.[130] Further, Nous Consultancy is undertaking an evaluation of EIAA's impact on the secondary system.[131]

According to [redacted], a Director in Statewide Operations at the Department, the EIAA is consistent with the Department meeting its statutory obligation under section 14 of the CP Act, namely to immediately have an authorised officer investigate where there is a risk of harm and a reasonable suspicion that the child is in need of protection and, if it can, assess the child's protective needs.[132] The reasons for that being so were set out exhaustively in a statement prepared by the Acting Chief Practitioner, Victoria Van Houdt. They can be briefly stated as being that:

1. A "Safety and Support Response" nevertheless involves a home visit with the family, a safety assessment of the child's immediate needs, and if the child is deemed safe, an assessment of the family's needs, and the supports and services required.
2. Where that information or engagement with the child and family indicates there is an increased level of risk of harm to the child, or the child is a child in need of protection, the response is escalated to a "Priority Response", which in turn requires the Department to undertake an urgent assessment within 24 hours.[133]

The Department's position was expressed as being that the "Safety and Support Response" process complies with the obligation in section 14(1)(a) of the CP Act and also falls within the ambit of section 14(1)(b), which enables the Department to "take other action" it considers

[129] Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 10.
[130] Statement of Victoria Van Houdt (18 March 2026) [43].
[131] Department of Families, Seniors, Disability Services and Child Safety, *Statewide commencement of Stage 2 implementation of the Enhanced Intake and Assessment Approach* (Director-General Briefing Note, 14 April 2025) [29].
[132] Statement of [redacted] (18 March 2026) [25].
[133] Statement of Victoria Van Houdt (18 March 2026) [7]-[26]

appropriate once it reasonably suspects a child is in need of protection.[134] On that basis, the Department contended that the CP Act permits responses to notifications to be undertaken by non-government agencies in appropriate circumstances.

The Commission has considered whether the design and use of the Safety and Support Response pathway in the EIAA appropriately reflects and complies with the Department's statutory duties once concerns meet the notification threshold. In particular, the Commission has considered the legitimacy and appropriateness of creating alternative pathways through which non-statutory agencies (being ASC providers) undertake functions necessary to discharge the Department's statutory obligations, in circumstances where concerns have been assessed as warranting notification.

The Commission's apprehension is that where concerns are assessed as meeting the notification threshold, the statutory response must be capable of demonstrating how risk, safety and child protection concerns have been assessed and addressed in accordance with the Department's statutory duties, prior to the Department disengaging. In that context, the Commission's primary concerns are whether it is appropriate and adequate for the State to discharge its statutory responsibility and authority, as described above, in circumstances where the statutory notification threshold has been met, and, relatedly, whether this approach is consistent with the best interests of children and community expectations.

There was insufficient information for the Commission to be satisfied as to how assessment of risk, family circumstances and reported child safety concerns are undertaken in a manner which complies with the Department's statutory duties when the Safety and Support Response pathway is used. If assessment of support needs is the primary driver for intervention, rather than a statutory assessment of the child safety concerns and risk, this gives rise to questions about the decision to record the matter as a notification in the first place. Conversely, in the absence of a comprehensive risk and family assessment being undertaken or directed by the Department, it is unclear how the Department can be assured that the child safety concerns giving rise to the reasonable suspicion have abated or are appropriate to be managed by some alternative pathway, and importantly, whether it is discharging its statutory duty to protect children at risk of harm.

[134] Statement of [redacted] (18 March 2026) [27].

In this sense, Safety and Support Responses raise a threshold governance question: whether the statutory intent of the notification threshold and response system is fully realised when the Department has limited its role to monitoring engagement and escalation triggers, rather than actively assessing risk, safety and notified child safety concerns at the point in time that these concerns are identified as sufficiently serious to warrant a notification. This question is important because Safety and Support Responses are only available where concerns have exceeded the assessed level of a child concern report and meet the threshold for a notification. The Commission's concern is not whether non-government services appropriately support families, nor whether families may benefit from engagement outside the direct exercise of statutory authority. Rather, the issue is whether the current configuration of Safety and Support Responses enables the Department to adequately discharge its statutory duties and responsibilities at the point at which those obligations are triggered.

The Commission considers that there are prima facie good reasons to conclude that the Safety and Support Responses, while intended to provide beneficial supports for the child and family, are not designed to establish a process for evaluation and assessment of risk to the child as required to discharge the Department's statutory duty of child protection. As the objective of the legislation is to determine harm and risk of future harm, the Department may not fulfil its statutory duties by requesting NGOs to assess concerns that have met a threshold for statutory intervention on their behalf.[135] Accordingly, the Commission recommends the Department prioritise the review of the EIAA, with a particular focus on how the Department is able to demonstrate that the process deployed under a 'Safety and Support Responses' is compliant with its statutory duty, and if it is not, what modifications are required to ensure compliance.

[135] Department of Families, Seniors, Disability Services and Child Safety, *Assessment and Service Connect – Models and Guidelines* (Policy, March 2025) 10-13; Statement of Victoria Van Houdt (18 March 2026) [22]-[25].

6. Implications for Reform

The evidence available to the Commission raises concerns that the Department's intake and assessment function has been compromised by the combined effects of delays, workload pressure, and inappropriate reliance on administrative finalisation. The consequences of these factors are borne not only by the system, but by children and families whose safety, stability and wellbeing depend on the quality of decisions made at this critical stage.

The issues identified in this chapter point to broader considerations for reform of the child safety system, particularly the need for greater clarity and alignment between the distinct functions of intake, assessment and targeted early intervention and support services.

Targeted early intervention and family support services, including non-government providers, play a critical role in supporting families to address identified needs, reduce stressors and build capacity to safely care for children. While the EIAA seeks to introduce greater proportionality and flexibility into front-end decision-making, the evidence before the Commission raises a concern that the boundaries between these functions have become blurred, with implications for the exercise of State powers.

The 'Safety and Support Response' pathway raises particular implications in this regard. Its use within the statutory notification threshold and intervention process has the effect of locating support-oriented functions within a response that has already crossed the statutory threshold. This creates tension between the purpose of statutory assessment and the purpose of targeted support services, which is to assist families to address needs and prevent escalation. It also raises questions about whether statutory assessment functions are being deferred or displaced at a point where the seriousness of concerns has already been recognised.

The Commission also notes the potential for duplication and inefficiency where multiple service systems undertake overlapping assessment and service-linking functions, particularly where families move between ASC providers, and other support services such as the Family and Child Connect (FaCC). Without clear delineation of roles and purpose, families may be subject to repeated assessments, fragmented service navigation and inconsistent messaging leading to confusion about the nature of the system's involvement and which services are actually voluntary.

The issues identified in this chapter highlight the importance of reform efforts that clearly align function with role: intake as triage and threshold decision-making; assessment as the exercise of statutory authority to assess risk and protective needs; and targeted family support as a distinct, relational function focused on voluntarily assisting families outside the direct exercise of coercive power.

Addressing this alignment is critical to ensuring that statutory authority is exercised appropriately, that non-government services are positioned to do what they do best, and that children and families experience a system that is both protective and supportive.

7. Recommendations

Recommendation 3: Review of intake 'Safety and Support Response' pathway	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government, within two months of the Government's response to this report, undertake a review and realignment of intake, assessment and family support functions that, in view of this Commission's provisional observations:

(a) restores functional clarity for these functions within the Department
(b) clarifies and maintains the integrity of intake thresholds
(c) clarifies roles, authority and accountability for decision-making within the statutory system
(d) ensures intake and assessment processes are not driven by demand-management tools or resourcing constraints, but are sufficiently resourced to carry out their critical statutory task
(e) specifically considers whether the Department is complying with section 14 of the *Child Protection Act 1999* in its Enhanced Intake and Assessment Approach.

CONTEXT:

While the Commission recognises the aim of reducing intrusive intervention and strengthening early support, it is concerned that the current design of the 'Safety and Support Response' pathway does not clearly demonstrate how the Department meets its statutory responsibilities once the notification threshold is reached. In particular, the pathway appears to rely on non-government providers to undertake functions central to assessing risk, safety and harm, without clear evidence that the Department has undertaken, directed or retained accountability for these assessments.

In the absence of clarity regarding how risk and safety are assessed and acquitted within this pathway, the Commission considers that Department review this approach as part of the broader realignment of the intake and assessment functions. This will ensure that any future model maintains alignment with legislative requirements, community expectations and the paramount objective of protecting children from harm.

IMPLEMENTATION NOTES:

The Commission notes that the Department is presently seeking an external evaluation of the Enhanced Intake and Assessment Approach. The extent to which these evaluations will address the Commission's concerns is unclear. Therefore, while these evaluations may inform the Government's consideration, they should not be determinative of the action taken in response to this recommendation.

Recommendation 7: Providing meaningful transition to adulthood	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, amend all necessary policies, processes and practices and identifies a single, responsible officer within the Department (most appropriately the 'Child Guardian' as described in Recommendation 44C) to ensure the Department meets the following obligations:

(a) that all children in care commence a 'transition from care' plan within 14 days of their fifteenth birthday;
(b) that this plan is regularly revised, every six months at a minimum, until their eighteenth birthday;
(c) that there is central coordination, monitoring and reporting on measures including the timeliness of transition plans being commenced and reviewed, a review of the quality of the plans, and the effectiveness of achieving the required needs of the care leaver.

The transition from care plan, at a minimum, should require:

(a) enforceable, equitable, transition arrangements;
(b) early and collaborative planning;
(c) whole-of-government responsibility for outcomes; and
(d) robust tracking of post-care pathways.

CONTEXT:

The Commission heard evidence that transition to adulthood planning is often delayed, inconsistent or absent. Where planning does occur, it is frequently inaccessible to young people, developed too late to be useful, or dependent on the young person being able to advocate for supports they may not know exist.

The Commission's view is clear that legal independence does not equate to readiness for adult life, and the Department's responsibilities as a corporate parent should not end, any more than a natural parent's responsibilities end, on the young person's eighteenth birthday.

This reform will support young people in experience continuity, stability and a safer and smoother transition into adulthood.

IMPLEMENTATION NOTES:

At a minimum, the Commission supports the inclusion of T2A aggregated aged-based milestone data by State and region in Departmental annual reporting.

Chapter 3

Supporting Pregnant Women and New Mothers

Companion Report 1

Functions of System

Chapter 3: Supporting Pregnant Women and New Mothers

Abstract

This chapter examines the child safety system's response to pregnant women where the Department is notified of concerns about the safety and wellbeing of an unborn child, focusing on whether current practice aligns with the preventative intent of the CP Act. it finds that, although pregnancy is a critical window for early help and prevention, there are significant delays in investigating unborn notifications and limited engagement with pregnant women. These failures have resulted in missed opportunities to address child protection concerns during pregnancy, with risk concentrated instead at or near the time of birth through crisis-driven intervention. This chapter concludes that re-orienting unborn notifications as time-critical early-help pathways, and embedding community-led engagement during pregnancy, is essential to reducing newborn removals, improving outcomes for children and families and relieving downstream pressure on the system.

1. Introduction

Pregnancy occupies a distinctive and critical place in Queensland's child safety system. It is a period during which concerns about a child's future safety may first come to the system's attention and a time when targeted intervention has the greatest potential to prevent harm, strengthen family capability and avoid the need for intrusive statutory intervention at or shortly after birth.

This chapter examines the child safety system's response to pregnant women where concerns are raised through the notification process[136] about the safety and wellbeing of an unborn child ('unborn notifications'). It is concerned not only with what the system does in these circumstances, but with how and why current approaches operate as they do, and how decisions made - or not made - during pregnancy shape outcomes at birth. In particular, it examines how the failure to provide timely, supportive and preventative responses during pregnancy produces crisis-driven decision-making at birth.

[136] *CP Act* 13A, 13B.

The chapter assesses the system's capacity to provide early, timely and effective support during pregnancy, consistent with the preventive intent of the CP Act.[137] The Act empowers the Department to take action before a child is born where it reasonably suspects that the child may be in need of protection after birth[138], with the express purpose of reducing that likelihood - not to interfere with the rights or liberties of a pregnant woman.[139] The legislation envisages that this preventive purpose will be achieved through investigation, assessment and the provision of help and support to pregnant women during pregnancy.[140] This structure relies largely, though not solely, on consent.

The Department's Practice Guide: *Respond to an unborn child* reinforces the importance of prioritising unborn notifications, engaging early with pregnant women and offering support as soon as practicable to maximise the opportunity to address risk factors before birth.[141]

As part of this Inquiry, the Commission undertook a focused review of newborn removals through the Newborn Project, which examined cases in which the Department sought orders for newborn children in one Queensland region over a defined period. The New Project involved detailed analysis of Departmental records, including unborn notifications, safety assessments, support service plans, court applications and outcomes. The Commission acknowledges that the Newborn Project was limited in geographic scope and does not purport to represent statewide practice. However, the depth of the review provides important insight into how unborn notifications are responded to in practice, the timing and nature of engagement with pregnant women and the availability (or absence) of preventative support during pregnancy. The findings of the Newborn Project are therefore used in this Chapter as illustrative of systemic issues, rather than measures of prevalence. The Newborn Project found:

- Most mothers were already working with the department as they had other children in care.
- Most notifications had a 10-day response timeframe.
- The average days between notification and birth of the child was 136 days.
- Less than a quarter of all unborn investigations were commenced within the required timeframe, most due to workforce capacity.
- Over a quarter were commenced more than 100 days after the notification.

[137] Ibid s 7(1)(b).
[138] Ibid s 22(1).
[139] Ibid s 22(5).
[140] Ibid s 22(2).
[141] CL-5, Department of Families, Seniors, Disability Services and Child Safety, Practice Guide: Respond to an unborn child, tendered 17 September 2025.

- One unborn investigation was commenced over a year after the notification was received due to workforce capacity.
- With on average over 4 months available from alert to pregnancy and birth of the child, there is a significant period of time available to intervene prior to birth and an opportunity for intensive assistance to be provided to support and plan for improved outcomes.
- Over a sustained period of time in one region alone, there are clearly evidenced capacity issues in responding to the needs of unborn children, thus limiting the opportunities for early and meaningful support to be provided to their mothers and support networks.

A detailed analysis of the Newborn Project is found in Appendix D.

The Commission's examination of unborn notifications and the corresponding Departmental response reveals a consistent pattern: significant delay between notification and investigation, support service cases consented to but not allocated, and women declining to engage with the Department or with support services.[142] The Commission heard that refusal to engage during pregnancy is not uncommon among women with prior child protection involvement and is often informed by past experiences of statutory intervention, and a rational apprehension that antenatal contact will increase the likelihood of removal at birth.

Where pregnant women decline engagement, the Department's capacity to assess changing circumstances, identify protective factors and provide targeted support is constrained.[143] This concentrates decision-making at birth, rather than enabling risk to be addressed earlier.

The chapter examines the inherent challenge of supporting pregnant women in a statutory child protection system that is structurally oriented toward crisis response. It recognises that system design, decision-making frameworks and organisational culture play a decisive role in shaping responses to unborn notifications. These factors help explain why practice often diverges from legislative intent, and how missed opportunities for prevention during pregnancy can set the conditions for urgent, intrusive and traumatic intervention at birth.

This chapter's scope encompasses:

- the receipt and handling of unborn notifications, including timeliness of response and engagement with pregnant women;

[142] Department of Families, Seniors, Disability Services and Child Safety, Departmental case files provided in response to Notice to Produce No. 21 (7 August 2025), Notice to Produce No. 116 (1 October 2025) and Notice to Produce No. 117 (1 October 2025).
[143] Transcript, Evidence of Witness W (17 November 2025) 2114-16, 2122:7-36.

- the use of investigative powers under s 22 of the CP Act;
- the provision (or absence) of preventive support to pregnant women, including Support Service Cases and support planning;
- decision-making thresholds applied during pregnancy;
- engagement with ATSICCOs; and
- the interaction between the Department, health services and specialist supports during pregnancy.

2. Why pregnancy matters in child safety

Across health, child wellbeing and child protection disciplines, pregnancy is widely recognised as a key window of opportunity for prevention and early intervention, during which many women are motivated to engage with supports to make behavioural or life-style changes that strengthen safety and wellbeing for their unborn child. Evidence before the Commission, including from health research and the findings of the Child Death Review Board, demonstrates that during pregnancy the desire to protect the unborn child can create meaningful conditions for change – women often reduce risk-taking behaviours and increase their engagement with services.[144]

Pregnancy may be a point of heightened fear and surveillance for women with prior child protection involvement. The Commission has heard that some pregnant women experience engagement with health and social services not as a support but as exposure to a process of statutory scrutiny, which might result in unborn notifications, birth alerts and the prospect of removal of their newborn.[145]

Media reporting across jurisdictions, including recent reporting in New South Wales and South Australia, has highlighted how hospital-based alerts and birth-suite interventions can be experienced by women and health professionals as abrupt, traumatising and dehumanising, despite child safety concerns being genuine.[146]

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[144] Child Death Review Board, *Annual Report* (Report, 2024-2025) 22- 25, citing Maria Magnus et al, 'Pre-pregnancy lifestyle characteristics and risk of miscarriage: the Australian Longitudinal Study on Women's Health' (2022) 22(1) *BMC Pregnancy Childbirth* 169; Lauren Rockliffe et al, 'Understanding pregnancy as a teachable moment for behaviour change: a comparison of the COM-B and teachable moments models' (2021) 10(1) *Health Psychology and Behavioural Medicine* 41, 41-59.

[145] Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3044:12-42; referring to CL-5, *Practice guide: Respond to an unborn child*, tendered 17 September 2025, 1, 4.

[146] The Guardian, Sarah Collard, 'Birth alerts are meant to help children at risk of abuse. They are routinely used against Aboriginal mothers' (Web Page, June 2025) <https://www.theguardian.com/australia-news/2025/jun/18/birth-alerts-are-meant-to-help-children-at-risk-of-abuse-they-are-routinely-used-against-aboriginal-mothers>; ABC News, Stephanie Richards, 'Baby removals trigger whistleblower to tell of inhumane practices and mothers' trauma' (Web Page, April 2024) <https://www.abc.net.au/news/2024-04-11/whistleblower-tells-of-baby-removals-at-sa-hospitals/103687624>; Samantha Burrow and Renna Gayde, 'Removing babies is still harming First Nations families almost two decades after the apology' (Web Page, 13 February 2025) <https://www.uwa.edu.au/news/article/2025/february/removing-babies-is-still-harming-first-nations-families-almost-two-decades-after-the-apology-to-stolen-generations>; Samantha Burrow et al, 'Parents' experiences of perinatal child protection processes: A systematic review and thematic synthesis informed by a socio-ecological approach' (2024) 166 *Children & Youth Services* Review.

This creates a paradox at the heart of the system's response to unborn children: the same period that is most effective for early help is often experienced as the most threatening.

Disengagement by pregnant women from services is therefore not necessarily a reflection of unwillingness to care for a child. Rather, the Commission has heard that disengagement may be fear-based and protective, shaped by prior experiences of the system and a rational desire to avoid harm or loss.[147] It is important to recognise that this reality is essential to understanding why current approaches to supporting pregnant women may not achieve their preventive intent.

3. Legislative intent – prevention, not pre-determination

The statutory framework is clear. Section 22 of the CP Act applies where, before the birth of a child, the Chief Executive reasonably suspects that the child may be in need of protection after birth.[148] In those circumstances, the Chief Executive must take action considered appropriate, including investigating the circumstances and assessing the likelihood that the child will need protection, or offering help and support to the pregnant woman.[149]

The introduction of unborn child provisions in Queensland

The Department's legal powers to provide support to a pregnant woman in relation to her unborn child were introduced in 2004 as part of the first stage of reforms resulting from the Crime and Misconduct Commission's 2004 Inquiry.

Amendments in 2010 included the significant expansion of the Aboriginal and Torres Strait Islander Recognised Entity role and the obligation to consult with them in relation to an unborn notification, subject to the agreement of the pregnant women.

In 2017, further amendments allowed prescribed entities (including the Department) to share information about a pregnant woman, with or without consent, for the purpose of reducing the likelihood that the unborn baby will be in need of protection at birth. At this time, the Recognised Entity was replaced in legislation by the Independent Entity or Independent Person with the role and purpose of the new Independent Person no longer involved in consulting on unborn notifications and the role focusing on providing help for the mother to participate instead.

[147] Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3044:12-42; referring to CL-5, *Practice guide: Respond to an unborn child*, tendered 17 September 2025, 1, 4.
[148] *CP Act* s 22(1).
[149] Ibid s 22(1).

involved in consulting on unborn notifications and the role focusing on providing help for the mother to participate instead.

The CP Act expressly states that the purpose of this provision is to reduce the likelihood that the child will need protection after birth, rather than to interfere with the pregnant woman's rights or liberties.[150] These provisions were introduced to enable earlier engagement and support, not to authorise coercive intervention during pregnancy or to facilitate pre-determined removal at birth.[151]

Where the unborn child is an Aboriginal or Torres Strait Islander child, the Act imposes additional obligations. Subject to the pregnant woman's agreement, the Department must arrange for an independent Aboriginal or Torres Strait Islander entity to facilitate the participation of the woman and her family in matters concerning the unborn child.[152]

The Child Safety Practice Manual (CSPM) reinforces this legislative intent. The Practice Guide *Respond to an unborn child* emphasises that the Department should respond to an unborn notification as early as possible in pregnancy, particularly where they are received in the early stages, to maximise opportunities for engagement, assessment and support.[153] It also makes clear that there are very limited circumstances in which it is appropriate to delay contact with a pregnant woman, namely where there is a high probability that early contact would result in disengagement from medical care and increased risk to the newborn.[154]

Information sharing and consent during pregnancy

While consent should be sought whenever possible, safe and practical, the Act provides a statutory framework that permits information sharing without a pregnant woman's consent in limited circumstances: where this is reasonably believed to assist in protecting a child or reducing the likelihood that an unborn child will be in need of protections after birth (*Child Protection Act 1999* (Qld), Ch 5A, ss159MC-159MD)

Chapter 5A of the Act establishes an information sharing scheme that allows the Department, prescribed entities and service providers to share relevant information for child protection purposes, including:

[150] Ibid s 22(5).
[151] Explanatory Memorandum, Child Safety Legislation Amendment Bill 2004 (Qld) 8.
[152] *CP Act* 22(3)-(4).
[153] CL-5, Department of Families, Seniors, Disability Services and Child Safety, *Practice Guide: Respond to an unborn child*, tendered 17 September 2025, 1, 4.
[154] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual: Respond to a notification* (Practice Guide) 133.

- assessing risk and needs
- planning and coordinating services
- offering help and support to a pregnant woman under s 22 of the Act, where there are concerns about an unborn child.

These provisions expressly contemplate information sharing during pregnancy and prioritise the safety, wellbeing and best interests of the child over the privacy of the mother, while still recognising that consent should be obtained where practicable (*Child Protection Act 1999* (Qld), s159B; Child Safety Practice Manual, *Support a child by sharing information*).

Neither the Act nor the CSPM requires a pregnant woman's consent for the Department to commence an investigation in relation to an unborn notification. Section 22(2)(a) expressly confers power to investigate and assess the likelihood that a child will need protection before the child is born.[155]

Evidence before the Commission indicates that misunderstandings about consent and information-sharing powers can contribute to delayed engagement and missed opportunities for early help during pregnancy.[156] The evidence of one Service Centre Manager was that a pregnant woman's consent was required before commencing of an assessment of an unborn notification, or even before discussing the Department's concerns with her. This is incorrect and suggests that there may be confusion at a frontline level about this important issue. The Department ought to take action, if it hasn't already after hearing that evidence, to clarify this matter to frontline staff.

4. The inherent challenge of supporting pregnant women and new mothers in a statutory system

A system driven by crisis responses will struggle to address the safety of a child not yet born. Evidence before the Commission confirms that this structural problem remains unresolved.

Mr Thomas Allsop, former Chief Executive Officer of PeakCare confirmed in public hearings that early intervention is clearly required, and the system should, 'look to services that are available

[155] *CP Act* s 22(2)(a).
[156] Transcript, Evidence of Witness W (17 November 2025) 2116:22, 2122:12-17; Transcript, Evidence of Corinne Porta (21 November 2025) 2575:9-24.

to support mothers with unborn children early…[yet] often…[it is seen that there are]… very few services available to support them.[157] His evidence highlights a structural gap in the system's ability to provide timely, supportive responses during pregnancy, reinforcing the Commission's broader findings that a statutory framework oriented toward crisis and post-birth intervention is poorly equipped to mitigate risk before harm crystallises.

Supporting pregnant women where there are child protection concerns requires the system to operate in conditions of uncertainty, forward-looking judgement and heightened scrutiny. Decisions must be made about future risk to a child who is not yet a legal person, based on incomplete information and evolving circumstances.

The system must balance the autonomy and rights of pregnant women with an obligation to act early to reduce the likelihood of a safety risk to an unborn child a birth, while operating within the limits of predictive risk assessment and under intense public, media and political scrutiny. Evidence before the Commission illustrates how this tension can play out in practice. In one case, a mother's refusal to engage in unborn case management was relied upon as part of the Department's assessment of future risk.[158] Importantly, however, there was no indication that the mother was failing to meet the unborn child's health or antenatal needs,[159] and no evidence to suggest neglect or unmet health care;[160] rather, the concern arose from the Department's limited knowledge, reflecting the consent-based nature of pre-birth engagement. In this context, the refusal of an unborn support case was described in evidence as 'a factor', but not the sole or determinative basis for subsequent intervention and removal.[161] This example highlights the inherent difficulty of distinguishing between risk arising from demonstrated harm and risk inferred from the absence of information.

Research from Australia and comparable jurisdictions consistently shows that surveillance-heavy and coercive approaches during pregnancy increase the likelihood that pregnant women will avoid care and disengage from services, and that while relational, voluntary and culturally sensitive models of care are more effective at reducing risk[162] - though by no means infallible.

[157] Transcript, Evidence of Thomas Allsop (15 September 2025) 705:42-6.
[158] Transcript, Evidence of Witness W (19 November 2025) 2250:34-6.
[159] Ibid 2251:20-1.
[160] Ibid.
[161] Transcript, Evidence of Witness W (19 November 2025) 2251:14; 2251:36.
[162] Samantha Burrow and Renna Gayde, 'Removing babies is still harming First Nations families almost two decades after the apology' (Web Page, 13 February 2025) <Removing babies is still harming First Nations families, almost two decades after the apology to Stolen Generations>; Samantha Burrow et al, 'Parents' experiences of perinatal child protection processes: A systematic review and thematic synthesis informed by a socio-ecological approach' (2024) 166 *Children & Youth Services* Review 107960.

Where early-help infrastructure and trusted intermediaries are absent, the system is more likely to resolve this dilemma by defaulting to control-oriented responses, even where support-oriented approaches would better serve the legislative purpose. Understanding this dynamic explains why practice repeatedly diverges from policy.

4.1 Decision-making thresholds and practice

A central issue identified by the Commission is how decision-making thresholds are applied during pregnancy and how these thresholds shape outcomes at birth. The CSPM provides the following guidance on immediate safety concerns for newborns:

> In exceptional circumstances, when a child is at immediate risk of harm at the time of birth and an alternative safety intervention cannot be implemented to ensure the immediate safety of the child, consult with the senior team leader and the OCFOS lawyer to decide the immediate action required to secure custody of the child. To secure custody of the child, take one of following actions:
>
> - negotiate with the parents for the child to be placed under a care agreement.
> - use powers under the Child Protection Act 1999 section 18.
> - apply for a TAO or CAO, where further assessment is required.
> - apply for a TCO, if no further assessment is required.[163]

The Commission heard evidence of a pattern in the Department's practice whereby unborn notifications are initially recorded and progressed as routine, but key assessments about future risk are formed early and are not meaningfully revisited during pregnancy.[164] As a result, determinations about risk are often effectively settled prior to birth, commonly relying on concerns relating to other children removed from the mother. For example, in Melanie's case, the determination about risk was effectively settled prior to birth, primarily relying on concerns relating to Melanie's older children who had been removed.[165] Concerningly, in some cases, decisions to seek temporary custody or assessment orders at birth were effectively made months in advance.[166]

[163] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual: Respond to a notification* (Practice Guide) 156.
[164] See Child Safety Commission of Inquiry, *Public Hearings*, Brisbane, 25 November 2025; See also Transcript, Evidence of Witness W (17 November 2025) 2105.45-6; Transcript, Evidence of Corinne Porta (21 November 2025) 2576; Transcript of Private Hearing (16 September 2025) 858, 952.
[165] See Melanie's case study in Appendix B.
[166] See the Newborn Project in Appendix B.

In one Child Safety region, 66 newborn removals occurred between 2021 and 2025. Of the 63 mothers involved, 58 already had at least one child subject to a child protection order at the time of birth.[167] These figures underscore both the scale of repeat removals from the same mother and the opportunity that pregnancy presents to interrupt that cycle through early targeted support.

The Commission notes the tendency of the Department – where there have been previous child removals from the same parents – to rely on previous safety assessments, court applications and child protection concerns held for older children subject to prior removal.[168] The Commission expressed concern about this approach – particularly where they related to the physical discipline of older children where there was no prior evidence of the parents harming a newborn.[169] However, the Commission recognises that it will generally be rational to consider these concerns in respect to the unborn child and the child's inherent vulnerability at birth. Reliance on historical concerns is not, of itself, impermissible. However, those concerns must be assessed in the context of new circumstances – such as protective acts by the mother, the availability of supportive kin to increase safety to the child, and the extent of the mother's progress in addressing issues, including by way of engagement with support services. Historical concerns cannot substitute for a genuine assessment of present and evolving risk to the unborn child.

The Newborn Project provided concrete examples of how risk assessments made prior to birth were not meaningfully revisited, even where circumstances had changed. This illustrates how early decision-making thresholds can become fixed. It is essential that the Department keeps an open mind, is willing and takes time to integrate new information into preliminary assessments about unborn children as the facts and circumstances change.

The Commission also observed a tendency for the nature of the risk assessment process to shift at the point of birth. Where antenatal engagement has been limited or delayed, assessments undertaken immediately after birth are often characterised by compressed timeframes, incomplete or outdated information, heightened emotional distress for the mother and limited opportunity for collaborative safety planning.

In this context, the absence of documented antenatal progress or support is relied upon as evidence of risk, even where the lack of documentation is itself a consequence of delayed

[167] Ibid.
[168] ATSILS, *Submission to Child Safety Commission of Inquiry* (28 August 2025) 17; See also Transcript, Evidence of Witness W (17 November 2025) 2105.45-6; Transcript, Evidence of Corinne Porta (21 November 2025) 2576.
[169] See Melanie's case study in Appendix B.

engagement. This creates a self-reinforcing system in which late intervention justifies more intrusive action.

An example of workload-driven failure is illustrative. One mother consented to a Support Service Case almost six months prior to the birth of her baby, however the case remained unallocated to a Child Safety Officer.[170] Departmental staff have acknowledged that workloads workforce capacity issues as an impediment to early engagement[171] and data confirms it as a primary reason for delayed commencement of unborn investigations.[172]

4.2 What is current practice and how does it contribute to harm?

Evidence before the Commission demonstrates that the removal of newborn children frequently occur not because risks only emerge at birth, but because opportunities for early, preventive intervention during pregnancy are missed, delayed or not meaningfully pursued.

Where unborn notifications are not responded to promptly, or where engagement with pregnant women is limited, assessments of risk during pregnancy often remain provisional, incomplete or heavily reliant on historical concerns relating to other children. These early assessments can nevertheless harden into settled expectations about future risk, without meaningfully revisited as pregnancy progresses or circumstances change.

In the absence of timely antenatal support, the system commonly defers substantive decision-making until the child is born. At that point, assessments take place in a context characterised by compressed timeframes, heightened emotional distress, limited information about current parental capacity, and reduced scope for collaborative or proportionate response. In these circumstances, removal may emerge as the most readily available option, not because it is the only means of ensuring a child's safety, but because alternative supports and safety plans have not been developed in advance.

The Commission heard that this dynamic can create a self-reinforcing cycle. Where there is little documented evidence of antenatal engagement or support, the absence of such mater may itself be relied upon to justify urgent intervention at birth. This risks treating the consequences of system delay as evidence of parental risk, rather than as indicators of missed preventive opportunity.

[170] Refer to the Newborn Project in Appendix B.
[171] CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 3 [18]; Transcript, Evidence of Corinne Porta (20 November 2025) 2407:35-2408:29.
[172] Refer to the Newborn Project in Appendix B.

This pattern underscores a central finding of this Chapter, where prevention during pregnancy is delayed or displaced, risk is not reduced but concentrated at birth, the point at which option are narrowest and consequences most difficult to reverse.

Delays in responding to unborn notifications materially reduce the time available for meaningful engagement, provision of support and demonstrable changes in risk factors and protective capacity during pregnancy. Departmental data reviewed by the Commission demonstrates that unborn notifications are frequently screened as (what is now) a Child Protection Notification - Standard Response ('Standard Response') and that investigations are commonly commenced well outside prescribed timeframes [173]

The Commission holds serious concerns about a lack of genuine and proactive attempts by the Department to manage and address concerns during pregnancy.[174] The absence of meaningful engagement may remove any real opportunity for parents to respond to or address perceived risks before birth and can result in a higher risk of the child being removed immediately upon birth. One submission described a matter in which the Department was actively asked during an investigation and assessment meeting to identify any concerns so that they could be addressed proactively; yet, no issues were identified at that time, and the next contact occurred only after the child had been removed from hospital following birth.[175]

In some cases, the Department had chosen not to inform pregnant women of unborn notifications or concerns until after the child was born and instead, issued high-risk alerts to health services.[176] This approach deprives women of procedural fairness, undermines trust and denies them the opportunity to understand concerns and seek targeted support to address those concerns prior to birth - or to make arrangements for safety planning, such as identifying and arranging for safe family or kin members to provide intensive support at and after birth.[177] This issue is explored in detail through the case study of Baby Nathan.[178]

This practice of withholding information has a compounding effect similar to the delay identified by the Commission in other child protection contexts. The Queensland Indigenous Family Violence Legal Service (QIFVLS) told the Commission that delay is unsatisfactory not only

[173] Refer to Chapter 2 – Intake and Assessment regarding time to commence an investigation; and specific unborn IA commencement data in Appendix D.
[174] Refer to the Newborn Project in Appendix B.
[175] Aboriginal and Torres Strait Islander Legal Service, *Submission to Child Safety Commission of Inquiry* (28 August 2025) 17.
[176] Refer to the Newborn Project in Appendix B.
[177] Transcript, Evidence of Michelle O'Connor (23 September 2025) 1548; Transcript, Evidence of Emily Hapea (17 September 2025) 1008; Transcript, Evidence of Witness W (17 November 2025) 2116.
[178] Refer to Baby Nathan's case study in Appendix B.

because parents are required to wait "more than is absolutely necessary to have that issue determined" but because events occurring in the interim can materially alter the position of the child.[179] By postponing disclosure and engagement, the Department risks allowing removal and early attachment to reshape the factual landscape before concerns are properly tested, addressed, or resolved, giving rise to a *fait accompli*.[180]

4.2.1 Removals under TCOs without current Safety Assessments

The Newborn Project revealed 12 cases where a newborn was removed under a TCO without a Safety Assessment having been completed. Ms Victoria Van Houdt, Acting Chief Practitioner, assisted the Commission in understanding how this pattern arises.[181] Ms Van Houdt explained that within the current legislative framework, the Department is unable to finalise an assessment as to whether a baby is in need of protection until after birth. However, Ms Van Houdt was clear that pre-birth assessments and planning do occur; particularly where there are historical child protection concerns with respect to the family.[182] Considering this, in circumstances where pre-birth engagement and reassessment is limited, assessments undertaken post-birth are more likely to rely on historical risk over contemporaneous evidence of change.

Ms Van Houdt explained that the relevant CSOs assessed the newborns' safety and risks before making the application for the TCO by means other than undertaking a Safety Assessment. The Commission reviewed documentation provided by the Department that detailed assessment outcomes and Safety Assessments. These documents highlighted that these assessments were predominantly undertaken for the newborn's siblings, some of which were years old, and some cases had copies of the unborn assessment undertaken prior to birth.[183]

Melanie's case provides an illustrative example of the way in which Departmental processes for unborn children may be experienced by mothers.[184] Melanie felt that the Department placed too much weight on historical concerns, and did not acknowledge her efforts to address the identified risks during her pregnancy. By contrast, although the Department acknowledged Melanie's engagement with services the STL maintained that Melanie had not *demonstrated* sufficient insight into the concerns or behavioural change. Further, although Departmental records show that Melanie was informed about the likelihood of removal following birth Melanie understood that this was contingent on a risk assessment to be completed once her child was

[179] Transcript, Evidence of Thelma Schwartz (22 September 2025) 1455:11.
[180] Ibid 1455:26.
[181] Statement of Victoria Van Houdt (17 October 2025).
[182] Ibid (21 August 2025) [7]-[122].
[183] Statement of Victoria van Houdt (17 October 2025) [38]-[211].
[184] Refer to Melanie's case study in Appendix B.

born. Conversely, it was clear that the Department considered the child would be in need of protection based on historical concerns; it was not clear what Melanie could possibly have done to change this assessment.

4.2.2 Contact arrangements following removal

The removal of a child from parental care at birth or shortly thereafter carries profound consequences for both parent and child. For parents, such removal occurs at a period of acute physiological and psychological vulnerability, and may be a source of significant grief, trauma, and long-term psychological harm.[185] For children, the consequences are equally as serious. The formation of a secure attachment bond between the infant and primary care giver is essential to healthy cognitive, emotional and social development.[186] The hours and days immediately following birth is a sensitive period during which maternal-infant bonding is particularly susceptible to disruption, with physiological processes actively facilitating the formation of that bond.[187] Removal of a child from its mother at this juncture risks interrupting these critical processes and may impact a child's development well beyond the immediate period of separation.[188]

Ms Michelle O'Connor, Director of Midwifery, Cooktown Hospital, Torres and Cape Hospital Health Service outlined the importance of maternal-infant bonding immediately post-birth:

> It's pivotal. Bonding and attachment is pivotal to the future health of any child, any infant. The quality of that bonding attachment will affect their brain chemistry, particularly in the first three years and, depending on the scale of the quality of that bonding and attachment, the future health of that individual. And that cannot be understated.[189]

Similarly, QATSICPP observed:

> Separated mothers and babies are deprived of the opportunity for skin-to-skin contact, breastfeeding, bonding, and early mother-infant attachment, all critical for an infant's

[185] Bowlby, J, *Attachment and Loss, Vol 1: Attachment* (Basic Books, 1969).
[186] Ibid.
[187] Transcript, Evidence of Dr. Marnie Fraser (26 September 2025) 1995:5-22; Klaus, M H and Kennell, J H, *Maternal-Infant Bonding* (Mosby, 1976); Schore, A N, *The Science of the Art of Psychotherapy* (Norton, 2012); Schore, A N, 'Effects of a Secure Attachment Relationship on Right Brain Development, Affect Regulation, and Infant Mental Health' (2001) 22(1–2) *Infant Mental Health Journal* 7; Moore ER, Brimdyr K, Blair A, Jonas W, Lilliesköld S, Svensson K, Ahmed AH, Bastarache LR, Crenshaw JT, Giugliani ER J, Grady JE, Zakarija-Grkovic I, Haider R, Hill RR, Kagawa MN, Mbalinda SN, Stevens J, Takahashi Y, Cadwell K. Immediate or early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews, '*Immediate or early skin-to-skin for mothers and their healthy newborn infants*' (Web-based publication, Issue 10, 2025) accessed at <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003519.pub5/pdf/full>.
[188] Transcript, Evidence of Dr. Marnie Fraser (26 September 2025) 1994-6.
[189] Transcript, Evidence of Michelle O'Connor (23 September 2025) 1549: 25-31.

> physical, cognitive, sensory and relational development. Once lost, this unique period of time in the life of a child and family cannot be recovered.[190]

The Commission is unable to locate any guidance within the CSPM as to the frequency, type, and method of family contact that should be facilitate between parents and their newborn child following removal. As part of the Commission's review of Departmental case files,[191] the following contact arrangements were observed:

- One breastfed newborn was provided family contact with their mother three times per week for one hour on each occasion;
- Multiple newborn babies had no specified contact provisions outlined in their respective emergent order applications, despite the legislative requirement for contact arrangements to be specified in same;[192]
- One newborn baby had daily supervised contact with their mother in order to ensure that the mother was sober for contact due to her previous alcohol use;
- One newborn had daily contact established three days after their birth for the purpose of breastfeeding until the newborn was returned to their mother's care pursuant to a non-custodial assessment order, as the Court did not grant the Department ongoing custody;
- Despite the Department having custody of a newborn for five days, no contact arrangements had been made at the time the further emergent order application was filed. This was in circumstances where the newborn was to be breastfed.

4.2.3 Support service cases

The primary mechanism available to the Department to support a pregnant woman when it has been assessed that her baby is likely to be at risk of harm upon birth is called a "support service case".[193] A support service case provides early intervention the goal of increasing capacity to protect a child in need of protection following birth.[194] It requires the Department to have assessed that the unborn child will be in need of protection when born, and requires the pregnant woman's consent. For pregnant Aboriginal or Torres Strait Islander woman, arrangements must

[190] Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions on Far North Queensland* (August 2025) 36.
[191] See Department of Families, Seniors, Disability Services and Child Safety, Data provided in response to Notice to Produce No. 116 (1 October 2022).
[192] Note: *CP Act* s 25(2)(c) requires that the Temporary Assessment Order application includes the proposed arrangements for the child's care.
[193] See for example Transcript, Evidence of Witness W (17 November 2025) 2111:29-44.
[194] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual: Respond to an unborn child* (Practice Guide).

be made for an independent person to facilitate participation in the support service case and discuss a referral to the Family Participation Program.

Where consent is obtained, a support plan is developed with the pregnant women and where appropriate her partner and support network, identifying actions and interventions to reduce the risk to the baby following birth.

The plan may be reviewed in the four weeks prior to the estimated delivery date and a decision made on what intervention (if any) is required once the baby is born. If the support needs have been met and it is assessed the unborn child is not likely to be in need of protection at birth, the support service case can be closed. Where consent is refused or withdrawn to the support service case, the Department must:

- Allow the opportunity for re-consent and inform them that a notification or a child protection order may be required at birth (unless such advice to the mother will increase the risk to the baby).
- Complete a high risk alert form which is sent to the relevant hospital to notify child safety when the baby is born.

Where a pregnant woman has not received early help, decision-making is deferred to the immediate post-birth period: a context characterised by compressed timeframes, emotional distress and limited scope for proportional responses. Evidence before the Commission demonstrates that crisis-driven assessments at birth are more likely to result in removal, not because it is the only option, but because it is the most readily available course of action under pressure that will ensure the child's safety.

The Newborn Project showed 20 Support Service Cases were opened, and 17 support plans were provided to the mother prior to birth – fewer than a third of the cohort of mothers. Of those17 cases, 12 children were removed within seven days of birth, and one was removed three months after birth following a further notification. Four children remained at home on non-custodial orders.

The Department reported that nine Support Service Cases in the Far North Queensland Child Safety region were closed prior to birth between January 2021 and April 2025, and of those 9 cases, 6 children remained in their parent's care.[195] While the number of closed Support Service

[195] Department of Families, Seniors, Disability Services and Child Safety, Explanatory Notes provided in response to Notice to Produce No. 132 (3 November 2025) 5(k-l).

Cases is low, the families who successfully worked through a support plan have a relatively good chance of avoiding tertiary child protection intervention

5. Prevention and support during pregnancy

Re-orienting the system towards effective help during pregnancy requires a deliberate shift in practice and institutional mindset. Evidence before the Commission identifies the following core principles to enable effective antenatal early help:

- transparency and timely engagement
- voluntariness and respect for maternal autonomy
- community-led support
- health-led collaboration and trusted intermediaries
- proportional responses informed by current circumstances.

These principles must, as always, be applied in the context of the overarching paramount principle in s 5A of the CP Act.

Evidence before the Commission establishes that preventive support during pregnancy is under-utilised, and often delayed, and constrained by significant levels of non-engagement. Data reviewed as part of the Newborn Project shows that unborn notifications are frequently responded to outside prescribed timeframes, and the Support Service cases and antenatal support plans are often commenced late in pregnancy or not offered at all. In many cases, this leaves insufficient time for meaningful change or for women to demonstrate protective capacity prior to birth.

Where support is offered, it is not always aligned to the practical realities facing pregnant women.[196] In this context, when early help is experienced by pregnant women as monitoring or investigation rather than genuine support, it can discourage engagement with services, limit disclosure and reduce the system's ability to identify and recognise protective change.

Effective prevention during pregnancy therefore requires more than early contact. It requires transparent, relational and voluntary engagement, grounded in trust and practical support and

[196] Transcript, Evidence of Thomas Allsop (15 September 2025) 712:38-715:38; Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3109:9-3110:38.

delivered in partnership with health services and community-based organisations that pregnant women already trust.

5.1 The role of Aboriginal and Torres Strait Islander Community-Controlled Organisations and specialist services

The dilemmas and harms described above are not evenly distributed. Aboriginal and Torres Strait Islander women and babies are disproportionately affected by unborn notifications and birth-suite removals [197] - although this is not evidence that the notifications or removals are unjustified. Despite this, referrals for support to prevent concerns from escalating appear limited. The Commission acknowledges the practical difficulty the Department may face in engaging directly with a pregnant woman and obtaining consent to refer to an ATSICCO.

Data from the Newborn Project shows that the process of referrals of pregnant Aboriginal and Torres Strait Islander women to Family Wellbeing Services, Family Participation programs and other community-controlled supports during pregnancy is inconsistent. In many cases, referrals occur late in pregnancy or only after birth, limiting their preventive impact. There was also evidence – including in the case study of Baby Nathan[198] – that these services were at capacity at the critical time, preventing timely intervention.

ATSICCOs are well placed to play an important role in supporting pregnant women and mitigating risk to unborn children. QATSICPP submitted the likelihood of a pregnant woman accepting offers of help may be improved where a trusted support service or community-controlled organisation is able to make that offer directly, rather than through statutory processes.[199]

Where prevention and early engagement are the primary aims, there are circumstances where initiation of contact by ATSICCOs may be more effective, noting that some Aboriginal and Torres Strait Islander families may be remain reluctant to engage for a variety of reasons, including shame at needing help and a desire to keep this hidden and not wishing those working within ATSICCOs to 'know their business'.[200] Nonetheless, the Commission considers there is merit in the principle of initial contact with pregnant Aboriginal and Torres Strait Islander women to discuss concerns for an unborn child coming from an ATSICCO.

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[197] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (6 August 2025); Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025).
[198] Refer to Baby Nathan's case study in Appendix B.
[199] Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions on Far North Queensland* (August 2025) 36. Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025).
[200] Transcript, Evidence of Rachael Ham and Francis Jose (Wuchopperen) (18 September 2025) 1129:22-38.

The Commission also heard from health services and ATSICCOs that early, warm referrals and co-response models significantly improve engagement and outcomes. Specialist services, such as perinatal mental health, family violence, housing and substance use services are also critical to effective early help during pregnancy. However, the Commission also heard that access to these services is often fragmented, and that coordination between child protection and health systems can be inconsistent.

Examples of community-led early engagement models

The Commission heard evidence of local, community-led models that demonstrate how early, relational engagement with families, including during pregnancy, can improve participation and reduce the need for more intrusive statutory intervention.

One example is the Early Indigenous Response Collective (EIRC) operating in the Moreton Region. EIRC brings together Aboriginal and Torres Strait Islanders community-controlled organisations, the Department and relevant service providers to collectively triage and respond to concerns at intake. The model emphasises culturally informed discussion, co-response and warm introductions to support services, with the aim of increasing engagement and addressing concerns early, including prior to birth.

A related example is the Helping Aboriginal and Torres Strait Islander Families Together (HALT) panel, also operating in the Moreton Region. HALT involves Aboriginal and Torres Strait Islander practitioners and community-controlled organisations in collective decision-making at intake, enabling shared understanding of family context, strengths and risks. Evidence before the Commission indicates that families presented to HALT experience improved engagement with community-controlled organisations and are less likely to progress to ongoing statutory intervention.

While these models operate in a specific region and are not designed solely for unborn notifications, they provide practical examples of how early, culturally led engagement and collective decision-making can shift system responses away from crisis-driven intervention and toward prevention and support.

6. Implications for Reform

The analysis in this Chapter demonstrates that challenges in supporting pregnant women are not primarily the result of individual decision-making or poor intent. Rather, they arise from structural tensions within the child safety system, tensions that have been recognised for more than a decade but remain unresolved in the context of unborn notifications.

The evidence before the Commission shows that pregnancy is widely acknowledged as a time in which early help can be most effective, yet current system settings often promote uncertainty, fear and scrutiny through delay, secrecy and crisis-driven intervention. These approaches increase the likelihood of intrusive action at birth, undermine procedural fairness and compromise the preventive purpose of the legislation.

Reform in this area therefore requires more than incremental practice change, it requires a deliberate re-orientation of the system toward early help during pregnancy.

The findings of this chapter point to the need for reform that realigns practice with the preventive intent of the legislation and the evidence on effective early help during pregnancy.

Key reform directions emerging from the evidence include:

1. Reprioritising unborn notifications as early-help pathways: Unborn notifications should be treated as time-critical opportunities for prevention, rather than as administrative precursors to post-birth intervention. This requires timely response, early engagement and a clear expectation that support, not pre-determined decision-making, is the primary objective during pregnancy.
2. Clarifying decision-making expectations during pregnancy: Clear guidance is required to reinforce that risk assessments during pregnancy must be responsive to change, and that decisions about removal should not be pre-determined prior to birth. Decision-making frameworks should explicitly require consideration of antenatal engagement, maternal actions taken to protect the unborn child and the availability of less intrusive safety planning options.
3. Subject to capacity building, embedding ATSICCO-led and co-response models: Where an unborn child is Aboriginal or Torres Strait Islander, co-response models, warm referrals and culturally led engagement should be the norm, not the exception.
4. Strengthening collaboration with health services: Health services are universal providers during pregnancy and are well placed to support early identification, engagement and

prevention. Stronger, clearer pathways between the Department, health providers and ATSICCOs are essential to effective early help.

These options do not require the creation of new powers. Rather they require a shift in emphasis, expectations and practice, so that pregnancy is treated as the critical prevention window the legislation intends it to be.

7. Recommendations

Recommendation 4: Reorienting unborn notifications	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 3)**
RECOMMENDATION: That the Queensland Government, within two months of the Government's response to this report and as a part of the Government's redesign of intake processes and pathways, reorient unborn notifications as a time critical early help pathway by establishing a specialised intake response for concerns raised during pregnancy in line with the preventative intent of section 22 of the *Child Protection Act 1999*.	
CONTEXT: Pregnancy is widely acknowledged as a time in which early help can be most effective, yet current system settings often promote uncertainty, fear and scrutiny through delay, secrecy and crisis-driven intervention. These approaches increase the likelihood of intrusive action at birth, undermine procedural fairness and compromise the preventive purpose of the legislation. Reform in this area therefore requires more than incremental practice change, it requires a deliberate re-orientation of the system toward early help during pregnancy.	
IMPLEMENTATION NOTES: This response should be designed to: (a) prioritise timely contact and assessment during pregnancy (b) facilitate early, practical support planning (c) embed culturally appropriate and community-led engagement, particularly for Aboriginal and Torres Strait Islander families (d) ensure that decisions about removal are approached as a last possible option, informed by current circumstances and the availability of less intrusive supports.	

Recommendation 5: The role of ATSICCOs in supporting pregnant women	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 3)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, embed and resource community-led engagement models, including ATSICCO co-response approaches as the default pathway for responding to unborn notifications for Aboriginal and Torres Strait Islander families.

CONTEXT:

ATSICCOs are well placed to play an important role in supporting pregnant women and mitigating risk to unborn children. The Queensland Aboriginal and Torres Strait Islander Child Protection Peak submitted the likelihood of a pregnant woman accepting offers of help may be improved where a trusted support service or community-controlled organisation is able to make that offer directly, rather than through statutory processes.

Where prevention and early engagement are the primary aims, initiation of contact by ATSICCOs may be more effective, noting that some Aboriginal and Torres Strait Islander families may be remain reluctant to engage for a variety of reasons, including shame at needing help and a desire to keep this hidden. Nonetheless, the Commission considers there is merit in the principle of initial contact with pregnant Aboriginal and Torres Strait Islander women to discuss concerns for an unborn child coming from an ATSICCO.

IMPLEMENTATION NOTES:

This approach is intended to include:

(a) earlier involvement of Aboriginal and Torres Strait Islander community-controlled organisations during pregnancy;

(b) use of collective, culturally informed decision-making models (such as HALT or EIRC-style approaches); and

(c) stronger collaboration with health services as universal antenatal providers.

Chapter 4

Placements and Casework

Companion Report 1

Functions of System

Chapter 4: Placements and Casework

1. Introduction

Once a court order is made and the State assumes responsibility for a child's care, the child safety system enters its most consequential phase. From this point on, a child's day-to-day safety, stability, development and sense of belonging are shaped not by statutory thresholds or judicial oversight, but by a series of placement and casework decisions, delegated by the chief executive to Department practitioners and made over time. These decisions determine where a child lives, who cares for them, how often they move, whether they remain connected to family, culture and community, how crises are responded to, and how the State exercises its role as corporate parent in practice.

Placement and casework decisions are not discrete or episodic events. They form a continuous decision pathway that extends across a child's time in care and often across multiple teams, workers and settings. Decisions made in moments of urgency, including during placement breakdowns, after-hours crises, hospital discharges or police involvement, frequently set trajectories that are difficult to reverse. When decision-making is poorly supported, weakly governed or driven by system pressure rather than children's needs, the result is often instability, escalation and harm generated by the system itself.

This chapter examines, in relatively brief terms, how Queensland's child safety system makes and manages placement and casework decisions once children are subject to court orders. Many specific issues relating to placements are addressed in detail in other chapters, or companion reports. For example, types and care models are examined in detail in Companion Report 3: Models of Care. This chapter is simply concerned with situating placement decision-making within the suite of functions in the child safety system.

The issues addressed in this chapter emerged across evidence, including testimony in public and private hearings, written submissions, case studies, review of Departmental material and the accounts of children, carers and practitioners describing their direct experience of the child safety system.

Importantly, this chapter does not treat placement and casework decision-making as an operational or workforce issue alone. It examines it as an expression of State power over children's lives, exercised through law, policy and practice. The Commission does not consider

the delegation of statutory authority to be an appropriate or effective response to the challenges identified in this Companion Report. Instead, the analysis emphasises the need for clearer decision architecture, stronger safeguards, and more deliberate support for decision-making once the State has intervened in a child's life through the exercise of statutory power.

The sections that follow briefly examine how statutory authority is exercised in practice through placement and casework decisions once court orders are in place.

This chapter is premised upon the present litigation model. The expanded role of the Childrens Court recommended in Companion Report 2: Child Protection Litigation, if implemented will substantially alter the placement power of the Department and introduce Court scrutiny and decision making in relation to placement decisions at the entry of a child into the child into the child safety system, at intervals thereafter and at the point of reunification or long-term placement.

2. From court orders to everyday decisions: authority and responsibility

Once a child is removed from parental care under statutory authority, responsibility for decisions affecting the child's life shifts from the court to the child safety system. While courts ultimately determine whether the statutory threshold for intervention has been met and make orders authorising removal, it is through placement and casework decisions that the State's authority is exercised on an ongoing basis.

These decisions are often described as operational or administrative. In practice, they are the decisions that most directly shape a child's experience of State care.

They include decisions about:

- where a child lives and with whom;
- whether siblings are placed together or apart and under what model of care;
- how contact with parents, family and kin is managed;
- permanency planning and whether reunification is pursued, delayed or ruled out; and
- how cultural, educational and therapeutic needs are prioritised and addressed.

Taken together, they determine whether a child experiences safety, stability, continuity of relationships and a sense of belonging, or instability, uncertainty and repeated disruption.

In the statutory framework, statutory authority remains with the State. However, responsibility for making placement and casework decisions are exercised through allocated decision-making roles within the child safety system. Authorised officers and managers make decisions on the State's behalf within defined legislative and policy parameters, and across multiple points in time. As a result, many of the most consequential decisions affecting children's lives occur outside the courtroom, through everyday judgements made once court orders are in place.

The distribution of decision-making responsibility is a practice feature of a large statutory system. However, the way in which responsibility is allocated, supported and constrained is critical. Some placement and casework decisions involve the exercise of coercive power over children and families. Others shape long-term outcomes that are difficult, or impossible, to reverse. The cumulative effect of these decisions can be profound.

3. How placement and casework decisions operate in practice

In principle, placement decisions are intended to be guided by an assessment of a child's safety, developmental needs, relationships, cultural needs and long-term wellbeing. Legislation and policy envisage that children will be placed in settings capable of meeting their needs, that placements will support stability and continuity of care, and that decisions will be made with regard to family connection, cultural identity and pathway planning. [201]

In practice, placement and casework decisions are frequently made under conditions that differ markedly from this ideal.

The Commission is aware that placement decisions are commonly made at points of crisis, following removal under court order, after placement breakdown, during behavioural escalation or at times in response to concerns raised by carers, schools, hospitals or police. In these moments, decision-makers are frequently required to act quickly, with limited placement options and incomplete information.

Under such conditions, availability can displace suitability as the primary determinant of placement. Decisions are shaped by what is immediately accessible rather than by what best meets a child's assessed needs. While these decisions are often made in good faith and with the

[201] *CP Act* ss 5B(h), 5B(i), 5E, 74, 83A(1)(a), 83A(4), 83A(5); Department of Child Safety, Seniors and Disability Services, *Child Safety Practice Manual – Assess the information and decide the response* (Policy, 9 July 2025).

intention of keeping a child safe in the moment, the cumulative effect can be repeated moves, poor matching and instability that undermine a child's sense of security and belonging.

Placement decisions do not occur in isolation. They are shaped by the quality and continuity of casework that surrounds them. In this Chapter, casework refers to the relational and evaluative work undertaken by the Department with children, families and carers once statutory intervention has occurred, including how children are listened to, how their experiences are understood, how carers are supported and how professional judgement is exercised as circumstances change.

This is distinct from case management, which typically refers to administrative and procedural factors such as recording, reporting, compliance with timeframes and coordination of services. It is also distinct from formal decision-making, which involves specific determinations made under statutory authority, such as placement changes, contact arrangements or permanency decisions. While these functions are interconnected, they are not always aligned in practice.

For children, these distinctions are not visible. Children experience the system through the consistency of relationships, the responsiveness of adults and whether decisions make sense in the context of their lives. Where casework is constrained by workload pressure, frequent staff changes or administrative burden, placement decisions are more likely to be reactive, poorly explained and difficult to sustain.

> *'They don't read files when taking on new cases. So you are going around in circles. They don't listen to the carers who know us and love us. They take a we know best approach. Can't even get our names right in paperwork.'*
>
> Youth survey response from child in care[202]

A recurring theme in the evidence is the mismatch between children's assessed needs and the placements available to meet them. Decision-makers described operating in an environment where suitable placements are limited, particularly for sibling groups, adolescents, children with disability and Aboriginal and Torres Strait Islander children requiring culturally appropriate placements.

[202] Youth survey response No 66 from child in care (5 October 2025).

In this context, placement matching often becomes an exercise in risk containment rather than care planning. Decisions are driven by vacancy rather than fit, and the question confronting the system becomes 'not what does this child need?', but 'where can this child go right now?'. Poorly matched placements are more likely to break down, escalating children into more restrictive or unstable arrangements and compounding the very risks the placement was intended to address.

Casework and placement decisions are made and revisited across a child's time in care, often by different workers, teams and managers. Responsibility for decision-making may shift as cases are transferred, workloads change or staffing pressures arise. Information about a child's history, needs and relationships does not always follow the child consistently across these transitions.

The Commission considers that this fragmentation weakens continuity of decision-making and dilutes accountability. Decisions that appear reasonable at a single point in time may, when viewed cumulatively, contribute to drift, escalation or harm. Without clear ownership of a child's placement pathway and a shared understanding of long-term goals, the system can default to managing immediate risk and crisis, rather than progressing stability or reunification.

The Commission heard that many casework and placement decisions involve separation of siblings, significant changes to contact arrangements or placements that are unlikely to be sustainable. The absence of structured decision support and clear escalation pathways increased the risk that short-term solutions become long-term arrangements by default.

For children, casework and placement decisions are not experienced as a series of discrete administrative actions. They are experienced as repeated disruptions to relationships, routines and identity. Each move carries emotional and developmental consequences, particularly for children who have already experienced trauma, loss and instability.

> *"it wasn't good [residential care]. no one loved me"*
>
> Youth survey response from child in care[203]

Children repeatedly report that they experience placement decision-making as something that happens to them rather than with them. Where decisions are made rapidly, with limited explanation or involvement, children can disengage from the system, lose trust in adults and

[203] Youth survey response No 47 from child in care (2 October 2025).

withdraw from carers. In some cases, this disengagement manifests as self-placement, increased risk-taking behaviour or interaction with police and youth justice systems.

> *"I didn't feel safe or I wasn't really being heard so I felt the only way I could make myself heard or seen was to run away."*[204]

The issues identified reflect recurring patterns in how the system operates when placement demand exceeds capacity, when early intervention has failed to prevent escalation and when downstream decisions are required to absorb pressure generated elsewhere in the system.

Viewed in this way, placement instability, crisis-driven decision-making and the use of unsuitable or temporary placements are not aberrations. Addressing these issues requires clearer decision architecture, stronger safeguards for consequential decisions, and a system design that support stability rather than perpetrating crisis.

4. Placement instability, escalation and cumulative harm

The consequences of placement and casework decisions are rarely confined to a single moment in time. Decisions about where a child lives, how placements are supported and how instability is responded to accumulate across a child's experience of care. Over time, this accumulation can produce trajectories characterised by repeated disruption, escalation and harm generated by the system itself.

> *'Success is finding a placement where you can feel like a family, where you don't have to worry about being removed, and where you can say whatever you want, without having the fear of being shut down.'*[205]

Placement instability is not experienced by children as a neutral or temporary inconvenience. Each placement change involves loss – of carers, routines, schooling, friendships, cultural connection and a sense of safety.[206]

The Commission heard that many children experience multiple placement changes during their time in care, often within short periods. These changes may be triggered by placement

[204] Youth survey response No 128 from child in care (16 February 2026).
[205] Youth survey response No 108 from child in care (23 October 2025).
[206] Transcript, Evidence of Witness E (19 February 2026) 4420:5-42.

breakdown, behavioural escalation, carer fatigue or concerns about safety within a placement. While each decision may be reasonable justified when viewed in isolation, the cumulative effect is instability that becomes increasingly difficult to address and reverse.

As placement breaks down, options narrow. Children may be moved further from family, community and school. Siblings may be separated. Placements become shorter, more temporary and less able to meet a child's needs. The result is that placement decision-making can become reactive and availability-driven, reinforcing the conditions that increase instability.

As instability increases, placement and casework decisions are more frequently made in crisis contexts. Children who feel unsafe, unheard or disconnected may respond with distress-based behaviours, including absconding, aggression, withdrawal or risk-taking. The Commission heard that in some circumstances, these behaviours are often managed through escalation responses which increasingly involve emergency interventions including short-term placements in hotel or motel accommodation.

> *"[service provider] got me into school then 3 weeks later the resi moved me to [city] so I haven't been back to school since"*[207]

Education disruption is one of the most immediate and enduring consequences of placement instability. Changes of placement often involve changes of school, long travel distances, disrupted routines and gaps in attendance. In crisis placements, it is understood some children miss schooling altogether.[208] Over time, this instability can contribute to disengagement from education, exclusions and loss of access to consistent supports. The Commission notes that the evidence concerning crossover and dual-order cohorts identifies exclusion from education as recurring system mechanic that interacts with placement instability and contributes to escalation into police and youth justice responses.

For some children, repeated placement changes and crisis-driven responses lead to disengagement from the care system altogether. The Commission heard evidence of children who self-place, refuse placements or disengage from casework because they no longer perceive the system as safe, predictable or responsive to their needs.

[207] Youth survey response No 83 from child in care (10 October 2025).
[208] Transcript, Evidence of Aimee (16 February 2026) 4121-4123.

'sometimes [self placing is] *the only way to be around someone who cares about me and feel normal for a little bit. or its when ive been physically abused by carers. Miya carers had the most physical abuse from and i tried to tell my cso and she didnt listen or didnt care and just left me there'*[209]

Case Study: Witness S

At the Toowoomba public hearings, the Commission heard evidence from Witness S, now a young mother in her twenties. Witness S had previously made a written submission to the Commission. Witness S gave evidence about her contact with, and experience within the child safety system, the genesis and escalation of her offending from aged 12 and her perspective that she was left homeless and unsupported by the Department and criminalised for survival crimes, whilst also being sexually exploited and abused during her time in care.

Witness S was removed from her family – and accepted that she ought to have been removed – at a young age on the grounds of emotional abuse. Witness S disclosed incidences of sexual abuse by her father – but the allegations were unsubstantiated. Initially placed in foster care, she was sent to her grandmother, who abused her to the point of leaving scars, and allowed both parents unsupervised access to Witness S, continuing the cycle of abuse.

By age 12, Witness S had left her grandmother's house. She began smoking marijuana as a means of escape. She was suspended from school for possessing marijuana (which her father gave her). This was a catalyst for discussions between Witness S, her school and the Department. Witness S disclosed fears for her safety if sent home to her father, and physical abuse at the hands of her grandmother. However, the child safety officers (erroneously) advised the school that Witness S had no child protection history, and to call the police if Witness S refused to return to her father's house. To escape the cycle of abuse, Witness S started couch-surfing with extended family and friends, before ultimately becoming homeless.

[209] Youth survey response No 116 from child in care (29 October 2025).

> Following a period of youth justice offending and homelessness, Witness S was placed by the Department in a series of residential care placements, initially with other young persons, but later in two-on-one or one-on-one placements.
>
> Witness S spoke of her struggles to attend school whilst in residential care due to changing placements, the distances between placements and school, and the lack of resources within placements. At one point, she had to take four to six buses to get to school. At times, there were three to four young persons living in a residential care placement, and only one vehicle to support them all to attend school (often at different schools) as well as family contact and other appointments, and no support workers rostered on during the day. At times, the Department would not support Witness S's enrolment, so she enrolled herself in the local high school. Ultimately, Witness S did not complete her schooling beyond year 9 whilst she was in care. However, she did return to school as an adult and completed year 12.

Disengagement is sometimes framed as a child's choice or problematic behaviour. However, the evidence before the Commission indicates that disengagement frequently follows periods of prolonged instability and a loss of trust in decision-making processes. Children described feeling that decisions were made without them, that their voices carried little weight, and that moves occurred with limited explanation or regard for their wishes.

> *Nothing ever gets done, often the complaints are sent back to the exact people we are complaining about for them to happily dismiss and say are lies. Our voices ARE NOT HEARD, those complaints all always get ignored and we all know it. I have made, at least a hundred complaints, to everybody possible, since I was 15 (now 23) with absolutely nothing ever ever coming from it. CPS always wins, we are voiceless and helpless.*[210]

Once disengaged, children are at increased risk of harm and exploitation, and they system's capacity to discharge its responsibility as corporate parent is significantly weakened. The Commission's analysis is that the absence of a stable placement does not remove the State's responsibility for the children, but it does make the responsibility harder to enact lawfully and safely.

[210] Youth survey response No 125 from former child in care (5 December 2025).

The Commission considers that placement instability, escalation and disengagement are best understood as system outcomes, not as failures of individual children, carers or workers. They reflect patterned responses in a system operating under sustained pressure, where early instability is not addressed, where placements are mismatched or unsupported, and where decision-making becomes dominated by crisis management. Young people in OOHC generally leave the State's care when they turn 18, and reach legal adulthood.[211] The evidence before the Commission shows that this legal threshold rarely aligns with readiness for independence. Unlike many of their peers, most care leavers do not have reliable access to enduring family support, safe housing, or consistent adult guidance and advocacy.[212] For many, turning 18 can mean an abrupt withdrawal of support, rather than a supported step into adulthood.

[211] *CP Act* s 62(8).
[212] Office of the Aboriginal and Torres Strait Islander Children's Commissioner, *Submission to Child Safety Commission of Inquiry* (30 March 2026) 6.

5. Recommendations

Recommendation 6: Casework decisions in best interests of the child	
Executive Report (Chapter 5)	**Companion Report (Chapter 4)**
RECOMMENDATION: That the Queensland Government, commencing immediately as part of its cycle of case planning reviews and in all future decision-making, ensure that all decisions relating to the placement and casework for children in care are made with the best interests of the child in mind, in accordance with the paramount principle in section 5A of the *Child Protection Act 1999* (and as amended in response to this report).	
CONTEXT: The *Child Protection Act 1999* already requires all decisions to be made in the best interests of the child. However, the evidence before the Commission suggests that other considerations may impact on this singular focus. In particular, the caseloads and roles of the Child Safety Officers in undertaking multiple functions, including supporting parents to work towards reunification, may be impacting on both their assessment of the best interests of the child, and also their capacity to focus on the true best interests of the children in their care.	
IMPLEMENTATION NOTES: The Department's existing cycle of case planning reviews enables this recommendation to be commenced immediately, given the existing statutory obligation to apply the paramount principle in all matters. The recommendation obviously relies on the Department undertaking the casework and planning required under the *Child Protection Act 1999*. It will not be sufficient to merely report that this has been implemented. Identifiable changes will need to be shown to Department practices, policies, processes, and training to overcome current workload and organisational culture barriers and deliver on the intent of this recommendation.	

Recommendation 7: Providing meaningful transition to adulthood	
Executive Report (Chapter 5)	**Companion Report 1 (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, amend all necessary policies, processes and practices and identifies a single, responsible officer within the Department (most appropriately the 'Child Guardian' as described in Recommendation 45C) to ensure the Department meets the following obligations:

(d) that all children in care commence a 'transition from care' plan within 14 days of their fifteenth birthday;
(e) that this plan is regularly revised, every six months at a minimum, until their eighteenth birthday;
(f) that there is central coordination, monitoring and reporting on measures including the timeliness of transition plans being commenced and reviewed, a review of the quality of the plans, and the effectiveness of achieving the required needs of the care leaver.

The transition from care plan, at a minimum, should require:

(e) enforceable, equitable, transition arrangements;
(f) early and collaborative planning;
(g) whole-of-government responsibility for outcomes; and
(h) robust tracking of post-care pathways.

CONTEXT:

The Commission heard evidence that transition to adulthood planning is often delayed, inconsistent or absent. Where planning does occur, it is frequently inaccessible to young people, developed too late to be useful, or dependent on the young person being able to advocate for supports they may not know exist.

The Commission's view is clear that legal independence does not equate to readiness for adult life, and the Department's responsibilities as a corporate parent should not end, any more than a natural parent's responsibilities end, on the young person's eighteenth birthday.

This reform will support young people in experience continuity, stability and a safer and smoother transition into adulthood.

IMPLEMENTATION NOTES:

At a minimum, the Commission supports the inclusion of T2A aggregated aged-based milestone data by State and region in Departmental annual reporting.



Child Safety

Commission of Inquiry



Companion Report 2

Child Protection Litigation

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Chapter 1
Introduction

Companion Report 2
Child Protection Litigation

Chapter 1: Introduction

This companion report addresses the child protection litigation model, and the court processes, that govern the removal of children into the State's care.

It is hard to imagine a more consequential exercise of State power, whether executive or judicial, than the decision to remove a child from their family into the State's care. If the State does not get this decision right, the child and their family may suffer immeasurable and irreparable harm. So, when the State is compelled to intervene to protect a child from harm, it must discharge its protective duty scrupulously, with the utmost care, and at all times in the best interests of the child.

Whether the State's power is exercised in the best interests of the child depends, in practice, on a number of factors. One factor is the quality of the Department's[1] decision-making processes in respect of a removal decision and any later legal process. Quality decision-making processes ensure that removal decisions are based on proper and sufficient evidence and informed by thorough investigations and risk assessments.[2] Another factor is the material and the persons that are before the Magistrates or Childrens Court when those courts make orders that affect or maintain a child's removal. The likelihood of those orders being made in the best interests of the child increases when the Court is provided with proper and sufficient evidence, made aware of persons who may be suitable to provide the child care, and when key persons concerned with the care, welfare, or development of the child have an opportunity to be heard.

The Commission undertook a detailed examination of these matters. The Commission considered the applicable statutory framework, as well as the processes of the key institutions, being the Department, and the Magistrate and Childrens Courts. It also considered the other key actors in those processes, including the:

- Office of the Director of Child Protection Litigation or 'DCPL';
- Office of the Child and Family Official Solicitor or 'OCFOS'; and
- The key frontline Departmental officers, including Senior Team Leaders or 'STLs' and Child Safety Officers or 'CSOs'.

[1] 'The Department' is used to refer to the Department of Families, Seniors, Disability Services and Child Safety, as well as its predecessor departments with responsibility for the Child Safety portfolio.
[2] These questions, as well as the processes and procedures of the Department, are explored further in the Executive Report and Companion Report 1: System Functions.

The court process and the child protection litigation model were the focus of public hearings held over eight days in Brisbane, between December 2025 and February 2026. During these public hearings, the Commission heard evidence from:

- Ms Angela Schifilliti, Official Solicitor of OCFOS;
- Ms Clair Martin, a Principal Legal Officer of OCFOS;
- Mr Nigel Miller, the Director of DCPL; and
- Ms Victoria Van Houdt, the Acting Chief Practitioner of the Department.

The Commission's examination was also aided by submissions received from a broad range of stakeholders including parents, peak bodies, advocacy agencies, support services and lawyers.[3] Broadly, those submissions revealed that most stakeholders regard the Court process as *critical* to ensuring that the key State bodies discharge their respective roles properly and accountably, and that the child protection system operates fairly, and commands trust and public confidence.[4]

The themes that emerged from the Commission's inquiries are outlined below. In brief, despite the significant reforms following the Carmody Inquiry, many issues remain in need of resolution, and some well-intentioned reforms have had unintended consequences. This is further explained in the Commission's detailed review and analysis of the child protection litigation model and court process, outlined in Chapters 2 to 5 of this companion report. Chapters 4 and 6 of this companion report set out the Commission's proposal to unify and streamline the child protection litigation process.

1.1 Terms of Reference

The Commission's Terms of Reference require the Commission, among other things, to consider the Department's investigation, assessment and decision-making practices,[5] tertiary child protection interventions and associated decision-making frameworks,[6] frontline resourcing pressures and court processes,[7] and the adequacy of governance, coordination and accountability across State entities involved in the exercise of child protection powers.[8] This companion report's analysis responds to those terms.[9] In addition, the child protection litigation

[3] Child Safety Commission of Inquiry, 'Call for submissions – Director of Child Protection Litigation and the litigation model' (Media release, 13 November 2025).
[4] *Submission No 84 to Child Safety Commission of Inquiry* (14 November 2025); Family Inclusion Network, *Submission to Child Safety Commission of Inquiry* (21 January 2026).
[5] 'Commissions of Inquiry Order (No. 1) 2025' in Queensland, *Queensland Government Gazette - Extraordinary*, Vol. 399 No. 16, 23 May 2025, 3(b)(i).
[6] Ibid 3(b)(ii).
[7] Ibid 3(b)(vii).
[8] Ibid 3(b)(iv)–(vi).
[9] Ibid 3(b)(v), (viii)–(ix) and 3(c).

model and associated court processes are amongst the factors that have 'contributed to the growth and reliance' on the residential care sector, such that reforms to that model and those processes may also assist in arresting the growth in that sector.[10] Ultimately, the Commission proposes structural, procedural and legislative reforms to simplify litigation pathways, strengthen judicial oversight across the child protection continuum and ensure State intervention is proportionate and reviewable. The Commission regards the recommended reforms as feasible reforms to legislation, systems and institutions necessary to achieve safer outcomes for children and families.[11]

1.2 Themes

In the course of the Commission's inquiries, these themes have emerged:

1. Some uncertainty surrounds the paramount principle, and in particular its relationship with the Aboriginal and Torres Strait Islander Child Placement Principle or 'ATSICPP'.
2. The burden on CSOs to prepare court applications and affidavits diminishes their ability to perform their core duties of working with children, families and carers.
3. Child protection proceedings are too long, complex, and inefficient. The introduction of the bifurcated litigation model has worsened the problem.
4. There is fragmentation and also poor coordination between the relevant entities: the Department, OCFOS and the DCPL. The bifurcated model has made the litigation process unduly bureaucratic.
5. There are real procedural fairness concerns in the way child protection orders are currently made, arising from the use of significant untested allegations, the lack of a contradictor on many applications, and the prevalence of *ex parte* applications, including for Temporary Assessment Orders or 'TAOs' and Temporary Custody Orders or 'TCOs'.
6. Parents and other people who play a significant role in a child's life face barriers to meaningful participation in the court process. These include a lack of early independent legal advice and support, limited standing to participate in child protection proceedings and limited opportunities to otherwise participate in decision-making in relation to a child.
7. Opportunities for alternative dispute resolution or 'ADR' and case planning arise too late in the current court process.

[10] Ibid 3(a)(i).
[11] Ibid 3(e)–(f), 5(b) and (g)–(h).

Chapter 2

The Paramount Principle

Companion Report 2

Child Protection Litigation

Chapter 2: The Paramount Principle

2.1 The principle

The main principle for administering the *Child Protection Act 1999* ('the CP Act') is the 'paramount principle' — namely, that the 'best interests of a child, both through childhood and for the rest of the child's life, are paramount'.[12] The paramount principle guides any action by the Department, by the courts and by any non-State actor when engaged in the work of child safety. This chapter advances four contentions in respect of the paramount principle:

1. ***First,*** the paramount principle necessitates a 'balance of harm' evaluation, which requires consideration of the practical ability of the State to care for children who are removed into its care.
2. ***Secondly,*** the removal of children into State care has *dynamic* consequences that cannot be ignored in decisions to remove, reunify or place children.
3. ***Thirdly***, the paramount principle must be understood and applied in context, distinguishing between the State in its capacity as a corporate parent for a particular child under its care, on the one hand, and State actions aimed at broader preventative objectives.
4. ***Fourthly***, the ATSICPP falls into the category of broader preventative objectives and must not be treated as overriding the paramount principle, or avoiding the necessity to properly evaluate each individual child's case.

2.2 The balance of harm

There is no removal of a child from his or her family that does not cause harm and trauma to that child, at least to some degree. The unavoidable harm caused by removal is justified by satisfaction of the twofold test in s 10 of the CP Act — namely, that the child has suffered harm, is suffering harm, or is at unacceptable risk of harm *and* does not have a parent able and willing to protect them from harm.

The legal test in s 10 is one-sided, in that it does not expressly mandate any analysis of the counterfactual, that is the relative safety and wellbeing of the child *if* removed into State care. On one view, there is an unstated assumption that children removed into the care of the State will be

[12] *Child Protection Act 1999* (Qld) s 5A.

safe from harm and cared for in accordance with the paramount principle. If in any given case that unstated assumption is unsound, the test in s 10 may misfire.

In other legal contexts, such as where injunctive relief is sought, courts are commonly required to engage in a balancing analysis, weighing any harm in making an order against the harm of not doing so. This is referred to as the 'balance of convenience'.

The possibility that the making of an order may involve some, and even greater relative harm, should also be allowed for, and analysed, in any decision to remove a child into State care. If, for example, the evidence suggests that the State will be unable to find the child a placement that:

(a) will provide that child reasonable care; and
(b) reduces the child's overall risk of harm of some kind,

that ought to be taken into account in deciding whether a removal order should be made.

This is far from a theoretical possibility. There are increasing numbers of children being taken into State care. The availability of family-based care is decreasing in relative terms. There is increasing reliance on unsatisfactory residential care placements, including for large numbers of children who are best suited to families. The evidence before the Commission is that for a child who is suited to family-based care, being placed in residential care instead is associated with much worse outcomes,[13] including high rates of trauma, self-harm, suicide attempts, unmet mental health needs, placement instability, children going missing from care, and exposure to further abuse.[14] The strain upon placement options and the shortcomings of non-residential care placements is further discussed in the Commission's Executive Report and Companion Report 4: Understanding and Reforming the Residential Care System.

In those cases where the State is not able to demonstrate it is able, or likely to be able, to provide reasonable and *less* harmful care for the child, lesser intrusive interventions than removal, such as the ongoing monitoring of the child and supervision of the family, will warrant consideration.

The CP Act does not presently expressly provide for such a 'balance of harm' evaluation, although on one view, the paramount principle might at least accommodate such an evaluation. However, for the avoidance of doubt, the CP Act should *expressly* allow for a balance of harm evaluation.

[13] Transcript, Evidence of Daniel Short (10 March 2026) 5138–39; Transcript, Evidence of the Honourable Ms Leanne Linard MP (16 March 2026) 5463.
[14] See the companion report entitled 'Understanding and Reforming the Residential Care System' 28.

An indicative example is set out below:

> **5A Paramount Principle**
>
> ...
>
> (2) In evaluating the wellbeing and best interests of the child, regard must be had to any consequences for the child of:
>
> (a) removal of the child from the child's family; or
>
> (b) removal of the child from the child's current placement, including all:
>
> (i) circumstances relevant to the child's proposed new placement; and
>
> (ii) any other matters relevant to the effect of the proposed action upon the child's wellbeing and best interests.

A balance of harm analysis in these terms would inform not only removal decisions but also reunification and placement decisions where there are similar competing harm considerations as between the status quo (the child remaining in his or her current placement) and the counterfactual (being reunified with his or her family or being placed with a different carer, including a kin carer). The need to consider and balance relative harm again in that context is necessary because the best interests of the child are not static but evolve dynamically, as discussed further below.

2.3 The paramount principle is not static

The effects of any removal of a child into State care are not static. It is not possible to 'freeze the frame' from the child's perspective, or to 'stay' the status quo until suitable longer term arrangements are made for the child.

In other litigious contexts, interim orders generally operate to stay or preserve the status quo until the matter in dispute can be finally determined. That is not possible when a child is removed from his or her family, even for a short time. Immediately upon removal the child's life is changed materially and continues to change. The uprooting effect of removal and placement outside the family becomes more significant the longer the child remains in State care.

Other factors come into play as the child, in his or her new placement, develops attachments with carers and forms connections with peers at school and through social, sporting or other community connections. The child's life inevitably and unavoidably changes as the child settles into a new and different environment. These unavoidable changes in circumstances cannot be ignored or underestimated when at a later point in time the question becomes whether the child should be reunified with family or kin or whether a different placement decision should be made. These decisions must be evaluative, individual decisions made in the actual factual context in which the child in question is found, at that time the decision is made.

2.4 The distinction between the State as a corporate parent and its pursuit of broader preventative objectives

The capacity in which the State is acting must be kept clearly in mind when evaluating whether a decision or action is in accordance with the paramount principle. In one capacity, the State acts as the notional corporate parent for a particular child. In another capacity, the State pursues broader preventative objectives. By pursuing these objectives, the State seeks to reduce the need for its corporate parenting generally, or to seek to reduce the time children generally need to remain in its care. Different considerations apply depending on the capacity in which the State acts.

In one capacity, the State cares for an individual child; in another, the State pursues general objectives. These capacities are not inimical. They will often align. But they will not necessarily *always* align.

For that reason, in its capacity as the notional corporate parent, the State cannot assume that the child's best interests and the State's broader interests in preventative objectives align. In every case, and irrespective of the State's preventative objectives, there must be a real, genuine, and individual evaluation of the wellbeing and best interests of the child, 'as is where is'. Otherwise, there is a risk that the child becomes a non-consenting participant in a policy experiment which may not be in the child's best interests.

The Commission appreciates that the topic of evaluating the wellbeing and best interests of children raises boundless individual circumstances which defy generalisations or strict rules. Indeed, it is for that reason that the core thesis of this chapter is that there is no substitute for *individual* evaluation, however worthy a particular identified objective or principle, such as the ATSICPP, may be.

It is for that core reason the Commission recommends that the Court be given a greater role in oversight of critical decisions relating to placement *and* reunification as discussed in Chapter 6 of this companion report. Courts are institutionally suited to making evaluative decisions in respect of individual cases and are able to do so unburdened by overlapping or countervailing policy objectives.

2.4.1 The phrase 'through childhood and for the rest of the child's life' should be removed from the paramount principle

The paramount principle presently includes the above phrase. The principal difficulty with those words is that they call for speculation as to future matters.

Take, for example, the decision to remove a child. It is far from clear that decision can be assisted by asking what effect the removal decision will have on the child through childhood. That question does not readily admit of an answer. At the time the decision is made the likely duration of the child's removal will not be known or, in many cases, knowable. The duration will depend upon a range of factors, including the efficacy of efforts made to reunify the child as soon as possible, and availability of family or kin to care for the child. To ask what effect the removal decision will have throughout the child's *adult* life is even more speculative.

There are sufficient immediately ascertainable relevant matters which bear upon an evaluation whether a child should be removed. These include, primarily, the particular harm or risk or harm to which the child is presently exposed, and the availability and quality of placement options for the care of the child. Similarly, there are sufficiently ascertainable matters bearing on whether a child should be reunified with their family or placed with kin. Of course, depending on the child's age and ability to form an opinion, the child's views will also be a significant, ascertainable, factor in the mix of factors to be evaluated.

In reality, the phrase introduces a licence to make unspecified and unreasoned assumptions and untestable predictions concerning the long term best interests of the child. This is undesirable for various reasons. It introduces uncertainty as to the meaning and effect to be given to the paramount principle. It does not provide any practical guidance in relation to the proper application of the principle in any given case.

5A Paramount Principle

(1) The main principle for administering this Act is that the safety, wellbeing and best interests of a child~~, both through childhood and for the rest of the child's life,~~ are paramount.

2.5 The relationship between the paramount principle and the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP)

2.5.1 The paramount principle's uncertain relationship with ATSICPP

The gross overrepresentation of Aboriginal and Torres Strait Islander children in the child safety system is rightly regarded as a matter of grave concern that demands redress.[15] The ATSICPP is a scheme of related and interdependent principles aimed, among other objectives, at remedying and abating the displacement of Aboriginal and Torres Strait Islander children. The importance of cultural connection for Aboriginal and Torres Strait Islander children, and indeed children from other cultural backgrounds, cannot be underestimated. The separation of a child from family, kin and culture has potentially lifelong adverse effects on the child's sense of belonging and identity.

However, there is evidently a degree of uncertainty in practice as to how the paramount principle and the ATSICPP relate.

As submissions received by the Commission reveal, and as certain decisions by the Department illustrate, there is presently a school of thought that the paramount principle permits making assumptions which are congruent with one or more of the elements of the ATSICPP, without also separately evaluating whether the action or decision in question is in the best interests of the particular child. The two elements of the ATSICPP which are superficially susceptible to use in this way are the placement and connection principles in ss 5C(2)(c) and (e) respectively. Put another way, there is presently a school of thought that the paramount priority should be given to the ATSICPP in respect of Aboriginal and Torres Strait Islander children.

An example is the joint statement dated 3 March 2026 from the principal entities representing Aboriginal and Torres Strait Islander communities in the field of child safety ('the joint statement'): the Office of the Aboriginal and Torres Strait Islander Children's Commissioner,

[15] This topic is discussed in the Executive Report. Elements of the discussion which follow overlap with the discussion in that chapter and should be read together.

National Commission for Aboriginal and Torres Strait Islander Children and Young People, Child Protection Peak and SNAICC. The concluding paragraph of the joint statement states:

> The ATSICPP maintains the primacy of a child's safety and best interests without compromising their identity. Safety and continuity of cultural connection are not mutually exclusive; they are mutually reinforcing. Application of the ATSICPP ensures *they never have to choose*.

What is missing from this conclusion is that the alignment depends upon two conditions. First that the ATSICPP has been comprehensively implemented with respect to the child in question. Second, that upon an evaluation of the child's best interests in the particular circumstances the paramount principle and the ATSICPP is aligned. This will not invariably be the case and should not be assumed. An alignment between the ATSICPP and the paramount principles depends upon boundlessly different individual circumstances in which the child may be found.

The Commission has examined a number of Departmental decisions, which could only be reasonably explained by the aspirational application of the ATSICPP rather than a real and genuine evaluation of the child's best interests in the circumstances. An example of such a decision can be found in the case study of Witness AB (hereafter referred to as Ellen) outlined in Appendix B of the Commission's Executive Report and will be discussed further below in various contexts in which such decisions have arisen at various stages throughout the continuum of the child safety system.

All of this suggests a lack of clarity as to the proper relationship between the paramount principle and the ATSICPP. That is undesirable. Clarity is essential for Departmental decision-makers, carers, children, and the courts.

Accordingly, if the intended operation of the ATSICPP is to give paramount priority to ATSICPP in respect of Aboriginal and Torres Strait Islander children, then the CP Act should be amended to make that plain. The criteria upon which the wellbeing and best interests of Aboriginal and Torres Strait Islander children are to be evaluated would then be clear and unequivocal.

However, absent that sort of amendment, that is not how the ATSICPP should be understood. Rather, it should be understood as a scheme of interrelated principles which direct action generally towards achieving the desired goal of reunification, not principles, taken individually or in aggregate, which override the necessity to evaluate a child's best interests in a particular case.

2.5.2 Absent amendment, the paramount principle must have priority over the ATSICPP

Unless and until the ATSICPP is declared by legislative amendment to have paramountcy for Aboriginal and Torres Strait Islander children, when the State makes decisions affecting Aboriginal and Torres Strait Islander children in its capacity as the notional corporate parent, the ATSICPP must remain genuinely subordinate to the paramount principle in the final evaluative analysis. No Aboriginal and Torres Strait Islander child should be subject to anything less than a bona fide analysis of his or her best interests in the circumstances and at the time the decision or action occurs.

If the ATSICPP is not substantively subordinate to the paramount principle there is a grave risk of paternalistically discriminating against Aboriginal and Torres Strait Islander children, albeit in pursuit of otherwise laudable social and cultural objectives. Howsoever worthy those collateral objectives might be, the unintended consequence is that the best interests of Aboriginal and Torres Strait Islander children may become subordinate to the attainment of other objectives that, while collectively desirable, are not always aligned with a particular child's individual best interests.

To be clear, it is not suggested that the ATSICPP should be discarded; but, at the risk of repetition, the ATSICPP must be understood to be *subordinate* to the paramount principle and substantively applied in the evaluation of the best interests of Aboriginal and Torres Strait Islander children genuinely subject to the paramount principle.

The risks of applying a different paramount principle to Aboriginal and Torres Strait Islander children, whether expressly or *de facto*, are grave. The risks are graver if the standard is de facto or opaque. The obvious risk is that a decision to remove a child for his or her protection might not be made because of other considerations, for example a desire to keep the child with family or kin, though the child is not safe. The same risks arise if a child is reunified with family or placed with kin when the child is not safe.

The decisions whether to remove or reunify a child necessarily involve risk assessment and predictions. There will inevitably be times when the risk assessment and prediction turn out to be wrong. That is unavoidable. But if the evaluation is infected by some predisposition toward achieving some other goal, albeit a generally beneficial goal, the likelihood of the risk assessment and or prediction being wrong inevitably increases.

2.5.3 The role of individuals and the proximate causes of harm

The Commission acknowledges that the success of the ATSICPP depends on all elements being genuinely implemented as fully as possible. But as discussed above, as with any policy, or actions taken under it, that concerns human behaviour, individual agency is always a critical factor. It is not possible to achieve intended aims that, by their nature, require individual choices without the individuals concerned making the desired choices. This includes the choice to change behaviours that cause harm to families and children.

In the context of child safety, when generally the individual choices depend on adults whose actions and behaviours directly determine the safety and wellbeing of a child, no textual formulation of a principle, nor any fully comprehensive implementation of it, can ensure that the child is kept safe. It is for this critical reason that no statement of policy or principle, be it the ATSICPP or otherwise, however well implemented, is a substitute for examining the actual facts and circumstances in which the child is found and genuinely evaluating the child's needs and best interests in that context. Those facts include individual behaviours such as domestic violence and drug or alcohol abuse which cause harm to the child, and the risk that ongoing harm will be caused by those behaviours. Critically, the facts include the preparedness of the perpetrators of harm to change their behaviours and evidence as to the likelihood of that change occurring. There is no suite of principles, no policy scheme, however well implemented, that will provide confidence that the human behaviour, invariably the direct cause of the harm, will change and abate the risk to the child, unless that conduct, on an assessment of the actual facts is found no longer to be an unacceptable risk.

The contentions advanced in the joint statement are consistent with a wider tendency in the discourse concerning child safety to avoid specific and direct recognition of the role individual behaviours and the proximate causes of harm play in causing harm to children. This subject is further discussed in the Commission's Executive Report. The Commission notes that in the discourse on the subject of child safety generally, as well as in the submissions received, there is very little reference to the proximate causes of harm and individual behaviour. The general absence of policy discourse that focuses on proximate causes and what to do to help address the behaviours which directly cause harm, may in part be explained by the desire not to apportion blame or create feelings of shame on the individual's part.

There are pervasive behaviours that are well known to be indisputable causes of harm to children, but the commentary is focused at an aggregated de-personalised level. The policy prescriptions tend to be offered on the implicit assumption that the 'drivers', socio-economic, historical and

cultural, if properly and fully remedied will redress the issue of harm being caused to children and the consequence of removal into the care of the State. The Commission does not suggest that all of these 'drivers' are not significant, quite the contrary.

However, if the significant challenges posed by the child safety system are to be confronted, then policies that focus on the proximate causes of harm and the consequent *individual* behaviours must also be more widely developed and implemented. Alongside policies addressing broader 'drivers', the Commission considers that more focus needs to be given to preventative policies, including community-led policies and interventions, that are directed specifically at the proximate causes of harm and at changing harmful behaviours at the individual level. These policy efforts should acknowledge human agency and not characterise the 'drivers' as intractably deterministic.

The Commission's emphasis upon proximate causes and individual behaviours is not confined to Aboriginal and Torres Strait Islander children, the same proximate causes and behaviours which directly cause harm are applicable to all children regardless of ethnic or cultural background. Neither is that emphasis intended as a denial of the broader historical or socioeconomic context in which the proximate causes perpetuate and flourish. The Commission's sole purpose in this respect is to focus upon the reality of the hypothetical child in the circumstances as and where they are found. It is no answer to that child's protection to explain the many converging forces which have contributed to the child's harm or ongoing risk of harm. From the child's perspective the harm is real and immediate, whatever its context or antecedence. In the timeframe of the child, whatever time is left for childhood, the need for protection is urgent and thus urgent intervention is called for. That is the child's reality, and it is that urgency which defines the state's immediate duty.

Returning to the subject of the ATSICPP, it does not follow from the above discussion that the ATSICPP is inutile. Rather, the point is it should not be assumed that the ATSICPP is somehow an infallible set of principles, which if fully and properly implemented, will achieve the desired outcome in all circumstances and within the required timeframe.

In its helpful submission to the Commission in August 2025, QATSICPP submitted:

> The ATSICPP is also founded on our community's decades long experience that decisions about our children are best made when we are involved with them. The ATSICPP does not propose that children can be placed in unsafe environments or that reunification or reconnection with family should occur in all circumstances, regardless of the risk to the children. The paramount priority of QATSICPP and our members is the safety and wellbeing of our children and whilst we support our children's rights to grow with family and

> community, we support careful and considered implementation of the ATSICPP to ensure decision making to best ensure its application is in alignment with 5A of the Child Protection Act.[16]

This submission is generally consistent with the submission by the Office of the Aboriginal and Torres Strait Islander Children's Commissioner et al. referred to above. However, the Commission understands QATSICPP's submission to accept the application of the ATSICPP must align with the paramount principle in relation to the child in question.

2.6. Active efforts

ATSICPP is not a single principle but an interdependent scheme: it has 'five connected elements'. To succeed, *each* element of the scheme needs to be properly implemented.

The importance of real and genuine implementation of the ATSICPP is fortified by s 5F of the CP Act. Section 5F(2) provides that in making a decision about Aboriginal and Torres Strait Islander children, a relevant authority must make 'active efforts' to apply the ATSICPP. The concept of 'active efforts' is defined in s 5F(6) to mean: 'purposeful, thorough, and timely efforts to apply the principle.'[17]

For the ATSICPP to achieve its intended purpose, it is not sufficient to 'skip over' the partnership principle in s 5C(2)(b) or provide only nominal or performative compliance with the participation principle s 5C(2)(d) and the connection principle in s 5C(2)(e). It is not sufficient, in other words, to simply 'jump', to the placement principle in sub-paragraph 5C(2)(c). Some of the incongruous decisions which emerge from the examples described in the case studies in Appendix B of the Commission's Executive Report, may in whole, or in part, be due to the Department doing too little to implement the other elements of the ATSICPP and 'jumping' straight to the placement principle. These incongruous decisions may be explained by a determination to achieve an outcome before that outcome could reasonably be achieved, the 'groundwork' having not been laid or laid early enough. Functioning properly and interdependently, the ATSICPP should produce a desired outcome arrived at *after* the groundwork has been done and *after* the desired

[16] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (August 2025) 33.
[17] See AT-17, *Article by Judge Leonard Edwards "'Active Efforts" and "Reasonable Efforts": Do they mean the same thing?', The Juvenile Court Corner (2015) 6*, tendered 5 February 2026. This article, tendered by the Aboriginal and Torres Strait Islander Legal Service, notes the frequent use of "Active Efforts" and "Reasonable Efforts" as interchangeable terms in the American child protection legal system and advocates for 'active efforts' as a higher threshold than 'reasonable efforts.'

outcome has been evaluated and found in the circumstances to align with the best interests of the child.

2.7. Recommendations

<table>
<tr><th colspan="2">Recommendation 8: ‘Balance of harm’ analysis to the paramount principle</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 2)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of Government’s response to this report, amend the Paramount Principle in section 5A of the Child Protection Act 1999 to introduce a ‘balance of harm’ analysis. An indicative example is set out below:

5A Paramount Principle
…
(2) In evaluating the wellbeing and best interests of the child, regard must be had to any consequences for the child of:
(a) removal of the child from the child’s family; or
(b) removal of the child from the child’s current placement, including all:
i. circumstances relevant to the child’s proposed new placement; and
ii. any other matters relevant to the effect of the proposed action upon the child’s wellbeing and best interests.</td></tr>
<tr><td colspan="2">CONTEXT:

There is no removal of a child from their family that does not cause harm and trauma to that child, at least to some degree. The unavoidable harm caused by removal is justified by satisfaction of the twofold test in section 10 of the Child Protection Act — namely, that the child has suffered or is suffering harm, or is at unacceptable risk of harm and does not have a parent able and willing to protect them from harm.

The legal test in section 10 is one-sided, in that it does not expressly mandate any analysis of the counterfactual, that is the relative safety and wellbeing of the child if removed into State care. On one view, there is an unstated assumption that children removed into the care of the State will be safe from harm and cared for in accordance with the paramount principle. If in any given case that unstated assumption is unsound, the test in section 10 may misfire.

In other legal contexts, such as where injunctive relief is sought, courts are commonly required to engage in a balancing analysis, weighing any harm in making an order against the harm of not doing so. This is referred to as the ‘balance of convenience’.

The possibility that the making of an order may involve some, and even greater relative harm, should also be allowed for, and analysed, in any decision to remove a child into State care. If, for example, the evidence suggests that the State will be unable to find the child a placement that will provide that child reasonable care, and that reduces the child’s overall risk of harm of some kind, this factor ought to be considered in deciding whether a removal order should be made.

A balance of harm analysis in these terms would inform not only removal decisions but also reunification and placement decisions where there are similar competing harm considerations as between the status quo (the child remaining in his or her current placement) and the counterfactual (being reunified with his or her family or being placed with a different carer, including a kin carer). The need to consider and balance relative harm again in that context is necessary because the best interests of the child are not static but evolve dynamically.</td></tr>
</table>

Recommendation 9: Amending the paramount principle	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 2)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, further amend the Paramount Principle in section 5A of the *Child Protection Act 1999* to remove the words 'both through childhood and for the rest of the child's life'.	
CONTEXT: For reasons explained in the Companion Report, the words which the Commission recommends excising are undesirable because they give a licence to make unspecified and unreasoned assumptions and untestable predictions concerning the long-term best interests of the child. They introduce uncertainty as to the meaning and effect to be given to the paramount principle. Further, this phrase does not provide any practical guidance in relation to the proper application of the principle in any given case.	

Chapter 3

The Current Child Protection Litigation (CPL) Model

Companion Report 2

Child Protection Litigation

Chapter 3: The current child protection litigation (CPL) model

This chapter describes the current CPL model, explains the circumstances in which it was established, and identifies the principal design features. The purpose of this chapter is to provide the necessary context for the Commission's analysis of whether the model's present arrangements continue to serve the objectives for which they were introduced, and whether those arrangements should be maintained or reformed.

Part 3.1 of this chapter commences with the model that existed before the Carmody Inquiry reforms were implemented on 1 July 2016. Next, the part identifies the rationale for the child protection litigation model proposed by the Carmody Inquiry, and the particular reforms implemented from 1 July 2016 including the introduction of a 'bifurcated model'. Part 3.2 summarises the subsequent reviews and evaluations of the post-Carmody CPL model, to the extent the Commission is able given that State's successful public interest immunity claim in respect of key documents.

3.1 Background

The current CPL model was formally established on 1 July 2016. Before turning to that model, it is necessary to identify the model which preceded it.

3.1.1 The pre-Carmody model

Under the preceding model, applications for emergent orders and child protection orders were prepared and prosecuted by 'Court Coordinators' within the Department who were embedded in Child Safety Service Centres. Court Coordinators, who did not need to be (and usually were not) legally qualified, conducted child protection proceedings on behalf of the Department, except in highly contentious matters or where a matter was to proceed to a final contested hearing. In those circumstances, the Department would instruct Crown Law and/or Counsel to act on its behalf.

3.1.2 The Carmody model

The Carmody Inquiry found that this previous model:

- did not comply with model litigant principles;

- resulted in material filed in Court which often relied on hearsay, rather than direct and admissible evidence;
- did not afford access to appropriate legal representation for children and families; and
- did not afford Departmental officers access to appropriately qualified legal professionals to provide legal advice and assist in the preparation of high-quality Court material.[18]

These factors, amongst others, contributed to, '…a widespread mistrust and concern in relation to the conduct of proceedings by the department and its ability to present material that is sufficiently supported by evidence'.[19] As a result, the Carmody Inquiry recommended the child protection litigation model be redesigned to reflect a 'dual entity approach', in which decision-making for legal matters was separate and independent from decision-making for casework in child protection matters.[20] The policy intent of the dual-entity approach for legal advice and representation was:

> [T]o establish greater accountability and oversight for the applications that are being proposed by individual Child Safety service centres and particular regions to ensure that only necessary applications are being made and those that are made are managed appropriately.[21]

The Carmody Inquiry made the following relevant recommendations:

> **Recommendation 13.16**
>
> That the Department of Communities, Child Safety and Disability Services enhance its in-house legal service provision by establishing an internal Office of the Official Solicitor within the department which shall have responsibility for:
>
> - providing early, more independent legal advice to departmental officers in the conduct of alternative dispute-resolution processes and the preparation of applications for child protection orders
> - working closely with the proposed specialist investigation teams so that legal advice is provided at the earliest opportunity
> - preparing briefs of evidence to be provided to the proposed Director of Child Protection in matters where the department considers a child protection order should be sought.
>
> **Recommendation 13.17**
>
> That the Queensland Government establish an independent statutory agency – the Director of Child Protection – within the Justice portfolio to make decisions as to which matters will be

[18] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013), 477–483.
[19] Ibid 481.
[20] Ibid 476-483.
[21] Ibid 482.

> the subject of a child protection application and what type of child protection order will be sought, as well as litigate the applications.
>
> Staff from the Director of Child Protection Litigation will bring applications for child protection orders before the Childrens Court and higher Courts, except in respect of certain interim or emergent orders where it is not practicable to do so. In the latter case, some officers within the Department of Communities, Child Safety and Disability Services will retain authority to make applications.
>
> **Recommendation 13.18**
>
> That the Department of Communities, Child Safety and Disability Services move progressively towards requiring all Court coordinators to be legally qualified and for their role to be recast to provide legal advice (within the Office of the Official Solicitor) or to transfer the role to the independent Director of Child Protection office.

The Queensland Government accepted Recommendations 13.16 and 13.17 and accepted Recommendation 13.18 in principle.[22] Then, on 1 July 2016, the Government implemented the bifurcated child protection litigation model. Specifically, the OCFOS was established within the Department and given responsibility, among other things, for making applications for emergent orders.[23] Separately, the office of the DCPL was established by the *Director of Child Protection Litigation Act 2016* ('the DCPL Act') and given responsibility for making applications for child protection orders.[24]

In implementing a bifurcated model, Queensland became (and remains) the only Australian jurisdiction in which responsibility for litigating child protection matters sits outside the department with responsibility for child safety. It is unnecessary for the Commission to express an opinion as to whether the bifurcated model ought to have been recommended. It is however necessary for the Commission to assess whether this dual and serial responsibility between the OCFOS and the DCPL is presently beneficial and whether it should be continued. For the reasons outlined further in Chapter 4 of this companion report, the Commission has concluded that it is not beneficial and that it should not be continued.

3.2 Reviews of the current model

The Carmody Inquiry recommended a review of the CPL model five years after implementation**.** In September 2016, the Queensland Government announced that an Expert Panel would work with the Queensland Family and Child Commission ('QFCC'), to conduct a review. In 2017, the QFCC submitted a report, titled *Strengthening Capacity Across Queensland's Child Protection*

[22] Queensland Government, *Queensland Government Response to the Queensland Child Protection Commission of Inquiry Final Report* (December 2013), 29.
[23] Ibid.
[24] Explanatory Memorandum, *Director of Child Protection Litigation Bill 2016* (Qld).

System, and commonly known as the 'Apelt report'.[25] The Apelt report built on another report prepared by KPMG entitled *Review of Demand and Resourcing for Child Protection in Queensland* ('the KPMG report').[26] The KPMG report recommended, among other things, a range of improvements in relation to the CPL model. It was through those reports that many issues examined in this chapter were first identified and raised publicly.[27] In the following years, the CPL model was the subject of ongoing evaluation by the Department, external consultants and other bodies within government. The outcomes of the evaluations have generally not been publicly released. They were confidentially provided to the Commission but were not formally received into evidence because the State successfully claimed public interest immunity in respect of those documents. It is unnecessary to say anything further about them.

[25] Queensland Family and Child Commission, *Strengthening Capacity across Queensland's Child Protection System* (Final Report, March 2017) (*Apelt Report*).
[26] KPMG, '*Review of Demand and Resourcing for Child Protection in Queensland*' (Final Report, February 2017), app 2 to the Apelt Report.
[27] Ibid.

Chapter 4

Should the Bifurcated Model be Maintained?

Companion Report 2
Child Protection Litigation

Chapter 4: Should the bifurcated model be maintained?

This fourth chapter addresses two separate but interrelated questions:

1. ***First,*** should jurisdiction continue to be bifurcated, with responsibility for emergent order applications remaining within the Department through the OCFOS and responsibility for child protection order applications remaining with the DCPL?
2. ***Secondly***, if not, then should responsibility for *both* emergent orders and child protection be given to OCFOS or alternatively, under the DCPL or another similar body?

To answer those questions, the Commission undertook a detailed analysis of the respective roles and functions of the OCFOS and the DCPL, reviewed how matters progress from frontline assessment through emergent order applications and referral to the DCPL and analysed the way in which the current arrangements operate in practice. This analysis is set out at Parts 4.1 and 4.2 of this chapter.

Part 4.3 of this chapter outlines the Commission's evaluative conclusions and sets out the basis for structural reform, including the proposed abolition of the bifurcated model and the conferral of a unified jurisdiction upon a single, statutorily independent litigation authority. Part 4.4 of this chapter sets out the Commission's evaluation as to which entity should be conferred with integrated and exclusive jurisdiction. Finally, Part 4.5 outlines the Commission's proposed reforms and recommendations to ensure a more independent, accountable, timely, responsive and child-centred CPL model in the future.

4.1. Office of the Child and Family Official Solicitor (OCFOS)

The OCFOS is comprised of a team of legal officers, led by a Child and Family Official Solicitor ('the Official Solicitor'). Its function is to provide legal advice and assist Department staff to prepare for Court.[28] OCFOS legal officers are located in most CSSCs across Queensland. They provide expert legal services relating to the Department's obligations under the CP Act, as well as intersecting legislation including the *Human Rights Act 2019* (Qld), the *Family Law Act 1975*

[28] Department of Families, Seniors, Disability Services and Child Safety, 'Information sheet 1', What is the Office of the Child and Family Official Solicitor?' (Information sheet, n.d.) <https://www.families.qld.gov.au/_media/documents/protecting-children/what-is-ocfos.pdf>.

(Cth) ('the FLA'), the *Domestic and Family Violence Protection Act 2012* (Qld) and the *Adoption Act 2009* (Qld).[29]

The OCFOS represents the Department in all applications for emergent orders (discussed below). It is also responsible for referring matters to the DCPL and preparing briefs of evidence to support the referral.

4.1.1 Initial model – OCFOS as Applicant

When OCFOS was established in 2016, the Official Solicitor was delegated responsibility as decision-maker in relation to:[30]

- whether to bring an application to make, extend or vary a TAO, CAO or TCO, and if so, what application to bring;
- whether to refer a matter to the DCPL to consider seeking a child protection order ('CPO'), and if so, what CPO to seek; and
- preparing the DCPL referral brief.

In practice, the Official Solicitor conditionally delegated this responsibility to OCFOS legal officers. As a result, OCFOS legal officers were the decision-makers in relation to whether applications for emergent orders ought to be brought, whether matters were referred to the DCPL, and the proper order to seek in each case. OCFOS legal officers were then responsible for all aspects of the emergent order process including:[31]

- drafting the application for an emergent order;
- deposing that application and filing it as the applicant; and
- appearing in Court and acting for the Department in relation to the application.

Likewise, OCFOS legal officers were responsible for preparing and completing any referral to DCPL and preparing the brief of evidence. The relevant CSO was responsible for drafting the affidavit material, with assistance from the OCFOS legal officer.[32]

[29] Statement of Legal Officer, OCFOS (November 2025) [9]; Transcript, Evidence of Angela Schifilliti (9 December 2025) 3283.
[30] Data provided by the Department under Notice 230 of Instruments of Delegation and Authorisation issued on 15 May 2017.
[31] Transcript, Evidence of Clair Martin (12 December 2025) 3631:36.
[32] Ibid 3632:17-3632:20; Statement of Director, OCFOS (3 November 2025); Data provided by the Department under Notice 143 of Exhibit C OCFOS Operating Guidelines 2016 [4-8].

The Carmody Inquiry recommendations proposed the responsibilities of the former Court Coordinators would eventually be fully vested in the OCFOS.[33] This was reflected in the OCFOS Operational Guidelines at the time, which noted that:

> OCFOS legal officers, senior advisors and senior legal officers are authorised officers under the CPA and may be the applicant for an emergency order. In the medium term, service centre staff will retain the necessary delegations to make applications for assessment orders and temporary custody orders. These delegations will be reviewed in 2019 with a view to OCFOS being the applicant in most if not all applications for emergency orders so that it is an analogous situation to the DCPL for child protection orders.[34]

4.1.2 The change to an 'instructional model' of practice

Following the establishment of the OCFOS, and throughout the early reviews outlined above, there was disquiet in the Department about the new model and the integration of the OCFOS. In brief, there was confusion about OCFOS's role, and how to resolve any disagreement between an OCFOS officer and the Child Safety officer (usually, the senior team leader) as to whether an emergent order application should be made. Inevitably, this confusion produced conflict.

The Official Solicitor sought to resolve those concerns by transitioning OCFOS to an '*instructional model of practice'*. Under an 'instructional model' the senior team leader makes an assessment that an emergent order should be sought, and OCFOS is expected to act on their instructions.[35]

That transition was underway by 2018 and was complete by mid-2020. It was accompanied by:

- revised operational guidelines embedding an instructional model of practice;
- new policies, procedures and practice resources designed to inform and guide staff on engagement with legal practitioners, including an escalation procedure where instructions from the senior team leader conflicted with legal advice given by OCFOS; and
- communiques to staff advising of the transition to an instructional model of practice.

It was accompanied, for example, with the making of additional, parallel delegations to the senior team leader and manager, on the matters originally only delegated to OCFOS. This effectively distributed the authority of OCFOS to determine what, if any, emergent order was required. Notwithstanding the terminology sometimes used internally to describe the transition — such as a 'clarification' — the move to the 'instructional model of practice' was a very significant change.

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[33] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013) 483.
[34] Statement of Director, OCFOS (3 November 2025); Data provided by the Department under Notice 143 of Exhibit C OCFOS Operating Guidelines 2016 [5].
[35] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3184:89.

The Department's current guidelines, policies and procedures for the OCFOS are clear: OCFOS operates on an 'instructional model'. Only an STL (or Manager) is delegated to provide instructions to an OCFOS lawyer. The Department's guidance states that OCFOS *must* act on the Department's instructions, provided those instructions are based on legal advice.[36]

In circumstances where the delegate's instructions conflict with legal advice given by an OCFOS legal officer, there is an escalation procedure:[37] the OCFOS officer must escalate the matter to a senior legal officer at OCFOS. That procedure may be invoked if there is a significant legal issue, or if the OCFOS officer believes that the application or referral lacks reasonable grounds or otherwise holds significant concerns for a child's safety. If a matter is escalated, the senior legal officer is obliged to review the file and confer with the Departmental delegate (normally the senior team leader). If required, the senior legal officer may escalate the matter with OCFOS, to the relevant Manager, then the Principal Legal Officer, and then, if still unresolved, to the OCFOS Director. If required, the Director will raise the matter with the relevant Regional Director in the Department. Nonetheless, at the end of that process the Department's Regional Director holds the final decision-making power with respect to the matter and will issue instructions on a final basis. Upon receipt of those instructions, the Director will direct the relevant OCFOS officer to act as instructed.

4.1.3 The 'instructional model' is misconceived

The Commission has heard compelling evidence that the instructional model within OCFOS has not achieved meaningful independence from the Department, with legal positions continuing to be shaped by Departmental perspectives and operational constraints.[38]

Ms Schifilliti and Ms Martin each opined that the escalation procedure is effective in resolving concerns about the instructional model.[39] Ms Schifilliti also gave evidence that where disagreements exist, it is appropriate to simply put the matter before the Court (or Magistrate, depending on the order sought), for determination.[40] That suggestion sits very uneasily indeed with the Department's gatekeeping function, as a model litigant — that is, to ensure that the Courts are not presented with applications that lack a proper or sufficient evidentiary basis. This

[36] Data provided by the Department under Notice 240 of Working with the Office of the Child and Family Official Solicitor; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3181:3-4.
[37] Data provided by the Department under Notice 240 of Escalation process for emergent orders, Department of Families, Seniors, Child Safety and Disability Services ; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3183:28-32; Transcript, Evidence of Angela Schifilliti (9 December 2025) 3320:22-36.
[38] Transcript, Evidence of Angela Schifilliti (8 December 2025), 3185:21–30; Transcript, Evidence of Clair Martin (12 December 2025) 3631:36–45; 3645:5–14.
[39] Transcript, Evidence of Angela Schifilliti (8 December 2025), 3189:14-21; Transcript, Evidence of Clair Martin (12 December 2025) 3684:13-31; Statement of Senior Legal Officer, OCFOS (3 November 2025) [26]-[27].
[40] Transcript, Evidence of Angela Schifilliti (8 December 2025), 3186:29; (9 December 2025) 3319:21.

issue was recently the subject of judicial comment in a decision of the Childrens Court in *VD and WD v Department of Child Safety, Seniors and Disability Services*.[41] That case involved an appeal against a TAO. The Magistrate heard the application *ex parte* in the absence of the respondent parents, and in doing so relied solely on the information provided by the Department. The respondent parents claimed that the Magistrate erred in granting the TAO, where the information contained in the Department's application was incapable of establishing that the TAO was necessary in the circumstances. The Department conceded that the application was so incapable, though submitted that the appeal was futile because the TAO period had already expired. The Court allowed the appeal. In her reasons, Judge Holliday stated (at [33]):

> A matter of concern is that the respondent, rather than taking responsibility for the concession that it is now making on appeal, states, 'the orders themselves were made by an independent Magistrate and not officers of the respondent.' Whilst that is true, the respondent is conceding that the information founding the application for the Temporary Assessment Orders was 'incapable of satisfying the Magistrate that the orders ought to have been made.' This ought to have been known to the relevant persons within the respondent Department at the time. There are aspects of concern which need to be addressed by the Department. **The clear and obvious need to protect the interests of children cannot override an obligation to ensure that an application is not made unless there are sufficient grounds to do so.**[42]

The Official Solicitor and Departmental leadership considered the issues raised by the Court. In response to the decision, OCFOS reviewed its policy, procedure and guidance documents however, as far as the Commission is aware, no change was made to the escalation procedure itself or to the instructional model.[43]

In evidence before the Commission, the Department did not advance any convincing reason for introducing the 'instructional model'. Ms Schifilliti suggested that for the OCFOS legal officer to be the decision-maker in relation to the making of applications for emergent orders, it would potentially place the OCFOS legal officer in a position of conflict with his or her client, being the Department.[44] Further, it was suggested that if the legal officer was the named applicant, as was the case prior to the 'instructional model', that had the potential to create a conflict of interest and duty between the OCFOS legal officer and the Department as the client.

[41] [2025] QChC 2.
[42] Emphasis added.
[43] Statement of Director, OCFOS (17 December 2025) [10].
[44] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3299:34-43.

The Commission does not agree that either conflict would arise. The overarching duty of a lawyer is to the Court and accordingly if there is any disagreement between the client and the lawyer as to whether there is a proper basis for an application, that should be resolved by a process involving evaluation by lawyers.[45] In that respect, there should be no disparity of interest between the legal officer and the Department. Both the Department and the legal officer ought to share an interest in ensuring that an application is not brought before the Court unless there is a proper basis upon the available evidentiary material. If anything, the potential for conflict in a practical sense is more likely where the Department officer is the decision maker and the legal officer is operating under the 'instructional model'. Under that model, the legal officer may be instructed to advance an application which that lawyer does not agree has a proper basis, putting the lawyer's obligation to the Department as its client at odds with their overarching duty to the Court.

As mentioned, the Department's position is that the escalation process resolves disagreements about whether an application should be brought. The Commission holds serious concerns as to the effectiveness of the escalation procedure, given cultural and structural factors that exist within OCFOS and the Department. But ultimately, it is, rather, beside the point. The escalation procedure is a *consequence* of the decision resting with the STL and CSO rather than with the OCFOS legal officer; it is not a *reason* for that decision to rest there. The essential question is whether the lawyer is best placed to make an evaluation of whether there is sufficient material to warrant an application for an emergent order.

The importance of an independent evaluation of the evidence supporting an application was illustrated in the case of Baby Charlie.[46] In that case, the Department sought an emergent order to remove newborn Baby Charlie from his mother in the birth suite. After extensive examination with the Department and Charlie's mother, the Court declined to grant the application. The Court made findings about significant deficiencies both in the Department's evidence, and (in the Commission's view, more importantly) the Department's decision-making. The Court found evidence of bias towards removal, with a rigid assessment based on historical concerns. The Department had not conducted a genuine safety assessment following the birth of the child and had not given weight to a range of protective factors that served to keep Baby Charlie safe.

Given the academic and professional training of CSOs and lawyers respectively, it must surely be accepted that the lawyers are better placed to make the legal and forensic evaluation of this

[45] *Australian Solicitors Conduct Rules 2023* (Qld) rr 3.1, 4.1.4.
[46] See Appendix B of the Commission's Executive Report.

question.[47] For these reasons, the Commission is of the view that the final decision to bring an application before a Magistrate or to file in the Childrens Court should rest with a lawyer.

4.2 The Director of Child Protection Litigation (DCPL)

The DCPL was established in 2016 under the DCPL Act as an independent statutory office within the then Department of Justice and Attorney-General (now Justice) portfolio.[48] Although situated within Justice, the DCPL Act makes explicit that the DCPL is not under the control of the Minister.[49] The DCPL is given exclusive jurisdiction to make applications for CPOs on behalf of the State and to conduct the resulting legal proceedings in the Childrens Court of Queensland.[50] The DCPL is centrally located in Brisbane but appears in all Childrens Courts proceedings across Queensland.

Figure 1 below shows the number of CPO applications made by the DCPL each year.[51]

	2022-23	2023-24	2024-25
CPO applications	3,456	3,481	3,988

Figure 1: number of CPO applications made by the DCPL in 2022-23, 2023-24 and 2024-25 (FY).

4.2.1 Centralisation of the DCPL

The Carmody Inquiry envisaged DCPL having a presence across the State (for example, by being co-located with other Justice-related bodies, such as the offices of the Director of Public Prosecutions).[52] However, the Queensland Government established the DCPL only in Brisbane.[53] The Brisbane-based model has three 'chamber groups' of lawyers with each group allocated a region of the State, as shown below in Figure 2.

Region	Court Locations
Blue Chambers	
Brisbane	Brisbane
	Caboolture
	Cleveland

[47] *VD and WD v Department of Child Safety, Seniors and Disability Services* [2025] QChC 2.
[48] Director of Child Protection Litigation (Qld), 'About DCPL' (Webpage, n.d.) <https://www.dcpl.qld.gov.au/>.
[49] *Director of Child Protection Litigation Act 2016* (Qld) s 13.
[50] Ibid ss 9-10.
[51] CA-51, *Statement of Nigel Miller,* tendered 9 December 2025 [206].
[52] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013), 482-483.
[53] CA-51, *Statement of Nigel Miller*, tendered 9 December 2025 [41].

	Holland Park
	Pine Rivers
	Redcliffe
	Wynnum
Sunshine Coast	Caloundra
	Gympie
	Kingaroy
	Maroochydore
Central Queensland	Emerald
	Gladstone
	Rockhampton
Longman Chambers	
Darling Downs and South West Queensland	Charleville
	Dalby
	Goondiwindi
	Ipswich
	Stanthorpe
	Roma
	Toowoomba
	Warwick
Northern Queensland	Bowen
	Charters Towers
	Mackay
	Proserpine
	Townsville
Western Queensland	Longreach
	Mt Isa
Brisbane	Richlands
McDonald Chambers	
South-East Queensland	Beenleigh
	Southport
Wide-Bay Burnett	Bundaberg
	Hervey Bay
	Maryborough
Far North Queensland	Atherton
	Cairns
	Innisfail
	Mossman
	Mareeba

Figure 2: DCPL Chamber groups and regional coverage. Source: CA-51, *Statement of Nigel Miller*, tendered on 9 December 2025, [44] – [46].

In practice, the DCPL attends regional courts as required, attending some courts almost exclusively by telephone.[54] Undoubtedly, DCPL's geographic remoteness from the regions it

[54] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (12 December 2025), 5; Queensland Indigenous Family Violence Legal Service (QIFVLS), *Submission to Child Safety Commission of Inquiry* (1 December 2025), 1-2.

services impedes awareness as to regional child protection needs and practices, and the experiences of families, children, and Child Safety staff 'on the ground'. Stakeholders attribute this lack of awareness to DCPL's centralisation in Brisbane, noting that, 'it is often difficult for each agency to have a full working understanding of the steps or decisions taken by the other due to the physical and organisational separation between them'.[55]

4.2.2 Length of proceedings

The Director, Mr Miller, provided data to the Commission as to the average number of days between lodgement and determination of child protection applications in the three previous financial years.[56] As shown in Figure 3 below, there has been a sustained increase in duration and in procedural intensity over time.

	2022-23	2023-24	2024-25
Applications determined	3,111	2,987	3,110
Average court events	8.2	8.7	9.4
Average days	290.2	312.9	357.1

Figure 3: average duration of CPO proceedings in 2022-23, 2023-24 and 2024-25 (FY).

This shows that, across the previous three financial years, there has been an increase of approximately 67 days (over two months) in the average time to finalisation, together with a steady rise in the number of court events required per application.[57]

Figure 4 below demonstrates that the trend is even more pronounced in matters involving applications seeking Long-Term Guardianship to the Chief Executive ('LTG-CE'), which are of the greatest permanency significance for children.[58]

[55] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry* (2 September 2025), 3.
[56] CA-51, *Statement of Nigel Miller*, tendered 9 December 2025 [244].
[57] Ibid [245].
[58] Ibid [251].

	2022-23	2023-24	2024-25
Applications determined	866	836	763
Average court events	9.5	10.0	10.9
Average days	350.6	369.5	426.0

Figure 4: average duration of proceedings for Long-Term Guardianship to Chief Executive applications in 2022-23, 2023-24 and 2024-25 (FY).

This represents an increase of approximately 75 days in the average time to finalisation over the same three years. The result is an average time to finalisation approaching 14 months for long-term guardianship determinations.[59] That is, for obvious reasons, a concerningly long period.

4.2.3 Information sharing

Information sharing between the DCPL and the Department (including OCFOS) was frequently raised as a major barrier resulting in undue delays. The positioning of the DCPL within the Justice portfolio has meant the DCPL does not hold direct access to the Department's client information system. Rather, the DCPL is dependent on the Department to identify, collate and provide all records and information relating to the matter through other systems. Similarly, the DCPL has relied on emails and other file-sharing systems to provide information to the Department about the progress of the litigation.[60]

The DCPL has a statutory duty to disclose all relevant material in the proceedings.[61] The Department is similarly required to offer full cooperation to the DCPL in undertaking its statutory functions, including a duty of disclosure to the Director.[62] However, as noted by the Together Union:

> [W]hen managing proceedings in relation to a matter, a DCPL lawyer has no access to the Department's case management system, no visibility of the contemporary file notes made by

[59] Ibid [252].
[60] Statement of Nigel Miller (7 November 2025) [109], [130]-[131]; Data provided by the Department under Notice 144 of DCPL – Business Process Map – Managing Proceedings (7 November 2025). The Commission understands these processes are presently under review.
[61] *Child Protection Act 1999* (Qld) ss 189C-189D.
[62] *Director of Child Protection Litigation Act 2016* (Qld) ss 16, 23-24; *Child Protection Act 1999* (Qld) s 53A.

> the practitioners working with the family, and no access to the sourced information on which the Department's assessment is built.[63]

The Together Union contended that this places an undue burden on Departmental staff to furnish the DCPL with the information it needs to undertake its litigation functions:

> Each request-and-response cycle consumes time and effort from practitioners who can afford neither, directed not at working with families but at satisfying the information requirements of a separate organisation.[64]

This is not a minor issue. Figure 5 below shows the proportion of matters in which the DCPL requested further evidence or information from the Department in order to deal with a referral.[65]

	2022-23		2023-24		2024-25	
	No.	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Matters DCPL sought further evidence or information	2,168	61.8%	2,596	72.2%	2,990	73.2%

Figure 5: matters where the DCPL sought further evidence or information from the Department in dealing with a referral between 2022 and 2025.

This data indicates that in almost three-quarters of referred matters, the DCPL has not been provided with all information and evidence it requires to deal with the referral. This structural barrier to information sharing has serious downstream consequences in the court process, the most significant being the Director being unable to fulfil his duty of disclosure. A survey of professionals conducted by the Child Protection Practitioners Association Queensland reported the Department frequently withholding or refusing to provide relevant information to the DCPL or providing late or incomplete responses.[66] One respondent described a direct refusal to provide relevant information:[67]

[63] Together Union, *Submission to Child Safety Commission of Inquiry* (6 March 2026), 50.
[64] Ibid.
[65] Statement of Nigel Miller (7 November 2025) [183].
[66] Child Protection Practitioners Association of Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (29 March 2026) 15.
[67] Ibid 44.

> 'At a contested final hearing the STL advised me at court that the child was having issues in his placement, including an adult brother threatening to kill him the day prior. I requested disclosure. The STL stated 'I will not be providing that information as it will open up a can of worms' and 'that is not relevant.' The STL subsequently swore at myself and my assistant director and said they would write in the affidavit that the placement was 'stable'. This is extremely concerning as the child is in a home where he has reported his life has been threatened.'
>
> *Anonymous child protection practitioner (11 – 20 years' experience)*

A related issue that arose in the course of public hearings was the disclosure of OCFOS' legal advice (given to departmental officers) to the DCPL. The OCFOS has maintained a position that legal advice given by OCFOS to department officers as its 'client' is subject to legal professional privilege and is not subject to disclosure to the DCPL.[68] The Director disagreed, and further noted that this contributes to duplication and/or confusion, particularly where the DCPL is considering matters that have already been the subject of consideration and advice by OCFOS.[69]

The Commission doubts that the privilege asserted by the OCFOS would prevent disclosure of relevant documents to the DCPL. ***Firstly***, any privilege in advice given to the Department, as a government agency, likely belongs to the Crown in right of Queensland, rather than the Department. ***Secondly***, and, in any event, in the Commission's view there is clearly a common interest between the OCFOS and the DCPL, which would allow the sharing of the advice without waiving any privilege.[70] ***Thirdly***, and relatedly, the statutory duty of disclosure placed upon both the Director and the Department reinforces the common interest: it is a clear statutory signal that information between the two agencies should flow freely and not be subject to technical constraints.

The Commission notes that the implementation of the Department's new Unify system presented an opportunity to resolve many, if not all, of the above issues. The Commission heard that there was extensive consultation with the Department by the Director to integrate the DCPL's systems with Unify, 'to do away with any need for re-entry of data as part of this exchange of information'.[71] Ultimately, this did not occur.[72]

[68] Transcript, Evidence of Clair Martin (12 December 2025) 3717:41.
[69] Transcript, Evidence of Nigel Miller (10 December 2025) 3478:3.
[70] Transcript, Evidence of Clair Martin (12 December 2025) 3717:41.
[71] Transcript, Evidence of Nigel Miller (11 December 2025) 3561:3.
[72] Ibid 3562:8; The Commission understands that the DCPL has limited access to Unify via a restricted 'portal'.

The Commission is of the view that all of the issues described above would be resolved by granting the DCPL an appropriate level of access to Departmental information systems, sufficient to discharge their statutory litigation responsibility. Allowing the DCPL to directly identify, access and produce relevant, up-to-date information will lessen the associated administrative burden on departmental staff, and will allow the DCPL to make decisions in the best interests of children based, directly, on current information.

4.2.4 Matters referred back to the Department

Where the Department has assessed that a child protection order is required and referred the matter to DCPL, if the Director decides not to file an application the matter is then referred back to the Department. This can be with or without the Department's agreement. DCPL reports that between commencement and 30 June 2025 it referred back 693 matters to the Department.[73] DCPL further reports that it later had no further involvement in 260 matters (37.5%), meaning that 62.5% of matters initially declined by DCPL ultimately returned and required the filing of a child protection application at a later date.[74]

4.2.5 Difference between the Department's and DCPL's assessments

In the current framework, the decision whether to apply for a CPO rests solely with the DCPL.[75] If the Department makes an assessment that a CPO is required for a child, that is the trigger for the Department to refer the matter to the DCPL.[76] In dealing with the referral, the DCPL must consider the Department's assessment (among other things).[77] If the DCPL intends to deal with the matter differently to the Department's assessment, it must consult with the Department and, if there is no agreement, must give written reasons for the decision.[78]

Figure 6 below shows the proportion of matters in which the DCPL dealt with differently compared with the Department's initial assessment.[79] This includes matters in which the DCPL sought a different order or referred the matter back to the Department without filing an application.

[73] CA-51, *Statement of Nigel Miller*, tendered 9 December 2025 [205].
[74] Ibid.
[75] *Director of Child Protection Litigation Act 2016* (Qld) s 10 states: 'The director may, on behalf of the State, apply to the Childrens Court for…a child protection order for a child…' (emphasis added). See also s 13.
[76] *Director of Child Protection Litigation Act 2016* (Qld) s 15.
[77] Ibid s 16.
[78] Ibid s 18.
[79] CA-51, *Statement of Nigel Miller*, tendered on 9 December 2025, [217].

		2022-23		2023-24		2024-25	
		No.	(%)	No.	(%)	No.	(%)
Matters DCPL dealt with differently	Total	523	14.9%	664	18.5%	767	18.8%
	With agreement	433	12.4%	538	15.0%	588	14.4%
	Without agreement	90	2.6%	126	3.5%	179	4.4%

Figure 6: matters in which the DCPL dealt with differently compared with the Department's initial assessment between 2022 and 2025.

This data indicates that in almost one-fifth of referrals, the DCPL took a different view of the application with respect to the Department's initial assessment.

Nothing in the current framework requires the DCPL to give effect to the Department's assessment. To do so would fundamentally undermine the role of the DCPL as an independent litigation body. However, the Commission accepts that, under the current framework, effective collaboration between the Department and the DCPL is desirable. The Together Union observes that the 'divergence rate' reported above, being the proportion of matters where the DCPL dealt with a referral in a way that was different to the Department's initial assessment, has never been evaluated with respect to child outcomes.[80] The Commission recognises that there is force in that suggestion: such an evaluation may well provide information that assists DCPL in discharging its litigation function.

4.3 The bifurcated model should be abandoned

The Department (including OCFOS) and the DCPL agree that the bifurcated model has not been successful in practice. The Commission agrees. The evidence before the Commission was that Queensland's bifurcated model has failed to deliver the benefits of independence, accountability and timely, child-centred decision-making it was intended to achieve. It should now be abolished, for six reasons.

Firstly, as discussed above, the making of an order, even an emergent one, to remove a child from his or her family into State care is a highly consequential step. Therefore, the decision-making process followed must be rigorous and robust, to promote confidence in and eliminate

[80] Together Union, *Submission to Child Safety Commission of Inquiry* (6 March 2026), 48–49. The Union's submission provides a 'divergence rate' of 16.4%, though the Commission notes that this figure does not include matters referred back to Child Safety (see – CA-51, *Statement of Nigel Miller* tendered 9 December 2025 [34], [211]).

reasonable criticism of the decision. OCFOS's lack of independence from the Department tends to undermine confidence in the decision-making process. Notwithstanding its titles, OCFOS is not in substance, independent of the Department. Neither is the Office separate and independent of the Department in a practical sense. The co-mingling of the Department and the OCFOS creates a structure in which conflicts are, and would reasonably be perceived to be, likely.

As already explained, the so-called 'instructional model' as between the Department and OCFOS further erodes OCFOS's perceived and actual independence. Further, it conflates related but different functions and evaluations in the context of child protection on one hand and child protection litigation on the other. The proper function of the CSO and the STL in this context is to investigate and evaluate concerns about whether a child is in need of protection or remains in need of protection and, if so, the most appropriate intervention to secure their ongoing care and protection needs. The Department has extensive processes and procedures for the evaluation of children at risk of harm. That is different, though related to, an analysis of whether there is sufficient evidentiary material upon which to properly make an application to a Court, in satisfaction of the relevant legal and evidentiary standards. The latter analysis is a legal and forensic analysis and ought to properly be done by a lawyer, unconstrained by a CSO or STL's instructions.

For these essential reasons, it is critical that decisions to invoke the court process for the removal of a child are made by a body legally and practically independent of the Department's operations.

Secondly, the bifurcation has led to the duplication of work undertaken across all stages of the child protection proceedings and does not facilitate a timely and efficient legal process.[81] Both Ms Schifilliti and Mr Miller observed that there is considerable duplication, particularly in the referral process.[82] Other evidence before the Commission suggested that the bifurcated model had contributed to delay and procedural complexity. Matters routinely take longer to resolve, parents are frequently unrepresented at critical procedural stages, and children remain subject to prolonged interim or temporary orders that undermine stability and permanency outcomes.

Thirdly, the very nature of the dual entities, each established under separate ministerial portfolios, has created a structural separation between the agency responsible for operational child protection functions and the entity responsible for litigating matters within its purview.

[81] This is particularly the case in the referral stage of proceedings, where both OCFOS lawyers and DCPL lawyers play a role in reviewing the brief of evidence and settling affidavit material (including redaction) in support of any application for CPO. Further, where new concerns arise in child protection proceedings already on foot, there may be circumstances where a further emergent order is required to be sought to secure custody of a child (PSO/Directive Orders).
[82] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3211:26 to 3213:47; Transcript, Evidence of Nigel Miller (10 December 2025) 3475:24.

While intended to preserve independence, this arrangement has diffused accountability: one is responsible for service delivery, the other for legal decisions, however both influence the safety and permanency outcomes for children. Relatedly, the existence of the dual entities has resulted in entrenched inefficiencies, with workforce costs for both OCFOS and DCPL increasing each year since their respective establishment.[83]

Fourthly, the current approach whereby multiple lawyers are charged with the responsibility to litigate a matter at different stages of a proceeding[84] is antithetical to sound litigation practice. This is further compounded by the serial transfer of responsibility between the different legal entities which fractures legal stewardship. The Commission has heard that this disjunction manifests acutely in child protection proceedings as unexplained changes in the State's case, divergent risk thresholds applied to the same evidentiary material, and the repeated re-litigation of issues that ought properly to have been settled earlier in the life of proceedings.[85] These effects are not anomalous; they are the predictable by-product of a model that severs the continuity of forensic responsibility by way of design.

Across jurisdictions, it is a foundational assumption that litigation is conducted as a single, continuous proceeding overseen by a legal representative who maintains responsibility for the forensic integrity, strategic coherence and proportionality of the case from commencement to resolution. Continuity of legal stewardship enables informed interlocutory decision-making, consistent evidentiary evaluation, principled amendment or concession where required, and disciplined articulation of relief. By contrast, the serial transfer of responsibility between different legal entities fractures that stewardship.[86] It invites retrospective re-characterisation of evidence, shifting legal thresholds and defensive or overly technical approaches disconnected from earlier assessments and commitments.

Critically, this fragmentation undermines the State's model litigant obligation to act consistently, transparently and fairly.[87] Where no single lawyer or entity bears responsibility for the litigation as a whole, accountability for delay, escalation, pleading drift and disproportionality is weakened, and the Court is deprived of the assurance that the State's case has been subject to a unified and ongoing forensic evaluation. In a jurisdiction concerned fundamentally with the

[83] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3198:33.
[84] Transcript, Evidence of Nigel Miller (10 December 2025) 3475:24–45.
[85] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3216:1-9; Transcript, Evidence of Nigel Miller (10 December 2025) 3465:22-28; 3475:24-31.
[86] Transcript, Evidence of Nigel Miller (10 December 2025) 3478:3-14.
[87] Queensland Government, *Model Litigant Principles* (Web Page, 26 January 2023) <https://www.justice.qld.gov.au/about-us/services/general-counsel/legal-services-coordination-unit/legal-service-directions-and-guidelines/model-litigant-principles>; Transcript, Evidence of Angela Schifilliti (8 December 2025) 3235:5-15.

protection of children rather than the vindication of adversarial interests, such fragmentation is not merely undesirable; it is incompatible with the proper administration of justice and with the Court's legitimate expectation that the State will present its case with coherence, restraint and fidelity to the child's best interests throughout the life of proceedings.

***Fifthly*,** the relationship that exists between OCFOS, DCPL and the Department is perceived by stakeholders as competitive and uncollaborative. This tension has been observed firsthand by the Commission during public hearings[88] and through its inquiries. Families are often left confused where different stakeholders take a different view with respect to their matter and professional stakeholders have observed the tensions between the State entities, resulting in poor coordination and inconsistent practice.

Sixthly, the bifurcated jurisdiction, reflected in the suite of different orders that may be sought under the CP Act, has led to an unnecessarily complex legal process involving serial proceedings, duplication and inefficiency.

For the above reasons, the Commission recommends that the bifurcated model as between OCFOS and the DCPL as described should be abolished.

4.4 Where should unified responsibility for emergent and child protection orders lie?

It follows that if the bifurcation between the two entities is abolished, there is a need for a single entity with responsibility for the bringing of emergent order and child protection proceedings in Queensland. Therefore, the Commission has considered the question of *who* should be conferred with the integrated and exclusive jurisdiction to apply for both emergent and child protection orders.

The Commission received various submissions:

- OCFOS contended that it should take over the function of the DCPL, such that the legal process would be unified within OCFOS;

[88] Ms Schifilliti expressed doubt about the appropriateness of a lawyer, such as the DCPL, having the power not to file a CPO application against the assessment of a CSO or STL – see Transcript, Evidence of Angela Schifilliti (8 December 2025) 3235:5-15; Ms Martin referred to a case in which the DCPL Guidelines appeared to create additional evidentiary requirements – see Transcript, Evidence of Clair Martin (12 December 2025) 3645-58. Mr Miller expressed frustration about withholding of legal advice provided by OCFOS to Child Safety staff in referring matters to the DCPL – see Transcript, Evidence of Nigel Miller (10 December 2025) 3478:3-18.

- The Together Union, in its first submission to the Commission,[89] contended that the DCPL's role and functions should be subsumed within OCFOS. In its final submission to the Commission, the Together Union was less wedded to OCFOS being the body with unified responsibility, contending simply that there be 'a single legal body with responsibility for the full lifecycle of child protection matters, from early advice through to final hearing' and that legal body should sit within the Department;[90] and
- The Director's position during public hearings was not to advance contentions as to the bifurcated model but rather to demonstrate, based upon empirical data, that the DCPL independently assesses the referrals from OCFOS in relation to the seeking of child protection orders in order to demonstrate the merit and utility of the function his office performs. In his final written submissions provided to the Commission, the Director outlined the practical considerations the Commission ought to have regard to if ultimately, recommendations were made to expand DCPL's role within the CPL model.[91] In essence, the Director recommends that the DCPL would require additional resources to take on expanded legislative functions.[92] In particular, the Director emphasises the importance of ensuring that Departmental staff have access to early, independent legal advice and that this could also fall within the remit of the DCPL.

For the reasons given above at Parts 4.1 and 4.3, the Commission does not support the amalgamation of the jurisdiction within the OCFOS. Instead, in the Commission's view, sole responsibility in relation to all child protection applications should rest in a ***single, statutorily independent litigation body*** responsible for the full lifecycle of child protection proceedings, including initiation, conduct, amendment, permanency decision-making and review.

A body with those qualities already exists, in the DCPL. The Commission therefore recommends that the DCPL should be conferred with unified responsibility in relation to all child protection proceedings, from commencement to conclusion of proceedings. The Commission regards the conferral of child protection jurisdiction upon an independent statutory body as a gold standard in relation to integrity and independence, presently unique in Queensland. This model has the potential to achieve efficiency and cost reduction. A unified jurisdiction under the stewardship of the DCPL presents a tangible opportunity for process and procedures to be fashioned in

[89] CA-49, *Together Union Submission in relation to the Child Protection Litigation Project*, tendered 9 December 2025, 4, 12.
[90] Together Union, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 12. It is important to note that the Together Union also represents employees of Justice including DCPL lawyers. Several DCPL lawyers are members of the Together Union. Despite this, no submission was made to the Commission on their behalf.
[91] Director of Child Protection Litigation, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (23 March 2026).
[92] Ibid [5].

cooperation with the Childrens Court, including an opportunity to adapt Court processes to align with the human services context in which the child safety system operates. Presently, these benefits are obstructed by the bifurcated model. Under a unified model, the Commission considers that the DCPL, in consultation with the Department and the Childrens Court, and by engaging with families, children, Aboriginal and Torres Strait Islander Community Controlled Organisations ('ATSICCOs) and other stakeholders, will be well placed to improve processes so that they better promote the just and timely resolution of proceedings.

The evidence before the Commission also establishes that the physical separation between applicant lawyers and Child Safety Service Centres ('CSSCs') has contributed to disconnection between litigation decision-making and frontline child protection practice. While independence from the Department is a critical feature of the DCPL's statutory role, independence ought not require physical or geographic isolation from operational child safety functions.

The Commission considers that effective child protection litigation requires more than formal independence; it requires functional integration with frontline practice. Applicant lawyers must have a practical appreciation of the operational and human service context in which protective concerns arise, including the realities of casework, placement availability, cultural considerations and service system constraints. Physical co-location with, or routine access to, CSSCs would enable applicant lawyers to:

- engage directly and informally with Child Safety staff at an early stage;
- interrogate evidentiary material collaboratively before proceedings are commenced or escalated;
- test assumptions and risk formulations in context; and
- reduce reliance on voluminous documentary material in favour of proportionate, relevant evidence.

The absence of such proximity risks reinforcing the structural dislocation between legal process and child-centred outcomes identified throughout this chapter. Equally, it is essential for the DCPL, as the unified litigation body, to have the level of access to Departmental information and system that it requires to properly discharge its functions.

4.5 Recommendations

Recommendation 10: Abolish the bifurcated model (OCFOS & DCPL)	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 4)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, confer the Director of Child Protection Litigation with responsibility, including decision-making responsibility, in relation to all child protection proceedings, from the commencement of court involvement to the conclusion of proceedings. The Government should, including by relevant amendments to *Child Protection Act 1999* (Qld) and the *Director of Child Protection Litigation Act 2016* (Qld) and any other relevant instrument:

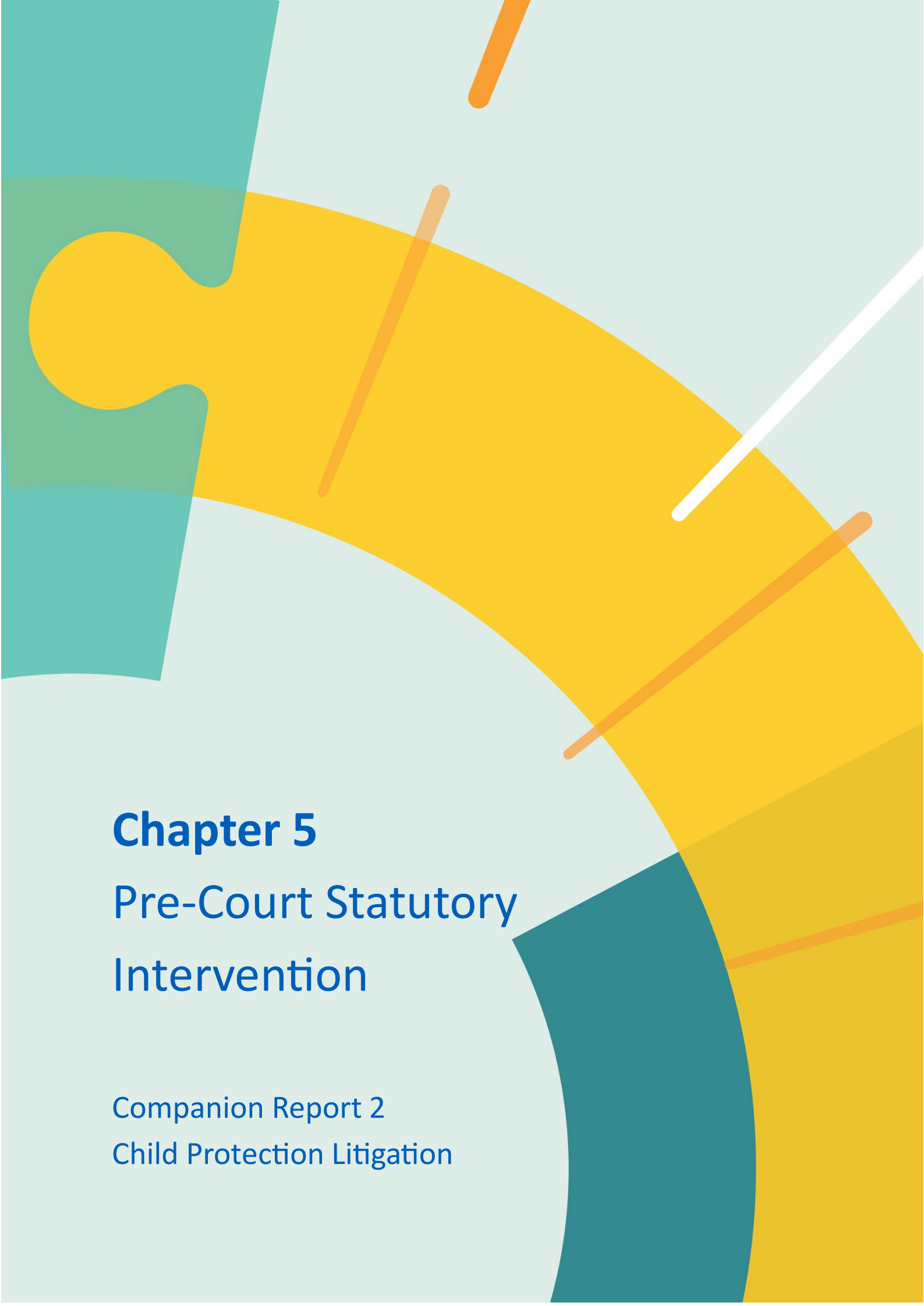
(a) place sole responsibility on the DCPL as the applicant and litigant on behalf of the State in all child protection proceedings;
(b) place appropriate obligations on the DCPL to:
    (i) engage systemically with families, children, ATSICCOs and specialist advocacy stakeholders;
    (ii) ensure DCPL lawyers complete relevant training with respect to cultural competence and trauma-informed practice; and
    (iii) litigate in a way which promotes meaningful participation by parents and children from the earliest stage of proceedings;
(c) provide suitable arrangements for the DCPL to access all relevant Departmental databases, information and systems, to the extent necessary to discharge its unified responsibility;
(d) provide suitable arrangements to facilitate an appropriate degree of co-location of DCPL lawyers with Child Safety Service Centres, to balance the need to preserve DCPL's statutory and practical independence while also facilitating engagement with frontline practitioners and families;
(e) promote clear governance arrangements identifying DCPL's accountability for litigation coherence, timeliness and proportionality across proceedings;
(f) require monthly public-facing reporting on trends in litigation duration, interim order length, reunification outcomes and permanency timeframes; and
(g) ensure there be an independent evaluation of outcomes of the unified model for children and families, particularly Aboriginal and Torres Strait Islander children.

CONTEXT:

The context to this recommendation is the subject of Chapter 3 of the Companion Report. In short, the bifurcated model fails because: OCFOS lacks substantive independence from the Department, and the 'instructional model' conflates the operational child protection function with the distinct legal and forensic evaluation that ought to be undertaken by an independent lawyer. Bifurcation also produces duplication, delay, diffused accountability across two ministerial portfolios, and a serial transfer of responsibility between OCFOS and the DCPL that fractures legal stewardship, undermines the State's model litigant obligations, and generates an unnecessarily complex process of serial proceedings under the CP Act.

IMPLEMENTATION NOTES:

This recommendation should be understood as being directed entirely to the analysis of the present bifurcated model, set out in the Companion Report, and not otherwise.



Chapter 5

Pre-Court Statutory Intervention

Companion Report 2

Child Protection Litigation

Chapter 5: Pre-Court Statutory Intervention

The determination that a child is no longer safe to remain in the care of their parents is intrusive and consequential. That determination marks the point at which the State intervenes in family life in its most direct and profound form — displacing parental authority, separating a child from their family (temporarily or permanently), and assuming responsibility for the child's safety and wellbeing.

In Queensland, many of these decisions are frequently made 'on the ground' and in circumstances of urgency and high stress. These decisions are made prior to judicial oversight, and often without contemporaneous legal advice being provided to parents or to the Departmental officers exercising the relevant powers conferred upon them pursuant to the CP Act.

The Commission heard from senior Departmental representatives that decisions made prior to the Court process (including investigations, assessments, safety planning and the exercise of section 18 of the CP Act) are characterised as matters of *practice* rather than *law*.[93] On that basis, they are generally treated as falling outside the scope of legal scrutiny until court proceedings are formally commenced.

The Department's distinction between practice and law is, for reasons that explained in this chapter, unsound. It is at these early stages, before the filing of any application and often before legal rights are explained, that decisions are made about whether a child remains at home, who may care for the child, and whether separation between a child and their parents can ultimately be avoided. These decisions set the trajectory of the matter and, in many cases, will effectively determine whether reunification in the future remains realistic. In many cases, matters characterised as matters or 'practice' involve significant exercises of public, indeed statutory, power.

Part 5.1 of this chapter examines the mechanisms by which children are currently 'removed' from parental care in Queensland *outside* the court process, focusing on arrangements characterised as both voluntary and involuntary. It focuses on the use of safety plans and care agreements as means of voluntary and early intervention and identifies deficiencies arising from their

[93] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3175, 3193, 3297–3299 , Transcript, Evidence of Clair Martin (12 December 2025) 3700, 3854; Transcript, Evidence of Victoria Van Houdt (27 November 2025) 2946-7.

categorisation within the Department as practice decisions. Part 5.2 explores the use of section 18 of the CP Act, being the administrative removal of a child. Decisions to separate a child from parental care (whether described as voluntary or involuntary) are among the most serious exercises of power undertaken by the State. The administrative removal of a child is a legal decision, not a matter of practice, and *must* be treated as such.

5.1 Voluntary removal

In Queensland, children may be effectively removed from parental care without a court order through mechanisms characterised as 'voluntary'. These mechanisms occupy a grey zone between support and coercion and are central to early statutory intervention. They are presently not accompanied by independent legal advice as a matter of course and are not subject to judicial oversight at the point they are implemented. Two principal mechanisms are utilised by the Department: (a) safety plans; and (b) care agreements. While labelled as 'voluntary', both mechanisms can involve the transfer of care away from parents, and result in extended separation or conditions being imposed.

5.1.1 Safety plans

If a CSO, through a Safety Assessment, identifies immediate risk indicators to a child, the CSO will try to develop an Immediate Safety Plan ('safety plan') to manage the risk.[94] As Ms Van Houdt, Acting Chief Practitioner explained:

> The safety assessment assists a practitioner in identifying the harm indicators and working through any other factors within the environment, protective factors in the environment or parental protective factors, vulnerability of the child, and then forming a view as to whether that child would be safe or if there needs to be action taken, which could be a plan with the family or otherwise, to make that child safe.[95]

A safety plan is an agreement developed by the CSO, in consultation with the STL, the child's parent(s), and (where relevant) extended family or kin.[96] It records:

- the immediate safety threat or harm indicator that has been identified;

[94] Department of Families, Seniors, Disability Services and Child Safety (Qld), *Structured Decision Making* (Policy No 407-8, 29 October 2024); Department of Families, Seniors, Disability Services and Child Safety (Qld), *Child Safety Practice Manual — Other Assessment Actions: Carry Out a Safety Assessment* (Web Page, 6 May 2026) <https://cspm.csyw.qld.gov.au/procedures/respond-to-a-notification/other-assessment-matters-actions#Carry_out_a_safety_assessment>.
[95] Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2809-10 ; See also Transcript, Evidence of Witness W (17 November 2025) 2080.
[96] Department of Families, Seniors, Disability Services and Child Safety (Qld), *Child Safety Practice Manual — Glossary: 'Immediate Safety Plan'* (Web Page) <https://cspm.csyw.qld.gov.au/glossary#immediate-safety-plan>

- the actions to be taken to mitigate that threat;
- where the child is to live during the plan's operation;
- who will care for, supervise, or be present with the child;
- restrictions on contact with persons identified as causing or contributing to the risk; and
- the steps the parent must take (e.g. attend services, refrain from substance use, maintain housing) and any review intervals.[97]

Practically, a safety plan can do — and routinely does — much of what a court order or care agreement does. It can, for example:

- Move a child out of the family home (placing the child with a grandparent, aunt, family friend, or another nominated adult);
- Require the child to be supervised at all times, by a nominated safe person;
- Restrict or prohibit contact between a parent and the child (for example, where the parent's substance use, mental-health symptoms or family violence is the identified risk);
- Require a parent's attendance at services (drug and alcohol treatment, mental-health treatment, parenting programs, domestic violence services);
- Impose conditions on the household (for example, that an identified person does not reside in or attend the home); and
- Set conditions for reunification (e.g., that the child can return home only after specified milestones are met).[98]

However, safety plans are not provided for in legislation. They are a structured decision-making tool, developed and regulated entirely through Departmental policy and practice. There is no statutory framework governing their use, duration, review, variation or termination, and no express legislative safeguards concerning consent, access to legal advice or external review or oversight. Their legal status is uncertain, notwithstanding their widespread and consequential use.

Departmental policy describes safety plans as: short-term and time-limited; focused on addressing immediate safety concerns; and subject to frequent review, commonly described as occurring at seven-day intervals.[99] However, the Commission heard that safety plans do not

[97] Department of Child Safety, Youth and Women (Qld), *Structured Decision Making in Child Protective Services: Policy and Procedures Manual* (Version 4.3, May 2019), 6-32
[98] Department of Families, Seniors, Disability Services and Child Safety (Qld), *Structured Decision Making* (Policy No 407-8, 29 October 2024) ; Department of Child Safety, Youth and Women (Qld), *Structured Decision Making in Child Protective Services: Policy and Procedures Manual* (Version 4.3, May 2019), 6-32
[99]Department of Families, Seniors, Disability Services and Child Safety (Qld), *Child Safety Practice Manual — Other Assessment Matters: Carry Out a Safety Assessment* (Web Page) <https://cspm.csyw.qld.gov.au/procedures/respond-to-a-notification/other-assessment-matters-actions#Carry_out_a_safety_assessment_>.

always have those characteristics in practice. In addition, parents are not always informed of their right to seek legal advice before agreeing to a plan.[100]

5.1.2 Functional equivalence to removal

Safety plans often result in the child being 'placed' *outside* the parental home, sometimes with extended family members, sometimes with individuals known to the family. In these circumstances, the practical effect of a safety plan is not far removed from voluntary removal under a care agreement. Despite this, safety plans are regarded by the Department as practice decisions and, on that basis, are not routinely subject to legal advice or legal review. This minimises the seriousness of the decision being made and diminishes accountability for its consequences.

The Commission accepts that safety plans can play a legitimate role in enabling families to engage voluntarily with the Department at an early stage and to identify appropriate, familiar carers who may be able to provide temporary care while immediate risks are addressed. Properly used, they can broaden the range of safe options available and reduce unnecessary escalation. However, the Commission considers that safety plans should not operate outside a clear legal framework. Where safety plans result in a child living away from their parents, or materially restrict a parent from exercising their parental responsibility, they impinge upon fundamental rights and should be accompanied by appropriate safeguards. Absent these safeguards, safety plans risk operating as a de facto removal mechanism, without the protections that ordinarily accompany such a profoundly intrusive decision.

Care agreements

A care agreement is a statutory voluntary mechanism by which the Department arranges for a child to be placed in the care of someone other than their parent — including, often, the Chief Executive — without recourse to a court order. [101] Unlike safety plans, care agreements are expressly provided for in the CP Act, and operate within a defined framework. The CP Act establishes two distinct forms of care agreement: (a) assessment care agreements; and (b) child protection care agreements.[102] While both forms of agreement result in a child being cared for by a person other than their parents, the legal thresholds governing their use, the effect of each agreement and the consequences that flow from them differ significantly. The availability of both types of care agreements is constrained by an important statutory limitation: they may only be

[100] Transcript, Evidence of Clair Martin (2 February 2026) 4008-9; Transcript, Evidence of Nigel Miller (10 December 2025) 3479.
[101] *Child Protection Act 1999* (Qld) Pt 4, Div 2.
[102] Ibid ss 51Z-51ZI.

entered into if the Chief Executive is satisfied that, should a parent withdraw consent to the agreement, the child would *not* be at immediate risk of harm.[103] As a result, care agreements are often unavailable in precisely those cases where a voluntary, non-coercive option would otherwise be desirable.[104]

Assessment care agreements

Assessment care agreements are intended to operate as a short-term and voluntary mechanism to facilitate assessment of a child's circumstances.[105] Unlike child protection care agreements, they do *not* require a determination that the child is a child in need of protection within the meaning of s 10 of the CP Act. The period of an assessment care agreement must not exceed 30 days and is unable to be extended.[106] Further, the CP Act is silent as to the effect of an assessment care agreement and accordingly, a child's parents retain custody and guardianship.[107]

Child protection care agreements

Child protection care agreements may only be entered into where the Chief Executive has determined that the child is a *child in need of protection*.[108] This determination mirrors the statutory threshold required for more intrusive court-based intervention. Unlike assessment care agreements, child protection care agreements are capable of being extended after an initial period of 30 days, and while in force, provide the Chief Executive with custody of the child.[109] Child protection care agreements may also be extended for up to six months in any 12 month period,[110] provided:

- there is a case plan is in force for the child; and
- the Chief Executive is satisfied the extension would be in the child's best interests, having regard to the progress made under the case plan and the child's developmental needs.[111]

The effect of this requirement is that child protection care agreements occupy an anomalous position within the statutory scheme. Although they are framed as voluntary agreements, their

[103] Ibid s 51ZE(1)(b).
[104] See, eg, the example discussed at Transcript, Evidence of Witness M (25 November 2025) 2699-2701.
[105] *Child Protection Act 1999* (Qld) ss 51ZD, 51Z(a).
[106] Ibid s 51ZH(2) – (3).
[107] Department of Families, Seniors, Disability Services and Child Safety (Qld), *Child Safety Practice Manual — Decision Making for a Child* (Web Page) <https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/decision-making-for-a-child>.
[108] *Child Protection Act 1999* (Qld) s 51Z(b).
[109] Ibid ss 51ZH(5), 51ZG.
[110] Ibid s 51ZH(8).
[111] Ibid s 51ZH(9).

use is predicated on the same legal finding that would justify the commencement of child protection proceedings.

5.1.3 Voluntary removal mechanisms: observations

The Commission has observed that arrangements described as voluntary, including safety plans and care agreements frequently operate as mechanisms for the de facto removal of a child from their parents' care. Where these arrangements result in a child living away from their parents, or materially restrict a parent's ability to exercise day-to-day care, they constitute an exercise of State power with coercive effect, regardless of terminology. The gravity of these decisions, and their profound impact on children and families, place them among the most intrusive forms of executive action undertaken outside the Court. They engage fundamental rights to family integrity, parental responsibility, cultural continuity and procedural fairness. Characterising such decisions as matters of practice rather than law obscures their true nature and weakens accountability at precisely the point where safeguards are most needed.

Consent obtained in circumstances of urgency, power imbalance or implicit threat of involuntary removal cannot be assumed to be fully informed or freely given. Whether consent is valid; whether statutory preconditions are met; whether less restrictive alternatives exist; and whether removal is lawful, necessary and proportionate are legal questions, not merely professional or operational ones.

5.2 Involuntary removal through administrative powers

In Queensland, involuntary removal of a child from parental care may occur through the exercise of administrative statutory powers, without prior judicial authorisation and often without contemporaneous legal advice being sought by Departmental officers exercising the powers. The principal mechanism is section 18 of the CP Act, which permits an authorised officer or police officer to take a child into the custody of the Chief Executive on the basis of a reasonable belief that the child is at risk of harm and likely to suffer harm if not immediately removed.[112] This power represents the most intrusive exercise of executive authority in the child protection system, authorising immediate separation of a child from family without Court oversight.

Temporary assessment orders and court assessment orders made after an administrative removal may consolidate removal, initiate Childrens Court proceedings, and maintain a child in

[112] Ibid s 18.

State custody for extended periods.[113] Although formally framed as assessment-enabling orders, they commonly operate as the functional gateway to longer-term separation, often preceding any judicial determination that removal itself is necessary, proportionate or justified.

5.2.1 Section 18 – Administrative removal in urgent circumstances

Section 18 of the CP Act confers power on an authorised officer or police officer to take a child into the custody of the chief executive without a court order where the officer reasonably believes the child is at risk of harm and that the child is likely to suffer harm if not immediately taken into custody.[114] This power is expressly framed as an emergency measure, intended to address circumstances of genuine and *immediate* risk.

The exercise of section 18 is subject to strict time limits. Custody under section 18 may only be maintained for up to eight hours, during which time the officer must, *as soon as practicable*, apply for a TAO.[115] Alternatively, it is also open to the Department to apply for a TCO.[116] The statutory design therefore contemplates section 18 as a bridging power, operating only until urgent court involvement can be obtained. In the current framework, the CP Act compels the Department to file a TAO (or TCO) application because section 18 was used and appears to override any assessment or legal advice that the OCFOS might provide about the merits of the TAO in the circumstances.

Accordingly, in the Commission's view, this administrative power should be exercised only in cases of genuine urgency which satisfy the above test. It is not designed to be used as a trigger for initiating the court process where proceedings could reasonably have been issued, heard and determined *before* the child is taken into custody. In genuinely urgent cases, administrative removal followed by an urgent application for a TAO is reasonable. However, it is not reasonable in circumstances where the department is aware of circumstances and could undertake an investigation and assessment into those circumstances without needing to urgently take the child into custody.

Even where reasonably exercised, the power ought to be accompanied by the provision of a concise written statement recording the reasons the power was exercised. It is striking that there is not presently any such requirement. The requirement to provide written reasons is a typical public law safeguard in circumstances where coercive power is exercised administratively. A contemporaneous record promotes accountability, disciplines decision-making at the point of

[113] Ibid s 18(1).
[114] Ibid.
[115] Ibid s 18(5).
[116] Ibid s 18(6).

removal, and enables meaningful judicial scrutiny and review of the lawfulness and proportionality of the decision later.

If the circumstances are not urgent in the sense required by s 18, the proper course in accordance with the CP Act as it presently stands is for the Department to seek a temporary assessment order or a court assessment order *before* taking the child into custody. Both forms of order are intended to allow the Department to further investigate whether the child is a child in need of protection within the meaning of s 10 of the CP Act. Temporary assessment orders and court assessment orders allow for, but do not require, the child to be taken into custody for that purpose of the assessment.

In express terms, the provisions relating to the making of temporary assessment orders and court assessment orders require only that the orders are required to assess whether the child is a child in need of protection.[117] Because those orders may authorise the child's removal, it is striking that the CP Act at present does not require that the court, in making either order, also be satisfied there is a reasonable belief the child is at risk of harm and that the child is likely to suffer harm if not immediately taken into custody.[118]

It is surprising that there is not an express requirement that the Court be satisfied there is a reasonable belief the child is at risk of harm and that the child is likely to suffer harm if not immediately taken into custody. Where an application is made for a temporary assessment order without there having been a prior exercise of power under s 18 (which generally should be the case save in genuinely urgent circumstances) it *cannot* be assumed that the requirement was implicitly satisfied at the s 18 stage. But even where the application is made *after* a prior exercise of power, the requirement *should* not simply be assumed; it should be properly established to the Court's satisfaction, on proper material.

That the requirement be express is all the more important because temporary assessment orders may be made, and very often are made, *ex parte*. Making orders without notice to affected parties — here the parent or parents — is only justifiable in circumstances of genuine urgency. Such genuine urgency will only exist where there is a reasonable belief that the child is at an imminent risk of harm which cannot practically wait to be addressed until notice is given to the parent or parents. There will be such cases, including in the context of flight risk, where not giving notice to the parent or parents is warranted. But that will not always be the case. *Ex parte* applications should only occur in genuinely urgent situations because that reduces the incidence of

[117] Ibid s 14: requires the Department to complete an assessment (or take other appropriate action) upon forming a reasonable suspicion the child is a child in need of protection.
[118] Ibid s 27.

unnecessary harm to the child arising when the child is detached from family, even for a short time.

Accordingly, the Commission recommends that this framework will need to be amended as part of the broader reform to streamline and unify the jurisdiction for child protection proceedings, as explained below.

5.3 Recommendations

<table>
<tr><th colspan="2">Recommendation 11: Amend section 18 of the Child Protection Act</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 5)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, amend section 18 of the Child Protection Act 1999 (Qld) in order to:

1. Provide that the administrative power to remove a child without prior judicial authorisation may only be exercised where:

(a) the risk of harm has arisen suddenly or escalated in an unexpected manner;
(b) the harm is such that it cannot reasonably be prevented through voluntary measures or other measures less intrusive than removal of the child into State care, including safety planning, supervision, placement with family or kin, or the timely filing of a court application with notice; and
(c) delay for judicial consideration would itself create, or materially increase, the risk of harm to the child.

2. Allow for an extended maximum duration of care to five business days, where the child is to be safely placed with a family member or another person with whom the child has an existing trusting relationship, and otherwise a maximum duration of eight hours.</td></tr>
<tr><td colspan="2">CONTEXT:

The context is set out in detail in Chapter 5 of the Companion Report. The intention of this amendment is to incentivise engagement with family members and consideration of voluntary care options before a child is removed, and to acknowledge that where a safe placement is arranged with family or a trusted person, there is likely to be less need for immediate adjudication of the removal by the Court.</td></tr>
<tr><td colspan="2">IMPLEMENTATION NOTES:

Making such legislative changes will require a broad review of the Child Protection Act 1999 for consequential amendments.</td></tr>
</table>

Chapter 6

The Court System

Companion Report 2

Child Protection Litigation

Chapter 6: The Court System

6.1 The powers of the Court

Presently, the court has four primary powers it can apply to ensure the safety of a child who needs protection:

- Directives;
- Supervision of a child's care and protection;
- Custody of the child; and,
- Guardianship of the child.

Figure 7 below sets out the maximum duration of child protection orders. Directives, supervision orders and custody orders are expressly short-term orders. Directives and supervision orders may be made for a maximum of one year.[119] Short-term custody orders may be made for a maximum of two years.[120] There is no power to make a long-term directive, require long-term supervision, or to grant long-term custody of a child to a person. Only guardianship may be short-term *or* long-term. Short-term guardianship may be granted for a maximum of two years.[121] Long-term guardianship is granted until the child turns 18 years old.[122]

Order type	Maximum duration	
	Short-term	Long-term
Directive order	One year	No provision for long-term orders
Supervision order	One year	
Custody order	Two years	
Guardianship order	Two years	Day before the child turns 18

Figure 7: maximum duration of child protection orders

Section 59 of the CP Act sets out the requirements for making any child protection order. These include:

- The child needs protection within the meaning of s 10 of the CP Act;[123]
- The order is appropriate and desirable for the child's protection; and,

[119] *Child Protection Act 1999* (Qld) s 62(2).
[120] Ibid s 62(3).
[121] Ibid s 62(3).
[122] Ibid s 62(6).
[123] Ibid s 10.

- The protection sought cannot be achieved by a less intrusive order.

The court must also be satisfied that:

- There is a current case plan for the child developed in accordance with the CP Act;[124]
- The case plan has been filed with the court and is appropriate to meet the child's assessed protection and care needs;
- The child's wishes or views, if able to be ascertained, have been made known to the court; and,
- If the application was contested, a conference has been held (or reasonable attempts made).

The above requirements apply to the making of any child protection order. The court may make any one or more orders as the court considers appropriate.[125] If the court makes an order granting custody or guardianship of the child, additional requirements apply. Notably, the court may grant short-term custody of the child to a member of the child's family, but it cannot grant short-term guardianship to that family member. These are discussed further below. The court must make the least intrusive order to meet the child's care and protection needs, and ensure the order is appropriate and desirable in the circumstances.[126]

This part analyses the unintended consequences that arise from the present, modular framework for CPOs, which do not always promote the purposes of the CP Act. Ultimately, the Commission recommends that the various types of CPOs be replaced with a simpler set of orders which are clearly linked to their intended purposes. In that connection, the Commission proposes that the concepts of 'custody' and 'guardianship' be replaced with the concept of 'parental responsibility'. As will be seen, these proposed reforms also promote greater court oversight of arrangements for children in the child protection system.

6.1.1 Types of Child Protection Orders

Directive and supervision orders

Not all children needing protection need to be removed from the care of their parents. As noted above, if the parent agrees, the Department may undertake certain voluntary interventions to support the family in addressing the child protection concerns.

[124] Ibid pt 3A.
[125] Ibid s 61.
[126] Ibid.

If a child needs protection and the parents do not agree to an intervention, the DCPL, upon referral, may seek a child protection order requiring the parent to do or not do certain things and/or, an order requiring the Department to supervise the child's protection. This may be either a 'directive order' or a 'supervision order' (also referred to as a 'Protective Supervision Order', or 'PSO'). These orders are commonly made together, commonly referred to as a 'PSO-DO'. Directive orders and protective supervision orders currently represent approximately 12% of all CPO applications, and approximately 10% of all CPOs granted.[127]

A ***directive order*** may require the person to do, or not do, certain things related to the care and protection of the child.[128] It may also restrict a parent's contact with the child, including placing conditions on contact.[129] A ***supervision order*** allows the Department to have reasonable contact with the child, and to direct a parent to do or not do certain things relating to the child protection.[130]

As neither directive orders nor supervision orders grant custody or guardianship of the child to another person, these orders are made on the basis that it is in the best interests of the child to remain in the care of at least one of their parents. The Commission notes there is some apparent tension in the nature of these orders and the fact a necessary condition of making these orders is that the child needs protection within the meaning of s 10 of the CP Act, because there is 'no parent willing and able' to protect the child from harm.

The Commission notes that the reforms proposed in this companion report, particularly with respect to parental responsibility, the 'balance of harm' analysis, and reforms to section 18 of the CP Act, would likely remove the need for directive or supervision orders as a special class of order. This is discussed further below.

Custody and guardianship orders

If a child needs protection and is not safe to remain in the care of their parents, the court may grant custody or guardianship of the child to another person so that the child may be placed in OOHC.[131]

The court may only grant ***custody*** of a child for a maximum of two years.[132] A person who is granted custody of a child has the rights and responsibilities to have and make decisions about

[127] Statement of Nigel Miller (7 November 2025) [220], [240].
[128] *Child Protection Act 1999* (Qld) s 61(a).
[129] Ibid s 61(b).
[130] Ibid ss 77-78.
[131] Ibid ss 67(1)(a), 61(d)-(g).
[132] Ibid s 62(3)-(5).

the child's daily care but will not have the power to make decisions about the long-term care, wellbeing and development of the child.[133]

The court may grant guardianship for either a two year period or until a child attains 18 years of age. A person who is granted ***guardianship*** of a child has the same rights and responsibilities with respect to daily care of the child, as well as all the powers, rights and responsibilities in relation to the child that would otherwise have been vested in the person having parental responsibility for making decisions about the long-term care, wellbeing and development of the child.[134]

6.1.2 Replace 'custody' and 'guardianship' with 'parental responsibility'

Maintaining a distinction between 'custody' and 'guardianship' does not promote the paramount principle of the CP Act

The distinction between 'custody' and 'guardianship' of a child imposes a binary that often fails to reflect the nuanced reality of children's care arrangements. For reasons explored below, the Commission recommends that Queensland should amend the CP Act to remove the distinction between 'custody' and 'guardianship' and replace those legal constructs with a framework of 'parental responsibility' that properly reflects the parental role all children need to be cared for and protected from harm.

'Parental responsibility' as a more effective framework for ensuring the child's care and protection needs are met

In Australia, each parent of a child under the age of 18 has parental responsibility for the child.[135]

This is the position set out in the *Family Law Act 1975* (Cth) (FL Act) and applies to all Australian children. Under the FL Act, parental responsibility in relation to a child means 'all the duties, powers, responsibilities and authority which, by law, parents have in relation to children'.[136] The attribution of parental responsibility to the child's parents is 'subject to any order of a court for the time being in force'.[137] This includes orders made under the CP Act.[138]

Orders made under the CP Act in Queensland may alter parental responsibility to the extent that they interfere in any way with the parent's 'duties, powers, responsibilities and authority' in relation to their child. The graduated intrusiveness of CPOs and emergent orders reflects the extent of this interference, with a long-term guardianship order reflecting the most complete

[133] Ibid s 12.
[134] Ibid s 13.
[135] *Family Law Act 1975* (Cth) s 61C(1).
[136] Ibid s 61B.
[137] Ibid s 61C(3).
[138] Ibid s 69ZK.

transfer of parental responsibility away from the parent(s) to the Department or another person. Whether this interference should occur, and if so to what extent and for how long, is the primary subject of child protection proceedings.

In the current framework, the distinction between 'custody' and 'guardianship' as well as 'directive' and 'supervision' orders seeks to separate the different components of parental responsibility like light through a prism. In fact, the concept of parental responsibility as it applies to all families in Australia is not so compartmentalised: it is flexible and adaptable. Importantly, it is capable of being altered without the need for narrowly defined concepts such as 'custody', which may or may not encompass the appropriate elements of parental responsibility that need to be transferred to keep the child safe.

The adoption of parental responsibility for child protection proceedings was recommended by the Carmody Inquiry and accepted by the then-government.[139] The Carmody Inquiry specifically recommended adoption of parental responsibility on the basis that it:

- aligns with the *Family Law Act 1975* (Cth);
- provides a universal and easily understood framework; and
- permits parental responsibility to be shared between the Chief Executive, parents and guardians, either concurrently or in specified respects.

The Carmody Inquiry observed that moving away from custody and guardianship would reduce unnecessary legal complexity and enable orders that more accurately reflect decision-making arrangements affecting children over time.[140] The then-government did not implement the recommendation. In the relevant closure report, it was noted:

> Amendments to implement this recommendation would require significant reform and a restructuring of the entire legislative framework and would affect amendments made to implement other QCPCOI recommendations. Further, legislative reform to implement this recommendation would have substantial impacts on front line Child Safety Officers and funded service providers, while achieving minimal benefits. It is also likely that any benefits of this change would be outweighed by the costs and resource implications.[141]

Respectfully, the Commission suggests that the necessary reform and legislative restructuring to revise the binary framework of 'custody' and 'guardianship' would in fact ultimately result in a significant *reduction* in complexity for children, families, services, carers, the Department, and

[139] Recommendation Closure Report provided by Department under Notice 3 issued 8 July 2025.
[140] Ibid.
[141] Ibid.

the courts. Further, the Commission considers that the adoption of this framework would permit the streamlined child protection litigation model outlined in this chapter, and increase reunification rates, improve children's care experiences, and reduce disincentives to prospective or current foster and kinship carers to provide family-based care.

If the concepts of 'custody' and 'guardianship' were replaced with the framework of 'parental responsibility', the Court could fashion an order in which the particular needs of the child are accommodated within the scope of the order. For example, the court could make an order granting parental responsibility for the child to the Department during the reunification period but may order that responsibility for cultural decisions is shared with the parents. This may also encourage parents to be more active participants in the court process and provide greater scope for parents to negotiate with the Department and the DCPL on the terms of the proposed child protection order.

Further, adopting and integrating with the prevailing family law in Australia would offer greater opportunities for families to more transition out of the child safety system through an application for parenting orders. Similarly, abandoning 'custody' orders and adopting parental responsibility would reduce difficulties presently associated with transferring orders to other jurisdictions.

6.1.3 Reframing child protection orders to focus on purpose rather than powers

The main purpose of a CPO is to ensure the child's care and protection in the stated time. But the legislation does not provide any express guidance or statement as to the purpose of the *different* CPOs set out in section 61 of the CP Act. By making a particular CPO – directives, supervision, custody, or guardianship – for a fixed duration, the role of the court is limited to creating the conditions for the child's protection rather than actually ensuring that the purpose is realised.

This system renders CPOs incomplete as a means of achieving the goals they are designed to achieve under the CP Act. For example, a short-term custody order provides time for work to occur, and it provides the power to meet the child's needs while the work occurs (to a limited extent). However, it neither requires that the work occur, nor that the child's needs are met while it occurs.

This disconnect has been the subject of judicial comment in the Childrens Court. An example is *Department of Communities v LE* [2011] QChC 4. At first instance, the Childrens Court made a custody order under section 61 of the CP Act accompanied by conditions regulating placement and kinship care – conditions that reflected the parties' shared understanding of how the order would operate in practice. On appeal, the Court held that there was no power in the CP Act to

place conditions that would fetter the Chief Executive's powers of custody. Further, the Court held it could not remove the conditions because they were the basis for agreement between the parties.[142] The Court observed that this outcome was 'unfortunate' and acknowledged that the statutory framework prevented a sensible and practical resolution of the matter.[143] In particular, the Court observed that the framework for parenting orders in the FL Act offered much greater flexibility to the court compared with the CP Act.[144]

In *DCPL v Starling (a pseudonym)* [2025] QChCM 4, the court made an order granting custody to the chief executive together with an order directing the chief executive to supervise each child's protection with respect to assessment and support of a family member as a potential reunification prospect.[145] In making the order, the court noted the directives were required to address the 'intransigence' of the departmental officers responsible for the case and ensure appropriate casework was undertaken to facilitate reunification.[146]

The Commission recommends that the powers conferred by a CPO should be expressly granted with reference to the purpose of those powers. In other words, the CPO should expressly state both the powers granted and the duration, and the *purpose* for the grant of the powers and that duration. In the Commission's view, this will be best achieved by abolishing the current suite of with two new types of child protection orders:

1. Reunification Orders; and,
2. Permanency Orders.

Reunification orders

A Reunification Order would address:

- Who is granted parental responsibility for the child, including any adjustments such as shared parental responsibility with respect to certain matters.
- Who the child will live with for the duration of the order (subject to further order of the court).
- Family contact arrangements for the child (subject to further order of the court), including a staged increase in contact where appropriate.
- The duration of the order, which should not be longer than twelve months.

[142] *Department of Communities v LE* [2011] QChC 4.
[143] Ibid [35].
[144] Ibid [30].
[145] *DCPL v Starling (a pseudonym)* [2025] QChCM 4.
[146] Ibid 25.

The care plan developed for the child should be annexed to the Reunification Order.

The Commission respectfully suggests the Court consider establishing a new 'Reunification Court List', whereby the Court can provide oversight of the reunification process as it progresses. Once the Court makes a Reunification Order, the matter is transferred to the 'Reunification List' and subject to regular review over the reunification period. For example, the Court may list the matter for mention every three months and review the progress of the proposed reunification, including by reference to:

- Departmental supports and case management provided for the family;
- Parents' demonstrated progress to address the child protection concerns, such as engagement with services, and contact attendance;
- Progress on kinship exploration and placement, particularly if the child is initially placed in residential care or in foster care; and
- Any significant changes for the child or the family during the review period.

Importantly, the Commission recommends that the Court is granted powers to make changes to the arrangements for the child as the Court sees fit, in the child's best interests. This may include changes to who the child lives with, family contact arrangements, dealing with parental responsibility matters, or updates to the annexed care plan. The Commission suggests that all parties feel more encouraged to participate in agreed actions, where:

- The stated purpose of the order is for the reunification of the child;
- The actions to achieve that purpose are documented in the care plan and annexed to the court order;
- The terms of the order are specifically crafted to give effect to the care plan; and,
- There will be an opportunity to be heard at regular intervals on issues that arise.

This reform will afford the Court much greater oversight of the child's journey through care, with much greater accountability for all parties in facilitating reunification. Critically, children and young people who are not able to return home will benefit from the court's attention to permanency arrangements in a proactive, rather than a reactive way.

Permanency orders

A Permanency Order would address:

- Who is granted parental responsibility for the child, including any adjustments such as shared parental responsibility with respect to certain matters;
- Who the child will live with for the duration of the order (subject to further order of the court);
- Family contact arrangements for the child (subject to further order of the court); and
- The duration of the order, which should be for the period as the court sees fit.

The care plan developed for the child should be annexed to the Permanency Order.

The Commission considers that if parental responsibility is granted to the Department, the maximum initial duration should be 12 months, with the Court able to extend such an order for up to a further 12 months, if it sees fit. Such orders should be reviewed by the court prior to the expiry of the order, with the court to determine:

- Whether there is a natural person who is a suitable person to be granted parental responsibility for the child; and if so,
- Make an order granting parental responsibility of the child to the suitable person, if satisfied it is in the child's best interests; and,
- The duration of the order, which should be for the period as the Court sees fit, subject to the maximum durations.

The Commission considers that this will encourage efforts to secure a safe family-based care arrangement for all children.

6.2 Initiating proceedings

6.2.1 Emergent Orders

As noted earlier, in Queensland there are three types of so-called 'emergent orders' – a Temporary Assessment Order (TAO), a Court Assessment Order (CAO), and a Temporary Custody Order (TCO).

Figure 8 below shows the latest data provided by the Department regarding the outcome of emergent order[147] applications.[148] These figures reveal that 97% of applications brought by the Department are granted, with only 3% of applications being dismissed, withdrawn, or otherwise not granted.

	2022-23	2023-24	2024-25	(%)
Dismissed or not granted	38	58	84	1%
Withdrawn	81	90	104	2%
Granted	3,892	4,416	5,379	97%
Total	**4,011**	**4,564**	**5,567**	

Figure 8: number of emergent order applications finalised, by court outcome in 2022-23, 2023-24 and 2024-25 (FY).

The Department gave evidence that emergent orders for the removal of children are sought only as a matter of last resort.[149] But the very high rate of endorsement of emergent order applications warrants further consideration. Many stakeholders have described a system in which the Department's assessment becomes fact, with inadequate opportunity for parents and children to scrutinise or contest the basis of these orders.[150]

Emergent orders routinely made without notice

The Commission heard from stakeholders that emergent orders are routinely made *ex parte* without notice to parents and are often filed after business hours. The Commission sought data

[147] Includes Temporary Assessment Orders, Court Assessment Orders and Temporary Custody Orders.
[148] Documents titled '*00081-1-0001 Datasheet - Emergent applications 01072023-31032025*' and '*00081-1-0002 Datasheet - Emergent applications 01042025-30062025.xlsx*' received 26 September 2025, produced in response to Notice 81 issued 5 September 2025.
[149] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3250:16.
[150] *Submission No 107 to Child Safety Commission of Inquiry* (14 November 2025); *Submission No 84 to Child Safety Commission of Inquiry* (14 November 2025); Women's Legal Service Queensland, *Submission to Child Safety Commission of Inquiry* (28 November 2025), [7]–[8], [25].

and information regarding the number and proportion of applications for emergent orders that were heard *ex parte*.

The Queensland Indigenous Family Violence Legal Service ('QIFVLS') noted that, 'After [business] hours removals are observed regularly…We have been involved in matters where, despite legal representation and a parent's wish to be heard, the TAO application is dealt with in Chambers'.[151] Legal Aid Queensland ('LAQ') noted that this practice occurs even when there are CPO proceedings afoot and the parties are represented:

> [I]nstances can arise during the course of child protection order application proceedings, where Child Safety makes an application for a Temporary Assessment Order or Temporary Custody Order…When this situation occurs parents have no opportunity to respond to the child protection concerns that are being raised with the Magistrate and the parents are denied the ability to make submissions.
>
> …
>
> [T]his approach places an after-hours Magistrate in the position where they are being asked to consider making orders 'in a vacuum', without access to any of the relevant evidence filed in the substantive child protection order application proceedings.[152]

Since its enactment, the CP Act has contained provisions allowing for TAO applications to be heard *ex parte*, by application to a Magistrate, with parents to be notified of the order once made but not necessarily heard on the application.[153] Conversely, it was intended that a CAO, which could be made for a longer period of up to four weeks, would only be made upon notice to the parents with the parents.[154] That was also the intended position in respect of the TCO.[155]

When requested by the Commission, the Department was unable to produce any data concerning the incidence of *ex parte* applications in respect of these emergent orders. It appears that although there is information recorded in the Department's information system as to who attended a given Court event, this data was unable to be produced and aggregated for reporting purposes. When asked directly about the number of *ex parte* applications for emergent orders, witnesses from the OCFOS – including Ms Schifilliti, the Official Solicitor[156] – were unable to provide any reliable indication. Conversely, Ms Martin described that at least some courts seem

[151] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (1 December 2025), 9.
[152] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (12 December 2025), 8.
[153] *Child Protection Act 1999* (Qld) ss 25(1), 28. Regarding the original provisions, see Explanatory Memorandum, Child Protection Bill 1998 (Qld) at 17, 19–24.
[154] Explanatory Memorandum, Child Protection Bill 1998 (Qld), 17, 19-24.
[155] Ibid 19-24.
[156] Transcript, Evidence of Angela Schifilliti (8 December 2025) 3171:45; 3277:8.

to have become inclined to make emergent orders *ex parte* even where the parents were on notice and able to be contacted, and this has been made known to the court.[157]

The lack of visibility as to this very drastic dispensation of basic procedural fairness presents serious issues for public confidence in the child safety system.

6.2.2 Referring a matter to the DCPL for a Child Protection Order

If the Department assess that a child needs protection and a CPO is appropriate and desirable to ensure the care and protection needs of the child, the Department must refer the matter to the DCPL. The DCPL must then decide whether to apply for a CPO, and if so, what CPO to seek. To enable the Director to properly deal with each referral, the DCPL Director's Guidelines establish minimum timeframes for referred matters to be received.[158] These are summarised below at Figure 9.

Existing intervention	Minimum referral timeframe
Emergent order (TAO, TCO)	24 hours before the order ends
Emergent order (CAO)	As early as possible and at least 24 hours before the order ends
Child protection order	20 business days before the order ends
Care agreement	As soon as practicable
No order or care agreement	As soon as practicable with a specific date provided to DCPL

Figure 9: minimum timeframes for referred matters to be received under the DCPL Director's Guidelines (2019).

Figure 10 below shows the proportion of matters that were referred within the required timeframe.[159] Figure 11 shows the proportion of matters that were referred on the day the existing order is set to expire.[160]

Matters referred within timeframe						
Order in place at time of referral	2022-23		2024-25		2023-24	
	No.	(%)	No.	(%)	No.	(%)
Emergent orders	1499	89.3%	1707	89.1%	2226	89.1%
Existing CPO	372	28.0%	339	28.7%	336	30.7%

Figure 10: matters referred to the DCPL within the required timeframe between 2022 and 2025.

[157] Transcript, Evidence of Clair Martin (12 December 2025) 3676:45
[158] *Director of Child Protection Litigation* '*Director's Guidelines*' (July 2019) [30]-[41D], marked as exhibit 1 to CA-51, *Statement of Nigel Miller*, tendered 9 December 2025.
[159] CA-51, *Statement of Nigel Miller*, tendered 9 December 2025 [171].
[160] Ibid [165].

	2022-23		2024-25		2023-24	
	No.	(%)	No.	(%)	No.	(%)
Matters referred that needed to be dealt with the day received	182	5.2%	218	6.1%	284	6.9%

Figure 11: matters referred to the DCPL that needed to be dealt with on the day they were received between 2022 and 2025.

These figures indicate that the priority for both the Department and the DCPL appears to be initiating proceedings for children who have recently entered care under an emergent order. This is appropriate to the extent that arrangements for those children are likely very temporary, in flux, and requiring early determination at an interim stage. Conversely, the poor timeliness in referrals for children subject to existing orders is of serious concern. These are the children who have already been subject to a CPO, some for a long time. In dealing with those referrals, the Department and the DCPL must collaborate with respect to a much larger volume of information and evidence.[161] Most applications for long-term guardianship orders will arise from these referrals, resulting in the most intrusive intervention for the family.

The present difficulties with the referral process between the OCFOS and the DCPL was the subject of much discussion and frustration from many stakeholders, including both the OCFOS and the DCPL. These difficulties have been discussed earlier in the report and would be addressed by the Commission's recommendation that the DCPL assume sole responsibility for all emergent and child protection orders, avoiding the necessity of referrals.

Timeframes for emergent orders

The timeframe for the operation of the emergent order, like any other urgent interim court order, should depend upon the circumstances of the individual case. For child protection matters, this timeframe should be no longer than the time reasonably required to address the immediate risk and to give the other interested party, here, the parents or kin, sufficient time to contest the making or extension of the order, or the making of an alternative order. This would align with the common practice in civil jurisdictions where an injunction or other interlocutory relief is sought pending the making of long term or final orders. It is all the more important in this context because, as discussed above, the removal of a child from his or her parents carries with it the unavoidable consequence that some harm will be done to the child by reason of the emotional and psychological impact of being separated from his or her parents, and adjusting to a new

[161] *Director of Child Protection Litigation* '*Director's Guidelines*' (July 2019) [25]-[27], [56]-[59], marked as exhibit 1 to CA-51, *Statement of Nigel Miller*, tendered 9 December 2025.

environment. The longer the child is placed in the new environment the more profound the ultimate impact on the child will be. For these reasons, the child's parents and kin should be afforded the earliest practical opportunity to contest the ongoing custody of the child by the State. Subject to the child's age and maturity, the child's views as to ongoing custody should also be considered.

6.3. CPO Proceedings

6.3.1 Filing and service of initiating material

Overreliance on section 99(2) of the CP Act to continue existing orders

The Commission has identified as an overreliance on section 99(2) of the CP Act. Section 99(2) is intended to ensure the ongoing safety of a child during the transition from emergent orders to a CPO application.[162] It provides that if an order[163] is in place in relation to the child at the point of referral, and the DCPL files an application for a CPO before the order ends, the order continues until the CPO application is decided, unless the Court otherwise orders.[164] Section 99(2) is also available to extend earlier emergent orders in subsequent TAO, CAO or TCO proceedings.[165] The intention of this provision is to protect the subject child '…by ensuring there is no 'gap' in the protective custody between one order and the next', where a CPO application has been made but cannot be heard by the Court before the existing order ends.[166] This provision has been part of the CP Act since it was first passed in 1999. It was never intended to operate beyond the earliest stages of litigation.

Figures 12 and 13 below show the number of days on average between the stated 'end date' of emergent orders and the first mention of the CPO application for the period 1 July 2022 to 30 June 2025.[167]

Emergent order	Avg. days from expiry to first mention
Court assessment order	28
Court assessment order (Non-custodial)	26
Temporary assessment order	25
Temporary custody order	28
Temporary custody order (Non-custodial)	25
Overall average days	**28**

Figure 12: Average days from expiry of emergent orders to the first mention of the CPO application (by order type)

[162] Ibid [234]-[236].
[163] Any order made under Chapter 2 of the *Child Protection Act 1999* (Qld): Temporary Assessment Order (**TAO**), Court Assessment Order (**CAO**), Temporary Custody Order (**TCO**), or Child Protection Order (**CPO**).
[164] *Child Protection Act 1999* (Qld) s 99.
[165] Ibid s 99(1)(a).
[166] Explanatory Memorandum, Child Protection Bill 1998 (Qld), 37.
[167] Document titled '*CL_DOCS-#19041544-v1-ODCPL_Report__2nd_Notice_to_Produce_Part_2.xlsx*' received 27 November 2025 in response to Notice 144 issued 21 October 2025.

Year	Avg. days from expiry to first mention
2022	23
2023	27
2024	29
2025	31
Overall average days	**28**

Figure 13: Average days from expiry of emergent orders to the first mention of the CPO application (by year)

The above data, provided by the DCPL, illustrates the significant 'gap' between the required end date of emergent orders, as determined by the court, and the next (or first) opportunity for the parent to be heard in relation to the Department's intervention. This is the period in which the child's safety is secured by section 99(2) of the CP Act, without any additional oversight by the Court. There may be additional delays if material is not filed and served in time. This means that for many families, the delay is likely to be greater. In this time, the child's life does not stand still – they may be in a new placement, with a new routine, or even at a new school. In one case considered by the Commission, it took three months before a respondent mother was heard in relation to the removal of her children.[168] This issue is further compounded for families in regional and remote areas, where Court availability may be reduced to one or two days per month (or even less).[169]

Viewed from the perspective of the parents and children who find themselves in this system, this process is undoubtedly highly distressing. A parent who is served with an emergent order after it is made, will see an order 'end date' subject to indefinite extension without notice. They are obliged to wait for the Department to serve the CPO Application and supporting affidavit, during which time one or more extensions may occur. They are unable to obtain legal advice until they are provided with the court material. They are unable to develop a case plan until the matter is referred to a Family Group Meeting convenor. By the time they are finally afforded an opportunity to appear and be heard, an entirely new status quo may have emerged.

The overreliance on this section to extend this transition period erodes accountability for both the Department and DCPL, as State parties. Leaving aside the question of what consequences, if any, there ought to be for non-compliance with procedural provisions, the important issue for parents

[168] Documents provided by the Director of Child Protection Litigation in response to Notice no. 144 issued 21 October 2025.
[169] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (12 December 2025), 7.

and children is the potentially significant delay between the day the child is removed and the first opportunity to be heard in Court regarding the removal. It also makes the job of the Courts more difficult, where the Court must weigh any decision as to the removal of the child (namely, whether it should continue) in circumstances quite different from the day the child was removed. It is clear that it does not take long for children who are removed into State care to experience the impacts of that change. Within four weeks, the child may have already developed an attachment to their carer, moved away from their community and changed schools. Alternatively, the child may have had several placement changes and be demonstrating significant distress. All these new matters must be considered in deciding what is in the child's best interests.

Service of Court material

The current Court framework requires respondents be given proper notice of the CPO application, and the facts underpinning it, prior to the first mention of the Application. The CP Act presently requires the Department to personally serve the CPO application on all respondents as soon as possible after it is filed, unless is it 'not practicable' to do so.[170] The *Childrens Court Rules 2016* (Qld) ('CC Rules') require that the initial affidavit is filed at least three clear business days prior to the first mention.[171]

The Department has reported difficulties in effecting service, including locating parents.[172] In response to increasing difficulties with service issues, the DCPL has published a Practice Note as to how the court can proceed in the absence of service.[173] The practice note provides useful guidance as to options available to the court, including dispensing with personal service.[174]

One solution to address both the difficulties for CSOs and the delays in proceedings could be funding the DCPL, or the Department, to engage process servers to serve filed material. Mr Miller advised of several instances where the court has directed the use of process servers to serve parents.[175] Another more direct solution to the difficulties with service of respondents will be expanding access to legal representation for all parents and children at an earlier stage, so that service may be facilitated by lawyers.

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[170] *Child Protection Act 1999* (Qld) s 56. This has been interpreted to mean 'practically impossible': *SKJ v HR & Another* [2023] QChC 17.
[171] *Childrens Court Rules 2016* (Qld) r 26 .
[172] Transcript, Evidence of Nigel Miller (5 February 2026) 4061:26.
[173] Ibid 4062:8; Director of Child Protection Litigation (Qld) (17 March 2025), *Practice Note: Guidance on Service of Documents in Child Protection Proceedings* <https://www.dcpl.qld.gov.au/__data/assets/pdf_file/0006/823479/dcpl-practice-note-guidance-on-service-of-documents-in-child-protection-proceedings.pdf>.
[174] *Childrens Court Rules 2016* (Qld) rr 29 (substituted service) and 30 (informal service). Informal service may be sought if the Department has sent the material to the respondent and confirmed receipt (for example, by emailing the document and receiving an email in response confirming receipt). Substituted service may be sought if the Department has sent the material to the respondent but has not been able to confirm receipt.
[175] Transcript, Evidence of Nigel Miller (5 February 2026) 4060:45.

6.3.2 First Mention

Access to legal representation

The extent to which there is legal representation for all participants, including parents, children and young people, and interested parties[176] contributes considerably to the efficiency and fairness of any child protection litigation model. Many submissions called for all participants to be afforded mandatory legal representation from the earliest possible stage of proceedings – and at the very least, from the time an application for a CPO is filed by the State. In its submission, the Family Inclusion Network ('FIN') observed:

> Done in the right way, legal representation and advocacy for parents (both legal and otherwise) will not exacerbate the inherent adversarial nature of the process. On the contrary, we envisage a new model can be cooperative, rights-based, and build fairness and accountability between parties.[177]

The CP Act is clear in its terms that all parties must be given every reasonable opportunity to obtain legal representation in proceedings.[178] However, Women's Legal Service ('WLS') notes that:

> There are limited options available to parents [to] receive free legal advice and assistance to assist with the early resolution of matters. Legal aid funding is not available until an application has been filed in Court. Free legal advice from services…is often limited due to high demands on our service and limited capacity to review length Court material to provide fulsome and strategic legal advice. In our experience, parents are often more willing to work with the Department when they understand their rights and the power imbalance is addressed with legal advice and support.[179]

WLS further notes the compounded difficulties in accessing legal representation for people who live outside metropolitan areas, in that, 'Child protection duty lawyers are only available in 19 locations on specific days. This results in many parties appearing before the Court with no legal advice or representation'.[180]

The Official Solicitor, Ms Schifilliti agreed that all parents and children should have legal representation in child protection proceedings, and from the earliest possible opportunity.[181] The

[176] 'Interested parties' will include persons who may be joined to the proceedings pursuant to s 113 of the *Child Protection Act 1999* (Qld).
[177] Family Inclusion Network, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (21 January 2026) 4.
[178] *Child Protection Act 1999* (Qld) s 109; *Childrens Court Rules 2016* (Qld) r 68.
[179] Women's Legal Service Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (28 November 2025) [18].
[180] Ibid [13].
[181] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3351:43.

Commission requested data from the Department and the DCPL with respect to the proportion of respondents who were legally represented in child protection proceedings. The Department was unable to offer this data and advised the Commission that it could not be obtained. The DCPL provided detailed data for the period 1 July 2022 to 30 June 2025.

Figure 14 shows the proportion of respondent parents who were legally represented in proceedings between 1 July 2022 and 30 June 2025, derived from data produced by the DCPL. Only 37% of respondent parents were legally represented in CPO proceedings in that period. Moreover, only 10% of respondent parents were represented at the first mention of the Application. On average, it took parents 145 days from the date the application was filed to obtain representation. Mothers were more likely to be represented and at an earlier stage compared with fathers.[182]

Role in proceedings	Represented in proceedings	Represented at first mention	Avg. days to obtain representation
Mothers	47%	14%	134
Fathers	26%	6%	163
Total	**37%**	**10%**	**145**

Figure 14: proportion of parents who were legally represented in proceedings between 1 July 2022 and 30 June 2025. Parents may be counted multiple times if they were respondents in multiple matters. Days to obtain representation shows average days between the date the CPO Application was filed and the date of the first court event at which the parent was represented.

These figures are concerning. The legislative framework is clear about the need for respondents to be afforded every reasonable opportunity to obtain legal representation. It is undesirable that, in a jurisdiction so significant as child protection, such large proportions of parents are not equipped to properly participate in the Court process.

LAQ is the leading provider of child protection legal services in Queensland.[183] LAQ provides a range of valuable services for families and children involved in the child protection system, including:

- Child Protection Early Legal Service ('CPELS') in South East Queensland;
- Child Protection Duty Lawyer services;
- Child Protection Outreach Legal Service; and,
- Ongoing legal representation in proceedings.[184]

[182] Document titled '*CL_DOCS-#19040187-v1-ODCPL_Report__2nd_Notice_to_Produce_Part_10_a.xlsx*' received 27 November 2025, produced in response to Notice 144 issued 21 October 2025.
[183] Statement of Nicola Davies (6 March 2026) [29]-[51].
[184] Ibid [24].

In addition, LAQ is responsible for funding and appointing separate representation and direct representation for children from a specialist panel of legal practitioners.[185] In the current system, a grant of legal assistance is available for parties, non-parties[186] and children to be represented in child protection proceedings or CAO proceedings.[187] There is no means or merits test to obtain representation in proceedings. The merits test only applies to applications for assistance for contested hearings (interim or final).[188] If a person obtains a grant of legal assistance, they may be represented by a solicitor employed by LAQ or by a private firm organised by LAQ ('preferred suppliers').[189]

LAQ reported facing growing challenges in responding to demand for child protection legal services,[190] including a decline in preferred providers.[191] More positively, there has been a significant increase in relevant funding since 2020.[192]

The Commission is not aware of any specialist *child protection* legal service in Queensland. The Commission received submissions from several specialist legal services with a broader remit, who often appear in child protection matters, including:

- Aboriginal and Torres Strait Islander Legal Service ('ATSILS');
- WLS;
- QIFVLS;
- Youth and Family Services ('YFS'); and,
- Youth Advocacy Centre ('YAC').

The Commission readily accepts that all respondents to child protection proceedings should, if possible, have legal representation. The Commission also accepts that there is evidence of increasing strain on legal services to meet increasing demand as the number of children entering

[185] Legal Aid Queensland, *Guidelines - State - Civil* (Web Page) <https://www.legalaid.qld.gov.au/About-us/Policies-and-procedures/Grants-Policy-Manual/Guidelines-State-Civil> [1.5]-[1.6].
[186] Non-parties will include persons who may seek to join the proceedings pursuant to *Child Protection Act 1999 (Qld)* s 113.
[187] Legal Aid Queensland, *Guidelines - State - Civil* (Web Page) <https://www.legalaid.qld.gov.au/About-us/Policies-and-procedures/Grants-Policy-Manual/Guidelines-State-Civil> [1.1]-[1.6].
[188] Ibid at [1.2].
[189] Statement of Nicola Davies (6 March 2026) [11].
[190] Legal Aid Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (12 December 2025), 6-7.
[191] Ibid 18.
[192] Statement of Nicola Davies (6 March 2026) [11].

out-of-home care each year increases. This strain is especially felt by community legal centres and by LAQ, who collectively provide the majority of legal services in child protection matters.[193] Further, the Commission observes that the specialist legal services servicing the child protection jurisdiction tend to reflect the overrepresentation of certain groups within the child protection system, including: Aboriginal and Torres Strait Islander people; women who have experienced domestic and family violence; people experiencing poverty. This means that before a person may obtain specialist child protection legal representation from such a service, they must needs be part of a relevant group. This reflects a gap in the system and may contribute to reduced access, or at least the perception of reduced access to legal representation for all participants.

Inclusion of children and the child's views and wishes

The right of the child to express their views in child protection proceedings is a feature of all modern child protection systems in Australia.

The general principles of the CP Act include that a child has the right to express their views about what is, and is not, in their best interests.[194] Before making a CPO, the views and wishes of the child (if able to be ascertained) must be made known to the Court.[195]

Under the *Charter of Rights For a Child in Care*, contained in the CP Act, every child who is placed into the care of the Department has the right to be informed and consulted in relation to decisions made that affect them, in a way that is appropriate to the child.[196] It is also a requirement that the child be supported to participate in case planning; or if they cannot participate, that their views and wishes are obtained and expressed to the participants.[197]

The Carmody Inquiry recommended amendments to enhance the voice of children in proceedings, which were ultimately implemented in the CC Rules, which included specific procedures for facilitating the participation of children in proceedings. Notwithstanding these amendments, the Commission heard that the views of children and young people continue to be marginalised and/or diluted within the court process. In some cases, it would appear that the views and wishes of children are not presented to the Court in any direct or meaningful way. The

[193] Q-1, Statement of Thelma Schwartz (19 September 2025) [34]-[45]; Aboriginal and Torres Strait Islander Legal Service, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (28 August 2025), 3; Women's Legal Service Queensland, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (28 November 2025), [18].
[194] *Child Protection Act 1999* (Qld) s 5B(n).
[195] Ibid s 59(1)(d). The obligation also applies to Court Assessment Orders but does not extend to Temporary Assessment Orders or Temporary Custody Orders.
[196] Ibid sch 1, s 74. See also ss 32(1)(d), 41(1)(c), 51AK(b) in relation to notifying children about emergent orders.
[197] Ibid ss 51L(1)(a), 51N(a).

below quotes were presented by the CREATE Foundation and come from young people with a lived experience of out-of-home care:

> Court process is so bad. I wanted to attend court to share my views, and opinions about the situation, but my CSO so wouldn't let me. I called the public guardian to get them to help me and they did help me write a letter to the judge who then let me come to the courthouse. Child Safety didn't tell me anything about court. It was my dad who would tell me about the info about what the date was and what was happening. (Child, 2024)
>
> One of the biggest questions I had was why is this happening? And that doesn't get explained. (Young person, 2024)[198]

The Commission also heard from children and young people through a series of Youth Forums, as well as submissions from and on behalf of young people, in which like concerns were raised.

It is highly concerning that there remains insufficient solicitation of children's views. This is a topic that warrants further examination.

6.3.3 Interim Orders

Once the DCPL files a CPO application, it is routine practice that the Court will adjourn the application. The initial adjournment(s) provide time for the parents to be served with the material and obtain legal representation, and for case planning to take place.[199] At each adjournment, the court is required to consider interim arrangements for the child.[200] The court may also make any procedural orders or directions for things to occur in the proceedings.[201] Applications are usually adjourned several times before they are determined.[202]

The Commission sought data from the DCPL regarding the number and type of interim orders made in CPO proceedings but was advised that the data was not able to be provided within the requested timeframe. The Commission's examination of interim proceedings was therefore limited to publicly available data and evidence obtained from witnesses and submissions.

Arrangements for the child

When adjourning a CPO proceeding, the Court must consider what arrangements should be made for the child's care, including:[203]

[198] CREATE Foundation, *Submission to Child Safety Commission of Inquiry* (27 November 2025), 5.
[199] Statement of Nigel Miller (7 November 2025) [261]-[266].
[200] *Childrens Court Rules 2016* (Qld) r 69.
[201] Ibid rr 69, 71.
[202] As of 30 June 2025, the average number of court events was 10.9: see Statement of Nigel Miller (7 November 2025) [251].
[203] *Childrens Court Rules 2016* (Qld) r 69.

- Temporary care of the child;
- Authorising a medical examination or treatment for the child; and,
- Family contact, including restrictions on contact and/or interim contact where a decision is under review by the Queensland Civil and Administrative Tribunal ('QCAT').

The range of interim orders includes directive orders, supervision orders, and orders granting custody of the child to the Department or a family member.[204] It was a theme of the evidence given to the Commission that the interim arrangements established at the early stages of proceedings often *de facto* become enduring arrangements over the life of the litigation. The DCPL Director's Guidelines note:

> Although section 67(5) of the CP Act provides that an interim order only lasts for the period of the adjournment, an interim order made at the first mention of an application may be continued until the application is finalised, which can be a period of many months. It is critical the DCPL gives careful consideration to an application for an interim order.[205]

This is particularly pertinent when considering the very high number of children placed in non-family based (residential) care in Queensland and the comparatively low number of children placed in kinship care. The evidence before the Commission suggests that: there continues to be insufficient consideration of family-based care and/or kinship care options for children at the interim phase; and interim arrangements are insufficiently interrogated or reviewed as proceedings progress.

Establishing suitable placement and family contact arrangements is arguably the most important objective of interim proceedings, if the overarching goal of reunification and/or permanency is to be achieved for the child. Accordingly, in the Commission's view, there needs to far greater effort by State parties and the court at or before the first mention, and before the matter is adjourned, to identify suitable family or kin-based placements and to establish safe, regular family contact arrangements.

Interim contact and placement arrangements

The Court is empowered to make orders in relation to contact including permitting, restricting, or placing conditions on the child's contact.[206] However, the Court does not currently have any

[204] *Child Protection Act 1999* (Qld) s 67(1)(a).
[205] *Director of Child Protection Litigation 'Director's Guidelines'* (July 2019) [238], marked as exhibit 1 to CA-51, *Statement of Nigel Miller*, tendered 9 December 2025.
[206] *Child Protection Act 1999* (Qld) ss 68(1)(c), 67(1)(b).

express power with respect to placement of a child in care.[207] Rather, the Court's power to place a child with a particular family member on an interim basis is generally confined to:

- Granting interim custody of the child to a member of the child's family;[208] and/or,
- Ordering that the child have contact with a family member on a full-time or '24/7' basis.[209]

Importantly, the Court may make the above orders to any suitable family member – even if the person is not an approved carer.[210] The Commission notes that this presents one solution to overcoming Blue Card-related issues for carers, particularly noting that carer approval issues have been frequently cited as a contributing factor behind the high rate of children placed in residential care.

If the Court grants custody to a family member, that family member must assume a greater role working with the Department to facilitate reunification of the child.[211] In the Commission's view, the current framework does not fully support family members to take on this role. There is no provision for the Court to grant interim guardianship, so that the parent will generally remain the child's guardian during the interim phase. Contact orders are even more limited, with the family member having neither custody nor guardianship. Contact orders are only available on an interim basis and must end upon the matter being finalised.[212]

In the Commission's view, the current architecture for ensuring the child's care and protection during the interim phase(s) of proceedings is complex, fractured and incomplete. The Commission recommends that the power to make interim care arrangements for a child be consolidated in the form of a single *Interim Care Order*, to be made on terms as the court sees fit to ensure the child's care and protection during the interim phase of proceedings.

In particular, the court should be expressly empowered to determine, in the best interests of the child:

(a) How often family contact is to occur between the child and their parents;

(b) How often family contact is to occur between the child and their siblings (if any);

[207] Ibid s 82 regarding the Department's power to place a child in care.
[208] *Child Protection Act 1999* (Qld) s 67(1)(a)(ii).
[209] Colloquially referred to as a '24/7 contact order'.
[210] For the definition of 'suitable person' in the context of custody and guardianship: see *Child Protection Act 1999* (Qld) sch 3; *Child Protection Regulation 2023* (Qld) s 18; See also *Child Protection Act 1999* (Qld) s 135(1)(b)(iv): family members must hold a Blue Card to become Departmentally approved kinship carers. This also applies to every adult household member in the family member's home.
[211] *Child Protection Act 1999* (Qld) ss 79, 80.
[212] Ibid ss 61(a)-(b) permit the court to direct a parent not to have contact with a child or to place restrictions on the contact. By comparison, s 68(1)(c) permits the court to make an order 'about the child's contact with the child's family'.

(c) How often family contact is to occur between the child and other family members (if any);

(d) What restrictions or conditions, if any, are necessary to ensure the best interests of the child in having family contact; and,

(e) Whether increased family contact could safely occur, including any supports required.

6.3.4. Case Planning

Case planning is an integral part of the child protection system in Queensland. The child's case plan is a written plan for meeting the child's care and protection needs.[213] Every child subject to Departmental intervention (including non-custodial interventions and interventions with parental agreement) must have a case plan.[214] Within the current system there is a great degree of reliance on the case plan as a source of clarity, certainty, and accountability for all parties involved in the care of the child. For the Court, the case plan is intended to clearly articulate how the child's care and protection will be ensured upon making a child protection order. In the current framework, the court is prevented from making a final child protection order until there is a case plan for the child, developed in accordance with the CP Act, and that it is appropriate for meeting the child's assessed protection and care needs.[215] The court must be provided a copy of the current case plan; it cannot rely on the assurance of the parties.[216]

In Queensland, each child's case plan is developed through a Family Group Meeting ('FGM').[217] FGMs have been an important component of Queensland's child protection system for many years.[218] This Commission heard that the case planning process as a collaborative, family-led process continues to be largely a positive and productive element of the child protection system.[219] For many, if not most families, the opportunity to meet with the Department in a facilitated, non-adversarial setting to discuss concerns was beneficial and contributed to prompt resolution.

[213] Ibid s 51B.
[214] Ibid s 51C.
[215] Ibid s 59(1)(b).
[216] Ibid s 59(4).
[217] Ibid ch 2, pt 3A.
[218] See, eg, Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Final Report, June 2013), 221; Department of Children, Youth Justice and Multicultural Affairs (Qld), *Family Group Meeting Convenor Handbook* (2nd ed, Version 2, August 2022) 5.
[219] Women's Legal Service Queensland, *Submission to Child Safety Commission of Inquiry* (28 November 2025) [9]; Social Care Solutions, *Submission to Child Safety Commission of Inquiry* (28 November 2025), 1-2.

Yet, there are concerns with the FGM process. For example, surveys undertaken by departmental officers (FGM convenors, CSOs, STLs, and leadership) revealed frustration felt by Department staff at 'interference' by the Court in the FGM process.[220] Equally, there are concerns with quality of case plans produced by the Department. In reviewing hundreds of Departmental case plans, the Commission observed a general vagueness and lack of specificity, in which it was often difficult to ascertain what commitments had actually been made. Arrangements for the care of children were frequently scant or absent, particularly with respect to placement and family contact. When case plans were revised, content appeared often to have been 'copied and pasted' from the initial plan into the revised plan without genuine consideration of progress made by the family or changes to the child's circumstances. Put simply, there appeared to be a heavy emphasis on the Department 'worries' but often little by way of a genuine care plan.

These issues are discussed below.

Significant delays in convening Family Group Meetings

The Commission heard extensive evidence of chronic delays in the case planning process. Data produced by the DCPL shows that the most common reason for an adjournment in child protection proceedings is to allow time for the Department to hold a FGM to develop a case plan.[221]

Reviews of the CFDM program conducted by the Department confirm that the time taken to develop an initial case plan has consistently increased.[222] In 2019, it took on average 70 days to approve an initial case plan (two to three months).[223] In 2024, most case plans took at least 90 days to approve, with more than a third taking between 120 and 200 days (three to seven months).[224] The Commission is aware of cases where the length of proceedings is longer than the duration of the order sought, even in cases where the parents were not opposed to the application. The Department acknowledged these delays and attributes them to a range of factors, including the following:[225]

(a) The wait time for an FGM in relation to an initial case plan can be up to 6 to 8 weeks;

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[220] Office of the Chief Practitioner, Department of Families, Seniors, Disability Services and Child Safety (Qld), *Collaborative Family Decision Making Program Review* (Review, 2024) 31, attached to the Statement of Victoria Van Houdt (3 March 2026).
[221] Office of the Director of Child Protection Litigation, Annual Report 2024-2025 (31 October 2025),126.
[222] Several review reports were attached to the statement of Victoria Van Houdt (3 March 2026) (See, e.g. Ipsos (2019), '*Collaborative Family Decision-Making Program Evaluation*', 47,).
[223] Ipsos (2019), '*Collaborative Family Decision-Making Program Evaluation*', 35, attached to the Statement of Victoria Van Houdt (3 March 2026).
[224] Department of Families, Seniors, Disability Services and Child Safety (2024), '*Collaborative Family Decision Making program review*', 37, attached to the statement of Victoria Van Houdt (3 March 2026). The figures here refer to case plans associated with a child protection order.
[225] Statement of Victoria Van Houdt (3 March 2026) [45].

(b) For First Nations children, a referral to a Family Participation Program ('FPP') must be made to convene the FGM. The FPP program is generally facing extensive delays and may take as long as six to nine months;
(c) Limited availability and responsiveness of legal representatives has resulted in FGMs being delayed for several months;
(d) High workloads, workforce capability and staff retention affects timely completion of case plans;
(e) Parents must be given a reasonable opportunity to participate in the case planning process. Without a clear definition in the legislation, there may be multiple attempts to hold an FGM due to non-attendance or limited contact;
(f) Where parents are incarcerated, there can be delays with booking meetings through the correctional facility;
(g) Case complexity impacted on the timely completion of the case planning processes. In particular, where there has been domestic and family violence separate meetings may be needed.

The development of the child's case plan is of critical importance to ensuring public confidence in the system. Good case planning encourages mutual respect, builds trust, and facilitates accountability between the Department, family, and the child. In some cases, delay is appropriate and necessary to properly ensure the full participation of the family.[226] However, routine delays due to chronic capacity issues are not productive and do not promote the best interests of the child.[227]

One question that arises is whether the need for a case plan 'that has been developed or revised under part 3A [of the CP Act]'[228] is hampering the court's ability to finalise matters. Although the child's case plan is central to the Court process, the Court's powers with respect to the case plan are primarily procedural. As LAQ observed, 'the Court does not have the power to make decisions about many of the issues that are covered in the case plan'.[229]

A solution may be to afford the court greater discretion to be satisfied that there is a plan to meet the child's care and protection needs, such as where an FGM has not yet been held but the Court is satisfied the parents are agreeable to the current care arrangements for the child. A 'care plan'

[226] Statement of Principal Team Leader, Collaborative Family-Led Decision Making Team (9 March 2026) [27].
[227] Transcript, Evidence of Nigel Miller (18 November 2025) 2138-39.
[228] *Child Protection Act 1999* (Qld) s 59(1)(b)(i).
[229] Statement of Nicola Davies (6 March 2026) [109].

in this format may be documented and provided to the court and ideally, would be annexed to the CPO.

Limited accountability and 'shifting the goalposts'

Stakeholders, particularly parents and legal representatives, expressed concern about a lack of accountability associated with case plans. Specifically, two common themes with respect to accountability emerged: ***firstly***, that agreed actions are not completed; and ***secondly***, that agreed actions are completed but are not recognised or acknowledged.[230] As noted above, the intent of the FGM process is to foster collaboration and trust through shared decision-making and discussion. Once the case plan is endorsed and approved the Department is obligated to support the implementation of the plan.[231] In that context, families will rightly expect that decisions made, or actions agreed, in the FGM process will be diligently implemented. They will rightly feel frustrated, angry or let down if they are not.

Case plan accountability was a key theme in Witness T's case (hereafter referred to as Melanie).[232] Over a period of eight years, Melanie had demonstrated ongoing engagement with a wide array of agreed services including family support, counselling, psychologists, doctors, employment supports, church and community supports, and parenting programs. Despite this, Melanie's engagement was consistently dismissed, downplayed or disregarded by the Department, who insisted that Melanie's engagement with services had not led to demonstrated change.

In the Commission's view, part of the problem is that case plans are often poorly documented. As a Principal Team Leader overseeing a team of FGM convenors observed:

> CSOs struggle to clearly describe the child protection concerns in plain language. Referrals are filled with jargon that is not suitable to take to a meeting with family.[233]

In its review of Departmental files, the Commission observed first-hand the cumbersome structure of case plans in the 'approved form'. There is a distinct deficit-focus, with extensive text describing the Department's concerns and child protection history comprising much of the case plan's content.[234] Crucial information such as placement details, family contact, and a proposed

[230] An example of the first issue might be an agreement by the STL to approve increased family contact, but the increased contact does not occur or is delayed. An example of the second issue might be where the parent completes an agreed parenting course, but the Department refuses to increase contact whereby the parent might demonstrate change.
[231] *Child Protection Act 1999* (Qld) s 51T(d).
[232] Appendix B, Melanie case study.
[233] Statement of Principal Team Leader, Collaborative Family-Led Decision Making Team (9 March 2026) [20].
[234] There also appears to be a significant degree of duplication between the information detailed in the Department's affidavit (usually deposed by the CSO) and the department's 'worries' as set out in the case plan.

reunification timetable were difficult to locate or absent. Carers reported that information contained in the case plan was frequently out-of-date or incomplete. Legal representatives observe a practice of 'copying and pasting' case plan goals from previous plans into the revised plan, without acknowledging parents' progress.[235]

In 2025, the Department revised the approved case plan form as part of the transition to Unify. The revised case plan template is a much-needed improvement, with a more streamlined, consistent and clear structure. It is to be hoped that the improved case plan structure will facilitate more a functional relationship between the Department and families through more clearly documented goals, actions and agreed steps.

At a broader level, the frustration and despair experienced by parents, children and families when they feel let down by the Department directly undermines the ability of both the Department and the family to work together in the best interests of the child. The central importance placed upon the child's case plan in the legislation warrants stronger accountability within the child protection system. This is particularly so where the court's decision to make a CPO is predicated in large part on its satisfaction with the contents of the case plan. It does not make rational sense that the Court must only grant a CPO once satisfied that the child's case plan is appropriate, only for the contents of the case plan to be ignored, disregarded or changed in a material way. By integrating the child's case plan with the child's CPO, all parties would be afforded a greater degree of accountability in the Department's ongoing intervention with the family.

Exclusion of carers from FGMs

An issue that was frequently raised with the Commission was a lack of timely communication and inclusion of carers in relation to the children in their care. The Commission heard from many foster carers that they are not communicated with in a responsive way, not included in decision-making, and are undervalued when it comes to their contribution to the care of the child and understanding of the child's needs.[236] In particular, carers reported they were not consulted on major decisions including proposed reunification, family contact, and in some cases, medical care.

When questioned on this issue, the Regional Manager for Far North Queensland Ms Porta insisted that the Department's expectation is for the views of carers to be sought and for consultation to occur with respect to major decisions for children in their care.[237] Departmental policy and

[235] Statement of Nicola Davies (6 March 2026) [102].
[236] Transcript, Evidence of Corinne Porta (24 November 2025) 2644:38.
[237] Ibid 2441:45. In this instance, Ms Porta was referring to the decision whether to reunify a child.

procedural guidance promotes inclusion of carers, unless it would be inappropriate to do so.[238] The FGM Convenor Handbook states:

> It is rare for a decision to be made to exclude a person, and only after all options to avoid exclusion have been discussed with the Senior Team Leader and Child Safety Officer.[239]

In 2019, an external review found that carers attended or even consulted in only 29% of FGMs.[240] With respect to FGMs, this practice is surprising given the express reference to carers as a person who would be a person with whom the child has a significant relationship.[241] Further, there is no reason for carers to be excluded from case planning unless their participation would prejudice the genuine participation of other parties or it is otherwise not in the child's best interests.

The Commission is of the view that carers should be included in case planning and decision-making, particularly in the court process. Generally speaking, the child's carer will have first-hand knowledge of the child's strengths and needs at that time. The Commission notes that the current framework is sufficiently flexible to balance the participation of all interested parties (including parents) with other considerations, with overall priority given to what is in the best interests of the child. If carers are excluded or not consulted as part of the case planning process, this must be properly justified and reviewable by the Court. In short, it is not productive that there be a general ability to exclude the person with daily care of the child from decision-making without a proper justification, clearly reasoned and documented.

6.3.5. Contested matters

In his statement, Mr Miller sets out the common timeline for a CPO application.[242] The process consists of at least nine court events (mentions), with several steps (not necessarily in order):

- The parents are served with material and given time to obtain legal representation;
- A FGM is held to develop the child's case plan;
- The case plan is filed, and if the parents are not opposed the application may be determined at this point;
- A Separate Representative is appointed;
- An independent Social Assessment Report is obtained;
- The parties attend a Court-Ordered Conference ('COC');

[238] Department of Families, Seniors, Disability Services and Child Safety, Family Group Meeting Convenor Handbook (August 2022), 28-29.
[239] Ibid 31.
[240] Ipsos (2019), *Collaborative Family Decision-Making Program Evaluation* (DFS.0281.0001.0138), 47.
[241] *Child Protection Act 1999* (Qld) s 51L(1)(d).
[242] Statement of Nigel Miller (7 November 2025) [259].

- If the application remains contested, the matter is listed for final hearing.[243]

Final hearings vary in length due to a range of factors, including complexity, the number of witnesses, logistical issues such as travel and distance, and court availability.

The number of matters that proceed to contested hearing is relatively small. The Commission was unable to ascertain detailed data on the number of contested applications and/or the number of applications that are listed for final hearing. Estimates provided to the Commission ranged from some 20% of matters to as few as 5%.[244] Over 50% of contested matters are resolved at COC.[245] Another 11% of applications are withdrawn.[246] Although the Commission is unaware of the exact figure, it is clear that only a small number of matters are determined by way of a contested hearing. Ultimately, the outcome is almost always consistent with the order sought by the DCPL at the time the order is made.[247]

The above picture tends to tell a different story depending on who is asked. It may reflect a proactive approach towards resolving matters where possible. It may support the proposition that parents often make progress while proceedings are afoot, which is recognised by way of the application being amended or withdrawn. It may be a consequence of low rates of legal representation, whereby parents disengage or struggle to advocate for themselves. It may reflect cultural barriers within the court process, particularly noting the near-total absence of Independent Entities. Further examination is warranted to understand the dynamics of contested applications in CPO proceedings.

The Commission accepts that in the main, it is in the best interests of children - and their families - that litigation is resolved promptly, fairly, and without the need for contest if possible. Contested hearings are onerous and highly stressful in any jurisdiction and are to be avoided if at all possible. That is not to say parents should not contest the removal of their children; rather, it is better if parents are able to do so through a genuine alternative dispute resolution process.

Court-Ordered Conferences

The COC is the primary dispute resolution avenue within the current child protection litigation system. COCs are administered by the Child Protection Conferencing Unit (‘CPCU’) within the

[243] If the application is contested, the case plan may need to be revised one or more times.
[244] Office of the Child and Family Official Solicitor, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (28 November 2025).
[245] Statement of Nigel Miller (7 November 2025) [259(f)].
[246] Ibid [240] which shows the number of applications withdrawn in (FY) 2024-25.
[247] Between 98-99% of cases, see Office of the Director of Child Protection Litigation, Annual Report 2024-2025 (31 October 2025), 153. Note, ‘at the time the order is made’ includes matters where the DCPL filed an amended application throughout proceedings (for example, following negotiations with parties).

Department of Justice and facilitated by an independent convenor.[248] Attendance at a COC is mandatory for all parties, although other persons are not permitted to attend without the convenor's approval.[249]

There is general acceptance that COCs assist parties to resolve issues and importantly, they contribute to earlier resolution without recourse to trial.[250] For many families, there is a degree of duplication between the Department-led FGM and the COC. A key difference is the inclusion of the DCPL in COCs, whereas the DCPL is almost always excluded from FGMs. In addition, as noted above a COC generally occurs only after the child's case plan has been developed.[251]

The Commission's view is that the court process must prioritise mandatory dispute resolution at the earliest possible opportunity. The Commission recommends that the early dispute resolution process noted above replace the need for parents to attend both an FGM and a COC.[252] These issues have been compounded by the bifurcated model, which the Commission has separately recommended should be abandoned.

For the above reasons, the Commission considers that the court process be redesigned so that mandatory early dispute resolution occurs at the earliest possible stage in proceedings. This process would incorporate both the case planning and a discussion about the CPO being sought. It would offer parties an opportunity to negotiate, identify family members and supports, and establish regular, safe family contact. On conclusion, the Court should be furnished with a report detailing the agreed outcomes of the meeting. Ultimately, the agreed plan should form part of the Court order (for example, as an annexure) and be subject to review over the course of proceedings.

All parties should be encouraged to make a meaningful effort to come to a resolution on the basis that there will be accountability for the outcome through the Court.

[248] Queensland Government, Court ordered child protection conferences (Webpage, 30 October 2025) <https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/settling-disputes-out-of-court/about-child-protection-conferencing>.
[249] *Child Protection Act 1999* (Qld) s 70.
[250] As noted above, the DCPL suggests that over 50% of contested matters resolve at COC.
[251] Generally, parties are only able to confirm their position on the application once the case plan is developed.
[252] This does not preclude the value of FGMs as a way of facilitating family-led decision making generally. Likewise, this would not prevent the Court from ordering further conferences at a later stage in proceedings.

6.4. Reunification and revocation of orders

6.4.1. Reunification

The most significant element of the child protection continuum without any current court oversight is the decisions by the Department to reunify children with their parents and in respect of long term placement decisions. Reunification is rightly regarded as the first and primary goal of any ongoing intervention for a child removed from their family.[253] The Commission heard extensive evidence on this topic, including evidence of some decisions to reunify which ought not have been made.

In practice, reunification most commonly culminates in the child being placed in the care of a parent pursuant to an exercise of power under s 82(2) of the CP Act, while the child remains subject to a child protection order granting custody or guardianship to the Chief Executive.[254] This mechanism allows 'reunification' to occur without first revoking a pre-existing child protection order, enabling the Department to continue its statutory involvement during a transitional period. Departmental practice guidance describes reunification as an incremental process occurring across assessment, planning, implementation, and review phases, rather than as a discrete legal decision point.[255]

The Commission has observed that 'reunification' is an expression used in an imprecise way. It is sometimes referred to as reunification with the parents from whom the child was removed, with or without ongoing custody or guardianship to the Chief Executive. At other times, it is used more broadly to refer to long-term placement with kin. In the Commission's opinion, there should be a clear statutory definition of 'reunification'.

The Commission is concerned that there is presently no judicial accountability in relation to administrative reunification or long term placement decisions under the CP Act. Further, only the child or the child's parents are notified of their ability to administratively review a decision to place the child with a parent under s 82(2).[256] Where reunification is effected administratively and followed by expiry of the order, there is no independent judicial evaluation or determination as to whether the child is no longer in need of protection.

[253] *Child Protection Act 1999* (Qld) s 5B(f).
[254] Ibid ss 10-11, 59, 82(2).
[255] Queensland Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Practice Manual – Decision Making for Reunification* (updated 2025–26).
[256] *Child Protection Act 1999* (Qld) sch 2, [4] – a placement decision made under s 82(2) is reviewable, as indicated by s 86(2)(c).

Reunification is a complex topic and one that tends to evoke strong emotion. Ellen[257], a foster carer, told the Commission about a failed attempt by the Department to reunify a young girl with her aunty and later grandmother, (ostensibly) in pursuit of the Aboriginal and Torres Strait Islander Child Placement Principle. Witness X (hereafter referred to as Jack)[258], now an adult who grew up in out-of-home care, described two failed attempts to reunify him to the care of his mother. Melanie[259] spoke about the Department's refusal to reunify her children to her despite extensive engagement with supports. Melanie's two oldest daughters, both subject to LTG orders, later 'self-placed' with their mother, where they live with their youngest brother who has been in Melanie's care since he was born.

Reunification is the proper aspiration for all children in care. However, the decision to reunify the child must be considered in the practical context that the child was at one time removed into State care for his or her protection. The removal of the child was sanctioned by Court order based on the available evidence, yet the power to place the child back with their parents requires no consideration or approval by the Court. There is an asymmetry: the court is heavily involved at the 'removal end' and largely absent at the 'reunification end' of the child protection continuum.

At present, the Court's power to return children to the care of their parents is exercised by refusing to make an order authorising the child's removal, refusing to extend interim custody, or in revoking an existing CPO.[260] If the Court refuses to grant or extend, or revokes, a CPO, the court may make a transition order for a gradual return of the child to the care of their parents.[261] In either case, the court's jurisdiction is only invoked upon application by a party.[262] This means the court has no oversight of reunification decisions that are made while a CPO is in place. This 'all or nothing' approach does not afford the court sufficient oversight or discretion with respect about reunification while the child is in the care of the Department. There is no compelling reason, other than perhaps administrative convenience, why access to the justice system at this part of the continuum should be limited.

To expand, the existing asymmetry is undesirable, for four reasons.

Firstly, it is not logically sound. The decision to reunify a child is potentially as consequential for the child as the decision to remove the child. The removal was based on the Court being satisfied

[257] Appendix B, case study of Ellen
[258] Appendix B, case study of Jack
[259] Appendix B, case study of Melanie
[260] Ibid ss 65-65AA.
[261] Ibid s 65A. A transition order is limited to a duration of 28 days pursuant to s 65A(5).
[262] Ibid ss 65(1), 65AA(1); *Director of Child Protection Litigation Act 2016* (Qld) s 10(1). Only the DCPL may make an application for a CPO. The DCPL, a parent or the child may apply to have a CPO varied or revoked (except a Permanent Care Order). Only the DCPL may apply to vary or revoke a Permanent Care Order.

as to the existence of significant safety concerns. If the child is to be reunified, it follows, the Court ought to be equally satisfied that there has been a demonstrable improvement in the circumstances present at the time of removal. Further, whether the child remains a child in need of protection is a question of fact, which, analytically, cannot be assessed in isolation from the facts and circumstances underpinning the making of the original order. It makes sense that the same body that assessed those facts and circumstances initially, in making the order, should decide whether the child is no longer in need of protection.

Secondly, the current asymmetry is anomalous. In the usual course a Court order would only end if the order was performed or the Court revoked or varied the order. There is no consideration by the Court *as a matter of course* whether the child remains a child in need of protection at the expiration of the order or following the making of a long-term guardianship order. The current process is that prior to the expiration of a short-term CPO, the Department decides whether to refer the matter to the DCPL for another CPO (such as a long-term guardianship order) or for an extension to the short-term CPO.[263] If there is no referral, or the DCPL decides not to file a further application, the order ends and the child is 'reunified' in one form or another.

Thirdly, if the Department is the decision-maker, it is placed in position of actual and apparent conflict which, at the very least, opens the door to perceived bias. Once a CPO is made, the State (in practice the Department) is a party to the issue as the child's notional parent and has the custody or guardianship of the child.[264] Therefore, it has a legal interest in the decision whether to relinquish those rights and obligations to the child's parents. This is not a theoretical interest as the State assumes, or has imposed upon it, extensive rights and obligations in relation to the care of the child. The State steps into the shoes of a parent and must manage the complexities of the child's ongoing care and use public funds (sometimes very substantial amounts[265]) to discharge its duties to the child. It assumes a significant level of accountability both for the care of the child and for the work it is required to undertake with the family to facilitate reunification. In the Commission's view, the State's status as the notional parent means that it cannot objectively be seen as a disinterested decision-maker when it comes to a decision to reunify, as it is relinquishing its rights and obligations as a parent.

Fourthly, reunification and long-term placement decisions are highly material to the safety and wellbeing of the child. If the Court is given the opportunity to consider and determine what

[263] This is not a reviewable decision under *Child Protection Act 1999* (Qld) sch 3.
[264] For the purposes of discussion about reunification, 'child protection orders' refers to an order by which a child is placed in out-of-home care.
[265] See Companion Report *Understanding and Reforming the Residential Care System* regarding the costs of funding residential care.

decision is in the best interests of the child, this will also afford others with a relevant interest such as the child, where practical, the family and relevant ATSICCOs to be heard as to whether the reunification or long-term placement is in the child's best interests. At present, these decisions in many instances are made under the power given to the Department pursuant to sections 82(1) and 82(2) of the CP Act, with little input from relevant stakeholders.

Accordingly, the Commission recommends that reunification and long-term placement decisions be subject to Court supervision.

Low rates of reunification

The number of children in Queensland who exit care by way of reunification is relatively low compared to the national average.[266] Figures 15 and 16 below shows the number of children living in OOHC, and data showing the number of children reunified to their parents.[267] The below figures were provided by the Department.[268]

	2021-22	2022-23	2023-24	2024-25*
Children in OOHC	12,327	12,496	12,958	13,568
Children reunified	556	602	572	342
Children reunified (%)	4.5%	4.8%	4.4%	2.5%

Figure 15: children in out-of-home care who were reunified to their parents.

	2021-22	2022-23	2023-24	2024-25*
Children in care of the CE	10,385	10,476	10,784	11,064
Children reunified	556	602	572	342
Children reunified (%)	5.4%	5.7%	5.3%	3.1%

Figure 16: children subject to child protection orders granting custody or guardianship to the Department who were reunified to their parents. The Department provided data up to 31 March 2025. The Commission was informed data for the full year was unavailable following the transition to Unify.

Figure 15 reflects children who are reunified as a proportion of all children living in OOHC in Queensland. Figure 16 reflects children who are reunified as a proportion of children who are

[266] Australian Institute of Health and Welfare, 'Child protection Australia 2023-24 – Pathways from out-of-home care' (Webpage, 27 March 2026) <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2023-24/contents/pathways-from-out-of-home-care#exittoreunify>. As at 2023-24, the proportion of children nationally who exited care by way of reunification was 41.3%, compared with 31.6% in Queensland.

[267] The Department provided the following notation on the number of children reunified: '*A reunification is a primary placement event closed with a reason for placement closure of either: 'Returned home to parent/s' or 'Placed with parent under S82 (2)' that is not followed by another primary placement within at least 60 days.*'. This definition would appear to include children who self-placed with their parents resulting in placement closure. The Commission notes this counting rule may not necessarily accord with the Department's policies on what constitutes reunification, namely a planned and supportive process involving an assessment that the child is safe to return home.

[268] Data showing children living in OOHC was provided in response to Notice no. 1. Data showing children reunified to their parents was provided in response to Notice no. 48.

subject to a CPO granting custody or guardianship to the Department. The second cohort of children is more likely to be those for whom reunification is being actively pursued.[269] The above data reflects a broad analysis. Undoubtedly there is a need for greater nuance when considering the number of children who are reunified. However, these figures suggest that for most children living in OOHC in Queensland, reunification is not a likely outcome.

6.4.2 Revocation

Where a child is subject to a long-term guardianship order, statutory intervention can only end if an application is made to revoke the order, requiring the Childrens Court to be satisfied that the order is no longer appropriate and desirable for the child's protection.[270].

Currently, the DCPL rather than the Department has standing to apply to the Court to revoke or vary a CPO. These applications are infrequently made, compared to the number of children that are reunified in practice; by authorised placement pursuant to section 82(2) of the CP Act or *de facto* in the form of 'self-placement'.[271] While parents are able to apply to revoke a CPO, the Commission heard that they often lack the resources or legal support required to initiate revocation proceedings.[272]

6.5 Other matters relevant to the Court process

6.5.1 The Court's power to assess and determine the suitability of family members and the Blue Card requirement

A significant constraint in finding kinship carers is the requirement that to be approved as a carer by the Department the person must hold a 'working with children authority', commonly referred to as a 'Blue Card'.[273] This requirement has been the subject of other inquiries and has led to certain legislative changes not as yet proclaimed and implemented. The effect of these changes, if implemented, would be to remove this requirement from the CP Act.[274]

The Department advised that the reason for the delayed commencement was 'to provide sufficient time for the Department to consult on the development of a new, fit for purpose

[269] The Department provided the following notation on the number of children in the care of the Chief Executive: '[Chief Executive] includes child protection orders granting custody/guardianship to the Chief Executive and court assessment orders granting custody to the Chief Executive.' The Commission has assumed this figure includes children subject to orders granting long-term guardianship to the Chief Executive, though the Commission notes that in those cases reunification may or may not be actively pursued.
[270] *Child Protection Act 1999* (Qld) s 65(6).
[271] CA-51, *Statement of Nigel Miller*, tendered 9 December 2025 [240].
[272] Transcript, Evidence of Thelma Schwartz, (22 September 2025) 1447-49; Transcript, Evidence of Clair Martin, (12 December 2025) 3645-46.
[273] *Child Protection Act 1999* (Qld) s 135(1)(b)(iv).
[274] *Working with Children (Risk Management and Screening) and Other Legislation Amendment Act 2024* (Qld) s 4.

screening framework for kinship carers'.[275] It is outside the scope of the Commission's Terms of Reference to re-interrogate this issue which has been much debated in Queensland in recent years.

However, as the CP Act presently stands there are powers the Court has to grant custody and guardianship to family members irrespective of whether they are a Departmentally approved carer, or hold a Blue Card.

Specifically, there is a power in the Court to determine for itself who might be a suitable family member for the purpose of granting custody or long-term guardianship of a child. The power is conferred by s 61(f)(i) which enables the court to grant long-term guardianship to a suitable person (other than a parent of the child) who is a member of the child's family.[276] In addition, the court may grant short-term custody of a child to a suitable family member, including on an interim basis.[277] Before making such an order the Court is required to have regard to any report given, or recommendation made, by the chief executive about the person, including a report about the person's criminal history, domestic violence history and traffic history.[278] The making of such orders on an interim basis is discussed above.

The power of the Court to grant custody or guardianship to a family member is not fettered by the Blue Card requirement that the Department is required to apply as a pre-condition to carer approval. The power under section 61(f) is sometimes used even where the Department has not presented family-based placement options, resulting in the only placement option being non-family based residential care. As discussed above in Chapter 2.2 of this companion report, a real and genuine evaluation of the child's best interests necessarily entails consideration of the consequences of removal from the family. That, in turn, requires recognition that placement of the child in a non-family-based environment is far less desirable in critical respects, particularly the ability of the child to form a trusting attachment to an adult, than placement in a family-based environment. Further, safe and practical, placement of the child with kin has even greater potential to abate the disconnecting impact of removal and, of course, makes it possible to maintain family, mob and cultural connection. These benefits are well recognised and broadly accepted. The benefits are recognised and entrenched in the CP Act, for example in the ATSICPP[279] and in the permanency hierarchy set out in s 5BA.

[275] Statement of Bernadette Harvey (10 November 2025) [36]-[37].
[276] This power relates only to the appointment of a family member. It does not apply to the appointment of any other person who might be suitable as s 61(f)(ii) is subject to nomination by the chief executive.
[277] *Child Protection Act 1999* (Qld) ss 61(d)(i), 67(1)(a)(ii).
[278] Ibid s 59(5). Under s 95(1)(a)(ii), the court can require a report to be given by the Department about such a person.
[279] Ibid s 5C.

The Commission applauds the proactive efforts of some magistrates to exercise the power under s 61(f) where appropriate. The necessity for such a judicial discretion has become more significant as the system has become increasingly reliant on residential care as the only remaining alternative to family-based care, which until very recently has become increasingly dependent on unlicensed providers operating under IPS funded arrangements. From the CSO's perspective, the Commission observes that the reality of extreme workload pressures may mean it is simply easier to arrange a residential placement compared with the active efforts required to locate, assess and place children with family members.[280] Thus, the Court and Department are faced with the choice of placing a child, often a young child, in an unlicensed residential care placement (a model of care not designed for children under 12 years) or looking for an alternative.

Finding an alternative requires looking first among the family and extended family of the child; then, if the family network does not yield a suitable carer, to other potential existing relationships the child might have. A suitable family-based carer may be found in the child's family's wider social network — that is, a person with whom the child has a trusting relationship of some kind or another.

Financial support for family members who are granted custody or guardianship of a child

At present, there is some degree of ambiguity about whether a long-term guardian who is not an approved carer will be eligible for financial allowances and supports to assist in the care of the child. Section 159 of the CP Act provides that the Department *may* pay the carer allowance to a child's carer, long-term guardian or permanent guardian.[281] The Department's policies are not entirely clear as to whether the guardian must have been approved as a carer by the Department. The policy regarding the carer allowance states:

> Child Safety will provide the fortnightly caring allowance to long-term guardians and permanent guardians under the CP Act ('eligible guardians'), when they are providing direct care for a child who is subject to a long term guardianship order or permanent care order.[282]

A related policy adds an additional qualification as to carer approval:

> Child Safety may pay an allowance to a long-term or permanent guardian when:

[280] The Commission understands that it is standard practice for CSOs to refer placement requests to the Placement Services Unit (PSU) who are charged with locating placements for children on an urgent basis. Compared with the work required for the CSO to personally locate, contact, assess and place a child with a family member, in the context of chronic understaffing and workload pressures it was suggested to the Commission that referrals to the PSU for urgent placement may be driven by workforce capacity.
[281] *Child Protection Act 1999* (Qld) s 159(1).
[282] Department of Families, Seniors, Disability Services and Child Safety (Qld), Expenses - Fortnightly caring allowance and interstate foster payments (Policy no. 365-17, 6 December 2023), 1.

- the guardian was the child's approved foster or kinship carer at the time the long-term guardianship order or permanent care order was made
- the child continues to be cared for by the guardian.[283]

Family members who are granted custody of the child (as opposed to guardianship) are expressly excluded.

The result is a practical disincentive for prospective kinship and other carers who do not obtain department approval, including due to not being able to obtain a Blue Card.

A further practical constraint upon the appointment of persons who are not first assessed by the Department as suitable is that such persons are obviously not put forward by the Department as candidates. Unless the court by its own initiative seeks out such persons — that is, non-approved but willing and potentially suitable persons, they are not considered.

Court to be provided with information about family and kin

The Commission accepts that there are cogent reasons for the Blue Card requirement.[284]

However, the Commission considers that the present discretion of the Court to grant custody or guardianship to a person it considers suitable (having regard to, but not bound by, any recommendations of the Department) should continue in the simplified litigation model proposed by the Commission.

The Commission considers that in the context of child protection, the Court is well placed to evaluate the suitability of a prospective kinship carer or foster carer, on either a short term or long-term basis. In the interests of facilitating, wherever possible, the placement of children with kin or other family-based carers, the Court should continue to be able to make its own evaluation of the suitability of the proposed carer.

In order to afford the Court the opportunity to consider potential kin or other family-based carers, the child, where practical, and the family of the child, should be afforded the opportunity to put forward and nominate a kinship or other carer whom they believe should be considered. In addition, there should be a positive obligation on the part of the Department to furnish the Court with all the information it requires to undertake that evaluation from the earliest possible stage.

This would remove the intractable obstacle of the Blue Card requirement, while allowing the Court to evaluate the suitability of the proposed carer having regard to all matters it considers

[283] Department of Families, Seniors, Disability Services and Child Safety (Qld), Support for children in the care of long-term and permanent guardians (Policy no. 607-4, 6 July 2023), 3.
[284] Statement of Bernadette Harvey (10 November 2025) [36]-[37].

relevant to a proper assessment of the carer's suitability. The Court may, of course, conclude that the absence of a Blue Card is a factor which outweighs other considerations. Equally, the Court may, having regard to its assessment of the best interests of the child, including the absence of placement arrangements other than with an unlicensed residential care provider, conclude that the absence of the Blue Card is not significance decisive impediment, particularly having regard to other beneficial and protective factors, including the relationship of the child with the proposed carer.

Further, the advantage of the Court considering this issue, rather than effectively being confined to the Department's assessment of suitability, is that the process of evaluation will provide public confidence that the assessment has been made by a Court informed by the paramount principle and after hearing contending evidence and submissions.

The Department, through the DCPL, may oppose the placement of the child with the proposed carer, as may other persons with an interest in the issue such as a foster carer. Conversely, the family, or an ATSICCO should be able to advance evidence and submissions in support of the placement of the child with the proposed carer. The Commission considers that evaluation by the Court of the carer's suitability to provide care for a particular child is of far greater depth and relevance than a generic requirement that the carer must hold a Blue Card. Such specific evaluation is targeted to the circumstances of the particular carer(s), child, and family and any associated protective factors. It is therefore a far more substantive and reliable basis for deciding the question of a carer's suitability. Certainly, the evaluation conducted by the Court will be more targeted and more individualised than the evaluation undertaken through the Blue Card process.[285] Further, such specific court evaluation should allay rational concerns about the placement of a child with a person not holding a Blue Card and generally enhance public confidence in the placement of children with kin and other family-based carers.

There are other protective factors which flow from a targeted judicial evaluation of the proposed carer. The first is that the Court may impose conditions upon the placement of the child with a carer as necessary. The Court may require that reunification with the family is subject to the family's ongoing engagement with the Department in specified ways, for example their agreement to ongoing visits by the CSO to assess the child's well-being. The condition may be that the family does not permit a certain individual, about whom there is genuine concern, to have unsupervised contact with the child. There are boundless possibilities for suitably framed conditions which

[285] Note, this is assuming that all the information available to Blue Card Services in refusing the person's blue card or exemption application will be made available to the Court (see *Child Protection Act 1999* (Qld) s 95), to be evaluated together with the information about the individual circumstances of the child, family and carer.

would fortify protective factors and diminish risk factors. The bespoke fashioning of appropriate conditions will also avoid anomalous unintended consequences for families which can arise because of the generic application of Blue Card constraints, such as a family member being required to move out of a residence for want of a Blue Card. Such circumstances can instead be considered in the context of the risk assessment undertaken at the time of making the order. It is important also that any such orders be subject to variation if circumstances change.

A further and distinct protective factor is the ongoing involvement of the Department with the child at the placement. The Department's line of sight of, and involvement with, the child is the single most critical protective factor. Conversely, as is clear from evidence heard by the Commission, the absence of contact with the child is significant risk factor for a child. It is ongoing knowledge of, and involvement with, the child that will reveal risks of harm and matters of concern affecting the wellbeing of the child. Further, the approval of a placement in the context of child safety is qualitatively different from the generic approval of an individual to work with children in a great variety of situations, some of which are less visible than others. To take the example of a childcare worker, while they should of course be subject to Blue Card qualification and oversight, recent notorious examples have shown that they may nonetheless engage in covert predatory behaviour which is undetected for a long period. The risk of covert predatory behaviour is a risk which obviously requires vigilant efforts to protect against, but such risks are not by any means avoided by means of the Blue Card requirement.

In the final analysis, it is the ability to discover what is really going on for a child in a particular placement that provides the greatest assurance that the child will be safe and nurtured. That depends upon the Department and members of the child's family, mob, community, responsible adults and the whole of the child protection system, from schools, medical centres, sporting associations, ATSICCOs, churches and any other adults with whom the child has contact, to be vigilant in their observations of the child's wellbeing and to act accordingly. If that network of supportive adults led by the Department is mobilised to pay attention to the child, that child is more likely to be safe and protected from harm.

The Commission considers that as an immediate step, Courts should be encouraged to exercise their powers under sections 61(f)(i), 61(d)(i) and 67(1)(a)(ii), with the active support of the Department. This is an interim step which could be taken before any other recommended reforms to the litigation process are implemented. This recommendation is not necessarily dependent on any legislative change, although some complementary changes are recommended below. As noted above, some pro-active magistrates are already exercising this power. If this recommendation is accepted, the Commission considers that this change has the potential to

make the single largest impact on increasing the availability of family-based care, particularly for Aboriginal and Torres Strait Islander children.

The reasons the Commission has come to this view are as follows:

1. The anecdotal evidence from confidential discussions is that proactive intervention by the courts in finding suitable kin are proving successful.
2. There is likely to be greater success in finding kinship carers who are suitable and prepared to care for a child compared with foster carers generally because the bonds of kinship provide a different and stronger motivation to volunteer to care for a child.
3. It is to be expected that the child's parents will be motivated to assist the Department in locating a suitable relative or person with whom the child may be safely placed.
4. There are existing ATSICCOs whose assistance in the search for, and assessment of, the suitability of kinship carers could readily be enlisted.
5. There is a strong motivation within Aboriginal and Torres Strait Islander communities to reduce the number and proportion of Indigenous children in state care, together with an allied motivation to ensure wherever possible that the ATSICPP is given full force and effect.

As noted above, a bureaucratic disincentive presently adversely affecting the availability of kinship carers is that if they are not approved by the Department, they are not entitled to the usual allowances paid to approved foster carers and kinship carers. The anecdotal evidence is that despite that disincentive, kinship carers are usually found following active judicial efforts. However, the Commission considers that this disincentive should be removed so that once the carer is approved by the Court, the usual financial supports should be made available.

The Commission also considers that in putting prospective family members before the Court, the focus should be on whether they are a 'suitable person' to be granted custody or guardianship and not whether they are approved (or not) as a kinship carer.[286] Specifically, the Department should not decline to put forward to the Court a potential kinship carer purely on the grounds that the carer does not have, or is unable to obtain, a Blue Card.

In addition, the Commission considers that the Department should apply this policy not only to kinship carers but also to other persons who, but for having, or being able to obtain, a Blue Card are potentially suitable carers. As noted above, the Court's discretion under section 61(f)(i) is

[286] See: *Child Protection Act 1999* (Qld) s 135(1)(b) (requirements for approval as a carer), sch 3; *Child Protection Regulation 2023* (Qld) s 18 (definition of 'suitable person' to be granted custody or guardianship of a child).

presently limited to family members. Under sub-section 61(f)(ii), the court may grant long-term guardianship to a suitable person who is not a member of the child's family, 'nominated by the chief executive'.[287] If the legislation were amended to allow the Court to consider granting guardianship to a suitable person 'if satisfied it is in the best interests of the child', assisted by the Department with respect to the person's suitability but not bound by the Department's 'nomination', that change could significantly broaden the scope of potential suitable carers. In due course the Court's discretion should be broadened legislatively to allow for consideration of this broader category of carers. Indeed, it is not apparent why the court's discretion under sub-section 61(f)(i) should be limited to family members and that it should be constrained in sub-section 61(f)(ii) to persons nominated by the Department.

The above recommendations are put forward for the reasons discussed above. That is not to suggest that the Department should be bound to put forward for evaluation by the Court a person the Department considers to be unsafe or unsuitable for substantive reasons. Indeed, the Department should maintain the ability at all times to actively oppose the appointment of a particular carer if there are substantive reasons to do so. If the Department were no longer constrained by the disqualifying effect of the Blue Card requirement, it would be of assistance in finding suitable kinship carers for the Department to engage with ATSICCOs, as well as using its present Finding Kin resources, with the aim that whenever possible children are placed with kin or other natural persons with whom they have some relationship. Both of these recommendations, if accepted, are capable of being implemented immediately as interim steps as they require only a change in Department policy and practice.[288]

A potential side effect of the approval process being decided by the Court is likely to be that the disputes concerning refusal of Blue Cards, at least for the placement purposes for children in State care, will not generate merits review applications to QCAT. The hypothetical applicant may wish to challenge a Blue Card refusal for other purposes, but the question will not arise in relation to the person's suitability to be granted care of the child by the Court.

This section is intended to outline evidence before this Commission with respect to the role of QCAT in child protection proceedings and present challenges experienced, particularly with the jurisdictional cross-over between the QCAT and the Childrens Court. The Commission notes that the government is currently undertaking a review of the *Queensland Civil and Administrative*

[287] *Child Protection Act 1999* (Qld) s 61(f)(ii).
[288] For example, there may be changes to the Department's processes and practices for identifying potentially suitable carers and presenting these to the court (via OCFOS or the DCPL) for consideration.

Tribunal Act 2009 (Qld), led by the Honourable David Thomas, where the matters below may also be addressed.[289]

Role of QCAT in the child protection system

Relevant to issues of accountability, procedural fairness and the veracity of the Department's decisions is QCAT's role as a review mechanism in the child protection system. Currently, persons aggrieved by a decision of the Department may apply to QCAT to have the decision reviewed on its merits ('merits review'). Merits review is unique in that the QCAT assumes the role of the original decision-maker, and in doing so, makes the decision that is preferable in the circumstances.[290] By contrast, review by a Court ('judicial review') is generally more limited – the Court may set aside the decision, or refer it back to the decision-maker, or make a declaration about a party's rights, but it may not substitute its own decision.[291]

Merits review (reviewable decisions)

As an administrative tribunal, QCAT's merits review jurisdiction is limited to the reviewable decisions conferred on it by an 'enabling act'.[292] In child protection, QCAT's jurisdiction is limited to 14 decisions that are subject to merits review.[293] These decisions can be broadly categorised as follows:

- refusing a request to review a case plan;[294]
- directing a parent in relation to a supervision matter stated in a CPO;[295]
- refusing to deal with a complaint about a permanent guardian;[296]
- placement decisions, including refusal to provide a parent with details about a placement;[297]
- family contact decisions, including restricting or refusing family contact;[298]
- removing a child from the care of a carer;[299] and,
- carer approval decisions, including refusing, amending, or suspending carer approval.[300]

[289] Department of Justice, *Terms of reference: Statutory review of the Queensland Civil and Administrative Tribunal Act 2009*, 23 May 2025 accessed at <https://www.justice.qld.gov.au/initiatives/qcat-act-review-2025-26>.
[290] *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 24(2).
[291] *Judicial Review Act 1991* (Qld) s 30.
[292] *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 17.
[293] *Child Protection Act 1999* (Qld) sch 2.
[294] Ibid sch 2 [1].
[295] Ibid sch 2 [2].
[296] Ibid sch 2 [3].
[297] Ibid sch 2 [4]-[6].
[298] Ibid sch 2 [7].
[299] Ibid sch 2 [8].
[300] Ibid sch 2 [9]-[14].

The Department is required to issue a letter to the parents each time it makes a reviewable decision advising of the decision and giving written reasons ('reviewable decision letter').[301]

Blue Card decisions

As mentioned, in addition to reviewable decisions set out in the CP Act, QCAT is also responsible for review of decisions relating to Blue Card checks. As noted above, the Commission has not undertaken a detailed examination of review of Blue Card requirement in the context of the child protection system but suggests this requirement should not be an immutable obstacle to the approval of a carer for the reasons discussed above.

Issues with the QCAT jurisdiction in child protection

Limited scope of reviewable decisions

It is clearly beneficial that a person aggrieved by a decision of the Department should have the ability to seek an independent review of the decision. However, like so many other aspects of the child protection system, the jurisdiction occupied by QCAT is suffering from significant delays and fragmentation. In its submission regarding the litigation model, QATSICPP recommended that QCAT required adequate resourcing to deal with matters in a timely way. QATSICPP observed that:

> Applicants that are seeking a contact review via QCAT are currently experiencing exorbitant delays when moving through the QCAT process and this has very real impacts for children and families.[302]

QATSICPP recommended reconsidering that the matters QCAT can deal with and the matters that the Court can deal with in the interests of expedient finalisation of child protection matters.[303] Stakeholders reported that applications for review were being declined on technical jurisdictional grounds, referring to the limited list of reviewable decisions.[304]

For a Department with such broad functions and decision-making powers,[305] the list of reviewable matters is, in the Commission's view, too limited. In particular, the Commission observes that there are many important decisions which appear to be effectively 'un-reviewable':

[301] Ibid s 86(5).
[302] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (28 November 2025), 10.
[303] Ibid 10.
[304] For example, see *Submission No 10 to Child Safety Commission of Inquiry* (14 November 2025), a father whose child was removed.
[305] *Child Protection Act 1999 (Qld)* s 7.

- a decision to place a child in the care of their parents pursuant to section 82(2) of the CP Act (reunification decisions) are reviewable only by the child or the parents, and not, for example, by a carer or family member who has had care of the child;
- Schooling, including a decision to change a child's school (refer to Jack's case study);[306]
- health and medical care;
- access to the NDIS and disability support (for example, a decision about whether to apply for NDIS and/or whether to appeal an NDIS decision);
- engagement with services and supports (for example, a decision about whether to engage a child with a particular service);
- decisions with cultural significance (for example, a decision to approve a child's first haircut) including connection activities;
- excluding a particular person from case planning; or
- authorising gender-affirming care.

The above list is not intended to be exhaustive or to place any special importance on any of the above decisions. On the contrary, the Commission is concerned that the current framework appears to limit reviewable decisions to a select group of matters. This means there is no apparent mechanism for independent accountability consistent with the key principles of the CP Act. It seems arbitrary to allow QCAT to review, for example, a placement decision, but not a decision to change the child's school or their usual medical practitioner. Likewise, for some parents a decision to not allow a child to attend a cultural event may be of just as much significance as a decision to place a child with a particular foster carer.

It might be that such factors are relevant to the merits of the decision, as may be a failure to give proper weight to those factors in deciding the placement. The issue is that in the current framework, each of those factors may be considered only as far as they flow from the placement decision, not as separate decisions in their own right. To take the example further – a parent may agree to the placement decision, and may accept the child will change schools, but may disagree with the *choice* of school.

[306] Appendix B, case study of Jack

6.6. The way forward: simplifying the Court process with a streamlined child protection proceeding

This part sets out a comprehensive reform of the court process within Queensland's child protection system, supported by a redesigned statutory intervention pathway. The reform model responds directly to the issues by establishing a single child-centred court process underpinned by more active judicial case management, a simplified and transparent architecture for CPOs and powers, and defined jurisdictional pathways.

The proposed statutory intervention model is operationalised through a single, structured pathway, illustrated in the tables below. These tables provide a visual representation of how the Commission proposes matters progress from investigation and assessment through to final resolution.

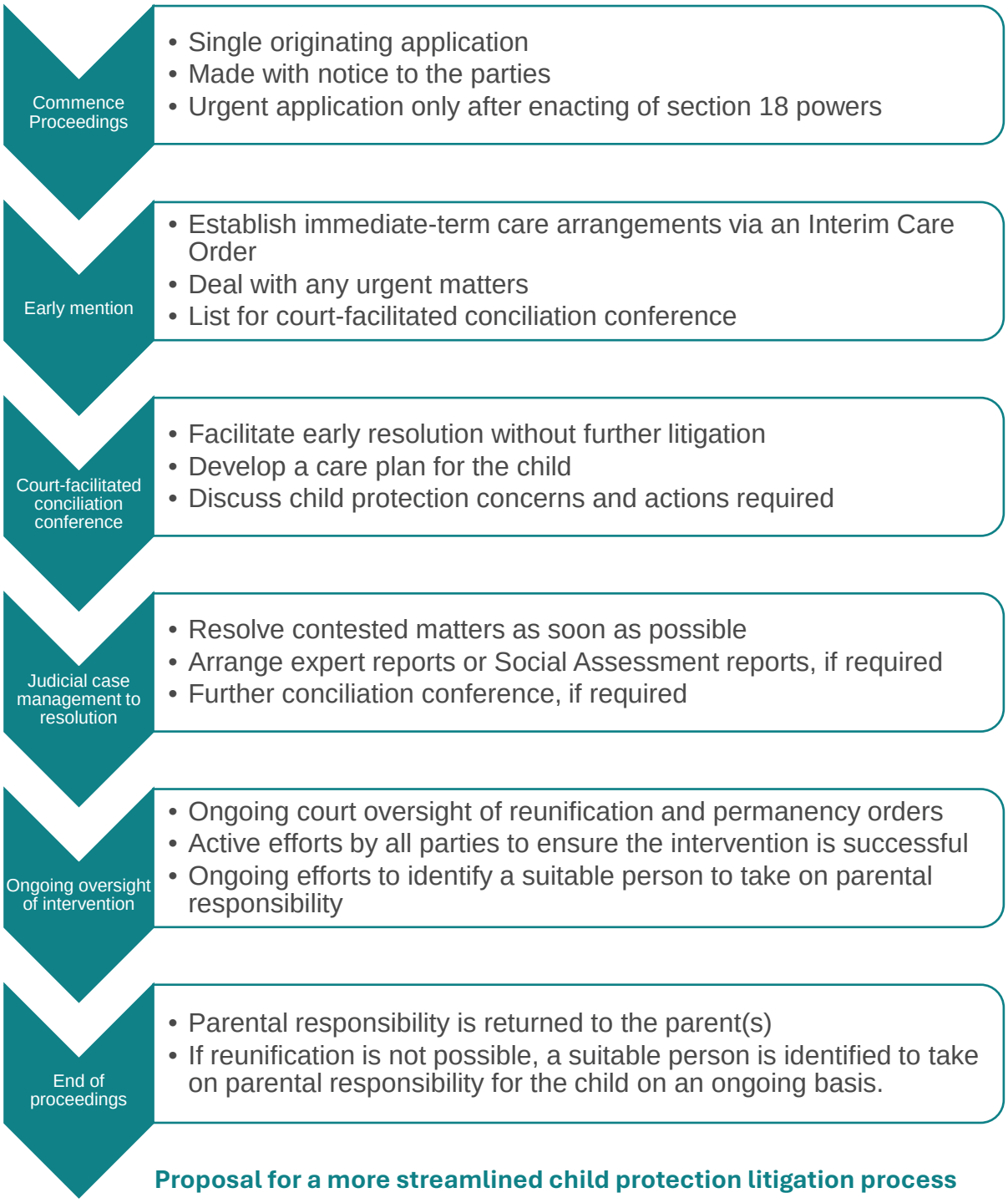
In summary, the streamlined court process has the following features:

- One court proceeding in relation to the child, not multiple serial applications;
- Parental responsibility as the organising legal concept underpinning care of the child;
- Early, independent legal oversight of child protection applications;
- Mandatory court conciliation at the earliest possible opportunity, including formalising arrangements for the child's care;
- More active judicial case management of proceedings;
- Greater Court oversight, particularly with respect to care arrangements for the child and progressing reunification;
- Greater integration with other related jurisdictions, particularly family law, where appropriate; and,
- Ongoing judicial oversight whenever the State holds parental responsibility, with greater impetus for continued active efforts towards family-based placement, kinship placement, and reunification.

The reforms proposed below support Queensland's unique independent litigation model, and at the same time strengthen accountability and access to justice by addressing the challenges outlined in this chapter.

6.6.1 Overview of the proposed Court process

The proposed court process introduces a clear, structured and child-focused approach to the commencement and management of child protection proceedings in Queensland, with the court to have oversight of the intervention until a suitable ongoing permanency arrangement for the child is achieved. The diagram below provides a summary of the proposed process.



Proposal for a more streamlined child protection litigation process

The proposed child protection litigation process involves six stages. These are summarised as follows.

The table below outlines the key steps to be undertaken at each stage of the process. For the purposes of this Commission, these steps are intended to reflect the desired outcome of each stage rather than a prescriptive list of recommendations. The implementation of the below reforms will necessarily require a great deal of collaboration and coordination between the courts, the litigation Director and the Department, as well as a range of stakeholders including parents, support services, ATSICCOs, legal services, and children and young people.

1. Commence proceedings – single originating application
Proceedings are brought by the Director upon being satisfied an order is required to protect a child. The Director files an originating application, clearly stating: ▪ Whether the application is brought with notice or on an urgent basis; ▪ Final orders sought – which may reflect a possible range of orders, to be confirmed through conciliation and before any final hearing; ▪ An *Interim Care Order* with arrangements for the protection of the child, including: o Who will have parental responsibility for the child; o Where the child will live; and, o Family contact arrangements (including restriction of contact, if required). ▪ Any necessary procedural orders sought; and, ▪ The date the application should be listed for mention. If the child is placed with a carer who is not a family member or known trusted adult, the Director must provide evidence of active efforts to identify and assess kinship carers prior to seeking an interim order.
Urgent applications
If the Department or other authorised officer has enacted section 18 powers, the Director may make an urgent *ex parte* application. In addition to the above, an urgent application must state: ▪ Why section 18 powers were acted upon; ▪ Why voluntary or less intrusive arrangements were not viable; and ▪ Whether continued separation is necessary and proportionate, including whether the child can safely return to their parents with conditions. Urgent applications must be filed and heard the next business day following the removal. At the urgent mention, if *ex parte*, the court may only adjourn the matter for the shortest possible period to enable the parents to be given notice of the application.

2. Early mention

At the first mention of the application, the court will make interim orders as the court sees fit, including:

- Whether the matter should be adjourned, and for how long;
- An *Interim Care Order* establishing arrangements for the child, as outlined above;
- Any necessary procedural orders, including filing directions or orders regarding service;
- Directing a copy of the application be given to Legal Aid Child Protection team and the Public Guardian, to facilitate timely legal representation for the parents and the child; and,
- Listing the matter for a court-facilitated conciliation conference.

Before making an order to remove a child from their parent(s), the court must be satisfied that it is in the child's best interests, upon a *balance of harm* analysis, having regard to the likelihood of emotional harm associated with the removal and the proposed *Interim Care Order* for the child.

Any adjournment should be for no longer than is strictly necessary to undertake the required actions, with those actions to be recorded in the order or in a schedule forming part of the order.

3. Court-facilitated conciliation conference

The first substantive stage of the proceedings should be a court-facilitated conciliation conference. The conference will involve all of the parties, as well as key stakeholders identified in the early stages such as:

- The Child Safety Officer and Senior Team Leader;
- If the child is Aboriginal and/or Torres Strait Islander, a Cultural advocate;
- A family support worker, such as a Family Wellbeing Service or Family Intervention Service;
- The person with care of the child; and,
- The child, if appropriate.

The court may make orders regarding who should attend the conciliation conference.

The conciliation conference should be facilitated by an independent and impartial convenor, preferably a court officer such as a *Judicial Registrar* with the designated role of assisting the magistrate with child protection matters.

At the conclusion of the conference, the convenor will provide a report to the court detailing:

- A summary of the child protection concerns in relation to the child;
- The final orders sought by the Director;
- The views of each of the parties on the application, noting any agreed matters; and,
- The proposed care plan for the child if the proposed orders are granted, including proposed interim care arrangements if the matter is contested.

If the application is contested, the contesting party(ies) must file a response setting out the reasons why they are contesting the application. An approved court form – *Response* should be developed and attached to each application, so that parties are assisted to make their views known to the court as soon as possible.

4. Judicial case management to resolution

If the parties reach agreement at the conciliation conference, the court may finalise the matter if satisfied it is in the child's best interests to do so.

The court will have ongoing oversight of the intervention until a suitable, long-term permanency arrangement is achieved for the child. See below – *Ongoing court oversight of orders*.

Contested proceedings

If the application is contested, the court should list the matter for a directions hearing. At the directions hearing, the court will make orders as the court sees fit, including:

- Any necessary procedural orders and directions for the expeditious hearing and determination of final orders;
- Commissioning an expert report or Social Assessment Report, if required; and,
- Any steps required to ensure the views and wishes of the child are made known to the court in a manner the court considers suitable and appropriate.

The court may decide to list the matter for final hearing at the same time, alternatively the parties may be required to do certain things before it is listed. For example, the court may order the parties attend a further conciliation conference.

At this stage, and at every subsequent adjournment, the court must review the interim care arrangements in place for the child and consider whether any changes should be made to those arrangements.

The court will manage all contested proceedings to ensure they progress without undue delay.

5. Ongoing court oversight of orders

If the court makes a short-term order for the purpose of reunification ('reunification order'), or a long-term order ('permanency order') granting parental responsibility for the child to the Department, the court will have ongoing oversight of the intervention.

For example, the court may transfer the matter to a 'Reunification List' to streamline oversight of active supervision or reunification orders. For these matters, the court will hold a review mention to occur at regular intervals, to be determined by the court. At the review mention, the parties will inform the court on the progress of the intervention including:

- The parents are accessing agreed services and supports;
- Appropriate funding, referrals and case management assistance has been afforded to the family;
- Evidence that the child protection concerns are addressed or will be addressed;
- Care arrangements for the child remain appropriate, including:
    - Parental responsibility (decision-making) arrangements;
    - Where the child is living; and,
    - Family contact;
- Any matters that have arisen requiring the court's attention.

At each review mention, the court may make any further orders as the court sees fit to ensure the success of the intervention and/or for the care and protection of the child.

Permanency orders granting care of the child to the Department must be regularly reviewed

If the court makes a permanency order granting parental responsibility of the child to the Department, the court must review the order every twelve months (or earlier). At each review, the Director must provide evidence showing:

- If the child is placed in residential care, active efforts to transition the child to family-based care;
- Whether there is a suitable person to be granted parental responsibility of the child; and,
- If there is not a suitable person, active efforts made to identify potential candidates and the reasons why each candidate is not considered a suitable person.

Permanency orders granting care of the child to a suitable person

If the court makes a permanency order granting parental responsibility of the child to a suitable person, the court may:

- List the order for ongoing review; or,
- Make the order on a final basis.

The end date of the order will be the date the court considers appropriate, having regard to the child's need for permanency and any other relevant matter in the circumstances.

6. End of proceedings

The court will maintain oversight of the matter for the duration of the intervention.

The court may finalise the matter when:

- Parental responsibility can be safely returned to a parent, because the child protection concerns have been addressed and child is safely in the parent's care; or,
- If reunification is not possible, a suitable person has been identified to be granted parental responsibility of the child on an ongoing basis.

Resourcing the Childrens Court

If the Commission's recommendations with respect to the legislative framework and the court process are adopted, the significant burden of duplication and inefficiency currently present in the system as a result of the bifurcated model would be removed. The Commission intends that the proposed reforms would result in a significant reduction in time, effort and resources, particularly in the earliest stages of the court process. In particular, the Commission envisages that:

- One State entity serving as the sole applicant in all child protection matters means that a single application can be brought as soon as a child is identified as being at immediate risk and/or if the child is assessed as requiring a child protection order.
- Interim care and protection arrangements can be achieved as part of this single application, without the need for up to three different – and separate – emergent orders. As noted earlier, in 2024-25 (FY) there were some 5,567 emergent orders made compared with 3,988 applications for CPOs. The number of emergent orders includes matters where multiple orders were made for the same child, and/or extensions of those orders.

- Time currently spent facilitating the referral of each matter from the OCFOS to the DCPL will instead be spent supporting parties' access to legal representation and preparing for a court-facilitated conciliation conference.
- Further, facilitating a mandatory conciliation conference before substantive litigation ensues will remove the significant delays associated with case planning from the court process. Similarly, Family Group Meetings will be repositioned as a collaborative process to facilitate family-led decision making in relation to the statutory intervention; a position which, in the Commission's view, is more reflective of the philosophy and purpose of FLDM in the child protection context.
- Regular court oversight of ongoing interventions will significantly decrease the burden of applications to extend short-term child protection orders, allowing the court to proactively address issues as they arise.
- Adopting parental responsibility as the core framework for care and removing the concepts of 'custody' and 'guardianship' will afford the court greater scope to make arrangements in the child's best interests. Importantly, it will enable the court to fashion an order that best achieves the goal of the proposed intervention taking into account each child's individual circumstances.
- Importantly, by discharging proceedings only when a suitable ongoing permanency arrangement has been achieved for the child, the court is able to give full effect to the paramount principle. It is hoped this will ultimately reduce the number of children subject to departmental intervention over time, increase carer recruitment and retention, and reduce the burden on departmental officers associated with high rates of orders granting long-term guardianship to the Department.

Expanding the role of the Court to provide greater oversight, rigorous case management and early dispute resolution will require sensible and commensurate increases in the resources available to the Childrens Court. The proposed streamlined system would benefit from additional specialist Magistrates and, potentially, from the introduction of child protection Registrars capable of assisting the court with mentions, conciliation conferences, directions hearings, and general case management. The Commission notes similar reforms have been recently implemented in the Federal Circuit and Family Court of Australia.

Additional resourcing means additional cost, but, in this case, it may also mean significant avoided cost. In particular, reforms which prioritise and facilitate finding kin and other family-based carers at an early stage will assist in avoiding the staggering wasted expense associated with children otherwise suited to families being placed in residential care, at an average annual

cost of around $500k per child. There should, as a result, not only be modelling of the additional Court resources required under the proposed model, but also the likely avoided cost.

6.7 Recommendations

<table>
<tr><th colspan="2">Recommendation 12: Replace ‘custody’ and ‘guardianship’ with ‘parental responsibility’</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 6)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of the Government’s response to this report, amend the Child Protection Act 1999 to remove the concepts of ‘custody’ and ‘guardianship’, and instead adopt the meaning of ‘parental responsibility’ as set out in section 61B of the Family Law Act 1975 (Cth).</td></tr>
<tr><td colspan="2">CONTEXT:

For reasons explored in section 6.1.2 of the Companion Report, the Commission considers that the present distinction between ‘custody’ and ‘guardianship’ of a child imposes a binary that often fails to reflect the nuanced reality of children’s care arrangements. The concept of parental responsibility as it applies to all families in Australia is preferable because it is flexible and adaptable, and may be shared between different persons.</td></tr>
<tr><td colspan="2">IMPLEMENTATION NOTES:

The Commissioner intends that the Child Protection Act 1999 adopt the meaning of ‘parental responsibility’ as set out in section 61B of the Family Law Act 1975 (Cth), such that any future amendment of section 61B definition of parent responsibility will apply to the Child Protection Act.</td></tr>
</table>

<table>
<tr><th colspan="2">Recommendation 13: Enlarge definitions of ‘suitable persons’</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 6)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of the Government’s response to this report, amend section 67 of the Child Protection Act 1999 to broaden the scope of persons in whose care the Court may place a child on an interim basis, to include a ‘suitable person’ with whom the child has a relationship of trust, including for example a family friend, neighbour or teacher.</td></tr>
<tr><td colspan="2">CONTEXT:

For reasons explored in section 6.5.1 of the Companion Report, the Commission considers it desirable to expand the Court’s existing ability to place a child with a suitable person, whether or not that person is a Departmentally approved carer, and whether or not the child is a family member.

The Commission considers it desirable to provide the Court the option, where appropriate, to place the child with a person with whom there is an existing relation of trust. By enlarging the pool of potentially appropriate family-based placements, it is intended to reduce the placement of children suited to families in residential care.</td></tr>
</table>

<table>
<tr><th colspan="2">Recommendation 14: Positive obligation to provide court with ‘suitable persons’</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 6)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of the Government’s response to this report, amend the Child Protection Act 1999 to:

(a) introduce a positive obligation on the DCPL to furnish the Court with all the information it requires to undertake the evaluation of who may be a suitable person, from the earliest possible stage in proceedings, and including persons who are not already approved as carers;
(b) clarify that the child (where practical), and the family of the child, are to be afforded the opportunity to put forward and nominate kinship or other carers whom they believe should be considered by the Court.</td></tr>
<tr><td colspan="2">CONTEXT:

This recommendation complements Recommendation 13 and is designed to encourage and facilitate the Court’s use of its powers to place a child with a suitable person, whether or not that suitable person is a Departmentally approved carer. It does so by ensuring that the Court is, through the DCPL and interested family members, made of aware of potentially suitable persons with whom it may consider, where appropriate, placing the child.</td></tr>
</table>

Recommendation 15: Suitable persons to receive financial assistance	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend section 159 of the *Child Protection Act 1999* to clarify that any person who is granted care of a child pursuant to a Child Protection Order, including on an interim basis, is eligible to receive payments for care and maintenance from the Department.	
CONTEXT: This recommendation complements the previous two recommendations and is designed to remove the financial disincentive to accepting care of a child which presently applies to a suitable person who is not a carer approved by the Department. It is intended that this will facilitate the Court's use of the power to place with suitable persons who are not Departmentally approved carers.	

<table>
<tr><th colspan="2">Recommendation 16: Childrens Court to replace QCAT review</th></tr>
<tr><th>Executive Report (Chapter 6)</th><th>Companion Report 2 (Chapter 6)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, will amend the Child Protection Act 1999 to:

(a) remove the power to review family contact and placement decisions from the QCAT and vest this power with the Childrens Court; and
(b) provide that a carer for a child has standing to appear and make submissions with respect to family contact and placement of the child.</td></tr>
<tr><td colspan="2">CONTEXT:

The context for this recommendation is explained in detail in section 6.5 of the Companion Report. In short, QCAT's existing review function is too limited, and the Commission considers that judicial oversight of decision-making across the child protection decision is best situated with the Childrens Court. The enlargement of standing is designed to ensure that all relevant parties have the opportunity to be heard on decision-making affecting the child's welfare.</td></tr>
<tr><td colspan="2">IMPLEMENTATION:

The Commission notes the Queensland Civil and Administrative Act 2009 is presently under review.</td></tr>
</table>

Recommendation 17: Simplify child protection orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the government remove the current suite of child protection orders contained in section 61 of the *Child Protection Act 1999*, and replace them with two new types of child protection orders:

a. A **Reunification Order**, being a short-term order designed to achieve reunification and establishing the necessary arrangements to ensure the care and protection of the child;

b. A **Permanency Order**, being a long-term order designed to achieve ongoing permanency for the child where reunification is not possible, achievable, or in the child's best interests. A Permanency order should confer parental responsibility on a suitable person; or if there is no suitable person, on the Department.

Each child protection order should address:

a. who is granted parental responsibility for the child, including any adjustments such as shared parental responsibility with respect to certain matters;

b. who the child will live with for the duration of the order;

c. family contact arrangements for the child;

d. an annexure, which is the care plan for the child.

The duration of any child protection order should be for the period as the court sees fit, and:

(i) for a Reunification Order – no longer than twelve months, subject to regular review by the court;

(ii) for a Permanency Order granting parental responsibility to a suitable person – for the period the court sees fit to ensure ongoing permanency for the child (up to age 18);

(iii) for a Permanency Order granting parental responsibility to the Department – no longer than twelve months, to be extended subject to annual review by the court.

CONTEXT:

For reasons more fully explored in section 6.6.1 of the Companion Report, the Commission considers that simplifying and streamlining the current process will reduce the duplication, inefficiency, and delay it has identified in the present system.

The Commission considers it highly desirable that there be active judicial supervision across the child protection, and that this recommendation would reduce the likelihood that children who are placed in the custody of the Department but are suitable for family-based placements remain in unsuitable residential care placements on an ongoing basis.

IMPLEMENTATION:

The Commission notes that this amendment would result in the removal or Directive orders and Supervision orders currently contained in section 61 of the CP Act. In the Commission's view, the proposed reforms – particularly with respect to parental responsibility, the 'balance of harm' analysis, and reforms to section 18 of the Act – would likely remove the need for special 'directive' or 'supervision orders'. For example, a child protection order may establish that a parent maintains parental responsibility subject to directions or alterations as the court sees fit.

Recommendation 18: Legal representation for all parties	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, seek to ensure all parties in child protection proceeding be afforded the practical opportunity to be legally represented from the commencement of proceeding, including at any contested hearing or conciliation model, whether under a duty lawyer model or some other suitable model which achieves that objective.

CONTEXT:

The context for this recommendation is explained in section 6.3.2 of the Companion Report. The Commission knows that rates of legal representation remain concerningly low, despite this also being a recommendation made in the Carmody Report.

Legal representation of the parties is beneficial not only for the parties but also assists the Court, including by assisting the Court in identifying suitable persons with whom the child may be placed, if necessary. Significant court costs and time can be avoided by providing early and adequate legal representation. The desirable goal of making the legal process more agile, and intervening earlier to resolve the length of time a child may remain in care, is dependent on legal representation being available.

IMPLEMENTATION NOTES:

In relation to this recommendation, see the discussion in section 6.3.2 of the Companion Report. Implementation of this recommendation may involve taking steps to:

(a) explore the costs and benefits of different models of providing legal advice, support, and advocacy for all parties in child protection proceedings, including at contested hearings, whether under a duty lawyer model or some other suitable model; and
(b) conduct a pilot program over at least 12 months (with independent evaluation of the return on investment) for the preferred model.

In addition, the Commission notes there may be a place for non-government organisations to assist with providing advocacy and support throughout the court processes.

Recommendation 19: Consolidate emergent orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* to abolish the current framework for emergent orders (TAOs, CAOs and TCOs) and replace those orders with a single *Interim Care Order*, to be made (on application by the Director) on terms as the Court sees fit to ensure the child's care and protection during the interim phase of proceedings.

CONTEXT:

The current architecture for ensuring the child's care and protection during the interim phase(s) of proceedings is complex, fractured and incomplete. This recommendation complements other recommendations designed to streamline and simplify the current litigation and court process, so as to reduce duplication, inefficient, and delay.

IMPLEMENTATION NOTES:

Under the proposed model, proceedings may commence and progress using single originating application in which the Director:

(a) outlines any Interim Care Order sought for the care of the child;
(b) outlines any procedural orders sought to progress the matter;
(c) files a supporting affidavit with relevant material, including the matters that are yet to be assessed and the proposed plan and timeframes for the assessment; and
(d) identifies the final orders sought, if known, otherwise the application to seek in the alternative (such as a Reunification or Permanency order). If, as is likely in many instances, it is unknown at the commencement whether reunification can be achieved, the Director will nominate either a Reunification or Permanency Order as soon as practicable.

Recommendation 20: Contact arrangements as part of child protection orders	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, ensure that where necessary or appropriate, family contact arrangements should be specified as part of all child protection orders (including both interim and final orders).

In particular, the court should be expressly empowered to determine, in the best interests of the child:

(f) How often family contact is to occur between the child and their parents;
(g) How often family contact is to occur between the child and their siblings (if any);
(h) How often family contact is to occur between the child and other family members (if any);
(i) What restrictions or conditions, if any, are necessary to ensure the best interests of the child in having family contact; and,
(j) Whether increased family contact could safely occur, including any supports required.

CONTEXT:

The Court is currently empowered to make orders in relation to contact including permitting, restricting, or placing conditions on the child's contact. However, in the current framework contact arrangements are generally decided by the person with custody or guardianship of the child without court input or oversight. This jurisdictional cross-over has contributed to duplication between the court and QCAT with respect to jurisdiction.

Family contact is an essential component of the child protection system. Contact arrangements made in the early interim phases of the court process tend to continue over a long period. The amount, quality and progress of family contact is a focus of case plans, review reports, and strength and needs assessments. Most importantly, many children and young people identify limited family contact as one of the most impactful elements of their experience in state care.

Given the centrality of family contact as an essential element of ensuring the child's protection, family contact arrangements should be established at the earliest possible opportunity following removal and expressly contained in any Interim Care Order (either within the order or as an annexure).

IMPLEMENTATION NOTES:

The intent of this recommendation is not to prevent any family contact prior to the court hearing an application or making an *Interim Care Order*. Such arrangements should be made in the child's best interests and would be subject to review by the court at the earliest opportunity.

By way of guidance as to how family contact arrangements should be determined, the Commission notes the considerable family law jurisprudence with respect to interim contact arrangements that may be applied. The Commission envisions this will be made easier with the adoption of parental responsibility as an element of all child protection orders.

Recommendation 21: Early Court-facilitated conciliation	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, amend the *Child Protection Act 1999* and other relevant instruments to require early court-facilitated conciliation as a mandatory step occurring as soon as possible upon the Director filing a child protection application, replacing the need for parents to attend both a Family Group Meeting and a Court Ordered Conference.

CONTEXT:

The Commission heard that very few child protection applications proceed to contested hearing, with most resolved by agreement, at various stages, or by withdrawal of the application.

In the current framework, the separation of case planning and dispute resolution within the court process creates duplication, confusion, and extensive delays in resolving matters. The Commission is aware of cases where the length of proceedings is longer than the duration of the order sought, even where the parents were not opposed to the application. Two amendments are required to address this impediment to resolution:

(a) Dispute resolution must occur at the earliest possible stage of litigation, not merely as a precursor to trial; and
(b) Case planning in relation to the child should form part of the dispute resolution process, being an essential element of the grounds for any CPO.

Further, the court process be redesigned so that court-facilitated conciliation is mandatory at the soonest possible opportunity following the litigation director bringing an application. On conclusion, the Court should be furnished with a report detailing the agreed outcomes of the meeting including the proposed care plan/s with respect to the child.

The purpose of the conciliation is to promote early resolution of the application, by:

(a) identifying agreed and disputed child protection concerns;
(b) clarifying the type of final order sought;
(c) developing a case plan with actions and timeframes; and
(d) determining whether the matter will be contested.

IMPLEMENTATION NOTES:

This recommendation does not deride the value of the FGM process or of family-led decision-making generally. As noted in the report, many stakeholders spoke positively of FGMs as a valuable opportunity to build rapport with families, establish trust, and take action. The main goal of this recommendation is to remove unnecessary delay from the court process – which fundamentally undermines case planning as it currently operates – by decoupling the FGM process from the court process. For example, the Department may continue to utilise the FLDM framework for engaging with families in the course of ongoing intervention.

Nor does this recommendation preclude the Department from holding a FGM.

The terms of the care plan developed in the course of proceedings should be contained in the order or as an annexure. It is envisioned this will promote a level of independence by which the Department can focus its efforts on supporting and engaging with families.

Recommendation 22: Improve case management framework	
Executive Report (Chapter 6)	**Companion Report 2 (Chapter 6)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, consult with the Childrens Court to review the current *Childrens Court Rules 2016 (Qld)* with a view to establishing an improved court case management framework for child protection proceedings, having regard to the observations and other recommendations made by this Commission as to judicial oversight, case management, and timely dispute resolution.

CONTEXT:

The proposed court process introduces a clear, structured and child focused approach to the commencement and management of child protection proceedings in Queensland, with the court to have oversight of the intervention until a suitable ongoing permanency arrangement for the child is achieved.

If the Commission's recommendations with respect to the legislative framework and the court process are adopted, the significant burden of duplication and inefficiency currently present in the system as a result of the bifurcated model would be removed. The Commission intends that the proposed reforms would result in a significant reduction in time, effort and resources, particularly in the earliest stages of the court process.

Currently, the *Childrens Court Rules 2016* (Qld) provide the case management framework for child protection proceedings. If the Commission's recommendations with respect to the litigation model and legal framework are implemented, the Rules should be revised to reflect the streamlined model.

This will also assist in identifying what additional resources will be required to enable the court to take on an expanded role, providing greater oversight, rigorous case management and early dispute resolution.

IMPLEMENTATION NOTES:

This Commission notes that the recommendations relating to the litigation model will necessarily involve an appropriate increase in resourcing for the court commensurate with the additional responsibilities conferred on the court.

The Commission notes the proposed streamlined system would benefit from additional specialist Magistrates and, potentially, from the introduction of child protection Registrars capable of assisting the court with mentions, conciliation conferences, directions hearings, and general case management. The Commission notes similar reforms have been recently implemented in the Family Court.



Child Safety

Commission of Inquiry



Companion Report 3

Models of Care

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Introduction

Companion Report 3
Models of Care

Introduction

This report examines the models of care available to children in Queensland's out-of-home care (OOHC) system. It focuses on what happens when the State has determined that a child cannot live safely with their parents, and must then decide how that child will be cared for, by whom, in what setting, for what purpose, and with what support.

These questions go to the core of the State's responsibility as corporate parent. Once a child enters care, the system is no longer dealing only with risk, placement availability or statutory authority. It is shaping the child's home life, relationships, routines, cultural identity, education, health, development and sense of belonging. The care arrangement chosen for a child can either support stability and recovery, or compound the disruption that brought the child into care.

This report proceeds from the starting position that care is not defined by placement type alone. A model of care must be understood by its purpose, the children it is designed for, the relationships it supports, the quality of daily care it provides, the safeguards it contains, and the pathway it creates for the child. A placement that provides a bed but lacks relationships, therapeutic support, or a pathway forward, should not be considered a sufficient care arrangement for a child.

Queensland's OOHC system includes a range of family-based and non-family based options. Family-based care is the preferred foundation of the system where it can safely meet a child's needs. It offers children the possibility of stable relationships, attachment, belonging and a relatively ordinary family life. However, the evidence before the Commission indicates that family-based care is under sustained strain. Foster and kinship carers are being asked to provide increasingly complex care in contemporary household conditions that differ markedly from those in which the current approach to foster and kinship caring was developed. They are also doing so within a system where information, authority, support, partnership with the Department and procedural fairness are not consistently provided, further disincentivising carers from entering or remaining in the system.

Non-family based care performs a different function. Residential care, Supported Independent Living and Safe Houses are necessary for some children at particular points in time. However, each of those types of non-family based care should have a clearly defined purpose. Non-family based care should not operate as a suite of residual options when family-based care is unavailable, unsupported or has broken down. The growth of residential care in Queensland is

one of the clearest indicators that the broader OOHC system is under pressure and out of balance. It also raises fundamental questions about whether care arrangements are being matched to children's needs or shaped by scarcity.

For a very small cohort of children, existing family-based and non-family based care arrangements may be unable to safely manage immediate and serious risk. This Companion Report therefore also considers secure care as a model of care. Secure care has a legitimate place in Queensland, and the Queensland Government has committed to its implementation. However, secure care needs to be considered only as a narrow stabilisation pathway. It must be distinguished from youth detention, lawful, therapeutic, time-limited, independently authorised, independently overseen, and connected from the outset to a pathway back to a less restrictive care arrangement.

Across the three chapters of this Companion Report, the Commission's concern is whether the available care arrangements form a coherent OOHC system that can respond to children's needs in a purposeful, relational, culturally appropriate and developmentally appropriate way. That includes whether children can remain connected to family, kin, siblings, community, culture and Country; whether disability, mental health and education needs are understood and responded to; whether carers and workers are supported to provide safe and consistent care; and whether children have clear pathways toward stability, permanency and adulthood.

The report also recognises that models of care cannot be separated from system design. Family-based care will not be sustained by goodwill alone. Non-family based care will not become therapeutic simply because it is described that way. Secure care will not be safe merely because it is tightly controlled. Each model depends on the supports, funding, workforce, governance, legal authority, cultural capability, information systems and accountability arrangements around it.

The three chapters of this report are therefore connected. The family-based care chapter examines the model that should remain the primary service delivery infrastructure of the tertiary child safety system, and the changes required to make it viable in contemporary conditions. The non-family based care chapter examines the role, growth and quality of care arrangements outside family homes, and the need to ensure those arrangements are purposeful rather than default responses to system pressure. The secure care chapter examines how Queensland can create a lawful and therapeutic pathway for the narrow cohort of children whose immediate risks cannot safely be managed in existing arrangements, and the safeguards such a care arrangement requires.

The reform task is to build a system of care in which each arrangement has a clear purpose, is matched to the child's assessed needs, is properly supported, and is connected to the child's relationships and future pathway. Children should not move through care because one part of the system has failed, and another is forced to absorb the consequence. They should be supported through care arrangements that are safe, stable, relational, culturally grounded and directed toward their long-term wellbeing.

Chapter 1

Family Based Care

Companion Report 3

Models of Care

Abstract

This chapter examines family-based care as the preferred foundation of Queensland's OOHC system. It considers the roles of both foster and kinship care, the pressures affecting carers and households, and the gap between the system's stated commitment to partnership and carers' experiences of information sharing, decision-making, support, safeguarding and complaints processes. The chapter concludes that family-based care cannot be sustained by goodwill alone, and that Queensland must both strengthen the operational foundations of the current system and redesign family-based care around children's relationships, contemporary household realities and the support required to keep placements stable.

Chapter 1: Family Based Care

1. Introduction

'Attachment is the core of everything.' [1]

Family-based care sits at the foundation of Queensland's OOHC system. It includes foster care, kinship care and other home-based arrangements in which a child who cannot live safely with their parents is cared for in a family setting rather than a non-family based environment. That position remains conceptually sound. Children need safety, stability, attachment, belonging and ordinary relationships with adults who know them, remain with them, and provide the day-to-day rhythms of family life. These are not incidental features of care. They are central to children's development, identity and recovery from trauma.[2]

The evidence before the Commission affirms why family-based care remains the preferred form of OOHC when it can safely meet a child's needs. Its central premise is that it can provide more than accommodation. Specifically, it can provide children with dependable adults, ordinary routines, relational safety and a place to belong.

[1] Transcript, Evidence of Witness H (8 September 2025) 123:19–123:25.
[2] John Bowlby, *A Secure Base: Clinical Applications of Attachment Theory* (Routledge, 1988); Marinus H van IJzendoorn et al, 'Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on development' (2020) 7; *The Lancet Psychiatry* 703; Aisha K Yousafzai, 'If not now, then when? The importance of intervening early to provide family-based environments for all children' (2020) 4(8); *The Lancet Child & Adolescent Health* 565, 565-66.

Stability, trust and a place to return

Witness X's evidence about the stability he experienced with his foster carer illustrates what family-based care can provide when it works well. From his perspective, stability was not simply a desirable feature of care. It was the condition that made attachment, trust, emotional safety and development possible.

That evidence is important because it shows family-based care as children may experience it: not as a placement category, but as a relationship, a home and a person who remains. In that sense, the value of family-based care lies not only in its setting, but in its capacity to give children continuity and belonging at a time when much else in their lives may be uncertain.[3]

The contemporary challenge for the child safety system is that family-based care is now operating under conditions very different from those in which it developed. It emerged, and expanded, in a social context that assumed a sufficient pool of households able to absorb demanding unpaid care over long periods. That assumption is less reliable today. Contemporary households are more diverse, more likely to involve dual workforce participation, more likely to carry housing and cost-of-living pressures, and more likely to balance overlapping caring responsibilities for children, older relatives and family members with disability or illness.[4] At the same time, many children entering care are highly vulnerable due to experiencing trauma, disrupted attachment, family violence, neglect, substance exposure, disability, mental health difficulty, school disengagement and multiple prior placements.[5]

The result is a growing mismatch between the expectations placed on foster and kinship carers and the support, authority, information and practical infrastructure provided to them. The model still relies heavily on goodwill, community spirit and volunteerism, but the task increasingly requires skill, time, therapeutic work, clear decision-making authority, respite, professional advice, financial assistance and rapid access to health, disability, education and mental health

[3] Transcript, Evidence of Witness X (22 September 2025) 146:29-1426:45; See also case study 5 at Appendix 2 to Executive Report.
[4] PeakCare and Queensland Family and Child Commission, *Preserving a Vital System: The Future of Foster Care, Queensland Foster Carer Demographic Insights Report* (Report, June 2024)12–13, 17–30; The Demographics Group, *Demographic Outlook: why the sector faces systemic change* (Report, April 2025) 4; UNSW Social Policy Research Centre and Uniting NSW.ACT, *Insights into the diversity of families raising children and young people* (Report, 2024) 3, 59.
[5] Statement of Bernadette Harvey (29 August 2025) [74]–[79], [90]–[99]; Hilary Miller and Kristel Alla, 'Understanding the mental health and wellbeing of children in out-of-home care' (Web Page, March 2024) <https://emergingminds.com.au/resources/understanding-the-mental-health-and-wellbeing-of-children-in-out-of-home-care/>.

services. The Commission considers that we cannot keep asking or simply expecting carers to absorb more complexity within the same model.

This matters for the whole OOHC system. When family-based care is not adequately supported, placements become fragile. When family-based placements break down, children are more likely to move to non-family based care and not return to the family-based system. When residential care expands, the system becomes more expensive, more reactive and less connected to the relational conditions children need.[6] This increases the risk that children will self-place, which brings with it myriad risks, to the child and to the community, discussed elsewhere by this Commission.[7] The pressure on family-based care is therefore not a discrete service issue. It is one of the key functional problems in Queensland's child safety system.

The Commission also heard substantial evidence that the strain in family-based care is operational and relational, as well as structural. Foster and kinship carers repeatedly described feeling undervalued, poorly informed, excluded from critical decisions about the child's life, experiencing delays in obtaining approvals, uncertain about ordinary parenting authority, and exposed to Standards of Care, Harm Report or complaints processes, which they regarded as unclear, disproportionate or punitive. Many carers acknowledged the significant and sustained pressure on departmental staff. The issue is that these pressures are often experienced by carers as poor communication, lack of trust, delayed decisions, exclusion and an absence of partnership. Those experiences affect children because they shape placement stability, carer confidence, advocacy and retention.

The Commission does not treat carers' evidence as a catalogue of individual grievances. The consistency of the evidence across hearings, submissions, private sessions and survey material indicates a broader system issue. Carers are expected to parent children with complex needs and trauma histories while operating under the authority of the State. They carry substantial responsibility for day-to-day care, role-modelling and boundary setting, but often lack commensurate authority, information and support. This responsibility-authority gap sits at the centre of the current family-based care model.

A contemporary model of family-based care must therefore respond to two related problems. The first is the operational and practice problem: how carers are treated, informed, involved,

[6] KPMG, Residential Care Analysis, ES.9–ES.14, A.32–A.50; Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024) 29-36.
[7] See case study 1 and case study 2 at Appendix 2 to Executive Report; See also Chapter 3.2 of the Executive Report 'Reforming the Residential Care system' – Terms of Reference clauses 3(a)(i)-(vi), paragraph [10].

supported and governed by the Department. The second is the design problem: whether a model created in a different social and economic context remains fit for purpose without substantial redesign. Reform must address both. Improving communication, information sharing, approvals and complaints processes will help, but those changes will not be sufficient if the underlying model continues to assume an unlimited supply of households able to provide complex care on a voluntary basis with limited support.

This chapter examines family-based care within that contemporary context. It first explains what family-based care is, who provides it, and why it is under strain. It then considers the experiences of foster and kinship carers, including their relationship with the Department, their involvement (or lack of involvement) in critical decisions, access to information, difficulties obtaining health and therapeutic supports, uncertainty about discipline and boundaries, and experiences of Standards of Care, Harm Report and complaints processes. The chapter then considers what effective family-based care requires: relational continuity, carers treated as partners in caregiving, practical and therapeutic scaffolding, culturally grounded care, and a flexible suite of family-based care types capable of supporting children with different needs. It concludes by identifying the reform implications for Queensland including how to move towards a contemporary model of family-based care that supports carers as partners, diversifies the available family-based care options, strengthens practical and therapeutic supports, and aligns system design with the realities of family life today.

The central proposition is straightforward. Family-based care is and should remain the primary service delivery infrastructure of the tertiary child safety system, but it cannot continue to be anchored to assumptions about family life, household capacity and unpaid care that no longer reflect contemporary reality. If Queensland is to reduce unnecessary reliance on residential care and improve outcomes for children, it must design family-based care so that carers are supported as valued and informed partners, children are held within stable and meaningful relationships, and the system is built around contemporary conditions that enable family-based care to succeed and expand.

2. Understanding Family-Based Care in the Current System

2.1 What is family-based care?

Family-based care is an OOHC arrangement in which children are cared for in a private household when the child cannot safely live with their parents. In Queensland, family-based care is delivered primarily through foster care and kinship care. Kinship care is provided by a family member, or by another person significant to the child or the child's family. For Aboriginal and Torres Strait Islander children, kin also extends to people with whom the child has a cultural connection.[8] Foster care is generally provided by an approved carer who is not biologically related to the child, and may include short-term, long-term, emergency and respite arrangements.[9]

Family-based care should be understood by its function, rather than by its setting alone. Its defining feature is that a child is cared for within the ordinary life of a household by consistent adults who are expected to provide daily care, emotional availability, stability, advocacy and a sense of belonging. That 'ordinary life' is what distinguishes it from non-family based care. Non-family based care arrangements care may provide accommodation, supervision and varying levels of skilled support, but it is structured around shift structures and rostered workers (see Chapter 2 of this Companion Report). Family-based care is intended to provide a consistent caregiving relationship that can endure beyond shifts, rosters, contracts and placement categories.

This difference matters because the child safety system is not an accommodation-only service. It is deciding the conditions under which a child will grow, attach, learn, regulate, recover and form identity. For children who have experienced harm, neglect, disrupted attachment or repeated placement changes, the quality and continuity of caregiving relationships can be as important as the formal placement type. Family-based care therefore reflects a developmental need, as children are more likely to benefit from stable, nurturing relationships embedded in everyday family life that is safe and properly supported.[10]

[8] *Child Protection Act 1999* (Qld) ss 5B(g), 5C; sch 3 (definition of 'kin').
[9] Statement of Bernadette Harvey (29 August 2025) [36]; Queensland Government, 'Types of care arrangements', *Child Safety Practice Manual* (Web Page, 16 May 2025) <https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements>.
[10] John Bowlby, *A Secure Base: Clinical Applications of Attachment Theory* (Routledge, 1988); National Scientific Council on the Developing Child, *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain* (Working Paper, May 2012); National Scientific Council on the Developing Child, *From Resources to Routines: The Importance of Stability in the Developmental Environment* (Working Paper, March 2026).

The preference for family-based care also reflects the history of child safety reform. Internationally, modern child welfare systems have shifted away from institutional and congregate care because those settings have been increasingly understood to be developmentally limited and, in some cases, harmful.[11] In Queensland, the Forde Inquiry documented the harms experienced by children in institutional settings and contributed to the broader movement toward care arrangements that better support safety, individualised attention, attachment and ordinary childhood experience.[12]

Family-based care is therefore intended to provide five related outcomes.

First, it is intended to provide safety. A child who cannot safely remain with their parents must be cared for in an environment that protects them from further harm and meets their basic daily needs.

Second, it is intended to provide stability. Children need continuity of place, people, routines, school, friendships and relationships. Stability is not only to be measured administratively, by placement duration. It is the child's experience of knowing where they belong and who will be there for them over time.

Third, it is intended to provide belonging and attachment. Children need adults who are emotionally available, responsive and consistent. Academic literature on attachment explains why this matters: children's development is shaped by the presence, or absence, of reliable caregiving relationships that help them build trust, regulate emotions and experience the world as safe enough to explore.[13]

Fourth, family-based care is intended to support development and wellbeing. Children in care may require support across physical health, mental health, education, disability, behaviour, identity and social development. Family-based carers are often the adults who notice developmental concerns, arrange appointments, speak with schools, advocate for assessment and support the child through daily challenges.

[11] Marinus H van IJzendoorn et al, 'Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on development' (2020) 7 *The Lancet Psychiatry* 703, 703-20; Aisha K Yousafzai, 'If not now, then when? The importance of intervening early to provide family-based environments for all children' (2020) 4(8) *The Lancet Child & Adolescent Health* 565, 565-6; Kathryn L Humphreys et al, 'Foster care leads to sustained cognitive gains following severe early deprivation' (2022) 119(38) *Psychological and Cognitive Sciences*.
[12] Leneen Forde, *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (Report, May 1999) 31-47; Clare Tilbury, 'A Modern History of Child Protection in Australia: Queensland 1965–1980' (2023) 76(2) *Australian Social Work* 159.
[13] John Bowlby, *A Secure Base: Clinical Applications of Attachment Theory* (Routledge, 1988; National Scientific Council on the Developing Child, *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain* (Working Paper No 12, May 2012).

Fifth, family-based care should support connection to family, culture, community and identity where possible. Queensland's child protection legislation recognises this for all children through aspects of the principles for achieving permanency[14] and the standards of care.[15] It provides additional recognition for Aboriginal and Torres Strait Islander children through the Aboriginal and Torres Strait Islander Child Placement Principle and through the statutory recognition of kinship and cultural connection.[16]

The Department's own evidence recognises the centrality of family-based care. It has described family-based care as the preferred form of care for children, particularly for children under 12, because it supports brain development, emotional regulation and trauma recovery, and enables children to experience predictability and stability with a consistent caregiver, supporting the development of a secure bond to a trusted, reliable adult.[17] That evidence aligns with the broader developmental basis for family-based care and with what children and carers told the Commission about the importance of being known, loved, safe and connected.

The Commission also heard from a psychiatric professional that children in care with one or two stable foster placements are more likely to have better life outcomes because that model more closely replicates healthy parental relationships and a normative upbringing than non-family based residential care. That evidence also identified that, in a family-based care arrangement, relationship and respect are established over time, allowing parental guidance and boundaries to be implemented more effectively.[18] This is an important bridge between theory and practice. The value of family-based care lies in the relationship and structure that develops through daily life including meals, transport, school routines, medical appointments, discipline, affection, advocacy, family events and ordinary presence over time.

That does not mean family-based care is suitable for every child at every point in time. Some children may require intensive therapeutic, disability, mental health or indeed more secure care settings at times to meet their needs, if that care that cannot safely be provided in an ordinary household without significant scaffolding. Some children may require short-term non-family based care, supported transition arrangements or, in the most exceptional cases, secure and therapeutic stabilisation. Nevertheless, the point is that family-based care remains the preferred

[14] *Child Protection Act 1999* (Qld) s 5BA(b).
[15] *Child Protection Act 1999* (Qld) s 122(1)(d).
[16] *Child Protection Act 1999* (Qld) 5C, 83.
[17] Statement of Victoria Van Houdt (5 September 2025) [153]-[158]; Statement of Bernadette Harvey (3 September 2025) [34].
[18] Submission No 287 to Child Safety Commission of Inquiry (31 March 2026) [67], [70].

foundation of the OOHC system because of what it can provide children when it is properly supported.

The Commission's concern is that Queensland's current model often treats family-based care as if the household alone is the intervention. It is not. The intervention is the household, as well as the relationship, the support around the household, and the system conditions that allow that relationship to endure. If those supports are absent, family-based care can become fragile. If they are present, it can provide children with the relational continuity and stability that no other care option can readily replicate.

A contemporary model of family-based care must therefore start from a clear understanding of what it is trying to preserve: not simply the use of private homes as placement settings, but the capacity of children to be cared for by people who know them, remain with them, advocate for them and help them experience family life in a way that supports safety, recovery, identity and development.

The value of kinship care should also not be misunderstood as meaning that kinship alone is enough. Kinship carers often assume care in urgent circumstances, at moments of family crisis, and without the preparation, planning or resources that may accompany other care arrangements. Many are grandparents, extended family members or community members who already carry family, cultural, financial and caring responsibilities.

2.2 The people who provide family-based care

Foster and kinship carers provide the daily care through which the State's responsibility for children is experienced in practice. They prepare meals, manage routines, take children to school and appointments, respond to distress, support family contact, advocate for services, manage behaviour, comfort children at night and make ordinary judgments throughout the day about safety, relationships and development.

In terms of foster carers, the *Child Protection Act 1999* (Qld) does not define foster care by reference to a complete description of the caregiving relationship. Rather, foster care is largely understood through the approval of carers, the placement of children and the statutory framework that authorises the arrangement. That is adequate for legal administration, but it does not fully capture the lived nature of the role.

Foster and kinship carers are also often described colloquially as volunteers. While that description is correct in a narrow sense, it is incomplete in practice. Foster carers are not ordinary volunteers who provide intermittent assistance to a service system. They provide daily parenting care to children for whom the State has accepted statutory responsibility. The role commonly requires sustained emotional labour, practical availability, advocacy, behavioural support, engagement with schools and health services, attendance at meetings, management of contact arrangements, and responsiveness to crisis outside ordinary business hours. For many carers, the role enters every part of household life.

This is why the carer role has an in-between character. Carers are expected to parent in practice, but they are not legal parents. They provide the daily care, but key legal and administrative authority often remains elsewhere. Depending on the order in place, authority may rest with the Department, with parents, or be divided across different decision-making arrangements. Decisions about placement, family contact, schooling, travel, medical treatment, therapeutic support, cultural planning and long-term permanency may require departmental approval, parental consent, court involvement or some combination of those processes.[19]

Queensland's legislative and policy framework recognises that carers are more than passive placement providers. The *Child Protection Act 1999* (Qld) includes a function of promoting a partnership between the State and foster carers that recognises the integral part carers play in caring for children.[20] Section 83A requires information to be provided to carers to assist them to make an informed decision about a placement and to provide care for the child, including information relevant to the safety of the child, the carer and the carer's household.[21] The Statement of Standards of Care establishes the standards expected for children placed in care, including dignity, care, health, education, family connection, culture, positive guidance and disability-related support.[22] The Statement of Commitment to foster and kinship carers similarly recognises that carers should be respected, informed, supported and included as part of the care team.[23]

Those provisions show that the system already contains the basic architecture for partnership. The problem, explored later in this chapter, is whether that architecture is consistently translated

[19] *Child Protection Act 1999* (Qld) ch 2, pt 4; ch 2, pt 5; ch 4; Zoë Haysom et al, 'Somewhere in-between: A qualitative study of Australian foster carers in the liminal space of parenting and professionalism' (2026) *British Journal of Social Work* 1, 1-20.
[20] *Child Protection Act 1999* (Qld) s 7(1)(k).
[21] *Child Protection Act 1999* (Qld) s 83A.
[22] *Child Protection Act 1999* (Qld) s 122.
[23] Queensland Government, *Statement of Commitment to Queensland's foster and kinship carers* (Statement, n.d.).

into practice. A statutory commitment to partnership has limited value if carers are not informed, not consulted, not responded to, or not supported to exercise ordinary caregiving judgment. Equally, safeguarding standards are essential, but they must operate in a way that protects children while also enabling carers to provide confident, stable and developmentally appropriate care.

The people who provide family-based care are therefore not incidental to the model. They are the model. The availability, capability, confidence and retention of foster and kinship carers determine whether family-based care can operate as the preferred foundation of the OOHC system. If carers are treated as peripheral to decision-making, given insufficient information, left without timely support, or exposed to unclear authority and disproportionate scrutiny, the system weakens the very care arrangement it says it prefers.

2.3 Why family-based care is under strain

Family-based care in Queensland is under strain for two related reasons. The first is social and demographic: the model was built around assumptions about household capacity that no longer hold consistently. The second is systemic: child safety practice, funding, commissioning, information sharing, and support arrangements have not adapted sufficiently to the complexity of the children now entering care or to the realities of the households being asked to care for them.

The demographic challenge is substantial. Family-based care developed in a context where a larger pool of households could absorb unpaid caring responsibilities over long periods, often within more stable housing conditions and family arrangements where one adult had greater capacity to provide care at home. That is no longer a reliable foundation for system design. Contemporary households are more diverse, more likely to involve both adults participating in paid work, more exposed to housing and cost-of-living pressures, and more likely to be balancing care for children, older relatives and family members with disability or illness.[24]

The fundamental issue is that the child safety system has not adapted to the conditions in which families now live. A model that relies heavily on voluntary care must be designed around the real capacity of households, not around assumptions about spare bedrooms, flexible work, available time, extended family support or a carer's ability to absorb financial and emotional pressure

[24] PeakCare and Queensland Family and Child Commission, *Preserving a Vital System: The Future of Foster Care, Queensland Foster Carer Demographic Insights Report* (Report, June 2024)12–13, 17–30; UNSW Social Policy Research Centre and Uniting NSW.ACT, *Insights into the diversity of families raising children and young people* (Report, 2024) 3, 59.

indefinitely. Even where a household is willing to care, willingness does not create unlimited capacity.

Both PeakCare and the Queensland Family and Child Commission (QFCC) have identified demographic pressures affecting the future of foster care in Queensland, including the diminishing pool of what has traditionally been understood as foster carers.[25] PeakCare's final submission to the Commission linked this to financial pressures on carers, rising living costs, housing pressures, dual-income households, insufficient support and carer burnout.[26] The Demographics Group has similarly identified broader demographic change as a structural challenge for the sector.[27] These sources point to a common conclusion: recruitment difficulties cannot be understood only as a messaging or community awareness problem. The underlying household economics and caregiving conditions have changed.

At the same time, there is clear evidence that the needs of children entering care are generally highly complex. The Department's own material identifies high rates of pre-care adversity and significant needs among children in care, including trauma, neglect, family violence, developmental concerns, disability, mental health difficulties and behavioural distress.[28] Emerging Minds has also identified that children in OOHC experience elevated mental health and wellbeing needs and that placement stability and care experience are relevant to those outcomes.[29] The practical effect is that foster and kinship carers are increasingly asked to provide care that requires trauma-informed responses, behaviour support, advocacy across service systems, educational engagement, disability navigation and emotional availability under conditions of uncertainty.

This does not mean children with complex needs cannot be supported in family-based care. Many can, and for many such children family-based care will remain the best available option. The problem is that responsibility for navigating complexity cannot be transferred to a household without the support required to hold it safely. The model still relies heavily on goodwill, but the work increasingly requires skill, time, therapeutic support, clear day-to-day decision-making authority and sustained practical scaffolding.

[25] PeakCare and Queensland Family and Child Commission, *Preserving a Vital System: The Future of Foster Care, Queensland Foster Carer Demographic Insights Report* (Report, June 2024).
[26] PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 64-65.
[27] The Demographics Group, *Demographic Outlook: why the sector faces systemic change* (Report, April 2025) 4.
[28] Statement of Bernadette Harvey (29 August 2025), [74]–[79], [90]–[99].
[29] Hilary Miller and Kristel Alla, 'Understanding the mental health and wellbeing of children in out-of-home care' (Web Page, March 2024) <https://emergingminds.com.au/resources/understanding-the-mental-health-and-wellbeing-of-children-in-out-of-home-care/>.

That mismatch produces system pressure. When family-based care is not supported, placements become fragile. When placements break down, children are more likely to move to non-family based care. When non-family based care grows, resources are drawn toward more expensive and reactive responses. This is the link between family-based care and Queensland's increasing reliance on residential care. That topic is explored in more detail in Companion Report 4: Understanding and Reforming the Residential Care System and in Companion Report 7: Enablers.

When comparing Queensland to other Australian jurisdictions, Productivity Commission data indicates that Queensland has the lowest proportion of children in family-based care and the highest reliance on non-family based care, based on the most recent comparable data available for Queensland.[30] KPMG identified that Queensland's residential care system had shifted over the past decade from a last-resort, short-term placement option toward a core component of the OOHC system.[31] The QFCC has similarly raised concern about residential care becoming a default response under system pressure and about the need to clarify care options between foster or kinship care and residential care.[32]

This pattern reflects more than demand growth. It reflects underdevelopment of the care options and supports that should sit around family-based care. The QFCC has identified a need for professionalised and in-home options that can provide intensive, tailored support to children with higher needs, and for a clear strategy to modernise foster care over the next decade.[33] That evidence is important because it shows the problem is not only the number of foster or kinship carers, it is also the limited range of family-based care arrangements, support intensities and step-up or step-down options available to meet different needs.

Kinship care faces particular pressures. It is rightly prioritised because it can preserve family, relational and cultural connection, and for this reason, the *Child Protection Act 1999* (Qld) requires consideration of kin as a first option when a child is removed from family.[34] However, kinship care is not self-sustaining simply because it is relationally preferred. Kinship carers may be older, on fixed incomes, living in crowded or insecure housing, caring for other family members, or navigating complex relationships with the child's parents and extended family. They

[30] Productivity Commission, '16 Child protection services: Table 16A.23' *F Community Services: Report on Government Services 2026* (Data, 29 January 2026) <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/>. Note: Based on 2024 data for Queensland, as Queensland did not provide 2025 data.
[31] KPMG, *Residential Care Analysis*, ES.9–ES.14, A.32–A.50.
[32] Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024) 29–36.
[33] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 41-42.
[34] *Child Protection Act 1999* (Qld) s 5B(g).

may also have less time to prepare for the placement, fewer formal supports, and less access to training or respite.

The Commission also heard that some Aboriginal and Torres Strait Islander potential kinship carers may be deterred by distrust of the child safety system, fear of scrutiny of their own household, previous involvement with child safety, or concern that engagement with the Department may create further risk for their family.[35] These are not peripheral concerns. A system that seeks to increase kinship care for Aboriginal and Torres Strait Islander children must confront the history and lived experiences that shape whether families feel safe to engage. Increasing kinship placements requires trust, support, timely assessment, and partnership with Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCOs).

The requirement for carers to have a Blue Card has also been identified as a barrier to kinship care. Under the current framework, assessment of prospective kinship and foster carers involves consideration of Working with Children authority requirements for the applicant and adult household members.[36] For present purposes, the relevant point is that safeguarding arrangements designed to protect children may be in practice creating barriers to the preferred model of safe kinship care.[37]

The strain in family-based care is therefore not explained by a single failure. It arises from the interaction between changing household capacity, increasing child complexity, insufficient practical and therapeutic support, limited specialist family-based options, kinship-specific barriers, and system practices that can shift responsibility to carers without giving them adequate authority or support. Those structural pressures then shape the experiences examined in the next section.

3. Experiences of Foster and Kinship Carers

The experiences of foster and kinship carers provide direct evidence about whether the family-based care system is working in practice. This matters for fairness to carers, but it also matters for children, parents and families of origin. The way carers are treated, informed, supported and

[35] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to call for submissions regarding Far North Queensland (Child Safety Commission of Inquiry* (August 2025) 30, 37, 39.
[36] *Child Protection Act 1999* (Qld) s 133; *Working with Children (Risk Management and Screening) Act 2000* (Qld) ss 12, 175(1)(a); sch 1, s 14.
[37] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (March 2026) 20.

involved affects placement stability, carer confidence, recruitment, retention, advocacy and children's day-to-day wellbeing.

The Commission received substantial evidence from carers through public hearings, private sessions, written submissions and survey material. That included 241 submissions from current foster and kinship carers and 49 submissions from former foster and kinship carers over the course of the Inquiry.[38] The Commission also reviewed Queensland Foster and Kinship Care (QFKC) survey material, including a 2024–25 carer exit survey in which 80% of exited foster carers surveyed said they would not recommend the role to a friend.[39] That figure is significant. It suggests that dissatisfaction is not only affecting individual carers, but also the sustainability of the family-based care system itself.

Carer evidence must be considered alongside other evidence before the Commission, including evidence from children, parents, departmental officers, service providers, peak bodies and oversight agencies. Even so, recurring concerns from carers provide important system intelligence. They identify patterns in the way family-based care operates in practice, particularly in relation to carers' relationship with the Department, access to information, involvement in decisions, delays in health and therapeutic support, uncertainty about ordinary parenting boundaries, Standards of Care and Harm Report processes, and complaints.

3.1 The partnership gap between carers and the Department

The relationship between foster and kinship carers and the Department is one of the strongest indicators of whether family-based care is functioning as intended. Carers provide daily care on behalf of the State. The Department holds statutory authority, carries legal responsibility and controls many key decisions. While the Department funds non-government providers to support carers, the relationship between carers and departmental staff remains central. It affects whether the adults around the child operate as a coherent care team, or as separate actors working around one another.

As noted previously, Queensland's legislative and policy settings recognise that carers are meant to be more than passive placement providers. The *Child Protection Act 1999* (Qld) includes a function of promoting a partnership between the State and foster carers that recognises the integral part carers play in caring for children.[40] The Statement of Commitment similarly

[38] Child Safety Commission of Inquiry, submissions data: foster and kinship carer submissions.
[39] Queensland Foster and Kinship Care, *Carer Exit Survey 2024–2025: Voices of Queensland's Exited Foster and Kinship Carers* (Report, 2025) 5.
[40] *Child Protection Act 1999* (Qld) s 7(1)(k).

recognises that foster and kinship carers should be respected, informed, supported and included as part of the care team.[41] The evidence before the Commission suggests that this commitment is not consistently realised in practice.

Consistent evidence from submissions is the lack of carer involvement in placement decision-making. For example, one kinship carer, a grandparent caring for grandchildren, submitted that they felt 'dismissed and unheard' when access decisions were made, and that the children's best interests were too often placed behind the wishes of parents. The submitter described the strain placed on the family, the emotional impact of visits on the children, and the feeling that their role as daily carers was overlooked despite putting their lives on hold to provide love, safety and stability.[42] That evidence illustrates the broader concern. Carers may be expected to hold the practical and emotional consequences of decisions, while feeling that their knowledge and deep care of the child is not recognised or respected.

The same theme emerged in public hearings. Witness L, a former foster carer of more than 16 years, described feeling that some frontline staff treated carers as if they were just volunteers.[43] Witness AB, a foster carer and registered nurse, described the tension between being treated as a volunteer and having relevant professional judgment. She said: 'I'm happy to be the volunteer and not be the professional. But I want to be listened to, and I think that's the problem.'[44] Witness L gave evidence of being told to take her professional 'worker hat off' and assume the volunteer role, even where her professional expertise was directly relevant to understanding and supporting the children in her care.[45]

Those examples are important because they reveal a structural tension in the family-based care model. Foster carers may be described as volunteers, but they provide daily parenting care for children with often complex needs, under statutory oversight, in their own homes and households. Many carers also bring relevant professional, parenting, cultural or lived experience. A system that asks carers to carry complex responsibilities should not treat their insight as incidental.

Carer experience snapshot: responsibility without partnership

Witness H's evidence illustrated the gap between the formal language of partnership and the practical experience of some carers. She described foster carers as being

[41] Queensland Government, *Statement of Commitment to Queensland's foster and kinship carers* (Statement, n.d.).
[42] Submission No 319 to Child Safety Commission of Inquiry (11 September 2025).
[43] Transcript, Evidence of Witness C (8 September 2025) 65:23-65:24.
[44] Transcript, Evidence of Witness AB (12 September 2025) 606:12-606-14.
[45] Transcript, Evidence of Witness L (17 February 2026) 4226:34-4226:37.

> treated as 'afterthoughts,' despite carrying the day-to-day responsibility of caring for children.[46]
>
> Witness H also described the system around the child as fragmented: 'You've got the department here, care agency here, and the kid and the foster carer here, and it needs to come back together, and the walls need to drop.'[47]
>
> That evidence captures a recurring theme in the Commission's material. Carers are expected to provide the ordinary care of a parent, but may experience the system as discounting their knowledge, limiting their authority and treating them as outside the core decision-making environment. Where that occurs, the impact is felt by the carer, but also by the child.

The Commission also heard evidence that the quality of the relationship often depended heavily on the individual Child Safety Officer (CSO) or other frontline connection point. Some carers reported positive relationships with departmental staff and acknowledged examples of good practice.[48] Those accounts matter because they show that respectful partnership is possible within the current system. They also show that the problem is not that partnership cannot be achieved. The problem is that it is too variable and too dependent on individual staff members, local practice and personal working relationships.

That variability has consequences in that where carers experience respectful engagement, timely communication and shared problem-solving, they are more likely to feel confident in their role and able to advocate for children. Where they experience mistrust, exclusion or dismissiveness, strain accumulates in the household which can affect carer confidence, placement stability and willingness to continue caring as well as the wellbeing of children in the household.

The evidence therefore points to a partnership gap. The Department recognises carers as part of the care team in legislation, policy and principle. However, in practice, carers do not consistently feel as though they are trusted partners. That gap matters because family-based care depends on carers being respected, informed, supported and treated as people who know the child. A system that positions carers as peripheral weakens the care arrangement it says it prefers.

[46] Transcript, Evidence of Witness H (8 September 2025) 118:33-118:35.
[47] Transcript, Evidence of Witness H (9 September 2025) 208:27-208:30.
[48] Transcript, Evidence of Witness I (9 September 2025) 267:3-267:6; Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025).

3.2 Information, participation and decision-making

Information sharing and participation in decision-making are closely connected. Carers need timely and accurate information to decide whether they can safely accept a placement, to understand the child's needs, and to provide day-to-day care. They also need meaningful opportunities to contribute information to decisions about the child. Without both, the system loses access to the knowledge held by the people who observe the child's daily presentation, routines, distress, relationships and development.

This is not only a matter of courtesy to carers. Information is a safeguarding tool. It allows carers to prepare the household, seek appropriate supports, respond to trauma and disability-related needs, understand risks, support family contact and advocate for the child's health and education. Inadequate information sharing can place the child, the carer household and the placement itself under avoidable pressure or risk.

Queensland's legislative and policy framework recognises this. The *Child Protection Act 1999* (Qld) requires the Department to provide information to a carer to assist the carer to make an informed decision about whether to agree to a placement, and to provide care for the child, including information relevant to the safety of the child, the carer and members of the carer's household.[49] The Statement of Commitment also recognises that carers should be provided with information necessary to care for the child and be included in decisions affecting the child.[50] The issue identified in the evidence is therefore less about the absence of formal authority to share information, and more about whether those requirements are understood and applied consistently in practice.

QFKC submitted that, despite clear legislative provisions, everyday practice does not consistently deliver the transparency and information sharing required to support carers. It identified concerns that confidentiality provisions are sometimes cited too broadly, or misunderstood, in a way that prevents critical information being provided to carers.[51] QFKC reported that about 67% of carers surveyed said that, if they had been aware of information known to the Department, it would have influenced their decision to accept the placement.[52] That is a significant figure. It suggests that information gaps are not marginal, but can affect placement matching, household safety and the sustainability of care arrangements from the outset.

[49] *Child Protection Act 1999* (Qld) s 83A.
[50] Queensland Government, *Statement of Commitment to Queensland's foster and kinship carers* (Statement, n.d.).
[51] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 29–33.
[52] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 32.

The Commission heard evidence consistent with that concern. Carers described children being placed with them without sufficient information about medical needs, trauma history, behavioural risks, mental health concerns or disability-related needs.[53] Witness C gave evidence about the importance of carers being provided with relevant information before accepting placements, including information that may be necessary to keep the child and others safe.[54]

Case illustration: information at the point of placement

The evidence of Witness L and Witness G illustrates the practical importance of accurate information before and during a placement. They gave evidence that the needs of the children placed in their care were more complex than initially represented. From their perspective, a clearer understanding of the children's health, developmental and behavioural needs would have allowed them to prepare the household, seek supports earlier and develop more appropriate strategies.

This example is not included to suggest that all risks can be known at the point of placement. They cannot. Children's needs may emerge over time. The point is narrower but important: where information is known to the Department, and is relevant to the child's care or the safety and preparedness of the household, it should be provided in a timely and usable way. The placement decision should not depend on carers accepting responsibility without understanding the task they are being asked to perform.[55]

Placement agreements were also raised as a recurring concern. Carers described agreements being delayed, outdated, incomplete or inaccurate.[56] A placement agreement should assist carers to understand the child's needs, the purpose of the placement, the responsibilities of each party, the support available and any specific risks or requirements. Where that document is missing or not current, carers may be left uncertain about what has been agreed, who is responsible for particular actions, and how to access support. Witness H gave evidence of a placement agreement not being in place for months, creating uncertainty and practical difficulty in managing the child's needs.[57]

[53] Transcript, Evidence of Witness C (8 September 2025) 97:5-97:14; Evidence of Witness H (9 September 2025) 166:4-166:37.
[54] Transcript, Evidence of Witness C (8 September 2025) 45:41–46:14.
[55] Transcript, Evidence of Witness L and Witness G (17 February 2026) 4219:4220:45; See also case study 9 at Appendix 2 to Executive Report.
[56] Transcript, Evidence of Witness AG (11 September 2025) 533:38-533-42; Transcript, Evidence of Witness AB (12 September 2025) 583:13-583-14.
[57] Transcript, Evidence of Witness H (8 September 2025) 126:13-126:33; See also case study 4 at Appendix 2 to Executive Report.

Information should also flow from carers back into the Department's decision-making. Carers may not hold legal authority, but they often hold the most immediate knowledge of the child's daily life. Their observations can be particularly important in decisions about contact, reunification, transition planning, school engagement, therapeutic support, placement stability and risk.

Again, the Department's formal material recognises this in principle. In response to a compulsory notice, the Department stated that foster carers' views on reunification are generally sought and taken into account through case planning, and that carers may participate in Family Group Meetings where they are considered significant to the child and their participation is not contrary to the purpose of the meeting or the child's best interests.[58] The Department also referred to practice guidance requiring the CSO to actively seek the views of the child, parents, key family members, carers and other members of the safety and support network before forming an assessment and recommendation or before a practice panel discussion.[59]

Those arrangements are appropriate as formal settings, but the evidence suggests they are not consistently experienced as meaningful participation. QFKC identified dissatisfaction among carers about limited involvement in case planning, family contact and reunification processes.[60] Carers described being told of decisions after they had been made, or being required to implement arrangements without having had a meaningful opportunity to provide information about the child's readiness, distress or response.[61] That undermines the stated partnership model and reduces the quality of decisions.

The Commission accepts that carer views cannot determine every decision. The child's views, parents' views, family and kin perspectives, cultural advice, professional assessments and statutory obligations all matter. The Department must balance those matters and make decisions in the child's best interests. However, treating all inputs as interchangeable risks missing the distinct value of carer knowledge. A carer who lives with the child sees patterns that may not be visible in meetings, files or periodic visits. Their input should be actively sought and weighed for what it is: direct evidence of the child's daily experience.

[58] Statement of [redacted] (28 October 2025) [69]–[70]; Department of Families, Seniors, Disability Services and Child Safety, Information sought from the Department regarding the evidence of Witness H (Letter, 7 October 2025) (COI.0001.0003.7487); Department of Families, Seniors, Disability Services and Child Safety, Family Group Meeting Convenor Handbook, Second Edition, Version 2, (Handbook, August 2022) (DFS.0001.0001.6277) 13, 28–30.
[59] Department of Families, Seniors, Disability Services and Child Safety, Practice Guide: Practice Panels (Practice Guide, August 2022) (DFS.0001.0001.6846).
[60] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 8, 10, 12.
[61] Transcript, Evidence of Witness C, 8 September 2025, 84:2-84:44; Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 8–12.

The Commission therefore considers that inadequate information sharing and weak participation are safeguarding risks. They affect whether carers can make informed decisions about placements, whether children's needs are understood, whether supports are arranged early, whether risks are managed, and whether placements remain stable. They also erode trust. A carer who discovers important information after a placement begins, or who feels excluded from decisions they must implement, is less likely to experience the system as honest, respectful or safe to work with.

The core point is straightforward. Information is not owned by the Department solely for departmental purposes. It must be used to support the child's care. Further participation is not a discretionary courtesy to carers. It is a mechanism for better decision-making. If family-based care is to operate as the preferred model of OOHC, carers must receive the information they need and the Department must use the information carers hold, so that all parts of the system work together to support the best interests of the child in care.

3.3 Difficulties accessing healthcare services and medical treatment

Carers are often the adults who identify a child's health, dental, developmental, disability or therapeutic needs. They are well positioned to notice speech delays, sleep disruption, medication concerns, pain, school difficulties, behavioural changes and signs of distress. They commonly make appointments, transport children, speak with teachers and clinicians, follow up referrals, manage symptoms at home and advocate for support. Yet in many cases, they may not have the authority to consent to treatment, approve expenditure, access funding, or obtain timely decisions from the Department.

This is one of the clearest practical examples of the responsibility-authority gap identified earlier in this chapter. Carers are expected to provide the daily care of a parent, but significant decisions about health care may require departmental approval, parental consent, funding approval or coordination between services. Where those processes are slow, unclear or fragmented, children experience delay as unmet need. Carers experience it as a bureaucratic burden. The system should understand it as a failure of the corporate parenting infrastructure.

The Commission repeatedly heard evidence of carers having to navigate complex and slow approval processes to obtain necessary health, dental, therapeutic and specialist services for children in their care.[62] In some cases, this involved delay in securing departmental approval. In

[62] Transcript, Evidence of Witness H (8 September 2025) 127:18-127:42, 128:32-128:43; Transcript, Evidence of Witness F (11 September 2025) 434:13-434:28.

others, carers described the difficulty of accessing public services, uncertainty about whether private treatment would be funded, or the burden of paying upfront and later seeking reimbursement.[63] The practical effect was that carers often carried responsibility for arranging care without having the authority, funding certainty or system support required to make that care happen promptly.

The evidence included examples of delayed access to medical review and treatment. Witness C gave evidence that a young person in her care waited approximately 12 months for a medication review by a paediatrician. Before that review occurred, the young person experienced a psychotic episode, the placement broke down, and the young person was subsequently placed in youth detention, where the medication review finally occurred.[64] That example is significant because it illustrates the potential consequences of delay. The issue is not simply whether an appointment was late. It is whether earlier assessment and treatment may have helped stabilise the child, support the placement and avoid escalation into a more harmful or restrictive system response.

Witness F, a kinship carer, also gave evidence about delayed access to therapeutic supports for the children in his care. He emphasised that every child taken into care has experienced something that may require support, and that unmet therapeutic needs can affect schooling and social relationships.[65] His evidence described the experience of moving through public system waitlists before being told that the children did not meet the criteria for the services for which they had been waiting.[66] This evidence points to a broader system issue. Children in care should not depend on carers navigating fragmented eligibility pathways in isolation before basic therapeutic needs are assessed and addressed.

The Commission also heard evidence about developmental or specialist treatment needs being identified but not responded to in a timely way. In one private session, a carer described taking in a four-year-old child who had been described as having communication issues, but who was in fact entirely non-verbal. The carer placed the child on waitlists for speech pathology. An initial assessment occurred months later, but recommended weekly therapy did not begin for a much longer period because of regional workforce shortages.[67] By way of a further example, Witness AB gave evidence about a child in her care with a significant skin condition. A general practitioner recommended that the child see a dermatologist, but the Department did not approve a private

[63] Transcript, Evidence of Witness F (11 September 2025) 432:24-432-29; Transcript, Evidence of Witness AG (11 September 2025) 532:32-532:45.
[64] Transcript, Evidence of Witness C, (8 September 2025) 49:45-50:5.
[65] Transcript, Evidence of Witness F (11 September 2025) 436:22-436-43.
[66] Transcript, Evidence of Witness F (11 September 2025) 434:13-434:28.
[67] Transcript, Evidence of Witness AG (11 September 2025) 524:9–530:47.

consultation and instead advised that the child be placed on a public hospital waitlist. Witness AB ultimately arranged a private dermatology appointment at her own expense so that the child could be seen within days.[68] Other carers described paying for appointments or treatment upfront and later attempting to obtain reimbursement through a process they described as burdensome and uncertain.[69]

These examples should not be read as criticism of carers for choosing to pay privately, nor as a suggestion that every child in care must receive private treatment. The issue is that where a child in care has an identified need, the system should know who is responsible for assessment, who can consent, who can approve funding, what timeframe is acceptable, and what escalation occurs if services are unavailable. Leaving carers to solve these matters through persistence, personal funds or informal workarounds is not a sustainable model of corporate parenting.

Consent issues create an additional layer of complexity. Depending on the child protection order in place, the Department may hold custody but not guardianship, meaning parental consent may still be required for major long-term decisions.[70] The Commission heard evidence that this can create serious practical difficulties where parents are uncontactable, unwilling to consent, or where urgent medical decisions are required. Far North Queensland Regional Director, Corinne Porta, gave evidence about practical impact custody and guardianship can have. [71] It was accepted that there may be a need to reconsider the chief executive's powers in such situations.[72]

The Commission accepts that parental rights and family participation are important. The answer is not to remove parents from decision-making wherever an administrative process is inconvenient. However, children in care should not experience avoidable delay in necessary health care because authority is unclear, consent pathways are slow, or escalation mechanisms are weak.

The evidence also demonstrates that health access cannot be separated from placement stability. A child whose pain, disability, mental health need, speech delay or medication issue is not addressed may present with distress or behaviour that places pressure on the carer household. The behaviour may then be understood as a placement problem, rather than as an unmet health or developmental need. In that way, delays in essential assessments, services and supports can contribute directly to placement instability.

[68] Transcript, Evidence of Witness AB (12 September 2025) 594:19-595:41.
[69] Transcript, Evidence of Witness AG (11 September 2025) 532:32-532:38.
[70] *Child Protection Act 1999* (Qld) pt 3 div 2.
[71] Transcript, Evidence of Corinne Porta (20 November 2025) 2394:35–2395:28.
[72] Transcript, Evidence of Corinne Porta (20 November 2025) 2394:35–2395:28.

The Commission therefore considers that access to health care and therapeutic support for children in family-based care should be treated as a critical part of the State's corporate parenting infrastructure. It should not depend on the persistence, professional knowledge, financial capacity or availability of individual carers. Carers will always play a central role in identifying needs and supporting treatment, but the system must provide clear authority, timely approvals, coordinated pathways, funding certainty and practical assistance.

3.4 Lack of guidance regarding discipline, boundaries and parenting decisions

Carers are expected to provide children with care, guidance, routine and boundaries. Those are ordinary aspects of parenting. They are also particularly important for children who have experienced trauma, disrupted attachment, instability or unsafe adult behaviour. Predictable routines and consistent boundaries can help children feel safe and to regulate their behaviour.

The difficulty is that carers provide this day-to-day parenting within a statutory care environment. They must support children's rights, use positive behaviour support, avoid inappropriate discipline, and comply with requirements concerning restrictive practices. Those safeguards are essential. Children in care are entitled to protection from excessive control, coercion, punishment or unnecessary restriction. However, the Commission heard evidence that the current environment can leave carers uncertain about whether ordinary parenting decisions may later be treated as restrictive practices, Standards of Care concerns or Harm Report matters.

Restrictive practices are generally understood as interventions that limit a child's rights or freedom of movement, primarily to protect the child or others from harm.[73] In some circumstances, the distinction between ordinary care and restrictive practice will be clear. Physical punishment, degrading treatment, punitive isolation or unnecessary force have no place in family-based care. In other situations, the boundary is less clear. The Commission received examples where carers were uncertain whether common parenting actions might be characterised as restrictive practices. These included removing a mobile phone from a child or young person, locking the front door of a house at night, using baby gates, buckling a toddler on

[73] Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour*, Policy No 646-2; Department of Child Safety, Seniors and Disability Services, *Positive behaviour support and managing high risk behaviour* (Practice Guide, n.d.) 15.

a change table, separating siblings after a fight, or physically intervening to prevent imminent serious harm.[74] It is reasonable for carers to expect clear, consistent guidance for such matters.

The Commission does not suggest that all of these examples should be treated alike. A decision about a mobile phone is different from a physical intervention. A baby gate in a toddler's environment is different from locking a young person in a room. The point is that carers need clear, practical and legally sound guidance about the difference between ordinary parenting boundaries, positive behaviour support, emergency intervention and restrictive practices. Without that guidance, carers may either overstep the limits of their authority or avoid reasonable action because they fear later criticism.

This uncertainty is critical because family-based care relies on adults being able to parent confidently. Children need adults who can set bedtimes, manage technology, respond to unsafe behaviour, interrupt aggression, maintain household safety and provide consequences that are proportionate, developmentally appropriate and non-punitive. Where carers are uncertain about what they can do, ordinary care can become hesitant and inconsistent. That can undermine safety for the child, other children in the household and the carer.

QFKC submitted that contradictory terminology and lack of clarity create a 'fear-based and risk-adverse' environment for carers.[75] It also reported that carers and practitioners can be confused about what constitutes a restrictive practice, particularly where disability and NDIS-related concepts are also present.[76] That evidence is consistent with what the Commission heard from carers. The problem is not simply that carers want greater freedom to discipline children. The problem is that they want to know what safe, lawful and appropriate parenting looks like in a statutory care context.

Case illustration: mobile phones, safety and ordinary parenting

Witness H's evidence concerning mobile phone use illustrates the uncertainty experienced by some carers. Witness H gave evidence that she felt unsupported and undermined when they tried to respond to a child's high-risk behaviour online by restricting mobile phone use. Witness H said she had been told that she could not take the phone away from the child or

[74] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints System* (January 2026) 8; Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour*, Policy No 646-2.
[75] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints System* (January 2026) 7.
[76] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints System* (January 2026) 7.

> check its contents because the phone belonged to the child, and that their parenting standards were too high.[77]
>
> The Department's evidence was that it had no record of staff advising Witness H not to remove the phone, and that it considered mobile phone use to be a daily care decision within the carer's authority.[78] The Commission does not need to resolve that factual dispute for the example to have significance. The evidence highlights a broader problem: in the absence of clear system guidance, carers and departmental staff may have different understandings of who can make decisions about technology, safety, privacy and risk.
>
> The Department confirmed that it had no overarching policy or guideline on mobile phone ownership and use for children in care.[79] That absence of guidance is significant. Mobile phone use can involve ordinary social connection, privacy and identity. It can also involve exploitation, sexualised communication, contact with unsafe adults (including grooming), bullying, criminal activity or absconding risk. Carers need guidance that recognises both sides of that issue and supports consistent decision-making aimed at setting reasonable boundaries and keeping children safe.

The Department's Managing High Risk Behaviour policy permits emergency use of a restrictive practice only where a child's behaviour presents an immediate risk to themselves or others and intervention is necessary to prevent harm.[80] That policy is important, but the evidence suggests that carers do not experience the boundaries as sufficiently clear in practice. The Commission also heard concerns that carers may be scrutinised after the event for decisions made in fast-moving, high-risk circumstances.[81]

The Commission questioned Witness O on how inconsistent decision-making from the Department affected his ability to parent children. Witness O replied that it was 'just an added level of stress' that carers did not need, but that he worked around it because 'the kids are why we do it.'[82] That evidence captures the practical impact of uncertainty. Carers continue because of the children, but unclear authority adds strain to an already demanding role.

This issue is also connected to the broader restrictive practices issues considered within this Report. Variations of the same conceptual problem arise in family-based care, non-family based care and secure care. The Commission considers that guidance about discipline, boundaries and

[77] Transcript, Evidence of Witness H (8 September 2025) 135:13–139:32.
[78] Statement of [redacted] (28 October 2025) [231].
[79] Statement of [redacted] (28 October 2025) [231].
[80] Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour* (Policy No 646-2).
[81] Transcript, Evidence of Witness L (17 February 2026) 4239:31-4240:37.
[82] Transcript, Evidence of Witness O (11 September 2025) 477:31–477:33, 478:1–478:3.

restrictive practices should be practical, rights-based and child-centred and, to the extent possible, permits carers access to the full range of parenting tools available to natural parents, acting responsibly. It should support carers to use positive behaviour approaches, avoid punitive or excessive responses, and understand when emergency action is lawful and necessary. It should also give departmental staff a consistent framework for assessing carer conduct. Clarity protects children. It also protects carers from being left to parent under uncertainty.

3.5 Standards of Care and Harm Report processes

Safeguarding children in OOHC is a core responsibility of the child safety system. The Commission accepts that concerns about the care of children must be identified, assessed and acted upon. The issue raised by the evidence is not whether Standards of Care reviews and Harm Reports conducted and delivered by the Department should exist. They must. The issue is whether those processes operate with clarity, proportionality, procedural fairness and proper regard to their effect on children, carers and placements.

The *Child Protection Act 1999* (Qld) establishes the standards for the care of children placed in care.[83] Those standards include matters such as the child's dignity and rights, physical and emotional care, education, health, disability-related needs, cultural needs, family connection, positive guidance and social participation.[84] The standards provide an important safeguard for children. They also provide the benchmark against which the Department assesses whether a child in care is receiving appropriate care.

The Child Safety Practice Manual establishes two main response pathways where concerns arise about the care provided to a child in care. A Standards of Care review is used where there is concern that the care provided to the child may not have met the standards in the legislation, but there is no reasonable suspicion that the child has experienced harm caused by the actions or inactions of a carer. A Harm Report is the more serious pathway. It is used where there is a reasonable suspicion that a child in care has experienced harm caused by the actions or inactions of a carer.[85]

[83] *Child Protection Act 1999* (Qld) s 122.
[84] *Child Protection Act 1999* (Qld) s 122.
[85] Queensland Government, 'Respond to concerns about the standards of care or harm to a child in care,' *Child Safety Practice Manual* (Web Page, 27 April 2026) <https://cspm.csyw.qld.gov.au/procedures/provide-and-review-care/support-and-monitor-care>; Queensland Government, *Child Safety Practice Manual - Provide and review care* (Policy); Queensland Government, *Child Safety Practice Manual - Respond to concerns about the standards of care or harm to a child in care* (Policy) 281–339; Queensland Government, 'Standards of care' *Rights and responsibilities* (Web Page, 8 December 2022) <https://www.qld.gov.au/community/caring-child/foster-kinship-care/information-for-carers/rights-and-responsibilities/standards-care>.

The difference between these two pathways matters. A Standards of Care review should be directed to whether care needs to improve and what support or action is required to ensure the child's needs are met. A Harm Report involves an allegation of harm and may have more serious consequences for the child, the placement, the carer's ongoing approval and, in some circumstances, the carer's Blue Card status or employment. Even where a Harm Report is unsubstantiated,[86] the experience of being investigated can be distressing and may affect the carer's confidence, willingness to advocate and willingness to continue caring.

The distinction between these pathways is important. A Standards of Care review should not operate as a lesser form of Harm Report. Where the issue is whether care standards are being met, but there is no reasonable suspicion of harm, the process should be directed to support quality improvement and placement stability. A Harm Report serves a different purpose. It is an investigative pathway for suspected harm and may carry serious consequences for the child, the placement and the carer.

The evidence before the Commission suggests that these pathways are not always experienced as sufficiently distinct in practice, and that carers do not experience either process as having clear, accessible and timely review mechanisms at the point where they need them most. Some consequences may be challengeable through review of carer approval decisions, Blue Card processes or complaints pathways, but that is different from carers having a clear and immediate process to understand, respond to and, where appropriate, challenge the substance of a Standards of Care or Harm Report process.

Correspondence from Crown Law acting on behalf of the Department reported there were over 12,000 Standards of Care reviews and Harm reports during the period from 1 January 2020 to 31 December 2025.[87]

The Commission's sample analysis of Standards of Care reviews found that approximately 55% resulted in a finding that the Standards of Care were not being met.[88] A similar sample analysis of Harm Reports found that approximately 56% resulted in a finding of substantiated harm.[89]

Those figures show that these processes are not rare or marginal features of the care system. They are significant safeguarding mechanisms. They also affect many carers and placements.

[86] Even if unsubstantiated, a Harm Report may be a reportable event for some carers, such that they may need to disclose the existence of the Harm Report to their relevant professional regulating body.
[87] See, Email from Crown Law to the Child Safety Commission of Inquiry, 23 February 2026 (COI.0001.0005.7369).
[88] See, spreadsheet provided by the Department of Families, Seniors, Disability Services and Child Safety regarding Standards of Care review and Harm Report outcomes, 1 January 2020 to 30 March 2025 (DFS.0322.0003.0001).
[89] See, spreadsheets provided by the Department of Families, Seniors, Disability Services and Child Safety regarding Standards of Care review and Harm Report outcomes, 1 January 2020 to 30 March 2025 (DFS.0322.0004.0001) (DFS.0322.0005.0001).

Their operation therefore matters for child safety, procedural fairness, carer confidence and the sustainability of family-based care.

The Commission received material from a significant number of carers who believed that Standards of Care reviews and Harm Reports had been used against them after they raised concerns, advocated strongly for children, or challenged departmental decisions.[90] The Commission does not accept every such account at face value. Nor does it suggest that safeguarding processes are generally retaliatory. However, the frequency and consistency of this evidence is significant in itself. A system in which carers fear that advocacy may trigger scrutiny is a system in which open communication and early problem-solving are weakened.

The Commission heard evidence that carers described Standards of Care reviews and Harm Reports processes as unclear, delayed, accusatory or disproportionate. Some reported that they were not told enough about the nature of the concerns to respond properly. Others described feeling compelled to consider legal representation because of the tone or seriousness of meetings with the Department.[91]

These concerns do not reduce the need for robust safeguarding. They point to the need for safeguarding processes that are fair, transparent and proportionate. A process can protect children and still treat carers fairly. Indeed, fair process strengthens safeguarding because it increases trust, encourages disclosure, supports learning and makes it more likely that carers will raise concerns early.

Case illustration: Witness L and Witness G

The evidence of Witness L and Witness G illustrates the effect that the process of a Harm Report process can have on carers and placements.

Witness L and Witness G gave evidence that the Department initiated a Harm Report based on a number of matters, including matters they understood to involve ordinary household expectations and parenting decisions. The matters included a child being sad about chores, being required to eat vegetables against their wishes, and having toys removed.[92] Their foster children were removed from their care during the investigation process. The relationship between the carers and the children was fractured, and the caring arrangement ultimately became unsustainable.[93]

[90] Transcript, Evidence of Witness AE (9 September 2025) 227:4-227:47.
[91] Transcript, Evidence of Witness O (11 September 2025) 481:12-481:16.
[92] Transcript, Evidence of Witness L and Witness G (17 February 2026) 4240:1-4240:34; See case study 9 at Appendix 2 to Executive Report.
[93] Transcript, Evidence of Witness L and Witness G (17 February 2026) 4243:44-4244:17.

> The Commission observed that some of the matters described appeared unlikely, on their face, to meet a threshold of significant harm, and may have been more appropriately addressed through discussion, support or a Standards of Care process if concerns genuinely existed.
>
> The Harm Report was ultimately unsubstantiated, and the Standards of Care were found to be met. However, Witness L and Witness G described the process as exhausting and distressing. They also gave evidence that the existence of the Harm Report remained formally recorded.[94] For Witness L, who worked in an allied health profession, the potential professional consequences of a substantiated harm finding were a source of significant anxiety.[95]
>
> This case illustrates the difference between a safeguarding process that is necessary and a process that is experienced as disproportionate or procedurally unfair. Even an unsubstantiated allegation can have serious consequences if the process itself destabilises the placement, undermines trust and contributes to carers leaving the system.
>
> This case also illustrates the risk of a safeguarding architecture that does not clearly distinguish between ordinary parenting disagreement, support needs, care-quality concerns and suspected harm. If matters that could be addressed through advice, support or a Standards of Care process are escalated into a Harm Report, the process itself can destabilise the placement and discourage carers from continuing to provide much needed care. Conversely, serious harm concerns must be investigated promptly and rigorously. The system therefore needs stronger front-end triage, clearer thresholds and a more graduated response.

The evidence before the Commission also raises issues of procedural fairness. Carers should be told, in clear and timely terms, the nature of the concern, the process being followed, the possible consequences, how they may respond, what support or advocacy is available, and how decisions will be reviewed. Where the concern relates to parenting practices, behavioural support or household boundaries, the process should distinguish between a serious allegation of harm, a standards issue, a training or support need, and a reasonable difference in parenting judgment. Those distinctions matter because the consequences for carers and children can be substantial.

The Commission also received evidence that Standards of Care reviews and Harm Reports may affect carer retention. QFKC reported recent exit data showing an increase in carers exiting the system following Standards of Care reviews, from 7.9% to 9.5%, and following Harm Reports,

[94] Transcript, Evidence of Witness L and Witness G (17 February 2026) 4246:29-4246:33.
[95] Transcript, Evidence of Witness L (17 February 2026) 4246:4-4246:27.

from 5.8% to 7.2%.[96] QFKC also reported an increase in Standards of Care and Harm matters involving kinship care families.[97] These data require careful interpretation. A carer leaving after a review or report does not prove that the process was inappropriate. But the trend is relevant because it shows that safeguarding processes can have workforce and placement stability effects.

The possible Blue Card implications heighten the importance of fairness and proportionality. Some carers work in occupations requiring a Blue Card. A substantiated finding, or information shared with the regulator, may affect their employment or professional standing. Where carer approval, Blue Card status, professional reputation and placement continuity may be affected, the process must be clear and fair. If carers are investigated without proper notice, without meaningful opportunity to respond, or without clarity about consequences, the process risks causing harm even where no finding is ultimately made.

The Commission's concern is therefore twofold. First, children must be protected from unsafe care. Any system that places children in private homes must have robust mechanisms to identify and respond to poor care, neglect, abuse, household risk and unmet standards. Second, those mechanisms must not be so unclear, disproportionate or adversarial that they discourage carers from continuing, deter carers from raising concerns, or create unnecessary instability for children.

A contemporary family-based care system should distinguish more clearly between quality improvement, support needs and serious safeguarding concerns. Some matters may require advice, training, supervision, respite, therapeutic input or practical support. Some may require a Standards of Care review. Some will require a Harm Report and formal investigation. The response should be matched to the seriousness of the concern, the evidence available, the risk to the child and the support required to stabilise care.

At a minimum, carers consistently identified the need for:

- clear and timely communication about the concern;
- enough detail to understand and respond to the allegation or issue;
- information about the process, possible outcomes and review options;
- access to independent support or advocacy;
- proportionality between the alleged conduct and the response;

[96] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 56–57.
[97] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 56–57.

- timely resolution; and
- clear differentiation between support or practice improvement issues and serious safeguarding allegations.[98]

The Commission considers that these requirements are not contrary to child safety. They are part of child safety. Children are better protected when safeguarding processes are trusted, understandable, fair and capable of distinguishing between serious harm and support needs. Poorly explained or disproportionate processes weaken the system by generating fear, discouraging advocacy and contributing to carer exit. Fair process strengthens safeguarding and supports the stability of the children the system is designed to protect.

3.6 Carers' experience of the complaints process

An accessible and trusted complaints process is an important safeguard in any child safety system. For foster and kinship carers, it should provide a clear pathway to raise concerns about departmental practice, placement safety, children's wellbeing, access to services, contact arrangements, delays, communication and the way decisions are made. It should also provide the Department with information about how family-based care is operating in practice.

The evidence before the Commission suggests that carers do not consistently experience the complaints process in this way. A significant number of carers described in submissions having low confidence in complaints pathways, uncertainty about whether concerns would be acted on, and fear that raising concerns could damage their relationship with the Department or affect the children in their care.[99] Many carers in submissions reported that the matters they raised were not recognised or recorded as formal complaints, or were managed locally without any clear outcome, escalation or broader learning.[100]

This is important because complaints from carers often relate directly to children's needs. The Commission heard that carers raised concerns about delayed therapeutic supports, contact arrangements, information sharing, placement safety, departmental responsiveness, decision-

[98] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 56–57.

[99] Queensland Foster and Kinship Care, *Submission to Child Safety Commission of Inquiry* (15 December 2025) 49–50.
[100] Transcript, Evidence of Witness H (8 September 2025) 140:31-140:40; Transcript, Evidence of Witness AB (12 September 2025) 606:43-607:1.

making and the practical effects of delay. These are not minor grievances. They are often early warnings about risks to children, strain on placements and weaknesses in departmental practice.

A recurring theme was fear of negative consequences. Carers told the Commission they were reluctant to complain because they feared being labelled difficult, subjected to greater scrutiny, having their carer status revoked or not renewed or having children removed from their care. One carer submitted:

> Foster carers like us are treated as an 'inconvenience' if we lobby on behalf of the foster child in our care. We are targeted if we complain. We are told by Child Safety Qld that we are meant to be a key part of the child's 'care team'. Yet we are treated like we are playing for the 'opposition team'.[101]

The Commission does not need to determine in every case whether a particular carer's fear of reprisal was objectively justified. The existence and consistent recount, of that fear is itself significant. If carers believe that raising concerns may place them, or the children in their care, at risk of adverse consequences, they are less likely to speak early and openly. That deprives the Department of information it needs to identify problems before they escalate.

This concern overlaps with, but is distinct from, the Standards of Care and Harm Report issues considered above. Standards of Care reviews and Harm Reports are safeguarding processes. Complaints are a feedback and accountability mechanism. The evidence suggests that some carers experience these mechanisms as connected in practice. A carer who has seen advocacy followed by scrutiny, or who has heard of that occurring to others, may be less willing to use formal complaint channels. That dynamic can produce silence where the system needs candour.

A weak complaints environment also affects system learning. If carer concerns remain localised, informal or unrecorded, the Department may miss patterns across service centres, regions, placement types and decision areas. Individual complaints about delayed approvals, poor communication, contact arrangements or information sharing may appear minor when viewed separately. Aggregated over time, they may reveal systemic weaknesses in corporate parenting, workforce capacity, decision-making culture or practice guidance.

This is particularly important in family-based care because carers occupy a unique position. They see how departmental decisions land in the household. They observe whether contact

[101] Submission No 225 to Child Safety Commission of Inquiry (15 August 2025).

arrangements destabilise a child, whether delays in health approvals increase distress or affect school attendance and performance, whether information gaps place others at risk, whether case planning is understood by the child, and whether workers are responding to emerging placement stress. Their complaints can therefore provide practical intelligence that may not appear in administrative data.

The Commission considers that a contemporary model of family-based care requires a complaints process that carers can use safely and confidently. That process should make clear how concerns are recorded, who is responsible for responding, what timeframes apply, how escalation occurs, and how outcomes are communicated. It should also distinguish between complaints about departmental practice, requests for review of decisions, safeguarding concerns about carers, and broader systemic feedback. Those pathways may overlap, but they should not be blurred in a way that leaves carers unsure of what process they are in or what consequences may follow.

The Department should also treat complaints from carers as part of its feedback and learning system. That requires more than resolving individual matters. It requires analysis of complaint themes, identification of repeat issues, reporting to regional and system leadership, and practice change where patterns emerge. Complaints data should be capable of showing whether carers are repeatedly raising concerns about the same issues, including delays in approvals, lack of communication, exclusion from decisions, poor information sharing, difficulty accessing supports, or perceived retaliation.

A trusted complaints process is not inconsistent with robust safeguarding. It strengthens it. Carers who can raise concerns without fear are more likely to identify risks early, seek help before placements deteriorate, and contribute to better decision-making for children. A complaints system that is poorly understood, inconsistently used or experienced as unsafe weakens the Department's ability to learn from the people providing daily care.

The evidence in this section therefore reinforces that the experiences of carers reveal how the system's commitments to partnership, information sharing, support, safeguarding and accountability are experienced in practice. Where carers are trusted, informed and able to raise concerns safely, family-based care is more likely to remain stable. Where they feel ignored, exposed or unsafe to speak, the system loses both carers and the intelligence needed to support

children well. The Commission discusses how best to provide this robust and accessible complaints mechanism in Companion Report 6: Complaint Systems.

4. What Effective Family-Based Care Looks Like

Effective family-based care is more than placing a child in a private household. It is a care model built around relationships, supported by the State, and sustained by the people who provide daily care. It meets an immediate safety need, but its effectiveness is measured by more than physical placement. It depends on whether children experience stability, belonging, cultural connection where relevant, and developmental support, and whether carers have the authority, information, resources and practical support required to provide that care.

The evidence considered in this chapter points to a clear proposition. Family-based care should remain the preferred foundation of Queensland's OOHC system, but it will only remain viable to meet demand if it is designed around the realities of contemporary caregiving.

4.1 Relational continuity as the core purpose

The primary value of family-based care as an OOHC option lies in relational continuity. Children who enter care need adults who get to know them, remain with them, advocate for them and provide ordinary daily care. Stability is therefore more than placement duration. It includes the child's experience of being known, remembered, included and able to return consistently to a person and place that feel safe.

Children and young people told the Commission that family-based care could provide a sense of love, safety and belonging. In the Commission's Youth Voices Survey, one child described success in care as 'being part of a family and being loved.' Another described success as 'being loved … cared for … being safe.'[102] These accounts are simple, but they identify what the system must preserve. Children do not experience family-based care as a legal category. They experience it through routines, affection, attention, food, safety, school, siblings, pets, sport, family events and adults who continue to show up.

That is why relational continuity should be a primary design objective of family-based care. The system should ask whether the care arrangement helps the child maintain stable relationships, remain connected to siblings and significant adults, attend school, access health and

[102] Youth survey response No 39 from former child in care (March 2026); Youth survey response No 80 from former child in care (March 2026).

therapeutic support, and develop a sense of belonging. Those matters should not be treated as secondary to placement administration. They are indicators of whether the care arrangement is doing what family-based care is meant to do.

Relational continuity also requires the system to manage transitions carefully. It may be in the child's best interests to return home, move to kin, enter long-term care, transition between carers, or move into alternative care arrangements such as non-family based care or secure care. Each transition carries lifelong relational consequences. The system should avoid treating a child's movement between placements as an administrative event. For the child, each move is likely to involve varying degrees of loss to home, routine, familiar adults, siblings, school, belongings and aspects of identity.[103] Effective family-based care therefore requires careful transition planning, child participation, relationship mapping, and continued connection where that is safe and in the child's interests.

4.2 Carers as partners in caregiving

Effective family-based care requires carers to be treated as partners in caregiving. This does not mean carers become the decision-maker. The Department retains legal responsibility and must make decisions in accordance with the *Child Protection Act 1999* (Qld). Parents, families of origin, children, cultural authorities, professionals and service providers may all have legitimate roles in providing input from different vantage points and knowledge. The point is that carers are part of the care team because they provide the daily care through which the State's responsibility is experienced by the child.

The Statement of Commitment and the *Child Protection Act 1999* (Qld) already recognise the importance of partnership with carers.[104] Effective practice requires that commitment to be translated into daily operation. Carers should be kept informed before and during placements, involved to the appropriate extent in decisions affecting the child, consulted about family contact, included in case planning where appropriate, and supported to exercise ordinary day-to-day caregiving judgment. Their knowledge should be actively sought because it is different from the knowledge held in departmental files or professional assessments. Carers see the child across time, in ordinary life, and often at moments when the child is distressed, dysregulated or

[103] See case study 5 at Appendix 2 to Executive Report.
[104] *Child Protection Act 1999* (Qld) s 7(1)(k); Queensland Government, *Statement of Commitment to Queensland's foster and kinship carers* (Statement, n.d.).

needing support. They are uniquely placed to be attenuated to the child's changing needs, fears, hopes and aspirations.

Partnership also requires clearer practical authority. Carers need to know what decisions they can make, what decisions require approval, who can provide that approval, and what should happen when delay places a child's needs at risk. This is particularly important for health care, school matters, travel, family contact logistics, technology use, household boundaries and therapeutic supports. A model that expects carers to parent in practice while leaving them uncertain about authority creates avoidable strain in the household.

The care team should therefore be organised around the child, rather than around institutional boundaries. A functioning care team should include, where appropriate and safe, the child; the carer; parents and family of origin; kin; cultural advisors or ATSICCOs; the CSO; the carer support agency; health, education, disability and therapeutic providers; and other significant people in the child's life. The task is to ensure those people are working to a shared understanding of the child's needs and pathway.

4.3 Practical, therapeutic and financial scaffolding

The evidence presented to the Commission indicates that family-based care cannot be sustained by goodwill alone. Many carers provide care to children with extensive trauma histories, disability, mental health needs, developmental delay, school disruption, complex family contact arrangements and behavioural distress. Effective family-based care requires practical, therapeutic and financial scaffolding around carers and the entire household.

At a practical level, carers need timely information, responsive departmental contact, clear approval pathways, transport support where needed, help coordinating appointments, respite, crisis response and access to advice outside ordinary business hours. These supports are especially important during the early phase of a placement, after family contact, when behaviour escalates, when a child is excluded from school, or when a placement is at risk.

At a therapeutic level, carers need training and support that goes beyond general induction. They need help understanding trauma, attachment, neurodevelopment, disability, grief, culture, behaviour, de-escalation, family contact and the child's individual formulation. They also need access to professional advice that is practical and timely. A carer facing serious, escalated behaviour at night, or a child deteriorating while waiting for assessment, needs more than a future referral. They need immediate support that helps them keep the child, household and placement safe and intact.

At a financial level, the care model must recognise the real costs of caring which may vary depending on the needs of the child and the household. Caring for a child in statutory care can affect employment, household income, housing needs, transport costs, childcare, health expenses, school costs and the carer's capacity to absorb unexpected costs. PeakCare and QFKC material before the Commission identified financial pressures, cost-of-living pressures and carer payments as relevant to carer sustainability.[105] A contemporary model should treat carer payments and financial assistance as part of placement stability infrastructure around a child's needs within each individual placement, rather than as an ancillary support. A variety of options exist to consider appropriate financial support for carers and the potential unintended consequences that exist for different approaches.

Strengthening and modernising carer payments and financial assistance is not about professionalising every foster or kinship care arrangement. While professional arrangements (inclusive of a 'living-wage') are undoubtedly appropriate for some high-risk, high-need children and are currently being piloted by the Department, the broader point is about recognising that different children and carers require different intensities of support. Some placements may need ordinary support and responsive casework. Others may need intensive therapeutic input, respite, disability support, after-hours crisis response, higher payments or specialist advice. Effective family-based care should be flexible enough to match financial support to need before the placement deteriorates.

4.4 Culturally appropriate family-based care

For Aboriginal and Torres Strait Islander children, effective family-based care must recognise and meet cultural needs, where relevant and appropriate. This requires more than placing a child with a family-based carer that matches heritage or culture. It requires, on a case by case basis, active consideration of, and attention to, kin, Country, community, culture, identity and the child's connection to family systems.[106]

Kinship care is especially important because it can preserve relational, cultural and community connection more readily than many foster care arrangements. However, kinship should not be treated as self-sustaining. Kinship carers may need financial support, practical assistance,

[105] PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 61-66; Queensland Foster and Kinship Care, Submission to the Australian Institute of Family Studies' Foster, Kinship and Permanent Carers Payments Review (9 April 2025); PeakCare and Queensland Family and Child Commission, *Preserving a Vital System: The Future of Foster Care, Queensland Foster Carer Demographic Insights Report* (Report, June 2024).
[106] *Child Protection Act 1999* (Qld), 5C, 83; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (3 April 2026) 13.

respite, training, therapeutic input, information, help navigating family relationships, and support from culturally capable organisations.

This approach benefits children and carers. Children are more likely to experience care as connected to who they are. Carers are more likely to receive culturally informed support. The Department is more likely to recruit and retain kinship cares, sustain long-term placements, find suitable guardians and support stability and permanency for children where this scaffolding exists.

4.5 A diversified suite of family-based care options

Effective family-based care should not be understood as a single model. Foster care and kinship care include different arrangements, including emergency care, short-term care, long-term care, respite care, sibling care, specialist care, kinship care, culturally attuned care, step-down from non-family based care and supported pathways toward reunification or permanency. Each requires different supports, timeframes, skills and accountabilities.

A diversified suite of family-based care options would help Queensland respond to children whose needs vary in intensity and change over time. Some children may need a short period of stabilisation before reunification. Some may need kinship care with intensive practical and financial support. Some may need specialist family-based care to avoid entry to residential care. Some may need step-down from residential care with therapeutic support wrapped around the carer household. Some may need respite that supports the primary placement rather than treating respite as a separate event.

The Commission received evidence of practice models that illustrate these design principles. They should not be understood as complete solutions or as models to be copied without adaptation. Their value is that they show how family-based care can be structured around support, relationships and intensity.

The Mockingbird Family Model, for example, creates a constellation of foster and kinship carer households supported by an experienced hub home provider. The model is designed to operate like an extended family network, providing peer support, advice, respite and a familiar place for

children and carers.[107] Its relevance lies in the way it reduces isolation and creates a support network around carers.

Treatment Foster Care Oregon, adapted in Queensland as TFCA-QLD for children aged 7 to 12 years old, provides a time-limited intensive treatment model delivered in a specially trained foster carer household with multidisciplinary support. The evidence before the Commission described daily engagement with the treatment team, 24/7 support, specialist training and a structured intervention designed to support children to avoid or exit residential care.[108] Its relevance lies in the way it shows that some children with high needs can be supported in family-based care when the model is properly funded, clinically supported and time-limited.

As touched on above, the Department's professional foster care pilot also reflects an attempt to create more intensive family-based options for young people with disability and high or complex needs who are currently in residential care. Evidence before the Commission described a model involving payments to carers, funding for agencies to provide intensive practical support, and departmental support to better leverage NDIS supports.[109] The pilot is significant because it acknowledges that some children will not be supported by traditional foster care settings without a different level of carer payment, professional support and service coordination.

The Department should also explore models that reflect contemporary family structures and caregiving patterns. This may include shared care arrangements between foster carers, between kinship carers, or between foster and kinship carers, or between parents and carers, where such arrangements are safe, planned and in the child's interests. Shared care should not be used to fragment responsibility or create instability. Properly designed, it may help sustain placements by distributing care across trusted adults, providing predictable respite, supporting sibling and kinship connection, and allowing children to maintain relationships across more than one household. Any such model would require clear roles, information sharing, consent arrangements, financial support, cultural safeguards and accountability for the child's overall stability and wellbeing. Exploration of models should also extend to payment structures and financial supports both to meet the needs of children and households and incentivise carers to start and continue caring.

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[107] Life Without Barriers, 'Connecting carers, children and families in community', *Mockingbird Family* (Web Page, n.d.) <https://www.lwb.org.au/our-approach/child-youth-and-family/mockingbird-family/>; Centre for Excellence in Therapeutic Care, *The Essential Elements of Therapeutic Foster* Care (Report, 2020) 16.
[108] Outline of Evidence of Lisa Griffiths OzChild (n.d.)[73], [101]; OzChild, *Submission to Child Safety Commission of Inquiry* (14 November 2025) 3–5.
[109] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5540:27-5541:19.

These models point to the same design lesson. The future of family-based care cannot depend only on recruiting more carers into the existing model. Queensland needs a broader set of family-based care options that allow carers to participate in different ways and allow children to receive support matched to their needs. That includes ordinary foster and kinship care, but also more intensive and structured arrangements where children's needs require them.

Effective family-based care therefore requires both preservation and redesign. The system must preserve the relational purpose of family-based care: children being cared for by people who know them, remain with them and help them experience safety and belonging. It must also redesign the support, authority, funding and care options around that purpose so that carers can continue to provide care in contemporary conditions.

5. Implications for Reform

The evidence examined in this chapter points to two related reform tasks. Queensland must strengthen the operational foundations of family-based care now, while also redesigning the model for the longer term. The first task concerns the way carers are informed, supported, involved and governed in the current system. The second concerns whether family-based care is designed around the contemporary realities of children's needs, carers' lives and the relationships that give children safety and belonging.

Family-based care should remain the preferred foundation of Queensland's OOHC system because, where it can safely meet a child's needs, it offers the strongest opportunity for stability, attachment, belonging and ordinary family life. That preference will not be achieved through aspiration alone. It requires a model that is deliberately designed, funded, supported, monitored and adapted to the realities of children's needs and carers' lives.

5.1 Strengthening the operational foundations of family-based care

The first reform implication is immediate and practical. The Department must improve how family-based care operates day to day. The evidence from carers shows recurring problems in information sharing, involvement in decision-making, access to health and therapeutic supports, clarity about ordinary parenting authority, Standards of Care and Harm Report processes, and complaints. These are not peripheral matters. They affect children's safety, placement stability, carer confidence and carer retention.

A reset of operational practice should start from the premise that carers are partners in care. This does not make carers the statutory decision-maker. It means the Department should treat carers

as people who hold critical knowledge about the child's daily life and whose cooperation is necessary for decisions to work in practice.

The practical requirements are clear. Carers should receive timely and relevant information before and during a placement. They should be meaningfully involved in case planning, family contact, reunification, permanency and transition decisions where their knowledge is relevant to the child. They should know what decisions they can make, what decisions require approval, who can provide that approval and what escalation occurs when delay places the child's needs at risk.

Health, dental, disability, therapeutic, school, travel and other ordinary caregiving decisions require faster and clearer approval pathways. Carers should not be left to manage a child's pain, distress, developmental delay or behavioural escalation while waiting for decisions or navigating unclear authority. The system should also provide practical and clear guidance and expectations on ordinary care, household boundaries, discipline, emergency intervention and restrictive practices, so carers can provide safe, predictable and developmentally appropriate care without acting under avoidable uncertainty.

Safeguarding processes also require attention. Standards of Care reviews and Harm Reports are essential to protect children, but they must operate with clarity, proportionality, procedural fairness and timely resolution. The same applies to complaints. Carers should be able to raise concerns about departmental practice, service access, delay, safety or decision-making without fear that doing so will expose them or the child to adverse consequences. Complaints and carer feedback should be treated as system intelligence, not as localised disputes to be managed and closed.

These changes should not wait for a broader redesign program to conclude. They are necessary to stabilise the current system and to protect the carers who are already providing family-based care.

5.2 Designing around children's relational worlds

The second reform task is more fundamental. A contemporary model of family-based care should start with the child's experience of family. Children in care do not necessarily experience family as a single household, a legal status or one placement category. Their relational world may include parents, siblings, kin, foster carers, foster siblings, grandparents in a foster family, community members, cultural connections, teachers, coaches and other significant adults. Some of those relationships may be safe and sustaining. Some may be complicated. Some may need boundaries. Many will still matter to the child.

Care planning should therefore be organised around the child's relationships, not simply the child's placement. This requires a more deliberate approach to identifying who matters to the child, which relationships support safety and belonging, which relationships require repair or boundaries, and how those relationships can be maintained during placement, reunification, transition or permanency planning.

This does not mean preserving every relationship in the same way, or prioritising adult wishes over a child's safety. It means recognising that children's identity, culture, grief, loyalty and belonging are shaped by a network of relationships. A placement decision that ignores those relationships may appear administratively workable, but still leave the child feeling displaced, divided or disconnected.

In practical terms, a contemporary family-based care model should require relationship mapping at entry to care, at placement review points and before major transitions. It should consider siblings, parents, kin, culture, community, previous carers and other significant adults. Where safe and in the child's interests, care planning should support continuity of relationships across households, rather than treating each placement move as a clean break.

5.3 Treating family-based care as shared caregiving

Family-based care should be understood as shared caregiving. The State holds legal responsibilities. Carers provide daily care. Parents, families of origin, extended kin and community may continue to hold legal, relational, cultural and emotional significance. For Aboriginal and Torres Strait Islander children, kinship, Country and community connection must be part of how care is designed and supported.

This shared caregiving frame helps avoid an unhelpful opposition between foster carers and birth families. Carers should not be asked to erase or replace the child's relational world. They should be supported to hold, stabilise and help the child navigate it. Equally, carers cannot perform that role effectively if they are treated as peripheral to decisions, denied relevant information, left without authority to make ordinary caregiving decisions, or expected to absorb the consequences of decisions made elsewhere.

The practical implication is that care teams must be more clearly defined and better supported. For each child in family-based care, the system should identify who is in the care team, what role each person has, what information must be shared, what decisions carers can make, what decisions require approval, and how disagreement or delay will be resolved. This is particularly

important for family contact, health care, education, culture, behaviour support, technology use, travel, respite and transitions.

A shared caregiving model also requires better support for carers to work with parents, kin and family networks where safe and appropriate. This may involve supported contact arrangements, clearer communication protocols, cultural brokerage, family-inclusive practice, and practical help to manage the emotional and behavioural effects of contact on the child. Where reunification remains the goal, carers should be supported to contribute to that pathway without feeling that their attachment to the child is treated as a problem.

5.4 Aligning family-based care with contemporary household realities

The system should no longer assume that there is a stable and readily available pool of households able to provide intensive unpaid care indefinitely. Contemporary families are diverse, often dual-income, affected by housing and cost-of-living pressures, and frequently balancing multiple caring responsibilities. That does not make contemporary families less capable of care. It means the system must be designed around the conditions in which care now occurs.

The practical implication is that support must become part of the core design of family-based care, not an optional supplement. Payments, respite, training, therapeutic advice, after-hours support, health and disability navigation, transport assistance, household support and crisis response should be matched to the needs of the child and the demands placed on the household or caregiving network.

This also requires a more flexible understanding of family-based care roles. Not every carer can, or should be expected to, provide every kind of care. Some households may be suited to emergency care. Others may provide respite, sibling care, long-term care, kinship care, culturally appropriate care, reunification support, step-down from residential care, or intensive specialist care for a defined period. A modern system should support carers for the role they are being asked to perform, rather than treating all family-based care arrangements as broadly interchangeable.

The same principle applies to shared care. The system should explore carefully planned arrangements involving more than one safe caregiving household or network. This may include shared care between foster carers, between kinship carers, or between foster and kinship carers where that is safe, stable and in the child's interests. Shared care should not fragment responsibility or create instability. Properly designed, it may distribute care across trusted adults, provide predictable respite, support sibling or kinship connection, and allow children to maintain relationships across more than one household.

5.5 Establishing family-based care redesign as a tier 1 reform

The reform task is larger than improving communication or increasing carer recruitment. Those matters are important, but they will not be enough if the underlying model remains misaligned with children's needs and household realities. Queensland requires a dedicated redesign of family-based care as the primary service delivery infrastructure of the tertiary child safety system.

That work should be treated as a tier 1 reform and assigned to the implementation taskforce established in response to this Report. It should not be left solely to ordinary business-as-usual processes. The current system is already under significant operational pressure, and that pressure risks narrowing reform to incremental fixes rather than the design work required.

The taskforce should design and commence staged implementation of a contemporary model of family-based care organised around children's needs, relationships and developmental interests, rather than fixed placement categories. The model should include foster care, kinship care, culturally grounded care for Aboriginal and Torres Strait Islander children, specialist family-based care, reunification support, respite, emergency care, step-down from non-family based care, therapeutic and practical supports, carer payments, professional advice, health and disability navigation, and placement stability mechanisms. These should not operate as rigid boxes. They should be components of a flexible model that can be assembled around the child.

The work should be developed in close partnership with the Department, ATSICCOs, foster and kinship carers, children and young people, parents, service providers, health, disability, education and oversight agencies. It should define the outcomes sought, the funding model, the carer support model, the decision-making authority of carers, the role of the Department, the role of non-government providers, the interface with health and disability systems, and the measures that will show whether the model is working.

Those measures should include placement stability, carer retention, child wellbeing, cultural connection, sibling connection, access to health and therapeutic supports, exits from residential care, and the experience of children and carers. The purpose is not simply to create new placement types. It is to create a family-based care system that can safely and sustainably hold children with different needs.

5.6 Using existing models as design tests, not ready-made answers

The evidence before the Commission shows that redesign is possible. Existing and emerging models provide practical examples of how family-based care can be supported through networks, specialist roles, funding, professional advice, peer support and purposeful respite. The

point is not that Queensland should adopt any single model as the answer. The point is that the current model is not the only available way to organise family-based care.

The Mockingbird Family Model illustrates how carers can be supported through a networked, extended-family-style structure that provides peer support, advice, respite and shared problem-solving.[110] TFCA-QLD illustrates how some children with high needs may be supported in family-based care through a time-limited, multidisciplinary and clinically supported model that can help prevent entry to, or support exit from, residential care.[111] The Department's professional foster care pilot illustrates an emerging recognition that some children require paid, supported and specialised family-based care, particularly where disability and high or complex needs are present.[112] Respite and emergency care models in other jurisdictions also demonstrate the value of recruiting carers for specific roles, rather than assuming all carers can perform every function.[113]

These examples should be treated as design tests. They ask practical questions Queensland must now answer. What support does a carer household need to safely care for a child with complex needs? What should be paid for, and at what level? What professional advice should be available and when? How should respite be planned so it strengthens the primary placement rather than destabilising it? How can family-based care support step-down from residential care? How should kinship care be supported so that family connection is not used as a reason to provide less assistance? How can shared care arrangements be designed so they increase stability rather than create fragmentation?

The reform direction is clear. Queensland should move from managing exceptions and workarounds to redesigning family-based care around children's relationships, carers' real responsibilities and contemporary household capacity. That reform should preserve what makes family-based care valuable, while building the support, authority, funding and care options required for it to remain viable.

Family-based care should remain the foundation of the OOHC system. But foundations need maintenance, reinforcement and redesign when the load they are carrying changes. The evidence before the Commission shows that the load has changed. The system must now change with it.

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[110] Life Without Barriers, 'Connecting carers, children and families in community', *Mockingbird Family* (Web Page, n.d.). <https://www.lwb.org.au/our-approach/child-youth-and-family/mockingbird-family/>; Centre for Excellence in Therapeutic Care, *The Essential Elements of Therapeutic Foster* Care (Report, 2020) 16.
[111] Outline of Evidence of Lisa Griffiths OzChild (n.d.) [73], [101]; OzChild, *Submission to Child Safety Commission of Inquiry* (14 November 2025) 3–5.
[112] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5540:27-5541:19.
[113] NSW Government, *Reform plan: Transforming the out-of-home care system in NSW* (Report, February 2025).

6. Recommendations

<table>
<tr><th colspan="2">Recommendation 24: Carers as genuine partners in the care team</th></tr>
<tr><th>Executive Report (Chapter 7)</th><th>Companion Report 3 (Chapter 1)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government should, within 12 months of Government's response to this report, implement operational reforms across the Department and funded carer support services to ensure that foster and kinship carers are treated as genuine partners in the care team surrounding a child in care.

The reforms should include:

a) the Standards of Care being refreshed so they are contemporary, fit for purpose, and recognise foster and kinship carers as integral members of the child's care team;

b) expectations for timely and appropriate information sharing with carers and how issues can be escalated;

c) carer participation in case planning, family contact, reunification, transition and permanency decision-making where relevant to the child;

d) a decision-making authority framework identifying what decisions carers can make, what requires approval, who can approve it, and what escalation occurs when delay places a child's needs at risk;

e) improved approval pathways for health, dental, therapeutic, disability, education, travel and other ordinary caregiving matters;

f) clear guidance on ordinary care (including discipline, household boundaries) as opposed to emergency intervention and restrictive practices;

g) reform of Standards of Care review and Harm Report processes to ensure clear thresholds, front-end triage, proportionality, procedural fairness, access to support, timely resolution and record-keeping that distinguishes substantiated, unsubstantiated and resolved matters;

h) education for carers about a trusted complaint pathways, with complaint themes aggregated and reported for system learning; and

i) routine measurement and reporting of carer experience, responsiveness, retention and the effect of these reforms on placement stability.</td></tr>
<tr><td colspan="2">CONTEXT:

The Commission has heard that foster and kinship carers can experience inconsistent information sharing, unclear decision-making authority, slow approvals, variable support and processes that leave them feeling scrutinised rather than supported. These operational failures weaken family-based care and contribute to carer dissatisfaction, placement stress and avoidable instability. They also act as disincentives to carers.

The intended outcome is to reset the Department's operational relationship with foster and kinship carers so they are treated as active caregiving partners, not peripheral parties. For children, the expected impact is more stable caregiving, faster responses to ordinary needs, stronger care planning and fewer avoidable placement pressures. For carers, the expected</td></tr>
</table>

impact is more stable caregiving and carer retention, potentially increased carers and more satisfied carers.
IMPLEMENTATION NOTES: Implementation should include: a) revised Standards of Care and supporting practice guidance b) updated departmental procedures for information sharing, approvals and carer participation c) a statewide decision-making authority framework for carers d) revised Standards of Care review and Harm Report processes e) education about carer complaints pathways, separate from ordinary casework escalation; and f) baseline and annual reporting on carer experience, approval timeframes, complaints, retention and placement stability. The reforms should be embedded in contracts, practice guidance, staff training and carer support service expectations. This recommendation is premised upon the current legal framework. If recommendations relating to legislation and the litigation model are implemented, any system reform will need to align with a new legal framework.

Recommendation 25: Revise model of family-based care	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, within 12 months of Government's response to this Report, design and commence the implementation of a revised approach to family-based care organised around children's needs, relationships and developmental interests, rather than around placement type.

The model should:

a) recognise family-based care as the primary service delivery infrastructure of the child safety system;

b) begin with the child's relational world, including parents, siblings, kin, carers, cultural connections, community and other significant adults;

c) support safe and appropriate shared caregiving arrangements involving foster carers, kinship carers, parents, siblings, extended family and other trusted adults;

d) provide flexible practical, therapeutic, cultural and financial support matched to the child's needs and the demands placed on the caregiving household or network;

e) include clear arrangements for carer authority, respite, crisis response, health and disability navigation, therapeutic advice, training, professional support and placement stability;

f) enable intensive and specialist family-based arrangements for children who would otherwise enter, remain in, or be unable to step down from non-family-based care;

g) include case-by-case financial arrangements, including enhanced subsidies, stipends, salaried or professionalised caregiving models where required to support the child and sustain the caregiving household; and

h) measure outcomes relating to stability, relational continuity, cultural connection, wellbeing, carer retention, reduced placement breakdown and reduced unnecessary reliance on non-family-based care and linked to guardian KPIs.

CONTEXT:

The Commission has heard that family-based care remains the preferred form of care for most children, but current arrangements are often organised around placement categories rather than the child's relationships, needs and developmental trajectory. Existing models do not always provide the level of practical, therapeutic, cultural or financial support required to sustain complex caregiving arrangements in the contemporary environment.

The intended outcome is to establish family-based care as a flexible, supported and structured model capable of meeting a broader range of children's needs and suitable to the current demographic and social context. For children, the expected impact is greater relational continuity, stronger connection to family and culture, fewer placement breakdowns and reduced unnecessary entry into residential or other non-family-based settings. For carers, the expected impact is more stable caregiving and carer retention, potentially increased carers and more satisfied carers.

IMPLEMENTATION NOTES:

The Queensland Government should treat this reform as a Tier 1 system reform and assign responsibility for its design, implementation and oversight to the independent implementation and reform assurance taskforce established in response to this Report (see Recommendation 51).

Implementation should include development of:

a) a statewide model of family-based care, including ordinary, enhanced, intensive and specialist family-based arrangements;

b) eligibility and support criteria based on the child's needs and the demands placed on the caregiving household or network;

c) funding models that allow flexible financial support, including stipends or professionalised arrangements where justified;

d) clear pathways for children to step down from non-family-based care into supported family-based arrangements;

e) shared caregiving models that preserve safe and appropriate relationships with parents, kin, siblings and other significant adults; and

f) outcome measures and public reporting on stability, carer retention, relational continuity, cultural connection and reduced reliance on non-family-based care.

Chapter 2

Non-Family Based Care

Companion Report 3

Models of Care

Abstract

This Chapter examines the role of non-family based care within Queensland's OOHC system. It explores how children enter, experience and move through these models, with particular attention to relationships, placement stability, cultural appropriateness, disability, mental health, education, quality of care and pathways out. The Chapter concludes that Queensland requires system redesign, not only residential care reform, so that all non-family based care is purposeful, therapeutic, and used only where it is the right response to a child's assessed needs.

This Chapter is complemented by Companion Report 4: Understanding and Reforming the Residential Care System.

Chapter 2: Non-Family Based Care

1. Introduction

This Chapter examines the delivery of non-family based care as one of Queensland's OOHC placement options. Its focus is on the types of care available, the role each plays in a child's pathway through the child safety system, and whether those arrangements operate as purposeful care responses or as default placements when other parts of the system are under pressure. The Chapter considers local and international models, identifies what constitutes quality of care from developmental and child-centred perspectives, and examines the approaches that best support children with high and complex needs, including children with disability and Aboriginal and Torres Strait Islander children.

The Chapter examines non-family based care as a downstream component of the OOHC system, whose scale and use reflects system pressures.

Non-family based care is defined in the Child Safety Practice Manual (CSPM) as care provided in residential premises, not in a carer's or young person's own home, by paid or contracted workers and/or volunteers.[114] In Queensland, non-family based care includes residential care, Supported

[114]Queensland Government, 'Types of care arrangements', *Child Safety Practice Manual* (Web Page, 16 May 2025) <https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements>.

Independent Living and Indigenous community residential care, commonly referred to as Safe Houses.

Residential care is the primary focus of the Commission's analysis in this chapter as it is the largest, most costly and most contested form of non-family based care and the need for its reform comprises a significant focus of this Commission's terms of reference. The rapid growth of residential care over the past decade – both in terms of cost and the number of children being placed within this model of care, is also one of the clearest indicators of pressure across the broader child safety system.

The appropriateness of residential care and its configurations has been a key issue in Queensland for some time. Oversight, peak and advocacy bodies have repeatedly raised concerns that residential care has drifted from a specialised and purposeful therapeutic response into a default placement under pressure. Those concerns include the need to clarify the role and function of residential care, and to fill the gap between foster and kinship care and residential care with more nuanced responses of support.[115]

Supported Independent Living and Safe Houses also require analysis because they perform different functions within the system of non-family based care. Supported Independent Living is a developmental transition program for young people moving toward adulthood who are assessed as having sufficient capacity, support and readiness to live with greater independence. Safe Houses have a purpose that is distinct from mainstream residential care. They are culturally grounded, community-based responses intended to reduce dislocation, support assessment and stabilisation, and maintain connection to kin, Country and community. The functional question is whether these services are being used for the purpose for which they were designed, with the governance, support and pathway planning required to make them effective.[116]

A central question is whether non-family based care operates as a pathway or a destination. Residential care may be necessary for – and in the best interests of – some children at a particular point in time, but it should be rare for it to become the end point of planning. Without clear purpose, residential care risks becoming a holding environment in which children remain because the system has not built, funded or coordinated the next care arrangement.

[115] Queensland Family and Child Commission, *Too little, too late: The progress made against the Queensland residential care roadmap* (Report, December 2024) 29; Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024) 26.
[116] Queensland Government, 'Types of care arrangements', *Child Safety Practice Manual* (Web Page, 16 May 2025) <https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements>.

This question must be considered from the child's perspective. A child entering care, often in crisis, does not experience the system as placement categories, service contracts or funding arrangements. He or she experiences it as people, places, routines, relationships and decisions made about his or her life. The relevant questions are whether they meet dependable adults; whether they feel safe and heard; whether placements endure; whether their culture and identity are preserved; whether transitions are planned or abrupt; and whether decisions are appropriately collaborative or transactional.

Many children entering non-family based care have needs that cannot be understood or responded to by the Department or residential providers alone and require a level of interface with disability, mental health and education systems (among others). A coherent model of care should not simply transfer complexity from one part of the child safety system to another. Effective non-family based care depends on timely access to disability, health, mental health, education and allied health supports, and on those support services sharing responsibility for the child's pathway and outcomes.[117]

Licencing, staffing, contracts and procedural compliance are necessary, but they do not establish quality on their own. The more important question is whether the child experiences the placement as safe, stable, relational, culturally connected, developmentally responsive and purposeful. Queensland already has sources that begin to show aspects of children's experience, including the Children in Care Census[118] and the My Life in Care survey.[119] Those sources should be used more deliberately to understand whether non-family based care is improving children's lives.

The analysis proceeds from a simple proposition. Non-family based care should not operate as the residual endpoint of an OOHC system that has exhausted other options. It should form part of a coherent OOHC system, in which each type of care has a defined purpose, target cohort, quality standard and pathway out. Where non-family based care is used, it should be because it is the right response to a child's assessed needs at that point in time, not because it is the only placement available. That ideal is presently constrained by a shortage of family-based placements for a range of reasons discussed in Chapter 1 of this Companion Report.

[117] Well Life Services, *Submission to Child Safety Commission of Inquiry* (29 October 2025).
[118] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024* (Report, 2024).
[119] Department of Families, Seniors, Disability Services and Child Safety, *My Life in Care Survey: 2024 Results* (Report, 2024).

2. Non-family based Care in the Current System

2.1 Types of non-family based care and their intended function

Non-family based care in Queensland takes a variety of forms, each with different settings, purposes, cohorts and risks. The evidence before the Commission suggests that these distinctions are not always sufficiently clear in practice. A well-designed OOHC care system should distinguish between therapeutic intervention, supported transition to adulthood, culturally grounded community-based care, emergency accommodation, step-down care and any specialist response for children with very high support needs.

Residential care is the dominant type of non-family based care. As at 18 February 2026, 19.7% of children in OOHC were in a residential care placement.[120] It typically involves small, shift-staffed houses accommodating one to four children, although configuration varies by provider, location, contract type and cohort. Residential care may be appropriate where a child requires a level of structure, supervision, therapeutic support or specialist response that cannot safely be provided in a family-based setting at that time. It is not, however, a substitute for family life and should not operate as a default placement for children whose needs could be met in foster, kinship or specialist family-based care with adequate support.

Thomas Allsop, former CEO of PeakCare acknowledged in his evidence to the Commission that residential care *'will never provide the same level of attachment, bonding and care, particularly for younger children.'*[121]

A child and adolescent psychiatrist told the Commission that a residential care placement poorly replicates a home environment, notably because the necessity for shift work of staff provides a barrier to stable and secure attachments, and at times, staff are unable to assert normal parental controls to manage behaviour.[122]

This section deals with residential care briefly at this point because its role, growth, entry pathways, cohort profile and exit pathways are examined in greater detail below. For present purposes, the key issue is that residential care is often treated as a single broad category, despite the diversity of configurations that operate in practice and the wide range of needs among children in those settings. The generic approach to commissioning residential care has

[120] Department of Families, Seniors, Disability Services and Child Safety, 'Operational data: Care arrangements', *Our Performance* (Web Page, 18 February 2026) <https://performance.dcssds.qld.gov.au/our-performance/operational-data/care-arrangements>.
[121] Transcript, Evidence of Tom Allsop (16 September 2025), 977:44-977:46.
[122] Submission No 287 to Child Safety Commission of Inquiry (31 March 2026).

contributed to uncertainty about what is meant by trauma-informed or therapeutic care. Most providers and sector participants recognise the importance of trauma-informed and therapeutic practice, but if therapeutic care is not defined, funded, monitored and supported, it risks becoming a label rather than a model.

Supported Independent Living performs a distinct function within the non-family based care system. The CSPM describes Supported Independent Living as an arrangement in which a small number of young people aged 15 years or older live in a residential setting, supported by case or youth workers through a structured support arrangement. According to Elizabeth Colahan, CEO of Anglicare, it is a model for young people who are in employment or school who need a less intensive type of model and an opportunity to develop their skills they will need to function within society as adults.[123] Workers generally do not live in the house (or, at least, not all the time)[124] but provide external support through regular visits. The purpose of the arrangement is to give young people opportunities to develop life skills that support their transition to adulthood.[125]

Supported Independent Living has an important place in the care system, but only if it is used as a planned developmental transition in readiness for adulthood. The transition from care to adulthood is already a high-risk period. Young people leaving OOHC often do so with fewer family resources, fewer stable relationships, disrupted education, higher rates of trauma, mental health concerns, disability, housing insecurity and reduced practical support than their peers.[126] The risk is therefore that a program described as 'independent living' may be used before a young person is developmentally, emotionally, practically or relationally ready for independence.

The Department's own practice material recognises that decisions about independent living should consider the young person's age and maturity, ability to make decisions about their own safety and wellbeing, capacity to live independently, availability of licensed Supported Independent Living services, case plan goals achieved, education and training requirements, benefit eligibility, and the views of the young person's parents and safety and support network.[127] That list reflects the real issue. Supported Independent Living should not be triggered by age alone. It should follow careful assessment of readiness, support, risk, housing, disability, mental health, education, relationships and the young person's own views.

[123] Transcript, Evidence of Elizabeth Colahan (19 September 2025), 1329:30-1329:40.
[124] Transcript, Evidence of Elizabeth Colahan (19 September 2025),1330:1-1330:2.
[125] Queensland Government, 'Types of care arrangements', *Child Safety Practice Manual* (Web Page, 16 May 2025) <https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements>.
[126] Monica Campo and Joanne Commerford, *Supporting young people leaving out-of-home care* (CFCA Paper, 2016) 6.
[127] Queensland Government, 'Support a care arrangement: Respond to a young person's request to live independently,' *Child Safety Practice Manual* (Web Page, 21 April 2026) <https://cspm.csyw.qld.gov.au/procedures/provide-and-review-care/support-a-care-arrangement>.

For some young people, Supported Independent Living may provide a constructive intermediate step between statutory care and adulthood. For others, particularly those with disability, complex trauma, unstable relationships, school disengagement or youth justice involvement, premature movement into a semi-independent model may intensify risk. Well Life Services submitted that young people with disabilities transitioning from child safety to NDIS-funded Supported Independent Living can experience poor matching, inadequate information transfer, loss of relationships with carers who understand their needs, homelessness, addiction, incarceration and financial crisis where planning and support are inadequate.[128]

The broader evidence on care leavers reinforces this concern. AIHW reporting notes that approximately one in three young people leaving OOHC experience homelessness at some stage within their first year after leaving care, while AHURI research found that more than half of care leavers in one study accessed homelessness services within four years of leaving care.[129] This data does not relate only to Supported Independent Living, but it highlights the risks of accelerated independence without stable housing, relationships, income, health support, disability support and practical life skills.

Supported Independent Living should therefore be understood as a care and transition response, not merely accommodation with outreach support. Its effectiveness should be judged by whether it assists the young person to build the foundations for adult life: safe and stable housing, education or employment pathways, health and disability supports, financial capability, trusted relationships, cultural and community connection, and support beyond the eighteenth birthday. If those elements are absent, Supported Independent Living risks becoming a pathway to unsupported independence rather than a bridge to adulthood.

Some of the risks identified in the evidence do not arise only from Supported Independent Living but apply more generally to the transition to adult housing and disability systems once young people exit statutory care.

Safe Houses perform a different function again. The CSPM describes Indigenous community residential care and family intervention services, commonly known as Safe Houses, as residential services specifically designed to meet the particular needs of Aboriginal and Torres

[128] Well Life Services, *Submission to Child Safety Commission of Inquiry* (30 October 2025).
[129] Australian Institute of Health and Welfare, *Specialist homelessness services annual report 2024–25: Clients leaving care* (Report, 4 December 2025); AHURI, *Accommodating transition: improving housing outcomes for young people leaving OHC* (Report, 30 September 2021).

Strait Islander children. They are located in Aboriginal and Torres Strait Islander communities to enable children to safely remain in, or return to, their communities of origin.[130]

That purpose is significant. Safe Houses are intended to reduce the cultural and geographic dislocation that can occur when Aboriginal and Torres Strait Islander children are removed from their communities and placed in distant regional centres or mainstream residential care. They are closely connected to the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) and to the obligation to maintain a child's connection to family, community, culture and Country.[131]

The functional question is whether Safe Houses are operating as culturally grounded, community-led care and assessment responses, or whether they risk becoming another form of shift-based residential care in a remote location. This distinction matters. A safe house cannot be considered culturally appropriate merely because it is located in an Aboriginal or Torres Strait Islander community. Its effectiveness depends on local governance, connection to kin, community leadership, workforce capability and family support.

The Commission has received submissions emphasising that cultural connection cannot be provided by the State alone. Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) submitted that culture, kinship and community connection are core factors that strengthen lifelong wellbeing for Aboriginal and Torres Strait Islander children, and that partnership, shared decision-making and self-determination are essential if those children in State care are to grow up strong, safe and connected.[132] It also identified that cultural support plans often do not translate into lived cultural connection, and that culturally grounded and self-determining models of care remain limited within residential care.[133]

Safe Houses should therefore be assessed against their intended function. They should not simply provide a bed close to community. They should support culturally appropriate assessment, stabilisation, family engagement, connection to kin, active efforts to identify family and community care options, and pathways either home, to kin or to another culturally appropriate arrangement.

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[130] Queensland Government, 'Types of care arrangements: Indigenous community residential care and family intervention services (safe houses)', *Child Safety Practice Manual* (Web Page, 16 May 2025) <https://cspm.csyw.qld.gov.au/practice-kits/care-arrangements/overview/types-of-placements>.
[131] Queensland Government, 'Principles', *Child Safety Practice Manual* (Web Page, 12 March 2026) <https://cspm.csyw.qld.gov.au/our-approach/principles>.
[132] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (February 2026).
[133] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (February 2026).

This is particularly important in regional and remote Queensland, where placement scarcity can result in Aboriginal and Torres Strait Islander children being moved long distances from home. QATSICPP has described children being removed to residential placements hundreds, and sometimes thousands, of kilometres from their communities, with little or no connection to anyone in the receiving community.[134] Properly designed Safe Houses may help reduce that dislocation. Poorly supported or poorly governed Safe Houses may simply reproduce the same risks in a different setting, or children may end up staying longer than appropriate or necessary due to poor planning, case management or alternative options. The Cape York Institute also emphasised the need for locally situated residential care facilities.[135]

The functional issue for the Commission is whether the OOHC system uses each type of non-family based care for its intended purpose. A well-designed system would distinguish between short-term assessment and stabilisation, therapeutic residential intervention, culturally grounded community-based care, step-down from residential care, supported transition to adulthood, and specialist responses for children with very high support needs. Queensland's current OOHC system does not yet provide that degree of clarity, consistency or flexibility.

2.2 The changed role of residential care: from specialist intervention to default placement

Historically and conceptually, residential care has been understood as a tertiary intervention: a specialised, time-limited response intended for a limited number of children whose safety, developmental or therapeutic needs could not, at a particular point in time, be met within a family-based setting. Its purpose is not to substitute for family life, nor to manage behavioural distress, system pressure or service gaps.

In Queensland, residential care has expanded in scale, cost and functional importance. It has become a routine rather than exceptional placement type for children whose needs are assessed as exceeding the capacity or tolerance of other parts of the system. From March 2015 to March 2025, there was a 229% increase in the number of children and young people living in residential care.[136] KPMG's analysis in the lead up to the residential care hearings described Queensland's residential care system as having shifted over the past decade from a last-resort, short-term placement option to a core component of the OOHC system. It identified that the number of children in residential care had more than tripled since 2015, driven largely by the reduction in

[134] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (February 2026).
[135] Cape York Institute, *Submission to Child Safety Commission of Inquiry* (April 2026) 9.
[136] Statement of Belinda Drew (3 September 2025) [30]; Statement of Bernadette Harvey (3 September 2025) [126]–[130].

family-based care supply and the increasing placement of younger children and children with highly complex needs into group-based settings not designed for long-term care.[137]

The scale of growth is also visible in expenditure and market composition. KPMG identified sustained cost growth driven by inelastic demand, rising input costs, increased use of residential care where family-based alternatives were unavailable, and greater reliance on high-cost short-term placements.[138] The QFCC's Buyer Beware analysis similarly framed residential care as a market shaped by government purchasing behaviour, in which residential care had become a billion-dollar sector and government had too often operated as a price taker in a market marked by weak value signals and poor alignment between cost and outcomes.[139]

Queensland's reliance on residential care is also disproportionate by national comparison. KPMG noted that 2023 data showed Queensland had 21% of Australia's children in care but 40% of Australia's residential care placements. Based on 2024 data, almost one in five Queensland children in OOHC were in residential care, the highest proportion in the country. By comparison, New South Wales and Victoria had far lower proportions of children in OOHC in residential care.[140]

This growth is not merely a service pressure. It is evidence of system imbalance. It reflects the interaction of increasing demand for OOHC, insufficient family-based care supply, limited or ineffective early intervention, placement instability, unmet disability and mental health needs, education disengagement, weak step-down pathways, and procurement arrangements that have allowed high-cost residential options to expand as an immediate response to crisis. Residential care has therefore grown not only because some children require intensive non-family based support, but because the rest of the OOHC system has not consistently been able to provide safe, supported and sustainable alternatives.

Properly conceived, residential care may provide short-term stability, intensive relational support and therapeutic intervention while longer-term solutions are developed. It can have ongoing utility in Queensland's child safety system if it is deliberately designed, tightly governed and used for a defined purpose.

This positioning aligns with a prevention-oriented child safety system, in which responses to harm and vulnerability are organised across a continuum of escalating statutory intervention.

[137] KPMG, Residential Care Analysis, Background BI.1.
[138] KPMG, Residential Care Analysis, ES.9, A.32–A.50.
[139] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, August 2025).
[140] KPMG, Residential Care Analysis, A.40–A.41.

Even within the statutory system, residential care should be considered only when family-based options are unavailable or unsuitable. The Department's Acting Chief Practitioner told the Commission that family-based care is preferred for all children because it enables children to experience predictability and stability with a consistent caregiver, supporting the development of a secure bond with a trusted adult.[141]

The scale and function of tertiary responses reveal the health of the broader child safety system. When tertiary responses grow disproportionately, that growth rarely reflects a rise in complex need alone. It usually reflects the cumulative failure of earlier, less intrusive supports to operate at sufficient scale, quality or coordination. Residential care should therefore be understood not as a stand-alone service type or placement option, but as one component within an OOHC system. Its growth is inferentially important because it indicates that other parts of the system are not working.

2.3 Residential care – an indicator of system performance

The scale and use of residential care are significant indicators of system performance. Where residential placements grow disproportionately, that growth often signals weaknesses elsewhere: in early intervention, family preservation, kinship and foster care support, disability and mental health responses, educational inclusion, placement matching and cross-agency collaboration.[142] Residential care growth is therefore both a symptom and a driver of child safety system pressure.

The pathway into residential care is rarely a simple result of assessed need. The evidence before the Commission indicates that placement decisions are often made under conditions of acute pressure, limited options and imperfect information.[143] In principle, placement decisions should be guided by the child's developmental, relational, cultural and therapeutic needs, and should identify the least restrictive placement capable of safely meeting those needs.[144] In practice, the question facing decision-makers too often appears to become: where can this child go right now?

When availability displaces need as the primary matching criterion, residential care becomes a placement of practical necessity rather than therapeutic purpose. It may be selected because it can accept a child quickly, because family-based placements are unavailable, because a prior

[141] Statement of Victoria Van Houdt (9 May 2025) [153]-[155].
[142] Together Queensland, Submission to Child Safety Commission of Inquiry (6 March 2026).
[143] Transcript, Evidence of Natalie Wilson (8 April 2026), 5000:30–5001:11; Transcript, Evidence of Deidre Mulkerin (14 April 2026), 5326:14-5326:26.
[144] Statement of Victoria Van Houdt (9 May 2025) [144]-[148].

placement has broken down, or because the system is seeking to contain immediate risk. In such circumstances, the placement may be lawful and operationally necessary, but still poorly matched to the child's longer-term developmental, relational, cultural or therapeutic needs.

These dynamics are intensified in regional and remote Queensland. When suitable local placements are unavailable, children may be placed far from home, school, siblings, kin, community and Country. The Commission heard evidence that some regions, including parts of North Queensland, rely heavily on fly-in fly-out workforces and have limited residential care capacity in places such as Mount Isa.[145] Residential care is also frequently used after family-based care has broken down. The Commission heard evidence that foster and kinship carers are not always provided with sufficient information, practical support, respite, therapeutic guidance or disability-related assistance to sustain placements.[146] When those placements break down, residential care absorbs the consequence. The downstream effect is that residential care becomes a default placement for children whose needs would very likely have been better met by family-based care, were it available.

The same dynamic is visible where disability, mental health and education needs are not identified or addressed early. A child may present with behaviours described as challenging, aggressive, absconding, disengaged or non-compliant. Those behaviours may be expressions of trauma. They may also reflect disability, neurodevelopmental difference, the undiagnosed effects of FASD, cognitive impairment, unmet mental health need, school exclusion, sensory overwhelm, communication difficulty, grief, cultural disconnection or some combination of those factors. If the child safety system does not understand the child's developmental and disability profile, it may misread need as behaviour and respond with placement change rather than support.[147]

This can have a direct effect on placement decisions. A child whose disability-related needs are not understood may be assessed as too difficult, or 'not suitable' for family-based care, or a child with acute mental health needs may be managed by residential workers who do not have clinical training or access to timely specialist advice. In each case, residential care is not only providing care, it is being asked to compensate for gaps in other systems and support services.[148] There is

[145] Department of Families, Seniors, Disability Services and Child Safety, Child Safety Investment & Commissioning Data Overview (Quarterly Data Analysis Report, April 2025) (DFS.0186.0002.0022).
[146] Transcript, Evidence of Witness C (8 September 2025), 46:16-47:2; Transcript, Evidence of Witness H (9 September 2025), 166:6-166:12; Transcript, Evidence of Witness L (17 February 2026), 4220:8-4220:45.
[147] Well Life Services, *Submission to Child Safety Commission of Inquiry* (29 October 2025); National Organisation for Fetal Alcohol Spectrum Disorder Australia, *Submission to Child Safety Commission of Inquiry* (31 October 2025).
[148] Submission No 287 to Child Safety Commission of Inquiry (31 March 2026) [71]-[73].

a paucity of testing for, and data in relation to FASD.[149] This equates to a significant gap in understanding and responding to the needs of children suffering from the condition – of presently unknown proportions.

Placement decision-making is therefore a major functional problem in the current OOHC system. A reformed system must ensure that placement decisions are based on assessed need, cultural and relational connection, therapeutic purpose and pathway planning, not merely availability. That requires a more developed range of care options, better information at the point of decision, stronger family-based support, and clearer entry and exit criteria for residential care.

2.4 The cohort in residential care

Departmental policy specifies residential care primarily as a placement option for young people aged 12 to 17 with complex or high support needs, while recognising that residential care may be considered for younger children in particular circumstances.[150] In practice, residential care accommodates a broader cohort, including children under 12 and children with overlapping disability, mental health, developmental and behavioural needs. The Acting Chief Practitioner recognised that it was not the Department's hope that young children would be placed in non-family based care, but that this sometimes occurred, including to maintain sibling connections or respond to complex medical needs.[151]

As at 31 March 2025, there were 2,258 children in residential care in Queensland, including 78 children under the age of five and 472 children under 10 years of age.[152] These children are, developmentally, least suited to shift-based, non-family based care. Early childhood is a period in which attachment, relational consistency, emotional regulation, language, identity and developmental foundations are being formed. The placement of very young children in residential care therefore raises a distinct concern. Even if the number of children under five is smaller than older cohorts, the developmental stakes are acute. The future trajectory of residential care growth is also concerning. Forecasts provided to the Commission indicate that the number of children in residential care is projected to almost double within the next 10 years, with corresponding workforce growth required to meet demand.[153] The Department's 2025/2026 Service Delivery Statements identify a total controlled budget of $3.617 billion, with expenditure

[149] See Chapter 4.4.4. of the Executive Report, at paragraphs [4]-[5].
[150] Statement of Victoria Van Houdt (5 September 2025) [156]-[157]; Statement of Bernadette Harvey (3 September 2025) [70].
[151] Transcript, Evidence of Victoria Van Houdt (28 November 2025), 3104:26-3104:29.
[152] Department of Families, Seniors, Disability Services and Child Safety, 'Improving care and post care support: Living arrangements of children', *Our Performance* (Web Page, n.d.) <https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/what-we-do/living-arrangements-of-children>.
[153] PeakCare and The Demographics Group, *The future residential care workforce: Demographic analysis* (Report, September 2025).

largely directed toward OOHC services and other outsourced supports for vulnerable children and families.[154] The Demographics Group observed that a continued shift toward residential care without systemic change would be financially unsustainable.[155] KPMG reached a similar conclusion in substance, identifying that current demand and cost modelling provides clear signals about the likely scale and direction of future non-family based care demand and associated cost risk if current pressures persist.[156] Buyer Beware likewise warned that the current trajectory of OOHC expenditure is unsustainable without reform.[157]

Sustainability is not merely a question of cost. A growing residential care cohort means more children are spending childhood in settings that are not designed, and in many ways unable, to replicate family life. This risks leaving them unanchored to a safe, stable adult and without the normative benefits of exposure to healthy parental controls and boundaries. It also means increased reliance on a shift-based workforce, greater pressure on providers, greater exposure to placement instability, and increased difficulty ensuring therapeutic quality across the system. If the projected trajectory occurs without major redesign, Queensland risks normalising residential care as a core placement response rather than constraining it as a specialist intervention.

2.5 Pathways through and out of residential care – and the consequences of their absence

A significant weakness in the current operation of residential care is the absence of clear, reliable and actively managed pathways through and out of it. If residential care is to operate as a purposeful intervention, each placement should begin with a clear understanding of why the child is there, what the placement is intended to achieve, what supports will be provided, who is responsible for progressing the next step, and how the system will know whether the placement is beneficial to the child's development.

Residential care is best understood as a point in a child's pathway through the child safety system. For some children, its purpose may be short-term stabilisation while family, kin or specialist family-based care is identified or restored. For others, it may be time-limited therapeutic intervention after repeated placement breakdown. For some older children, residential care may need to connect to Supported Independent Living and transition to

[154] Queensland Government, *Service Delivery Statements - Department of Families, Seniors, Disability Services and Child Safety* (State Budget Paper, 2025) 11. Note: This reflects controlled income for the entirety of the Department of Families, Seniors, Disability Services and Child Safety. Controlled items, which includes controlled income, are items which relate directly to the departmental operational objectives and arise at the discretion and direction of that department.
[155] PeakCare and The Demographics Group, *The future residential care workforce: Demographic analysis* (Report, September 2025)
[156] KPMG, Residential Care Analysis, ES.22–ES.28.
[157] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, August 2025) 20.

adulthood. For Aboriginal and Torres Strait Islander children, the pathway must include active efforts to maintain or restore connection to family, kin, community, culture and Country. For children with disability, mental health needs or neurodevelopmental vulnerability, the pathway must include integrated support from health, disability and education systems.

The Department's practice guidance on reunification reinforces the importance of intentional pathway planning. The CSPM describes reunification as the safe return of a child to the care of one or both parents after a period in care, and states that it is a planned and timely process requiring strong partnerships, thoughtful planning and considered practice so that reunification is sustainable. It also states that, for children on custody or short-term guardianship orders or placed away from home under a care agreement, reunification will usually be the primary permanency goal. The CSPM further states that planning for reunification should begin from 'day one' of a child coming into care.[158] The Commission's recommendations concerning the overhaul of the litigation process and court involvement in, and oversight of, the Department's decision-making are directed to enhancing the opportunities for the earliest possible reunification of the child, and if that is not possible, promoting the earliest possible permanent placement arrangement.

The Department's stated objective of planning for reunification from 'day one' has particular significance for children in residential care placements. If a child enters residential care after a family-based placement breakdown,[159] the system should not only ask whether the residential placement can contain immediate risk. It should ask what needs to change so that the child can return to family, kin or a family-based setting with the right support. The CSPM identifies factors associated with successful reunification. They include thorough assessment, adequate preparation for the child and parents, specialist services for the child and parents, consistent and purposeful intervention, and foster carers or non-family based care workers supporting parents and children toward returning home and being available to help afterwards. It also identifies factors associated with breakdown, including inadequate assessment, insufficient planning, inadequate or late service provision, and support ending too soon.[160]

[158] Queensland Government, 'Reunification', *Child Safety Practice Manual* (Web Page, 11 March 2026) <https://cspm.csyw.qld.gov.au/practice-kits/permanency-1/reunification-1>.
[159] See case study 2 at Appendix 2 to Executive Report, 'Regrettably, the breakdown of this long-term foster care placement – occurring at age 13.5 – appears to have been a critical turning point in YP's trajectory. In the following six months, YP began a rapid descent into absconding from non-family based care placements, self-placing and criminal offending.'
[160] Queensland Government, 'Factors associated with reunification success or breakdown', *Child Safety Practice Manual* (Web Page, 11 March 2026) <https://cspm.csyw.qld.gov.au/practice-kits/permanency-1/factors-associated-with-reunification-success-or-b>.

All placement decisions must be specifically evaluated against the paramount principle as it applies to the unique individual needs and circumstances of the child in question.[161] No system level objective should be allowed to intrude upon the proper evaluation and application of that principle, though it may result in the child remaining in residential care for want of an alternative. The broader systemic solution is to invest in, and expand the availability of family-based care, and to invest in, and expand the supports for families to enable them to care for their children. That solution is not achieved by making decisions to reunify children which are not rationally justified by an impartial assessment of the circumstances and environment in which the child is to be placed.

The need for material investment in family-based care is highlighted by the conclusions which emerge from the analysis referred to in Companion Report 4: Understanding and Reforming the Residential Care System. The Commission's analysis of the residential care sector and the consequences of over-reliance upon this sector, effectively as a band-aid solution, reveals some concerning consequences. One particularly concerning consequence is that many children remain in residential care for lack of any alternative. As at 27 March 2026, departmental material indicated that 1,555 of 2,800 children placed in residential care were assessed as ready for family-based care with intensive supports to meet their needs.[162] For those children, residential care is not only failing to respond to the child's needs, it is absorbing the system's constrained capacity to meet their needs.

QFCC material makes the same point in broader system terms. In its final submission, it identified the need to define and embed clearer pathways of care, stating that children entering OOHC have diverse and changing needs, and that contractual arrangements should articulate the purpose, scope and expectations associated with different placement types so that children receive care environments that match their needs. The submission also recorded the QFCC's earlier observation that there is an opportunity to fill the gap between foster or kinship care and residential care with new types of care that compete with residential care in its current design.[163]

The importance of having pathways out of residential care is also illustrated by evidence about Treatment Foster Care Australia Queensland. OzChild submitted that TFCA-QLD is a time-limited treatment model using specialist foster care placements, individualised behaviour plans and

[161] See Chapter 1.6.1. of the Executive Report for definition of the paramount principle; See Chapter 6.2.4 of the Executive Report for discussion of the relationship between the paramount principle and the ATSICPP.

[162] See, spreadsheet provided by the Department of Families, Seniors, Disability Services and Child Safety regarding children placed in residential care by region and whether suitable for family-based care as at 27 March 2026 (DFS.0392.0002.0001).

[163] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 33-35.

multidisciplinary support. It submitted that the model has proven success in exiting children from, and preventing entry into, residential care for children aged 7 to 12, and that since commencement in Queensland in 2018, 36 children have graduated from TFCA-QLD and either exited residential care or avoided entry into it.[164] The Commission need not accept (and does not endorse) any one program as the answer, but the evidence demonstrates the kind of intermediate and specialist family-based pathway that can reduce reliance on residential care where it is implemented with fidelity, funding and support.

A redesigned system should therefore require every residential care placement to have an entry rationale, therapeutic purpose, review point and exit trajectory. At each review, the system should ask:

- why the child remains in residential care;
- what therapeutic work has occurred;
- whether the child's safety, stability, relationships, education, health, disability and cultural needs are being met;
- what reunification, family, kin, specialist family-based, step-down or supported adulthood options are being pursued;
- who is responsible for progressing those options and over what time period;
- what barriers are preventing progression, in what respects and what might be done to address them; and
- what escalation occurs when a child remains in residential care only because the right care arrangement is unavailable.

The question should not only be whether the placement is safe today. It should be whether the placement is helping the child move toward stability, connection and permanency.

3. Experiences of Non-Family Based Care

The experiences described below are not presented as isolated failures, but as recurring patterns arising from the design and operation of non-family based care at scale.

The Commission heard about a wide range of experiences of non-family based care, with the majority reflecting experiences of residential care. It warrants mentioning at the outset that some children described their residential care placements as stabilising, particularly where staff were

[164] OzChild, *Submission to Child Safety Commission of Inquiry* (14 November 2025) 3–5.

consistent, attuned and predictable.[165] More commonly however, children described environments characterised by rotating workers, limited therapeutic planning, weak communication and uncertainty about decisions affecting their lives.

While the Commission did hear evidence of individual and service-level failings, the themes that follow are not presented as isolated examples. They identify issues in the design and operation of non-family based care that affect children's experience of the system, and the quality of care viewed from the child's perspective as the substantiative outcome.

3.1 The centrality of relationships

Children who enter residential care have almost universally experienced trauma, disrupted attachments, placement cycling and loss of trust in adults. Submitters described how complex childhood trauma affects neural pathways and can contribute to hypervigilance, emotional dysregulation and difficulty trusting adults.[166] Healing from complex trauma requires relational continuity from safe adults who have an understanding of the ongoing effects of trauma suffered by children consequent upon their detachment from their families.[167]

The evidence of witnesses with direct experience of the system, Witness X and Witness S, was particularly apposite.[168] Both gave powerful evidence about the long-term effects of fractured, inconsistent and withheld relationships during childhood in State care. Witness S described residential care as carrying an 'unnatural and cold' quality, with the home itself also functioning as someone's workplace.[169] She described an environment in which youth workers rotated through shifts, could not share personal information, and were constrained from expressing affection in ways that might ordinarily communicate care and belonging. Witness S said that she had been 'raised by policies and procedures and checklists,' with terms and conditions attached to relationships rather than the unconditional protection and care expected of a parent or family member. Further, she gave evidence of feeling unsafe in what should have been her home with unknown people often around.[170]

This evidence illustrates a that shift-based care poses particular difficulties. Residential workers can be caring, skilled and committed. Many children form meaningful relationships with individual workers. But the structure itself makes relational continuity more difficult. Workers

[165] Transcript, Evidence of Witness S (16 February 2026), 4183:40-4183:46.

[166] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 5.
[167] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026).
[168] See case study 1 and case study 5 at Appendix 2 to Executive Report.
[169] Transcript, Evidence of Witness S (16 February 2026), 4125:5-4126:1.
[170] Transcript, Evidence of Witness S (16 February 2026), 4150:29-4150:46.

change, shifts end, agencies change, and professional boundaries can make ordinary expressions of care more complicated. A child can experience adults as present but not enduring, kind but not permanent, responsible but not parental.

This does not mean residential care cannot provide good care. It means that any residential care structure must be intentionally designed to enhance relational continuity to the extent possible. Staffing, rostering, supervision, practice frameworks, therapeutic support and organisational culture must all be oriented toward creating consistent, attuned and reliable relationships. Without that, residential care will continue to provide, generally, the minimal necessary conditions of a safe residential setting but not the qualities which would support children emotionally and nurture them to realise their best potential.

While the inherent limitations of the residential care model must be acknowledged, it does not follow that the residential care model is not capable of material improvement. The essential test is whether the environment presents the young people within it with opportunities to form meaningful and trusted relationships with at least one adult in their lives, and an environment which promotes respect and appropriate boundaries, including between the young people living at the home.

3.2 Placement instability

Placement instability was a recurring theme in the evidence before the Commission. It often arises from inadequate placement matching, insufficient carer support, lack of timely therapeutic or disability intervention, risk-averse decision-making and fragmented service responses.

A significant number of submissions and witnesses described children entering residential care following placement breakdown, particularly where foster carers were unsupported to manage disability, trauma-related behaviours or escalating needs. A former residential care worker told the Commission that they were not provided with sufficient information about a child's complex needs, behaviours or past trauma, despite being the person responsible for the child.[171]

Children experience repeated moves not as administrative adjustments, but as losses. They lose schools, friends, belongings, routines, relationships and a sense of belonging. Witness X described the effect of chronic instability on his friendships and sense of self as an adult. Reflecting on numerous temporary placements and lack of participation in placement decision-

[171] Transcript, Evidence of Witness D (19 September 2025) 1289:47-1290:5, 1295:3-1295:8, 1323:1-1323:4.

making, he said there was 'no point getting emotionally attached to anyone if you're just going to move the next day.'[172] Foster carer Witness H similarly identified that the rapid movement of children between placements without proper consultation failed to account for the time children need to process information where they have already experienced trauma.[173]

Residential care has frequently become the first available placement when other options are unavailable, rather than a planned specialist intervention. This is demonstrated by the significant number of children in residential care who are assessed as ready for family-based care with intensive support.[174] That evidence suggests that, for many children, they have only been placed in residential care because the placement for which they are most suitable is either unavoidable or insufficiently supported.

Education also interacts with placement stability. The Principal Commissioner of the QFCC, Luke Twyford, gave evidence about the overrepresentation of children in OOHC who were excluded from school, and the serious consequences for children in residential care when exclusion affects placement viability.[175] Witness S gave evidence that her access to education was affected by departmental judgements about whether she would attend and whether it was worth funding a school uniform. She also described practical transport difficulties in residential care where multiple children attended different schools and one vehicle had to transport them all.[176] These examples show that residential care stability cannot be separated from education, transport, case planning and the practical organisation of daily life.

3.3 Experiences of Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children remain significantly overrepresented in OOHC in Queensland. As at 31 March 2025, 48.5% of children in OOHC were Aboriginal and/or Torres Strait Islander children.[177] For those children, the quality of non-family based care should also consider the individual child's needs in relation to connection to family, kin, community, culture and Country.

Witnesses highlighted the importance of connection to Country. Witness V from the First Nations Collective in the Department described returning to Country as healing, because of the spiritual

[172] Transcript, Evidence of Witness X (22 September 2025), 1403:3-1403:8, 1416:4-1416:8, 1420:25-1420:34.
[173] Transcript, Evidence of Witness H (8 September 2025), 121:5-121:27.
[174] Department of Families, Seniors, Disability Services and Child Safety, Notice to Produce 392 (2026) (DFS.0392.0002.0001).
[175] Transcript, Evidence of Luke Twyford (25 February 2026), 4768:6-4768:12.
[176] Transcript, Evidence of Witness S (16 February 2026), 4139:33–4140:4.
[177] Department of Families, Seniors, Disability Services and Child Safety, 'Improving care and post care support: Living arrangements of children', *Our Performance* (Web Page, n.d.) <https://performance.dcssds.qld.gov.au/improving-care-and-post-care-support/what-we-do/living-arrangements-of-children>.

connection to place.[178] Goolburri resident also described the healing nature of returning to Country, including connection with kin and the establishment of belonging.[179]

QATSICPP observed that missed opportunities for early referral to ATSICCOs undermined their ability to provide proactive support to families.[180] QATSICPP submitted that ATSICCOs are best placed to support families and uphold cultural safety, but are often excluded from critical decision-making.[181] This was consistent with the evidence of Witness AA, who observed that families often prefer to engage with ATSICCOs because of their positioning outside the Department.[182] Witness Y similarly emphasised the need for earlier engagement with ATSICCOs, given their local knowledge and ability to provide cultural direction, guidance and support.[183]

The Commission also heard evidence that cultural support can be episodic rather than embedded. Witness S, speaking from both her own experience and frontline experience, observed that many Aboriginal and Torres Strait Islander children in residential care experienced multiple placements without ever having a meaningful cultural plan or support to connect with culture.[184] She emphasised that all levels of OOHC should be able to demonstrate how they support cultural connection and continuity, rather than relying only on family contact or paper-based cultural plans.[185]

This evidence points to a fundamental principle. For Aboriginal and Torres Strait Islander children, connection to culture is not an add-on to care. It is part of care. A placement that provides accommodation and supervision but disconnects a child from family, kin, Country and cultural identity cannot be understood as fully safe or developmentally appropriate.

3.4 Disability, mental health and education as care interfaces

The Commission heard evidence that disability, mental health and education are not peripheral to the experience of children in non-family based care. They are central to whether the placement is safe, stable and capable of meeting the child's needs.

[178] Transcript, Evidence of Witness V (24 September 2025), 1779:17-1779:30.
[179] Transcript, Evidence of Trent Adams (25 February 2026), 4657:43-4658:4.
[180] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to call for submissions regarding Far North Queensland (Child Safety Commission of Inquiry* (August 2025).
[181] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to call for submissions regarding Far North Queensland (Child Safety Commission of Inquiry* (August 2025) 4.
[182] Transcript, Evidence of Witness AA (25 September 2025), 1831:44-1832:13.
[183] Transcript, Evidence of Witness Y (10 September 2025), 413:20-413:28.
[184] Transcript, Evidence of Witness S (16 February 2026), 4189; Transcript, Evidence of Witness K on 10 September 2025, 376:45-376:47.
[185] Transcript, Evidence of Witness S (16 February 2026) 4193:29-4193-34.

Well Life Services submitted that children with complex disabilities in care navigate multiple overlapping systems, including child safety, the NDIS, NIISQ, youth justice, housing, education and allied health. Its submission identified a gap in how the child safety system understands and responds to children with complex disabilities, including the risk that escalating behavioural symptoms are misunderstood as behavioural choices rather than unmet disability needs or inaccurate diagnoses.[186]

That evidence is important because children in residential care are often described through their behaviour. The child absconds, assaults, refuses school, self-harms, damages property or does not engage. Those descriptions may be accurate, but they are not sufficient. They do not explain why the behaviour is occurring, what disability or developmental needs may be present, what communication or sensory needs exist, what mental health support is required, or what environmental changes might prevent escalation.

NOFASD Australia made a similar point in relation to FASD. It submitted that FASD is a neurodevelopmental disability caused by prenatal alcohol exposure, that its prevalence among children in OOHC is alarmingly high, and that systemic responses remain inadequate. It also identified that children with FASD are disproportionately represented in Queensland's residential care system, which is frequently ill-equipped to meet their complex neurodevelopmental needs.[187] The broader significance is that a residential care system that is not disability-informed may misinterpret the presentation of children and escalate placement responses when the more appropriate response is assessment, environmental adaptation, behaviour support, clinical input and carer or worker training. As noted above, the failure to test for and collect data concerning the incidence of FASD presents a significant obstacle to meeting the needs of children who suffer from its effects.

Education is another critical interface. The Commission heard evidence about the effect of school exclusion and disengagement on placement stability. It identified consequences including inability to plan support, risk management gaps, missed opportunities for collaboration and difficulty anticipating or responding to emotional distress or behavioural change.[188] This evidence is relevant to non-family based care because school is often one of the few stable, universal settings in a child's life. If schools are not adequately informed, supported and included

[186] Well Life Services, *Submission to Child Safety Commission of Inquiry* (29 October 2025), 2.
[187] National Organisation for Fetal Alcohol Spectrum Disorder Australia, *Submission to Child Safety Commission of Inquiry* (31 October 2025).
[188] Queensland Catholic Education Commission, *Submission to Child Safety Commission of Inquiry* (November 2025).

in planning, education disengagement can contribute to placement stress, isolation, behavioural escalation and poorer long-term outcomes.

Mental health support is similarly central. Children in OOHC have often experienced trauma before and during their time in care and face increased risks of trauma and stress-related difficulties, attachment insecurity, depression and anxiety. Australian practice guidance identifies trauma-informed, culturally safe, strengths-based, child-centred, holistic, collaborative and relationship-focused care as important principles for supporting children's mental health and wellbeing in OOHC.[189] These principles cannot be delivered by residential workers alone without timely access to appropriate clinical advice and services.

The experience of children with disability in OOHC is particularly concerning. Australian research synthesised by AIFS and Emerging Minds indicates that children with disability are overrepresented in OOHC, that disability data is incomplete, and that children with disability are more likely to be placed in residential care, experience placement instability or breakdown, and face long-term challenges including transition from care and justice system contact.[190] It also identifies barriers to timely physical and mental health assessment, disability screening, NDIS access and coordination of services for children in OOHC.[191]

The functional point is that residential care should not be the place where other systems' failures are merely managed. It should be a care environment supported by those systems. Children with disability, mental health needs or education disengagement require shared planning, information sharing, assessment and intervention across child safety, health, mental health, disability, education, allied health and, where relevant, youth justice. Without that shared responsibility, the residential care home becomes the site of escalation, but not necessarily the site of effective response.

3.5 Workforce instability and care quality

Workforce instability affects the daily experience of children in non-family based care. Former PeakCare CEO Tom Allsop gave evidence that high staff turnover often occurs in residential care

[189] Emerging Minds and Australian Institute of Family Studies, 'Practice principles for supporting the mental health and wellbeing of children in out-of-home care', *Resources* (Web Page, March 2024) <https://emergingminds.com.au/resources/practice-principles-for-supporting-the-mental-health-and-wellbeing-of-children-in-out-of-home-care/>.
[190] Emerging Minds and Australian Institute of Family Studies, 'Supporting children with disability in out-of-home-care (OOHC),' *Resources* (Web Page, March 2024) <https://emergingminds.com.au/resources/supporting-children-with-disability-in-out-of-home-care-oohc/>.
[191] Emerging Minds and Australian Institute of Family Studies, 'Supporting children with disability in out-of-home-care (OOHC),' *Resources* (Web Page, March 2024) <https://emergingminds.com.au/resources/supporting-children-with-disability-in-out-of-home-care-oohc/>.

homes funded through structures that require casualisation.[192] Witness S described the effect of waking up to unknown agency youth workers in her residential care home, and the difficulty of distinguishing genuine care from professional role performance in a system where adults changed frequently.[193]

These workforce dynamics affect relational continuity, communication and therapeutic integrity. Children who have experienced trauma need predictable adults and consistent responses. Where residential care relies heavily on casual, agency or rotating staff, the structure itself works against those needs. These workforce dynamics directly affect care quality.

The Commission heard evidence of variability in quality across residential care settings. Some placements were described as stable, attuned and supportive. Others were described as procedural, reactive, inconsistent or unsafe. Differences in workforce experience, training, staffing models, supervision, organisational culture and access to specialist support contributed to markedly different care environments for children with similar levels of need.

This variability suggests that Queensland does not yet consistently guarantee a baseline level of quality across residential care. Children's experience of care can depend too much on provider capability, local leadership, workforce stability, regional availability and the particular adults on shift. A system that relies on residential care at scale must be able to guarantee more than physical placement. It must guarantee a minimum standard of relational, therapeutic, cultural and developmental care.

Creating stability within residential care

The Commission heard evidence of the innovative approaches of some providers to supporting relational continuity within residential care. Residential care provider, Miya Services provides an example of this by intentionally implementing longer shifts for workers to minimise transient connections and instability for young people in residential care (typically 24-hour shifts or extended 12–16-hour shifts with appropriate breaks and safe overlap periods).

This approach reduces the number of daily transitions, establishing consistent staff presence, stronger relational continuity, and more effective trauma-informed

[192] Transcript, Evidence of Tom Allsop (15 September 2025), 720:24-720:27.
[193] Transcript, Evidence of Witness S (16 February 2026), 4125:16-4125:36.

supports. Longer shifts allow workers to maintain routines, apply consistent de-escalation strategies, and build secure attachments with the young people in care.

3.6 Boundaries, restrictive practices and ordinary care

The Commission heard evidence of uncertainty about restrictive practices, behaviour support and ordinary care boundaries in residential care. This uncertainty affects children, workers and providers.

Children in care need rights protection and freedom from unnecessary restriction. They also need predictable routines, consistent boundaries and adults who are confident to provide care exercising the range of strategies as would a reasonable natural parent. The evidence suggests that the current ambiguity creates risk in both directions. Children may be exposed to inappropriate restrictions, informal containment or inconsistent responses that are not properly authorised or reviewed. Equally, carers and residential workers may avoid ordinary and developmentally appropriate boundaries because they fear that doing so will be treated as a breach of rights, a standards issue or a professional risk.

The Commission heard examples relating to mobile phones, bedtimes, leaving the home at night, preventing exploitation risk, physical intervention in emergencies and everyday consequences for behaviour. These were described as matters requiring case-by-case negotiation, rather than being governed by clear principles.[194] This creates inconsistency for children and uncertainty for workers. It may also undermine safety, because children who have experienced trauma often need predictable routines and consistent responses from adults.

A former residential care worker described uncertainty about when physical intervention was permitted, including in ordinary risk situations. She also described caring for a young person who regularly left the residential care home at night, sometimes entering vehicles with older men, in circumstances where the worker suspected drug use or sexual exploitation. The worker described being largely limited to recording observations, taking details, making incident reports to the Department and contacting police only in certain circumstances.[195]

This evidence demonstrates the need for a clear, rights-based framework that distinguishes ordinary care and parenting boundaries from behaviour support, restrictive practices, emergency intervention, environmental restriction and deprivation of liberty. The objective is not to authorise

[194] Transcript, Evidence of Elizabeth Colahan (19 September 2025), 1364:24-1364:33.
[195] Transcript, Evidence of Witness D (19 September 2025) 1285:28-1292:8.

unnecessary restriction. It is to ensure that children experience care that is safe, lawful, consistent and developmentally appropriate, and that adults understand what they can and must do to keep children safe; and enforce healthy boundaries.

The Commission considers that practical guidance lies not in specified prescriptions or proscriptions. Given the myriad circumstances that arise, often requiring immediate response, prescriptive and proscriptive procedures are unlikely to be workable. Rather, the Commission considers that the better solution is to borrow from the methodology of the common law – that is, set a principle, or standard, by which conduct is to be assessed. Such a standard leaves it to the notional jury to decide whether the conduct meets the standard. In the context of relevant conduct by a carer in the residential care sector, a kinship carer or a foster carer, the Commission posits the following standard: 'A carer shall act towards all children in his or her care, as would a reasonable parent towards his or her own children.' The Commission recommends that test be adopted as the generally applicable standard, and that any specific practice specifications, both prescriptive and proscriptive in nature, be subject to that overriding test. Any specifications should be framed to give expression to that principle and any assessment of whether a carer has failed to comply with a specific requirement should be assessed against that standard.

Violence in residential care and the impact on workers

The evidence before the Commission has focused, rightly, on the harm experienced by children in residential care. That analysis should also acknowledge the impact on workers. The two are connected. Residential care houses are both homes and workplaces. When children with complex trauma, behavioural, emotional, mental health or substance use needs are placed in settings that lack stable, skilled and well-supported therapeutic care, the risk of work-related violence and aggression increases. This is not to blame children. It recognises that the system can place children and workers in conditions that are unsafe for both.

Submissions to the Commission described residential care workers experiencing violence and aggression directly and as witnesses, including incidents escalating to physical assaults. PeakCare submitted that this can cause physical, psychological and emotional harm, contributing to absenteeism, high turnover and WorkCover claims.[196] OzChild cited WorkSafe Queensland data showing a 93 per cent increase in work-related violence and aggression claims in the residential care service sector over the 5 years to 31 January 2021, with 25% of claimants not returning to work in the sector.[197] Worker safety is therefore not

[196] PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 100.
[197] OzChild, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 8.

> a separate workforce issue. A stable, trained and supported workforce is part of child safety, because children cannot receive consistent, therapeutic care from workers who are injured, exhausted or unsafe.

3.7 What Effective Non-Family Based Care Looks Like

The central task for Queensland is not to eliminate non-family based care entirely. It is to define its proper role within a coherent OOHC system that is clearly balanced in favour of family-based care. Non-family based care should be used where it has a clear purpose that cannot be met in a family-based setting at that time.

Effective non-family based care requires five core features.

First, it must be purposeful. Each placement type should have a defined role within the OOHC care system. Residential care should operate as a specialist therapeutic intervention, not as a default response to placement scarcity. Supported independent living should be a supported developmental pathway to adulthood, not merely accommodation for older children. Safe Houses should be culturally grounded, community-based responses designed to reduce dislocation and support assessment and stabilisation close to home.

Second, it must be relational. Children need dependable adults, predictable routines and consistent care. A shift-based model does not remove the need for enduring relationships. Residential workers, clinicians, teachers, caseworkers, cultural advisors and family members must be organised around the child in a way that creates continuity rather than fragmentation.

Third, it must be therapeutic in a broad nurturing sense. Children entering residential care have often experienced trauma, instability, disrupted attachments and unmet health, disability or mental health needs. Variation in residential care practice is appropriate. Variation in minimum therapeutic quality is not.

Fourth, it must be culturally appropriate. For Aboriginal and Torres Strait Islander children, therapeutic quality cannot be separated from culture, kin, Country and community. Cultural support cannot be episodic or paper-based. It must be built into placement decisions, provider capability, daily care, family contact, case planning, review and quality assurance.

Fifth, it must be connected to a pathway. Non-family based care should not become a static destination. It should support movement toward reunification, family-based care, specialist care, permanency, step-down support and adulthood. That requires planning from the point of entry, multidisciplinary support, regular review and clear accountability for progression. Pathway

planning must be active rather than aspirational. It is not sufficient for a case plan to record that a child should eventually return home, move to kin, enter family-based care, transition to Supported Independent Living or prepare for adulthood. The system must identify the practical steps, supports, services, relationships and decisions required to make that pathway real. This includes family work where reunification remains possible, active kin finding and cultural consultation, therapeutic support to stabilise behaviour, disability and mental health assessment, education re-engagement, support to prospective carers, and step-down planning before a placement becomes entrenched. A pathway is only meaningful if someone owns it, reviews it and is accountable for progressing it.

In short, effective non-family based care is not defined only by the physical setting in which a child lives. It is defined by whether the child is safe, known, connected, supported, culturally grounded and moving toward a more stable future.

3.8 Repositioning residential care within the care system

Residential care occupies a legitimate place within a well-designed OOHC system. However, international evidence shows that its role must be intentionally limited, clearly defined and tightly governed.[198] It is not a substitute for family life, nor a default placement based on complexity or bed availability. Its value depends on being tied to therapeutic purpose, quality, and progression toward a better long-term arrangement.

For the future care system to function coherently, residential care must be quantitatively differentiated. It must be differentiated because children in residential care do not all have the same needs. Some require short-term stabilisation. Some require intensive therapeutic intervention. Some require a sibling placement. Some require disability-informed support. Some require culturally grounded care close to kin and Country. Some older children require support toward adulthood.

It must also be disciplined. Its use must be tied to a defined purpose, not bed availability, administrative urgency or market supply. A residential care placement should begin with a clear rationale: why this setting, why now, what is the therapeutic purpose, what is the child's pathway, and how will the system know whether the placement is helping?

[198] James K Whittaker, Jorge F Del Valle and Lisa Holmes, *Therapeutic Residential Care for Children: Developing Evidence-Based International Practice* (Jessica Kingsley Publishers, 2016).

A clearer system of care would allow the system to provide intensive therapeutic support where needed, offer lighter-touch or family-based care when appropriate, and reduce reliance on inappropriate one-size-fits-all placements.[199] It would also support better placement matching, improved stability, stronger workforce practice and more innovation.[200]

3.9 Minimum therapeutic quality

Residential care in Queensland should be differentiated by purpose and cohort, but consistent in minimum therapeutic quality. The Commission does not consider that all residential care homes should look the same. Differentiation is necessary. Yet differentiation should not permit ambiguity about the minimum quality of care.

Children placed in residential care have almost invariably experienced significant trauma, instability and relational disruption. The Inquiry was told that children in residential care have 'almost universally experienced significant complex trauma,' with profound implications for how the care system must be designed.[201] They usefully analogised complex childhood trauma with a visible injury such as a broken leg. When a child presents with a broken leg, the injury is visible, protocols exist, trained practitioners respond, and progress can be measured. In childhood trauma, the wound is invisible but no less real or damaging.[202]

Any residential care model that is not explicitly designed to respond to trauma, neurodevelopmental difference and relational instability will struggle to provide safety, healing or progress. Residential care should not be therapeutic simply because a provider describes it as trauma-informed. The system should define the core features that must be present in every residential care setting and should embed those features in contracts, licensing, monitoring and workforce requirements.

Therapeutic residential care has been described as intentional, relationally delivered care that promotes healing in children who have experienced complex trauma.[203] The intentional component requires care to be planned, rigorous and consistent across staff and the authorising organisation. The relational component recognises that healing occurs through sustained, safe and attuned relationships between the child and trained care workers. The healing component

[199] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 35.
[200] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 36.
[201] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026).
[202] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 4.
[203] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 6.

recognises that repeated experiences of developmentally appropriate care can support recovery from the neurobiological effects of trauma.[204]

At a minimum, residential care should include:

- a clearly articulated therapeutic framework;
- whole-of-organisation alignment to that framework;
- clearly articulated, evidence-based practice policies and procedures;
- trained, supported and supervised staff;
- stable rostering and continuity of relationships;
- regular reflective practice and clinical consultation;
- active cultural continuity;
- children's participation in decisions affecting them;
- integrated health, disability and education support; and
- routine measurement of child wellbeing, placement stability, incidents, missing-from-care episodes, justice contact and progress toward case plan goals.[205]

These requirements should not operate as a rigid script and extend well beyond the Department's current reliance on episodic Hope and Healing training for staff employed by licenced care providers. Residential care must be responsive to local context, culture, cohort and individual need. A therapeutic baseline is essential, without which Queensland will continue to have a residential care system in which quality depends too heavily on provider capability, local leadership, workforce stability and regional availability.

3.10 Therapeutic care models and lessons from other jurisdictions

Other jurisdictions provide useful lessons, although no model should be imported without attention to Queensland's geography, demography, workforce and cultural context. The common lesson is that therapeutic intent must be embedded structurally, not left to provider discretion.

International models emphasise the professionalisation of the residential care workforce. In Aotearoa New Zealand, Oranga Tamariki reforms have emphasised trusted, competent and confident professionals and multidisciplinary care in residential settings.[206] In Finland,

[204] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 6.
[205] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 7-11; Centre for Excellence in Therapeutic Care, *The 10 Essential Elements of Intensive Therapeutic Care in NSW* (Report, 2019) 9, 14, 15, 17.
[206] Oranga Tamariki, *Strategic Intentions 2024/25–2029/30* (Report, 2024); The Honourable Kelvin Davis Minister for Children, *Review of provision of care in Oranga Tamariki residences: Report of the Ministerial Advisory Board* (Letter, 14 February 2022); Oranga Tamariki, *Health Models of Care in Residences and Secure Facilities* (Evidence Scan, September 2025).

residential care is a professionalised field, with youth counsellors often holding university degrees in social services or health care.[207] In Scotland, residential care operates within a regulatory and practice framework emphasising relational care, the engagement of children and young people in decision-making affecting their care, and a safe and supported workforce.[208]

The Mulberry Bush School in Oxfordshire, England, provides a specialist therapeutic residential and education model for children aged 5 to 13 with trauma and significant social, emotional and mental health needs. It operates as a therapeutic community, with individualised therapeutic care, treatment and education plans overseen by a multidisciplinary treatment team. Its model emphasises structured routines, reflective practice, resilient and non-punitive relationships, and a carefully designed environment.[209] It is not a direct blueprint for Queensland, particularly given the age of the cohort, but it illustrates what it means to design a setting around therapeutic purpose rather than merely accommodation.

In New South Wales, the Therapeutic Care Framework applies to OOHC placements, including residential care. The framework establishes mandatory practice principles grounded in trauma theory, attachment and child development, and requires providers to demonstrate organisational alignment with therapeutic objectives, workforce capability and reflective practice.[210] This demonstrates that therapeutic care can be framed as a system-wide requirement rather than an optional provider model.

The economic case for therapeutic residential care is also relevant. A submission drew attention to evidence that therapeutic residential care may cost more upfront but can generate measurable avoided costs.[211] In a Victorian pilot evaluation, therapeutic residential care was funded at an additional $65,000 per child per year above standard residential care costs. The evaluation identified $44,243 in quantifiable avoided costs per child per year, drawn from reduced police, hospital and secure welfare costs, before longer-term benefits were counted.[212] The same

[207] Sigrid James et al, 'A Comparative Analysis of Residential Care: A Five-Country Multiple Case-Design Study' (2021) 51 *Journal of Research and Practice in Children's Services*.
[208] Independent Care Review, *The Promise* (Report, 2020) 30, 91, 100.
[209] Leslie M Gutman et al, 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409, 409–421; David Colley, Rebecca Seymour and Nicoleta Gaciu, 'The Mulberry Bush Nurturing Schools project: Evaluating the impact of investment in whole-school nurturing practices' (2024) *The International Journal of Nurture in Education* 76–98; Helen Price et al. '"A Bit Like You're Going to therapy": Reflective Practice Provision at the Mulberry Bush School' (2023) 40(4) *Residential Treatment for Children & Youth* 517, 517–536.
[210] NSW Department of Communities and Justice, *NSW Therapeutic Care Framework: A framework that guides service provision and works towards improving outcomes for children and young people in statutory Out of Home Care (OOHC)* (Framework, March 2017); Verso Consulting Pty Ltd, *Therapeutic Residential Care System Development: Evidence Guide* (Report, June 2016).
[211] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 14.
[212] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 14; Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary & Technical Report* (Report, 4 November 2011).

evaluation found substantially better wellbeing changes in the therapeutic residential care cohort than the standard residential care cohort.[213]

The Commission's interest in this evidence extends beyond cost. It shows that good residential care should be judged by outcomes for children, not only by daily cost or placement availability. A more expensive model may be better value if it improves safety, stability, wellbeing and life trajectories. A cheaper or more available placement may be poor value if it contributes to instability, police involvement, hospitalisation, educational disengagement or later adult harm.

3.11 Quality of care

Quality of care in non-family based settings must be defined against relational, cultural, therapeutic and developmental benchmarks grounded in evidence and children's experience. Queensland's current quality architecture is weighted too heavily toward structural inputs and compliance, and not sufficiently toward the lived experience and developmental outcomes of children. Witness S described a system in which successful parenting was measured through numerical indicators, such as the number of children in long-term placements, rather than by a deeper understanding of children's lived experience.[214]

Relational continuity should be a core quality indicator. Stability of staffing, placement duration, consistent adults, reduction in missing-from-care episodes, school engagement, and access to trusted relationships should not be treated as incidental outcomes. They should be primary measures of quality. Research consistently shows that positive, safe and trusting relationships are essential to wellbeing in residential care.[215] Trauma-informed practice and attachment theory similarly identify consistent, attuned caregiving relationships as central to emotional regulation and recovery.[216]

Quality assessment is incomplete if it does not measure whether Aboriginal and Torres Strait Islander children are connected to family, kin, community, culture and Country, to the extent it is safe and feasible, in a meaningful and sustained way.

Workforce stability must also be integrated into quality assessment. Consistent staffing and rostering facilitate predictable routines and trauma-informed practice.[217] A residential care

[213] *Submission from Blue Skies Independent Consulting to Child Safety Commission of Inquiry* (March 2026) 14.
[214] Transcript, Evidence of Witness S (16 February 2026), 4136:15-4136:18.
[215] Australian Institute of Family Studies, *Therapeutic residential care services in Australia: A description of current service characteristics* (Policy paper, 2019) 4.
[216] Australian Institute of Family Studies, *Therapeutic residential care services in Australia: A description of current service characteristics* (Policy paper, 2019).
[217] Centre for Excellence in Therapeutic Care, *The 10 Essential Elements of Intensive Therapeutic Care in NSW* (Report, 2019) 9.

service cannot provide relational care if children are repeatedly cared for by unknown adults, or by staff without adequate training, experience and supervision.

Children's voice and participation should be another quality measure. Children and young people in residential care should participate in decisions affecting their lives, including entry to the placement, care and treatment planning, exit planning and post-exit support.[218] The Commission heard from young people that environments where they felt heard, respected and involved in decisions were safer and less conflictual. Conversely, placements where young people felt excluded could become more adversarial.

Quality of care must therefore be measured by more than compliance. It should include whether the child feels safe, has trusted adults, remains connected to family and culture, attends school, receives health and disability support, participates in decisions, experiences stable routines, and is progressing toward a clear pathway.

4. Implications for Reform – and of Maintaining the Status Quo

A central implication of the evidence before the Commission is that reform of the OOHC system will take time. Even with significant investment in family-based care, the availability of foster and kinship carers is unlikely to increase in the short-term at the scale or pace required to meet current demand. Carer recruitment and approval processes are lengthy, and the broader workforce and social conditions shaping family capacity are not easily reversed.

The evidence in this Report suggests that reform cannot proceed with the assumption that the preferred care options will always be available when they are needed. In that context, the system cannot proceed with the assumption that non-family based care will remain short-term, exceptional or marginal. The question for the Commission is therefore not whether non-family based care should exist, but what standards, purposes and safeguards must apply when it is providing care for children for longer than intended because the preferred alternatives are unavailable.

Recognising the need for a whole-of-system approach does not diminish the importance of residential care reform. On the contrary, it sharpens it. If family-based care cannot be rebuilt at the scale and pace required in the short to medium term, then residential care will continue to

[218] Centre for Excellence in Therapeutic Care, *The 10 Essential Elements of Intensive Therapeutic Care in NSW* (Report, 2019) 11, 17.

carry a significant proportion of the system's responsibility for children who cannot safely live with their families.

For that reason, reform must proceed in parallel. While the system works to strengthen family-based care over time, it must also clearly define the role, purpose and minimum expectations of residential care as it exists now and is likely to operate for some years to come. Residential care cannot be treated as a temporary exception while it functions as a core component of the OOHC system.

In this context, the Commission considers that reform must focus not only on shifting the balance between care types, but on redesigning OOHC as a coherent system. This requires clarity about the two overarching care categories, family and non-family based care, and about the purpose of the different care types that sit beneath them.

More importantly, it requires the articulation of shared principles of care that apply wherever children live. Whether a child is placed in a foster home, kinship care, residential care, supported living accommodation or a culturally governed community setting, the Department's obligations do not change. The question is not simply where children are placed, but whether the care they receive is relationally stable, developmentally and culturally appropriate and oriented toward a clear pathway forward.

4.1 Benefits of reform

The principal benefit of reform is that, if implemented, children are more likely to receive care matched to their needs, rather than care determined by system scarcity. A clearer care system would allow residential care to be used where it has a genuine therapeutic purpose, Supported Independent Living to be used as a structured transition pathway, and Safe Houses to operate as culturally grounded local responses, with each care type governed by a clear purpose rather than by availability alone.

A rebalanced system would also reduce the likelihood that children enter residential care because family-based placements have failed without sufficient support. Strengthening family-based care, building step-down pathways and improving placement matching would reduce unnecessary reliance on residential care over time and help reserve more intensive settings for children who require them.

Importantly, a stronger pathway-out model would also reduce the time children spend in residential care after it has ceased to be the preferred or necessary care arrangement. It would

also ensure that time spent in residential care is purposeful, reviewed and actively governed, rather than open-ended. This matters because stability is one of the most influential factors in a child's experience of care. The QFCC has identified that providing resources to meet a child's assessed needs at the point of entry can keep children in stable placements, support family reunification and produce long-term economic benefit. Residential care should therefore be resourced and governed not only to accept children, but to help them move safely to the next stable arrangement.[219]

Embedding a minimum therapeutic baseline would improve consistency in the quality of care. Children would be more likely to experience predictable adults, purposeful routines, therapeutic support, cultural safety, education engagement, disability and mental health responses, and participation in decisions affecting their lives. This type of reform would also improve system accountability. If residential care has defined entry criteria, therapeutic purpose and exit pathways, the system can better assess whether each placement is achieving what it was intended to achieve, regardless of how long a child remains in that setting. This would support better decision-making, better commissioning and stronger oversight.

Finally, reform has the potential to reduce long-term cost and harm. Residential care is expensive, but poor residential care is more expensive still when it contributes to placement instability, disengagement from education, police contact, youth justice involvement, self-harm, exploitation, homelessness and poor adult outcomes. The QFCC has identified placement stability as one of the most influential factors in a child's experience of care.[220] Improving stability is therefore both a child-centred and system-wide reform priority.

4.2 Risks of maintaining the status quo

The central risk of maintaining the current trajectory is that residential care will continue to expand as the system's default response to instability elsewhere. If family-based care remains under-supported, if disability and mental health needs remain unmet, and if placement decisions continue to be shaped by availability, residential care will continue to absorb the consequences. This results in children entering residential care because there is no immediate alternative but then remaining there for extended periods because the system has not built the pathway out. Over time, a temporary response can become the child's lived childhood. This is especially

[219] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, August 2025) 36-37.
[220] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, August 2025) 36.

concerning where a child has already been assessed as ready for family-based care with intensive supports, but the care arrangement does not exist. In those cases, the system is not only overusing residential care, but also failing to provide the care arrangement it has itself identified as better suited to the child.

A second risk is that without reform, children will continue to experience non-family based care as impersonal, unstable or unsafe. Children who have already experienced trauma and disrupted attachments may be placed in environments characterised by rotating staff, inconsistent boundaries, weak therapeutic planning and insufficient cultural connection. That risks compounding the very harms the system is intended to address.

A third risk is cultural harm. If Aboriginal and Torres Strait Islander children are placed away from Country, kin and community because no appropriate local option exists, the system may preserve immediate placement availability while undermining identity, belonging and connection.

A fourth risk is that Queensland will continue to pay for intensity without necessarily purchasing quality. Without a defined therapeutic baseline and outcome measurement, increased expenditure may buy more placement nights without ensuring that children are safer, more stable or better supported, undermining both child outcomes and public confidence in the system.

A fifth risk is drift toward more restrictive responses. Where open residential care cannot safely support a child, and no therapeutic secure care framework exists, the system may rely on informal restrictions, police intervention, youth justice settings or crisis relocation. Conversely, if secure care is introduced without strict safeguards, it could become an overused containment option. Both risks point to the need for clear law, clear practice standards and strong oversight.

The evidence before the Commission points to a clear reform direction. Queensland needs to redesign the role of non-family based care within the broader OOHC system. This redesign should be guided by seven principles.

First, residential care should be deliberately constrained in scale and purpose. It should be used as a specialist intervention for defined cohorts, with clear entry criteria, therapeutic purpose, review points and exit pathways. It should not grow simply because other parts of the system are under strain.

Second, all residential care should meet a mandated minimum therapeutic baseline. Variation in model is appropriate. Variation below minimum quality standards is not. The baseline should

address therapeutic practice, workforce capability, reflective supervision, cultural safety, child participation, integrated supports and outcome monitoring.

Third, every residential care placement should have an entry rationale, therapeutic purpose, review point and exit trajectory. The exit trajectory should identify the preferred next arrangement, the barriers to achieving it, the supports required, the person or entity responsible for progressing it, and the escalation pathway if progress stalls. For children assessed as ready for family-based care with intensive supports, the system should identify why that care arrangement is unavailable, what is being done to secure or develop it, how long the child has remained in residential care for want of that alternative and how it will effectively support the needs of the child until the preferred care arrangement can become available.

Fourth, Queensland should develop and scale evidence-informed intermediate models that can operate as pathways out of, or alternatives to, residential care. These may include specialist family-based care, treatment foster care, intensive foster and kinship support, therapeutic respite, step-down placements, culturally governed kinship and community care, and supported transition models for older young people. The purpose is to build the missing middle of the care system, so that residential care is no longer the only option between unsupported family-based care and high-cost residential placement.

Fifth, Supported Independent Living and Safe Houses should be clarified as distinct functions within the care system. Supported Independent Living should be governed as a staged transition model for older young people, with clear readiness criteria, disability-informed matching, housing pathways, continuity of relationships, life skills development and support beyond the eighteenth birthday. Safe Houses should be governed as culturally grounded, community-based responses for Aboriginal and Torres Strait Islander children, with clear cultural authority, integration with ATSICCOs, active efforts to identify kin and community care options, and defined pathways home, to kin or to another culturally safe arrangement.

Sixth, the system should address the gap for the specific cohort of children whose risks cannot safely be managed in existing open settings. Therapeutic secure care is required, but only as a tightly defined, time-limited, judicially authorised and independently overseen response. It should be designed as therapeutic stabilisation with step-down planning, not as detention by another name or a system-wide safety net.

Seventh, Queensland should establish a clear framework for restrictive practices and ordinary care boundaries across OOHC. Carers and workers need to know what ordinary parenting and

care decisions are permitted, what constitutes a restrictive practice, when emergency action is authorised, and what safeguards apply. Without clarity, children experience inconsistency, workers act with uncertainty, and providers negotiate basic care boundaries case by case.

The reform task is therefore not merely to improve residential care. It is to build a coherent OOHC system in which non-family based care is purposeful, therapeutic, rights-respecting and connected to a pathway out, and in which shared principles of care apply wherever children live.

The evidence before the Commission does not support a binary choice between family-based and non-family based care. It supports a more difficult conclusion: that while Queensland works to rebuild family based care over time, it must also take responsibility for the quality, purpose and integrity of the care it is currently providing. Children cannot be asked to wait for system reform. Where non-family based-care is required, it must be good enough to hold them safely, relationally and developmentally, for as long as that care is needed.

5. Recommendations

<table>
<tr><th colspan="2">Recommendation 25: Revise model of family-based care</th></tr>
<tr><th>Executive Report (Chapter 7)</th><th>Companion Report 3 (Chapter 1)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within 12 months of Government's response to this Report, design and commence the implementation of a revised approach to family-based care organised around children's needs, relationships and developmental interests, rather than around placement type.

The model should:

i) recognise family-based care as the primary service delivery infrastructure of the child safety system;

j) begin with the child's relational world, including parents, siblings, kin, carers, cultural connections, community and other significant adults;

k) support safe and appropriate shared caregiving arrangements involving foster carers, kinship carers, parents, siblings, extended family and other trusted adults;

l) provide flexible practical, therapeutic, cultural and financial support matched to the child's needs and the demands placed on the caregiving household or network;

m) include clear arrangements for carer authority, respite, crisis response, health and disability navigation, therapeutic advice, training, professional support and placement stability;

n) enable intensive and specialist family-based arrangements for children who would otherwise enter, remain in, or be unable to step down from non-family-based care;

o) include case-by-case financial arrangements, including enhanced subsidies, stipends, salaried or professionalised caregiving models where required to support the child and sustain the caregiving household; and

p) measure outcomes relating to stability, relational continuity, cultural connection, wellbeing, carer retention, reduced placement breakdown and reduced unnecessary reliance on non-family-based care and linked to guardian KPIs.</td></tr>
<tr><td colspan="2">CONTEXT:

The Commission has heard that family-based care remains the preferred form of care for most children, but current arrangements are often organised around placement categories rather than the child's relationships, needs and developmental trajectory. Existing models do not always provide the level of practical, therapeutic, cultural or financial support required to sustain complex caregiving arrangements in the contemporary environment.

The intended outcome is to establish family-based care as a flexible, supported and structured model capable of meeting a broader range of children's needs and suitable to the current demographic and social context. For children, the expected impact is greater relational continuity, stronger connection to family and culture, fewer placement breakdowns and reduced unnecessary entry into residential or other non-family-based settings. For carers, the expected</td></tr>
</table>

impact is more stable caregiving and carer retention, potentially increased carers and more satisfied carers.

IMPLEMENTATION NOTES:

The Queensland Government should treat this reform as a Tier 1 system reform and assign responsibility for its design, implementation and oversight to the independent implementation and reform assurance taskforce established in response to this Report (see Recommendation 49).

Implementation should include development of:

g) a statewide model of family-based care, including ordinary, enhanced, intensive and specialist family-based arrangements;

h) eligibility and support criteria based on the child's needs and the demands placed on the caregiving household or network;

i) funding models that allow flexible financial support, including stipends or professionalised arrangements where justified;

j) clear pathways for children to step down from non-family-based care into supported family-based arrangements;

k) shared caregiving models that preserve safe and appropriate relationships with parents, kin, siblings and other significant adults; and

l) outcome measures and public reporting on stability, carer retention, relational continuity, cultural connection and reduced reliance on non-family-based care.

Chapter 3

Secure Care

Companion Report 3
Models of Care

Abstract

This chapter considers whether Queensland should establish a therapeutic secure care capability for a small cohort of children and young people whose imminent risk of serious harm cannot safely be managed in other OOHC arrangements. It examines the current gap in the OOHC system and recognises that secure care has a legitimate role as a short-term stabilisation pathway, but only if it is narrowly targeted, therapeutically designed and subject to strong legal safeguards. It recommends a legislated model supported by court authorisation, independent multidisciplinary assessment, strict admission criteria, transition planning, regulation of restrictive practices and independent oversight.

Chapter 3: Secure Care

1. Introduction

Secure care has a legitimate place in a child safety system as a narrow, stabilisation pathway for the cohort of children who represent an immediate and significant safety risk to themselves or others, that cannot be safely managed in other family-based or non-family based care arrangements. Its efficacy depends on clarity of purpose and precision in design. Secure care must be lawful, therapeutic, rights-compliant, independently authorised, independently overseen and connected from the outset to a pathway back to a less restrictive care arrangement.

The need for secure care in Queensland is not new. The Carmody inquiry considered implementing a secure care framework in response to concerns raised during the course of that inquiry about a cohort of children whose needs could not be met by existing placements. The Carmody Report acknowledged that the model would need to be thoroughly researched, planned and well resourced.[221] Carmody provided the following recommendation to the Queensland Government:

> 8.9 if and when the Queensland Government's finances permit, the Department of Communities, Child Safety and Disability Services develop a model for providing therapeutic secure care as a last resort for children who present a significant risk of serious harm to themselves or others. The

[221] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) xxxiii.

> model should include, as a minimum, the requirement that the department apply for an order from the Supreme Court to compel a child to be admitted to the service.[222]

Despite the Queensland Government at the time accepting this recommendation in principle, this recommendation was never implemented.[223]

The current Queensland Government has committed to deliver a Secure Care facility by 2028.[224] This will bring Queensland into alignment with Victoria, New South Wales, the Northern Territory and the Australian Capital Territory. These jurisdictions already admit children to secure care who are a significant risk to themselves or others.

The need for a secure care capability in Queensland became apparent throughout the course of the Commission. The Commission has heard evidence of children whose behaviours cannot currently be safely managed in existing family or non-family based arrangements. Those behaviours include high-risk absconding that exposes children to exploitation by others, serious injury or death; repeated physical violence towards peers, carers or staff; sexual assault of co-tenants; online grooming of younger children; acute suicidal or self-harming behaviour; and offending with serious consequences of community safety leading to youth detention and a pathway to adult incarceration. Many children in this cohort also have complex trauma histories, neurodevelopmental impairment, cognitive disability, chronic substance misuse, severe emotional dysregulation and co-occurring mental health difficulties.[225]

Those characteristics make secure care a high-risk, high-reward reform proposition. The children most likely to be considered for secure care are also among those most vulnerable to harm from containment, isolation, coercion and poorly governed restrictive practices. For that reason, secure care cannot be designed as a placement of convenience, a behaviour management tool, or a response to the absence of suitable placements elsewhere in the system. It must be directed to therapeutic stabilisation where the risk of serious harm to self or others is demonstrable, the need for containment is clearly established, and less restrictive alternatives cannot safely manage the risk to the child or to others. If well designed and implemented, secure care has the potential to greatly enhance the child safety system by providing much needed intervention and therapeutic care delivered in a safe and targeted way. It would also have the benefit of reducing

[222] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) xxxiii.
[223] Queensland Government, *Queensland Government response to the Queensland Child Protection Commission of Inquiry final report* (Report, December 2013) 13.
[224] Queensland Parliament, *Question on Notice No 1*, Education, Arts and Communities Committee, 31 July 2025; Queensland Government, *Budget to help deliver safer children, safer communities* (Media Statement, 24 June 2025).
[225] Office of the Public Guardian, *Submission to Child Safety Commission of* Inquiry (March 2026).

the collateral damage caused by this cohort: preventing further trauma to other children in care, and better protecting carers and the wider community from harm.

Secure care must be clearly distinguished from youth detention. Youth detention is a system response to offending within a youth justice framework. Secure care on the other hand, needs to be a child safety response directed to protection, stabilisation, treatment and safe transition. Secure care should not replicate the logic, culture or operation of youth detention. Secure care should also not be understood as simply a more intensive or environmentally robust form of residential care within the child safety system's OOHC options. Secure care involves active and deliberate deprivation of liberty and therefore requires a distinct legislative basis including a clear threshold for admission, independent authorisation, regular review, restrictive practice safeguards and external oversight.

The Commission's analysis throughout this chapter is subject to a clear central caution. While secure care is necessary for a narrow cohort of children, it must not become the place where the system contains the consequences of its own gaps. If family-based care, non-family based care, as well as broader universal and secondary services such as disability support, mental health services, education, and earlier family support, (including for the over-represented Aboriginal and Torres Strait Islander population) remain underdeveloped, secure care risks becoming the safety net for a system that has not built enough safe and therapeutic alternatives and diversion points.[226]

This chapter does not treat secure care as a stand-alone facility or as an isolated service response. It considers how the Department can establish a lawful and therapeutic pathway for the cohort of children whose immediate risks cannot be managed safely in existing OOHC arrangements. It then examines the safeguards required to prevent that pathway from becoming custodial, overused, or disconnected from pathways back to the broader OOHC continuum and/or transition to adulthood in a safe, supported way.

[226] Transcript, Evidence of Luke Twyford (25 February 2026) 4744:19–4754:29.

2. Understanding The System Gap Secure Care is Intended to Address

2.1 The current gap in Queensland

Queensland does not currently have a dedicated legislative framework that authorises and regulates therapeutic secure care for children in OOHC. The *Child Protection Act 1999* (Qld) provides the statutory framework for child protection in Queensland, but it does not establish a secure care regime.[227] Nor does Queensland currently have a comprehensive legislative framework governing the planned use of restrictive practices for children in OOHC.

This is a fundamental gap that must be remedied because any secure care model necessarily involves containment and restriction of a child's liberty. It may also involve other restrictive practices, including physical restraint, environmental restriction, seclusion, chemical restraint or emergency intervention to prevent harm. The current policy on managing high-risk behaviour recognises that restrictive practices affect a child's rights and freedom of movement, may contribute to trauma, and must not be used as the sole method of managing behaviour.[228] The policy also prohibits certain practices, including containment and seclusion, in care arrangements under section 82(1) of the *Child Protection Act 1999* (Qld).[229] That policy is important, but policy is not a substitute for a comprehensive statutory framework where the State is proposing to authorise a closed therapeutic environment for children.

The present gap therefore has two dimensions. First, there is no clearly authorised therapeutic secure care pathway. Second, there is no comprehensive statutory scheme governing how restrictive practices should be authorised, limited, recorded, reviewed and overseen across OOHC.[230] These gaps are connected. A secure care model cannot be responsibly established unless the legal status of both containment and other restrictive practices is resolved.

The absence of a lawful secure care pathway does not remove the risks presented by this cohort. Rather, those risks are managed through ad hoc, inconsistently implemented arrangements in a system that is not designed or equipped to do so, by persons not suitably qualified or trained. The practical consequences are considered in the next section. For present purposes, the central

[227] *Child Protection Act 1999* (Qld).
[228] Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour* (Policy No 646-2) 1-2.
[229] Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour* (Policy No 646-2) 4-5.
[230] Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Policy: Managing high risk behaviour* (Policy No 646-2) 3-5.

point is that Queensland has children whose circumstances may require a level of immediate safety, therapeutic containment and intensive multidisciplinary support that existing family-based and non-family based care arrangements cannot reliably provide, and whose needs are therefore not being met.

The manifest consequences of the absence of secure care in the current system impacts children who may be repeatedly leaving placements into situations of exploitation or serious harm; children whose behaviour places themselves, peers, carers or workers at serious risk; children whose self-harm or suicidal behaviour cannot be safely managed in family or - non-family based placement; and children cycling between child protection, health, education, police and youth justice responses. Many of this cohort have experienced significant trauma, disrupted attachment, disability, neurodevelopmental vulnerability, cognitive impairment, mental health challenges, substance use, school exclusion, cultural disconnection or exploitation. For these children, the absence of secure care may mean repeated crisis responses without sustained assessment, stabilisation or recovery: see, for example, the case studies of YP, Child A and Witness S[231].; for others, it may mean being subject to containment without suitable oversight in a sole-tenancy residential care placement with rotating youth workers, where the standard response to escalating behaviour is to call the police.

A secure care model, if established must not become a general response to complexity, placement scarcity or behaviour that is simply difficult to manage.

2.2 Current responses to the highest-risk cohort

In the absence of a lawful secure care pathway, the evidence before the Commission suggests that responses to the highest-risk cohort tend to fall into three broad patterns.

The first pattern is informal or poorly governed containment within non-family based care settings. This may occur where a child's behaviour presents serious risk, but workers and providers lack a clear legal framework to manage that risk. Non-family based care is not, and should not be, designed to operate as a 'secure care' environment. Where non-family based care workers (for example in residential care) attempt to prevent a child leaving; restrict access to parts of the facility, service or home; physically intervene; or rely on other forms of restriction without clear legal authority, it risks creating an informal version of secure care without the

[231] The Commission does not suggest that the children the subject of these case studies would definitely have been suitable for or subject to secure care placements had this placement option been available, but that their behaviours and mental health profiles may have resulted in such a placement being considered at certain points in their care trajectory.

safeguards that should attach to it. That is unsafe for children and unfair to the staff expected to manage risk in legally uncertain conditions.

Restrictive practices in the absence of a clear framework

In the opening hearing of the Commission, the Commissioner referred to an example of a support worker pulling a girl back by her hoodie to stop her from jumping in front of a car. The example is simple, but it illustrates a more complex problem.

In non-family based care, workers may be required to respond immediately to serious and imminent risks. In moments of immediate danger or crisis, the line between protective intervention and restrictive practice can become difficult to navigate. A worker may act to prevent serious harm, but still use physical force, restraint or control in a way that engages legal, ethical and practice concerns.

Without a clear legal and practice framework, workers are left to make high-stakes decisions in real time, often without certainty about what is authorised, what must be recorded, what oversight applies, and how the child's rights and safety are to be protected. This creates risk for children, for workers and for the system.

The point is not that urgent protective action should be discouraged. It is that foreseeable situations involving restraint, restriction or physical intervention should not be left to individual judgement alone. A clear framework is needed so that any restrictive practice is lawful, necessary, proportionate, time-limited, documented and subject to review.

The evidence of Corinne Porta illustrates this problem. When questioned about high-risk behaviours and whether children in residential care could be contained, Ms Porta accepted that Queensland does not have the legislative framework to authorise restrictive practices such as physical or environmental restraint. She also explained the practical difficulty faced by workers where a young person uses violence or demands to leave a property: youth workers may open the door, despite the risk.[232] This evidence captures the operational dilemma. The child may be unsafe if permitted to leave, but the workers may lack lawful authority, training, clinical support or a clear framework to deescalate the situation, safely contain the child and prevent harm.

The second pattern is repeated placement breakdown and cycling between services. Children in this cohort may move between residential placements, emergency arrangements, hospital,

[232] Transcript, Evidence of Corinne Porta (24 November 2025) 2617:7–2618:11.

police involvement and other crisis responses without receiving sustained therapeutic assessment or treatment. This only reinforces instability for the child and is likely to also deepen mistrust of adults and support services, particularly where each move is experienced as rejection, punishment or failure and the child's underlying needs remain unresolved. That mistrust can lead to the child rejecting assistance, assessment or treatment even when offered, leading to a self-perpetuating pattern of hopelessness, addiction, and harm to self and others: see the case study of YP.[233]

Submissions to the Commission provide examples of the systems conditions that contribute to this pattern. Well Life Services described a profound gap in the way the child safety system understands and responds to children with complex disabilities. It identified consequences including unmet needs due to poor coordination between stakeholders, escalating behavioural symptoms being misunderstood as behavioural choices rather than unmet disability needs or inaccurate diagnosis, and lack of engagement with education.[234] It also described children with complex disabilities navigating overlapping systems, including Child Safety, NDIS, NIISQ, education, youth justice, allied health and housing, which do not communicate effectively or share a common view of the child's outcomes.[235] That evidence is relevant because a child whose behaviour is being driven by disability, trauma, communication difficulty, sensory need, mental health distress or exploitation may be moved through placements when the more basic problem is that the system has not understood or responded to the drivers of risk.

The third pattern is potential escalation into youth detention as a de facto containment response. Where a child's risk cannot be managed in family or non-family based care, and where no secure and therapeutic pathway exists, the practical consequence for some (not all) children is homelessness or self-placing, which increases the risk of survival-based offending and/or risk-taking behaviour in community (such as stealing cars and joyriding or drug-taking). This pattern in turn leads to increased police involvement and, often, detention through the youth justice system. Containment via youth detention is not an appropriate substitute for a child safety response. Youth detention is a youth justice intervention. It should not become the de facto 'solution' mechanism thorough which children whose behaviour reflects trauma, disability, exploitation, unmet mental health need or failures in the care continuum are contained due to service delivery gaps.

[233] See case study 2 at Appendix 2 to Executive Report. Note: the Commission is not suggesting that YP is a suitable candidate for secure care (See Transcript, Evidence of Leanne Black (19 February 2026) 4381:12-4381:19).
[234] Well Life Services, *Submission to Child Safety Commission of Inquiry* (29 October 2025) 1–2.
[235] Well Life Services, *Submission to Child Safety Commission of Inquiry* (29 October 2025) 4.

The Honourable Amanda Camm said on 19 May 2025, 388 children aged 10 to 17 in Queensland were serious repeat offenders, and that 111 of these children were subject to a child protection order.[236] QATSICPP also observed that dual-order children experience high levels of school exclusion, disrupted attendance and significant unmet disability and mental health needs, and that behaviours linked to disability, trauma or distress are more likely to attract a justice response than timely therapeutic support.[237] That evidence supports the concern that, for some children, the pathway into youth justice may reflect the system's failure to provide an earlier therapeutic response.

The National Therapeutic Residential Care Alliance made a similar point in different terms. Its submission focused on the experience of children in residential care, the overrepresentation of children in care within youth justice, and the way current system structures and practices can contribute to the criminalisation of trauma rather than its therapeutic resolution.[238] It identified the over-reliance on police assistance and formal justice responses as part of the 'care criminalisation' phenomenon, particularly for children in residential care.[239]

The evidence of Ms Porta also demonstrates the practical need that sits behind this concern. She described the difficulty of supporting children who 'refuse to engage, leave residentials, leave placements, are basically transient,' and accepted that there is a place in the system for a secure care facility where children require intensive therapeutic and clinical support around substance misuse and mental health, provided the response is time-limited and rehabilitative.[240] Her evidence reflects the reality faced by parts of the system: some children are moving through family and non-family based arrangements in circumstances where the available care model cannot keep pace with the level of risk. Leanne Black, Regional Executive Director, South West Region also gave evidence that she had in the course of her career seen cases where there may have been a need for secure care – where the child has significant drug or alcohol issues or significant mental health issues and that secure care should be one of the suite of options available as a placement option.[241]

[236] Queensland Government, The Honourable Amanda Camm, *Queensland's most serious young criminals housed in Labor's broken State care system* (Media Statement, 19 May 2025).
[237] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (5 February 2026) 3.
[238] National Therapeutic Residential Care Alliance, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Youth Justice and Corporate Parenting* (January 2026) 1.
[239] National Therapeutic Residential Care Alliance, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Youth Justice and Corporate Parenting* (January 2026) 30, 20, 29-31.
[240] Transcript, Evidence of Corinne Porta (24 November 2025) 2421:33–2421:45.
[241] Transcript, Evidence of Leanne Black (19 February 2026) 4381:12-4383:28.

The above evidence should not be read as a case for generalised use of secure care. It demonstrates the opposite. The higher the level of risk, the more precise the legal and therapeutic design must be. A child who is repeatedly absconding into exploitation risk, self-harming, behaving violently, or cycling between care and youth justice requires more than containment and restriction. They require a lawful pathway that identifies the source of risk, provides clinical assessment, stabilises the immediate danger, protects rights, and plans from the outset for return to a less restrictive environment.

2.3 Design lessons from other jurisdictions

A number of jurisdictions within Australia and internationally have implemented secure care or equivalent welfare-based containment models. Models of care differ significantly across jurisdictions, however, recurring legal and policy questions arise across jurisdictions including who authorises admission, what threshold must be met, whether a less restrictive alternative must be unavailable, how long the child may be confined, how ongoing placement is reviewed, and what rights the child has to be heard, represented, supported and able to challenge the decision. This section of the report provides a comparative snapshot of key design features based on the experiences of other jurisdictions.

2.3.1 Authorisation pathway

A threshold design question for the Queensland Government is whether admission to secure care should be authorised by a court or through administrative decision-making. New South Wales and the Australian Capital Territory provide examples of judicial authorisation. In New South Wales, admission to Sherwood House occurs through court order, with the application determined in the Supreme Court. In the Australian Capital Territory, recent amendments to the Children and Young People Act 2008 introduced Intensive Therapy Orders, which may be made by the Children's Court and may permit confinement through a confinement direction where that is reasonably necessary as a last resort to prevent harmful conduct and ensure treatment in accordance with a therapy plan.[242]

Victoria, Western Australia and the Northern Territory provide examples of administrative authorisation. In those models, admission is authorised by a government decision-maker relying

[242] *Children and Young People Act 2008* (ACT) ch 16, including provisions relating to Intensive Therapy Orders and confinement directions; *Children and Young People (Intensive Therapy Place) Declaration 2024* (No 1) (ACT); Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences* 550.

on the State's parental responsibility or statutory child protection authority. In Victoria, the Secretary has authority to place a child in secure welfare services in specified circumstances, although the Children's Court also has a role in some interim accommodation contexts.[243] In Western Australia, the Chief Executive Officer of the Department of Communities may authorise secure care for children subject to relevant protection orders, with provision for reconsideration and review.[244] In the Northern Territory, available material indicates that secure care has operated on the basis of the government's guardianship status rather than a dedicated legislative secure care framework.[245]

Given secure care involves deprivation of liberty, judicial authorisation provides a more formal structure for testing evidence, applying a legal threshold, hearing from the child and parties, recording reasons and enabling review. Administrative authorisation may allow a faster operational response, but it places greater weight on internal safeguards and post-decision review. Kate Crowe highlighted a consequence of the use of administrative detention is that children 'in care' in Australia are being deprived of their liberty without legal representation or access to the right to appeal in a court of law.[246] There is very limited information available on secure care in Australia, and one contributing factor is the lack of secure care specific orders through the judicial system means that admissions data is not publicly available through mechanisms such as court annual reports relating to youth justice.[247] Ultimately, Crowe concluded by prohibiting the use of administrative detention and instead favouring judicial orders for all admissions.[248] Carmody also specifically recommended Supreme Court oversight for the secure care process.[249]

In terms of evidence presented to the Commission, the Office of the Public Guardian submitted that any intervention involving confinement of a child in a closed environment should be subject to independent judicial authorisation and review.[250]Evidence from the Aboriginal and Torres

[243] *Children, Youth and Families Act 2005* (Vic) ss 173 and 263–267; Department of Families, Fairness and Housing, 'Secure welfare service placement' *Secure Welfare* (Web Page, 17 July 2020) < <https://www.cpmanual.vic.gov.au/policies-and-procedures/out-home-care/secure-welfare/secure-welfare-service-placement>.
[244] *Children and Community Services Act 2004* (WA) ss 88D–88H.
[245] Territory Families, Housing and Communities, *Safe Care Framework and Model of Care* (Report, 6 April 2020), provided to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2021); Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences*.
[246] Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences* 1.
[247] Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences* 1, 10.
[248] Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences* 14.
[249] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) xxxiii.
[250] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 28.

Straight Islanders Legal Service further stated if secure care were to be implemented, it must be through an application from the Court to align with basic international standards for children's rights.

2.3.2 Duration and review

Secure care is generally presented as a short-term intervention. However, jurisdictions differ significantly in maximum duration, extension processes and review mechanisms. This matters because a secure care intervention that begins as short-term stabilisation may, without strict review, become drift to prolonged containment.

In the Australian Capital Territory, a confinement direction cannot authorise continuous confinement for longer than 14 days, although more than one confinement direction may be issued while an Intensive Therapy Order remains in force.[251] In Victoria and Western Australia, secure care is generally limited to 21 days, with one further period permitted in exceptional circumstances or for exceptional reasons.[252] In New South Wales, available material describes a longer-term model, commonly operating in three-month schedules.[253] In the Northern Territory, available material indicates a three-month minimum stay and no clear maximum duration under a dedicated legislative secure care regime.[254]

The review architecture is as important as the prescriptions on duration. The Australian Capital Territory model requires initial and ongoing review by the Director-General within prescribed timeframes, with shorter review periods where confinement is authorised. Reviews must consider the views of the child or young person, relevant parents or carers, and oversight bodies, including the Public Advocate and, where applicable, designated advocates for Aboriginal and Torres Strait Islander children.[255]

Western Australia provides for internal reconsideration by the Chief Executive Officer and further review by the State Administrative Tribunal, but does not appear to provide for automatic periodic judicial review of every ongoing placement.[256] Victoria provides a combination of statutory duration limits and court or administrative mechanisms, but extension criteria such as

[251] *Children and Young People Act 2008* (ACT) s 577.
[252] Children and Community Services Act 2004 (WA) ss 88D–88F; Children, Youth and Families Act 2005 (Vic) ss 173, 263–267.
[253] Kate Crowe, *Unlocking Doors: Learning from Alternatives to Secure Care in Scotland, The Netherlands, Canada and Hawaii* (Report, 2023); Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences*.
[254] Territory Families, Housing and Communities, Safe Care Framework and Model of Care, 2020; Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences*.
[255] *Children and Young People Act 2008* (ACT) ss 555–558.
[256] *Children and Community Services Act 2004* (WA) ss 88G–88H.

'exceptional circumstances' require careful interpretation and application. The Northern Territory model appears to provide the weakest formal safeguards because of the absence of a dedicated legislative framework governing admission, duration and ongoing review.[257]

The comparative lesson is that duration limits and review rights perform different but related functions. Duration limits prevent secure care from becoming open-ended. Review mechanisms test whether the threshold continues to be met, whether the child is receiving the intervention that justified admission, whether the placement remains necessary, and whether a less restrictive pathway has become available.

2.3.4 Procedural safeguards

Procedural safeguards are especially important because children in secure care may have limited practical ability to advocate for and protect their own interests. Relevant safeguards include legal representation, independent advocacy, child participation, reasons for decision, rights of appeal or review, and access to complaints mechanisms.

International standards are clear that a child deprived of liberty should have prompt access to legal and other appropriate assistance and the right to challenge the legality of that deprivation before a court or other competent, independent and impartial authority.[258]

The Australian Capital Territory model includes several procedural safeguards. The Children's Court must record written reasons when deciding an application for an Intensive Therapy Order, and must explain the meaning and effect of the order as plainly and simply as possible in a way the child, parents and other parties can understand.[259] The legislation also allows applications to amend or revoke an order and requires the Court to consider whether the order is no longer needed, whether a less restrictive way is available, or whether the order is no longer in the child's best interests.[260]

Western Australia provides for reconsideration of secure care decisions and access to State Administrative Tribunal review. A child, parent, carer or other person with a significant interest in the child's wellbeing may seek reconsideration of specified secure care decisions.[261] Written

[257] Territory Families, Housing and Communities, *Safe Care Framework and Model of Care* (Report, 6 April 2020), provided to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2021); Kate Crowe, 'Secure Care in Australia: An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia' (2025) 14(9) *Social Sciences*.
[258] United Nations *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3, Art 37(d).
[259] *Children and Young People Act 2008* (ACT) ss 527, 552.
[260] *Children and Young People Act 2008* (ACT) ss 570–573.
[261] *Children and Community Services Act 2004* (WA) s 88G.

reasons are required where a decision is challenged.[262] Those mechanisms provide review safeguards, although they operate after an administrative decision has been made.

The broader point is that secure care legislation needs to make the child visible in the process. The child should not be treated only as the subject of risk management. The child should be heard, represented, supported and able to challenge the deprivation of liberty. This is particularly important for children with cognitive impairment, disability, trauma histories, communication difficulties or limited family support.

2.3.5 Legislation settling the model

The above comparative material does not identify a single model for Queensland to adopt. It does, however, identify the questions that must be answered before any secure care model is established. As submitted by the Queensland Public Guardian, the Australian Capital Territory 'provides a useful reference point for considering how Queensland might strengthen its response to children with complex needs without expanding reliance on containment-based models.'[263] Those questions should be settled through legislation before infrastructure, commissioning or operational practice determines the model by default. Secure care involves the deprivation of liberty of children in the care of the State. Its safeguards should therefore be built into the legal architecture from the outset, rather than added later through policy or practice.

3. What the Commission has been told

3.1 Acknowledgement of the gap for high-risk children

The evidence before the Commission indicates broad acknowledgement of a gap in Queensland's OOHC system for a cohort of children whose risks cannot safely be managed in existing family-based or non-family based care arrangements. That evidence does not suggest that secure care should be understood or positioned as a regular care option, nor that it should become a routine response to complexity. Rather, it reflects that there are children whose immediate safety, or the safety of others, cannot always be protected within the current range of available OOHC settings.

Witnesses who supported consideration of secure care tended to describe a cohort of children with very high and often overlapping needs. Corinne Porta's evidence, discussed above, identified children who leave residential placements, refuse to engage, move transiently through

[262] *Children and Community Services Act 2004* (WA) s 88G(5).
[263] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 4.

arrangements and require intensive therapeutic and clinical support, including around substance use and mental health.[264] The A/Director General of the Department of Youth Justice and Victim Support also identified a cohort of young people with complex backgrounds and difficulty regulating their behaviour, for whom a more contained therapeutic response may be required.[265] In a September 2025 statement by the then-Director-General of Youth Justice and Victim Support:

> [D]ual order youths with neurodevelopmental issues present a complex cohort for engagement with Youth Justice. Youths who have been found unfit to plead continue to come before the courts for new offences, without suitable forensic and therapeutic supervision options. In Far North Queensland we have experienced the challenge of a very high-risk youth who requires significant forensic supervision to keep them and other members of the community safe, but there is not the framework or the facilities for managing these youths appropriately. This is a challenge for both Youth Justice and Child Safety. A secure care model for youths with cognitive disability involved in the youth justice and child safety systems would be helpful.[266]

Luke Twyford, Principal Commissioner of the QFCC referred to a cohort with heightened and complex behaviours, some driven by trauma backgrounds and some driven by mental health needs, who are a risk to themselves or to others where there is no other viable option to address the risk.[267] Luke Twyford also referred to the current system as having two current responses to these children who are demonstrating unsafe behaviours: (1) let them go and say there is no control or command over them, or (2) impose a restraint that his not legally justified and has no appropriate oversight.[268]

The significance of this evidence is that secure care is being raised because of a real operational and therapeutic gap, not merely as an abstract policy option. However, accepting the existence of a service delivery gap does not resolve the design questions at play. A child's high level of need does not, by itself, justify deprivation of liberty. Nor does the failure of existing placements. The evidence supports the need to pursue a lawful therapeutic secure pathway for the Department, but it also reinforces why such a pathway would need to be tightly confined. The case for secure care is strongest where it is framed as a response to imminent serious risk and the absence of a safe less restrictive alternative. It is weakest where it is framed as a general response to behaviour, placement scarcity or system exhaustion.

[264] Transcript, Evidence of Corinne Porta (24 November 2025) 2421:33-2421:45, 2618:13-2618:33.
[265] Transcript, Evidence of Michael Drane (23 February 2026) 4459:16-4459:20.
[266] Statement of Kate Conners (1 September 2025) [43].
[267] Transcript, Evidence of Luke Twyford (25 February 2026) 4743:31-4744:20.
[268] Transcript, Evidence of Luke Twyford (25 February 2026) 4743:31-4744:20, 4744:28.

3.2 Concern about overuse and system drift

The strongest caution in the evidence was that secure care could drift from an exceptional intervention into a broader system pressure valve. That concern was most clearly expressed by Luke Twyford who warned that secure care should not become 'the ultimate safety net for the whole system.' [269] His evidence was that secure care should be designed for 'the very few,' and only in circumstances where the rest of the system is improving its capacity and quality.[270]

That evidence identifies the principal risk in establishing secure care: the model may begin as a narrow response to exceptional risk, but gradually expand to absorb children whose needs are complex, whose placements are unstable, or for whom services are unavailable. If admission criteria are drafted too broadly, the cohort could grow beyond the children for whom deprivation of liberty can be reasonably justified. Mr Twyford warned that, if inappropriate weight is placed on the general risk associated with complex needs, there is a possibility that many of the children currently in residential care could be drawn toward secure care.[271]

The Commission considers that this is not only a legal threshold issue. It is a system capacity issue. A clear legal test is necessary, but it will not be sufficient if the rest of the OOHC system remains unable to respond to complex need. If therapeutic residential care quality is variable, disability support is delayed, mental health responses are inaccessible, education is not sustained, cultural supports are weak, and specialist family-based options are underdeveloped, secure care may become the placement that absorbs complexity rather than the pathway reserved for exceptional circumstances.

That risk is heightened by the current growth and pressure in residential care. Given Queensland's system is already using residential care as a response to scarcity,[272] it may be vulnerable to using secure care in the same way, particularly where children present with absconding, violence, self-harm or repeated police involvement. The policy challenge for the Queensland Government is therefore to design secure care in a way that resists system drift. That requires more than careful language. It requires a narrow statutory threshold, independent authorisation, time limits, mandatory review, step-down planning, and public accountability for who enters secure care, why they enter, how long they remain, and what happens when they leave.

[269] Transcript, Evidence of Luke Twyford (25 February 2026) 4751:28-4751:29.
[270] Transcript, Evidence of Luke Twyford (25 February 2026) 4745:15-4745:16.
[271] Transcript, Evidence of Luke Twyford (25 February 2026) 4745:37-4746:7.
[272] See Companion Report 4: Understanding and Reforming the Residential Care System.

Mr Twyford's evidence also identified several of those safeguards. He supported any secure care model being time-limited, connected to a step-down model, subject to judicial oversight, and governed by a clear legal test and criteria.[273] Those features are significant because they shift secure care away from being a placement destination and toward being a temporary stabilisation pathway. The underlying question is not whether a child can be contained. It is whether containment is necessary, lawful, therapeutic, time-limited, independently controlled, and directed to a safer less restrictive arrangement.

3.3 Rights, culture and overrepresentation

The evidence before the Commission also emphasises that secure care engages rights of a different order from ordinary placement decision-making. It involves deprivation of liberty, limitations on movement, heightened exposure to restrictive practices and reduced practical capacity for a child to seek help independently. This was supported The Queensland Indigenous Family Violence Legal Service which submitted that secure care must have judicial authorisation.[274]

The Office of the Public Guardian also warned that children in the child safety system are already at increased risk of harmful or risky behaviour and possible interaction with youth justice, and that a secure model drawing from residential or other OOHC placements must be designed with particular caution.[275] Its submission identified the risk that, if secure care does not address the underlying drivers of behaviour, it may create conditions in which more restrictive interventions are viewed as necessary to contain risk, resulting in prolonged containment.[276]

Various submitters raised generalised concerns about Aboriginal and Torres Strait Islander children being subject to secure care.[277] A submission from the Queensland Law Society raises concerns about overrepresentation when referring to how the residential care and secure care models operate in relation to young children and Aboriginal and Torres Strait Islander families.[278]

The Commission has heard that maintaining family connection, kinship systems, and staying on Country are concepts that are of varying levels of importance for many Aboriginal and Torres Strait

[273] Transcript, Evidence of Luke Twyford (25 February 2026) 4754:21-4754:23.
[274] Queensland Indigenous Family Violence Legal Service, *Submission to Child Safety Commission of Inquiry* (23 March 2026) 3.
[275] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 19.
[276] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 20.
[277] Transcript, Evidence of Witness S (16 February 2026) 4164:24-4164:27; Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 19; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (February 2026); Social Vantage Advisory, *Secure Care in Queensland: Evidence, Risks and the Path to a Culturally Led, Child Safe Model* (Evidence paper, March 2026).
[278] Queensland Law Society, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints Systems* (20 September 2025) 2.

Islander children, families and communities. Social Vantage Advisory submitted that any secure care model in Queensland would need to be culturally led, child safe and built with structural safeguards to avoid reproducing existing patterns of harm.[279] QATSICPP's broader evidence to the Commission similarly emphasised that culture, kinship and community connection are central to the wellbeing of Aboriginal and Torres Strait Islander children, and that these cannot be provided by the State alone.[280]

The Commission has therefore been told two things at once. There is a real gap for a cohort of children whose immediate risks cannot safely be managed in existing arrangements. There is also a real risk that secure care, if poorly designed, will become overused, custodial in intent, culturally unsafe or disconnected from the broader continuum. The task for the Queensland Government is to hold both propositions together.

Acknowledging the concerns and anxieties of the various parties, the Commission considers that much can be achieved by a focus on the paramount principle, and an establishment of a proper system of safeguards which allow for advocacy on the child's behalf at critical points, and which build genuine consideration of what it in the best interests of the child into decision-making – including, in respect of Aboriginal and Torres Strait Islander children (and indeed all children), their individual cultural needs. In those circumstances, cultural connection is a factor in the assessment, but not determinative. It must be recognised that secure care inherently entails a degree of interruption to physical access to cultural and family connection outside the facility.

Furthermore, the Commission notes secure care is intended as a short-term stabilisation intervention, not a long-term placement. This is not the type of environment in which a child's primary home, relationships and development environment could be said to be generally promoted. A child whose primary purpose in secure care is detoxification, acute psychiatric intervention or violence de-escalation treatment, is first and foremost, clinical intervention. Cultural considerations, to the extent they are relevant, belong to the transition and step-down phase, not the acute phase. Where a child meets the criteria for entry to secure care, the overriding legal and ethical obligation is safety and therapeutic treatment. To build mandatory cultural governance requirements into admission and placement design introduces competing obligations that may conflict with the primary therapeutic purpose of secure care.

[279] Social Vantage Advisory, *Secure Care in Queensland: Evidence, Risks and the Path to a Culturally Led, Child Safe Model* (Evidence paper, March 2026).
[280] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (February 2026).

4. What effective secure care looks like

The Commission considers that effective secure care must be understood as a legal, therapeutic and practice model, not simply as a robust and contained physical environment. Its purpose should be stabilisation of risk (preferably short-term), intensive assessment and intervention, and safe transition to a less restrictive family or non-family based care arrangement. The measures of success should not be occupancy, bed use or containment. It should be whether the child is stabilised, therapeutically supported, safely transitioned, and less likely to return to the circumstances that led to admission.

The first design requirement for the Queensland Government is lawful authorisation and a clear admission threshold. Admission should require evidence of imminent serious harm to the child or to others, and evidence that no less restrictive alternative can safely manage that risk. Complex need alone should never be enough. Nor should placement scarcity, repeated placement breakdown, behaviour that is difficult to manage, disability-related distress, or the absence of a suitable residential placement. The legal threshold should be framed so that secure care remains a last-resort intervention for exceptional circumstances, rather than a broader response to complexity within the OOHC system.

The second design requirement is independent and judicial authorisation (court order) and review. Because secure care involves deprivation of liberty, the decision to admit a child should not rest only with the Department. Independent judicial authorisation provides a critical and fundamental safeguard because it requires the evidence to be tested against a legal threshold, gives the child access to legal representation and advocacy, and ensures that containment is justified by necessity based on the needs and best interests of the individual child in question rather than operational pressure. However, the Commission respectfully differs from the Carmody inquiry in suggesting that the appropriate court to be given first instance jurisdiction in relation to secure care orders is the Children's Court, rather than the Supreme Court. This jurisdiction should be subject to the usual rights of appeal from decisions of the Children's Court.

The Commission recommends that the Children's Court should determine the duration and any extensions to confinement in secure care. The initial duration should not exceed 21 days, with any extension subject to evaluation against clear criteria. Ongoing review should test whether the threshold continues to be met, whether the child is receiving the therapeutic intervention for which admission was authorised, and whether a less restrictive pathway that could achieve the same objectives for the child is available.

The third design requirement is independent multidisciplinary assessment. Children who may be considered for secure care are highly likely to have multiple and overlapping needs involving trauma, disability, neurodevelopment, cognitive capacity, mental health, substance use, exploitation, education, family relationships and culture. Assessment must therefore go beyond behavioural risk. Independent multidisciplinary assessment should identify what is driving the risk, what supports are required, and what conditions are necessary for safe transition. A child who absconds, self-harms, assaults others or repeatedly disengages may be communicating distress, trauma, disability-related need, fear, exploitation or an absence of meaningful relationships. A secure model that responds only to behaviour will miss the child's needs and best interests.

The fourth design requirement is a therapeutic and child-centred model. Secure care should be designed around stabilisation, assessment, treatment, education, relationships and transition. Research on children's experiences of secure care emphasises that engagement is more likely where staff are flexible, interested in the individual's wellbeing, and responsive to individual circumstances.[281] Children are less likely to engage where care is experienced as punitive, punishment-based or rigid.[282] The daily model in the secure care setting should therefore include structured routines, education, therapeutic activity, clinical support, cultural connection as appropriate, family and kin involvement where safe, and skilled staff able to respond to trauma, disability, distress and escalation.

The fifth design requirement is that secure care must be time-limited and connected to disciplined transition planning from admission. Secure care cannot succeed if the child exits into the same instability that led to admission. The proposed exit pathway should be identified (and visible by the court) at the start, reviewed throughout the placement, and supported by step-down services. That pathway may involve return to family or kin; specialist family-based care; residential care; support to transition to adulthood, disability or mental health supports; or another less restrictive arrangements. The objective is safe exit and sustained stability, not prolonged containment.

The sixth design requirement is independent oversight and public accountability. Any form of closed or contained settings create heightened risk because children have reduced freedom of movement and reduced practical capacity to seek help. Any secure care model should therefore

[281] Graham Walker et al, 'Young people's experiences of secure care: A synthesis of qualitative research' (2025) 177 *Children and Youth Services Review* 9.
[282] Graham Walker et al, 'Young people's experiences of secure care: A synthesis of qualitative research' (2025) 177 *Children and Youth Services Review* 9.

include external oversight, independent advocacy, complaints mechanisms, review of incidents and restrictive practices, and public reporting on admissions, duration, demographics, use of restrictive practices, exits, readmissions and outcomes. Oversight should be capable of identifying not only individual incidents, but also patterns of overuse, drift, cultural harm or poor therapeutic quality. Queensland's existing detention oversight architecture is relevant here. Under the United Nations' Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Australia is required to allow international preventive visits to places of detention and establish domestic preventive monitoring of places where people are deprived of liberty; Queensland has already legislated for access to places of detention and established an Inspector of Detention Services focused on humane treatment, prevention of harm, inspection and transparent reporting.[283]

Overall, these requirements mean that secure care should be designed as a short-term therapeutic pathway with legal safeguards, not as a placement type that simply adds locked capacity to the existing system.

4.1 Restrictive practices

4.1.1 What are restrictive practices – in the secure care setting

Restrictive practices are interventions that limit a child's rights or freedom of movement, usually for the stated purpose of preventing harm to the child or another person. In the secure care context, restrictive practices are not incidental. Containment is inherent in the model. Other restrictive practices may also arise, particularly where children present with serious risk of self-harm, violence, absconding, exploitation, distress or dysregulation. The main forms of restrictive practice include:

- physical restraint: the use of physical force to prevent or restrict the movement of a child, or part of the child's body, for the purpose of managing behaviour that creates actual or imminent risk of harm;

[283] Australia ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) on 21 December 2017. OPCAT requires State parties to accept visits by the United Nations Subcommittee on Prevention of Torture and to establish domestic National Preventive Mechanisms to conduct regular visits to places of detention. Queensland has enacted the *Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Act 2023* (Qld), which facilitates Subcommittee access to places of detention and information, and the *Inspector of Detention Services Act 2022* (Qld), which establishes an Inspector of Detention Services with functions including reviewing detention services, inspecting places of detention and reporting independently and transparently. The Inspector's current statutory remit includes prisons, watch-houses, work camps, community corrections centres and youth detention centres. If secure care involves a place where children are deprived of liberty, its oversight arrangements should be designed consistently with this preventive inspection logic.

- mechanical restraint: the use of a device, material or equipment to restrict movement, usually to prevent injury or manage behaviour;
- chemical restraint: the use of medication for the primary purpose of controlling behaviour, rather than treating a diagnosed medical or psychiatric condition;
- seclusion: confining a child alone in a room or area where the child is unable to leave, or believes they are unable to leave;
- environmental restraint: restricting a child's access to parts of their environment, objects or activities, where that restriction is used to manage behaviour or risk; and
- containment: a form of environmental restraint in which the child is prevented from freely leaving the premises.

When Queensland establishes secure care, the legal framework will need to address containment expressly and determine how other restrictive practices are prohibited, authorised, limited, recorded, reviewed and overseen.

4.1.2 What the Commission has been told

The Commission has been told that restrictive practices present significant legal, physical, psychological and cultural risks for children in care. The Office of the Public Guardian submitted that restrictive practices can adversely affect a child's sense of safety, attachment and relationships, and may escalate distress and behavioural responses rather than resolve them.[284] Those risks are particularly acute for children with disability, neurodivergence, complex trauma histories, cognitive impairment or mental health difficulties, whose behaviour may reflect unmet support needs rather than wilful non-compliance.

The regulatory gap is also significant. The Office of the Public Guardian identified that child protection does not have the same kind of legislative framework for restrictive practices that exists in other settings, including disability and mental health.[285] That gap is material in the secure care context because any secure model necessarily authorises containment and may create circumstances in which other restrictive practices are used. A policy framework is insufficient where the State proposes to authorise a closed environment for children and young people who are among the most vulnerable in the child safety system.

[284] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026).
[285] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026).

The Office of the Public Guardian also raised concern about chemical restraint, including the use of psychotropic medication to manage behaviour without adequate safeguards.[286] This is especially important in a cohort likely to include children with trauma, disability, neurodevelopmental conditions, mental health needs and substance use. Medication may be clinically necessary in some circumstances, but its use to control behaviour requires strict safeguards, clinical justification, review and transparency.

The Office of the Aboriginal and Torres Strait Islander Children's Commissioner has raised similar concerns from a child rights and human rights perspective. It emphasised that authorising restrictive practices attracts strict requirements of necessity, proportionality, oversight and accountability, and that the State must ensure such practices are not normalised or used to compensate for deficiencies in service design, availability or system capacity.[287] It also highlighted the particular risks for Aboriginal and Torres Strait Islander children, children with disability, neurodivergent children and children with complex trauma histories, where restraint or seclusion may deepen distress, undermine trust and reinforce institutional harm.

The Child Death Review Board has also previously identified the need for a clear legal framework if secure care is introduced, including clarity about when and how restrictive practices may be used and how decisions and actions will be monitored with effective oversight.[288] That recommendation remains directly relevant. Secure care cannot be safely established by authorising containment while leaving the broader regulation of restrictive practices unresolved.

4.1.3 Safeguards for restrictive practices

A secure care framework should include a legislated restrictive practices framework. Its purpose should be the reduction and elimination of restrictive practices, not their normalisation. Restrictive practices should be exceptional, justified, time-limited and reviewable. Some practices should be prohibited entirely because they are punitive, degrading, unsafe or inconsistent with the rights and wellbeing of children.

At a minimum, the framework should include the following safeguards.

- There must be a clear legislative basis. The legislation should define each restrictive practice, identify prohibited practices, specify who may authorise use, and prescribe the conditions under which a restrictive practice may be used. It should make clear that

[286] Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026) 15.
[287] Office of the Aboriginal and Torres Strait Islander Children's Commissioner, *Secure Care in Queensland* (Policy Position Statement, April 2026) 1.
[288] Child Death Review Board, *Annual Report 2020–21* (Report, 28 October 2021).

restrictive practices may only be used in extreme circumstances, where strictly necessary to prevent imminent and serious harm, and for the shortest time necessary.

- The framework should prohibit use for punishment or convenience, or because of staff shortage or property management matters, or as a substitute for therapeutic support. Restrictive practices should not become a way to manage ordinary behaviour, distress, disability-related need or system incapacity.
- Restrictive practices should be authorised independently of the person or provider delivering the care. Different practices may require different authorisation pathways. For example, planned use may require clinical and statutory approval, while emergency use may be permitted only in narrowly defined circumstances and subject to prompt review. The greater the interference with liberty and individual intrusion, the stronger the authorisation and review safeguards should be.
- Restrictive practices should occur only within a positive behaviour support or therapeutic support plan developed by appropriately qualified professionals. The plan should identify the child's needs, triggers, communication style, disability, trauma history, cultural needs, de-escalation strategies and the steps required to reduce and eliminate restrictive practices over time.
- Every use should be recorded, monitored and reviewed. Records should include the circumstances leading to use, the type of practice, duration, who authorised or applied it, why it was necessary, what alternatives were attempted, the effect on the child, and what will change to prevent recurrence. Data should be capable of aggregation and public reporting, including by age, Aboriginal and Torres Strait Islander status, disability, placement type, provider and duration.
- The child's physical and psychological wellbeing should be monitored immediately after use. The child should be supported to express their views, understand what happened, access advocacy and make a complaint. Parents, carers, guardians, family or kin should be notified where appropriate and consistent with the child's safety and legal status.
- Misuse should trigger escalation. Unauthorised, excessive, punitive or harmful use of restrictive practices may constitute abuse, neglect or assault. The framework should therefore connect to reportable conduct, complaints, professional regulation, police referral where appropriate, and independent oversight.

Comparable frameworks in disability, NDIS and mental health settings provide useful design lessons. They demonstrate the value of legislative definitions, positive behaviour support planning, authorisation pathways, monitoring, reporting and oversight.[289] Those frameworks should not be copied without adaptation, because child protection involves different relationships, duties and care environments. They nevertheless illustrate that restrictive practices are capable of being regulated in law, and that regulation is essential when the State is authorising practices that interfere with liberty, bodily integrity and children's rights.

4.1.4 Broader implications

A legislative framework for restrictive practices in secure care would have broader implications for OOHC. Children will not remain only in secure care. They may enter secure care from residential care, return to residential care, move into family-based care, transition to kin, or enter another community setting. If the law provides clarity inside secure care but leaves uncertainty elsewhere, the system may simply shift risk back into settings where carers and workers remain unclear about what they can lawfully do.

This is particularly important because the same children most likely to be considered for secure care may also be the children most likely to move between residential care, family-based arrangements, hospital, youth justice and community services. Their support needs will not disappear when they leave a secure care setting. Nor will the legal and practice questions about ordinary care boundaries, behaviour support, emergency intervention and restrictive practices.

The establishment of secure care should therefore prompt and compliment broader consideration of restrictive practices across OOHC. That does not mean the same authorisation regime should apply in every setting. A family-based placement, a residential care home and a secure care facility are different environments. But the principles should be consistent: children should be protected from unnecessary restriction; carers and workers should understand what is permitted; restrictive practices should be reduced and eliminated wherever possible; and any use should be lawful, necessary, proportionate, recorded and reviewable.

The broader objective is to create clarity without normalising restriction. A secure care framework should protect children in closed settings, but it should also expose and resolve the uncertainty that currently exists across the wider care continuum.

[289] *Disability Services Act 2006* (Qld); *Forensic Disability Act 2011* (Qld); *Mental Health Act 2016* (Qld); *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth); NDIS Quality and Safeguards Commission, *Regulated Restrictive Practices with Children and Young People with Disability* (Practice Guide, March 2021).

5. Key Benefits and Risks

Secure care presents both a potential benefit and a serious risk. The benefit is that Queensland may be able to provide a lawful, therapeutic and accountable pathway for a cohort of children whose immediate risks cannot safely be managed in current family-based or non-family based care arrangements. The risk is that, if poorly designed, secure care may become a more restrictive expression of the same system pressures that have driven the growth of residential care.

The policy assessment therefore turns on design. Secure care is only justifiable if it is small in scale, time-limited before reviews, therapeutic in practice, culturally safe in design, independently and judicially authorised and accountable in law.

5.1 Benefits of reform

The principal benefit of implementing therapeutic secure care is that for the cohort of children whose immediate safety cannot be protected in existing care settings, a therapeutic secure care model could provide a structured period of stabilisation, intensive assessment and intervention.

If properly designed, the model should allow the Department to respond to imminent serious risk without relying on informal containment or repeated emergency placements, or for police and youth justice intervention to be the practical means of keeping a child, or others, safe. This is especially important where children are repeatedly leaving placements into a risk of exploitation, engaging in acute self-harm, presenting with serious violence, or cycling between residential care and youth justice involvement. In those circumstances, the absence of a lawful therapeutic pathway does not protect the child's liberty in any meaningful way. It may simply expose the child to repeated and less coherent interventions.

Secure care could also provide a valuable point of intensive multidisciplinary assessment. Children likely to be considered for secure care often present with overlapping trauma, disability, neurodevelopmental, cognitive, mental health, substance use, educational, cultural and relational needs. Existing responses may focus on the most visible behaviour: absconding, aggression, self-harm, disengagement or offending. A therapeutic secure pathway should require a more disciplined formulation of what is driving the risk and what is needed to reduce it. That assessment should then actively and comprehensively guide treatment, education, disability support, family and kin engagement, cultural planning and transition.

A further benefit is safer routine and therapeutic containment. For some children, a short period of containment may provide the stability required for nutrition, health assessment, withdrawal support, medication review, education re-engagement, trauma-informed intervention and planning. This benefit depends on the setting being genuinely therapeutic. Containment by itself is not a treatment. The benefit arises only if the secure environment is organised around relationships, clinical support, cultural safety, education, de-escalation and preparation for exit.

Establishment of a secure care model will also provide benefits in terms of clearer authority for staff and agencies. The evidence before the Commission shows that workers may be placed in situations where the child is unsafe if allowed to leave, but where the adults responsible for the child lack lawful authority or confidence to intervene.[290] A statutory framework would clarify what can be done, by whom, in what circumstances, under whose authority, for how long, and with what review. That protects children, but it also protects workers and providers from being left to make high-risk decisions in legally uncertain circumstances.

5.2 Risks of not pursuing secure care

The principal risk of no change is that Queensland will continue to manage a cohort of children through unsafe, informal and inconsistent responses. Where there is no lawful therapeutic secure pathway, the risk does not disappear. It is displaced into residential care, police responses, hospital presentations, emergency relocations, informal restriction and youth detention.

This creates risk for children. A child who repeatedly absconds into exploitation, self-harms, behaves violently, or cycles between placements may experience the system as reactive and rejecting rather than protective. Each failed placement can deepen instability, mistrust and distress. Each emergency response may address immediate risk without changing the conditions that produced it. Without sustained assessment and therapeutic intervention, the child's underlying needs remain unresolved.

No change also leaves the broader non-family based care continuum, in particular, residential care carrying risks it was not designed to hold. Non-family based care settings are currently expected to manage children whose behaviours exceed the legal authority, staffing model, physical environment and clinical support available in those settings. This risks informal

[290] Transcript, Evidence of Corinne Porta (24 November 2025) 2617:7-2617:44.

containment, inconsistent intervention or repeated calls to police. It can also expose other children in the placement to harm and place residential workers in situations of serious risk.

There is also a legal and ethical risk. Without a clear statutory framework, workers and agencies may be uncertain about the difference between ordinary care boundaries, emergency action, behaviour support, environmental restriction, containment and unlawful deprivation of liberty. That uncertainty can lead to two opposite harms: adults may intervene without adequate authority, or they may fail to intervene when a child is at imminent risk because they are unsure what is lawful.

The risk of criminalisation is also significant. QATSICPP and the National Therapeutic Residential Care Alliance both identified the overlap between children in care and youth justice, and the risk that trauma and unmet need are translated into justice responses rather than therapeutic support.[291] If the child safety system has no lawful therapeutic pathway for exceptional risk, youth detention may continue to operate as the practical containment mechanism for some children. That outcome is inconsistent with a child-centred system.

No change also leaves Queensland without a strong data and oversight mechanism for this cohort. The system may continue to record incidents, placements and orders, but fail to identify patterns: which children are repeatedly cycling through crisis responses, which needs are unmet, which services are unavailable, which placements are breaking down, and what would have prevented escalation.

5.3 Risks of poorly designed reform

The risks of implementing secure care are equally significant. Secure care, if poorly designed, could easily become de facto detention. It could be therapeutic in description but custodial in operation. It could rely on containment, compliance and behaviour control rather than assessment, treatment, relationships and transition. That would be a serious failure, particularly given the vulnerability of the children most likely to be admitted.

The first risk is overuse. If eligibility criteria are broad, secure care may draw in children because they have complex needs, have experienced repeated placement breakdown, are difficult to place, or because other services are unavailable. That would turn secure care into a pressure valve for the wider system. The evidence of Luke Twyford is important in this regard. Secure care

[291] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (5 February 2026) 3; National Therapeutic Residential Care Alliance, *Submission to Queensland Child Safety Commission of Inquiry in response to Call for Submissions regarding Youth Justice and Corporate Parenting* (January, 2026) 3, 20, 29–31.

must be designed for the very few, and only in a system that is also improving the capacity and quality of less restrictive care options.[292]

The second risk is behavioural management by another name. Children may enter secure care because of absconding, violence, self-harm, substance use or offending behaviour. Those behaviours may be serious and may create immediate risk. But they may also be the visible expression of trauma, disability, mental health distress, exploitation, grief, school exclusion or cultural disconnection. A secure care model that focuses on controlling the behaviour rather than understanding and treating its causes may stabilise the environment temporarily while leaving the child no better supported on exit.

The third risk is normalisation of restrictive practices. A secure care model necessarily authorises containment, and other restrictive practices may arise within it. If the framework is weak, restraint, seclusion, environmental restriction or chemical restraint may become routine features of practice rather than exceptional measures of last resort. The Office of the Public Guardian and the Office of the Aboriginal and Torres Strait Islander Children's Commissioner have both identified the risks of restrictive practices, particularly for children with trauma, disability, neurodivergence and cultural vulnerability.[293]

The fourth risk is facility-driven demand. Once a secure care facility exists, pressure may grow to use it. Beds can create expectations. Operational systems may begin to treat availability as justification. That risk is familiar in Queensland already, where scarce placement options shape decisions. This reinforces why secure care must be designed as a pathway with a legal threshold, not simply as a place with capacity.

Poorly designed reform may also fail at the exit or transition out point. Secure care cannot achieve its purpose if the child is discharged into the same environment, placement instability, unmet disability needs, school exclusion, exploitation risk or lack of therapeutic support that led to admission. Without disciplined planning pathways, secure care risks repeated admissions, longer stays, or potential eventual escalation into youth justice.

[292] Transcript, Evidence of Luke Twyford (25 February 2026) 4745:8-4745:17.
[293] Office of the Aboriginal and Torres Strait Islander Children's Commissioner, *Secure Care in Queensland* (Policy Position Statement, April 2026) 7; Office of the Public Guardian, *Submission to Child Safety Commission of Inquiry* (March 2026).

6. Implications for Reform

6.1 Legislation before infrastructure

The Queensland Government has committed to deliver a Secure Care facility by 2028 for young people with mental health needs who are a danger to themselves or others.[294] That commitment creates an opportunity to address a real gap in the current OOHC system. It also creates risk. If implementation proceeds through infrastructure, procurement and operational design before the model is settled, secure care may become custodial in function even if therapeutic in intention.

It is critical that legislation come before infrastructure. The legislation should define the purpose of secure care, the cohort for whom it is available, the admission threshold, the decision-maker, the maximum duration of any order, review obligations, transition requirements, the regulation of restrictive practices, independent oversight, data reporting and cultural safeguards. Those matters should not be left to policy, contract design or facility practice.

This is particularly important because secure care involves deprivation of liberty. The State should not build a closed care environment and then retrofit legal safeguards around it. The legislative framework should determine what the model is, who it is for, how it can be used, how misuse will be prevented, and how children will be supported to leave it. Infrastructure should then be designed to serve that legal and therapeutic model.

A rushed or under-specified rollout would carry unacceptable risk. It may create beds before there is a clear threshold for admission. It may create containment before there is a framework for restrictive practices. It may create a facility before there are step-down pathways. It may create a service response before there is a settled model of judicial authorisation, review, advocacy, cultural governance and public accountability. In that sequence, operational pressure could shape the model by default.

The Commission's position is therefore that the legal architecture should be settled first. That does not mean every operational detail must be prescribed in legislation. It does mean that the core safeguards, limits and accountabilities must be fixed in law before secure care commences.

6.2 Secure care as a pathway, not a facility

Secure care should be designed as a short-term stabilisation pathway, not as a placement destination. The practical design should follow the child's pathway from admission, through

[294] Queensland Parliament, *Question on Notice No 1*, Education, Arts and Communities Committee, 31 July 2025; Queensland Government, *Budget to help deliver safer children, safer communities* (Media Statement, 24 June 2025).

therapeutic intervention, to safe transition back to a less restrictive family-based or non-family based arrangement.

That pathway should begin with independent judicial authorisation. The front-end decision should test whether the statutory threshold is met, whether the risk is imminent and serious, whether less restrictive alternatives have been considered, and whether the proposed placement is capable of meeting the child's needs. Authorisation should also require early identification of the intended exit pathway. A child should not enter secure care without an initial plan for how they may safely leave it.

During placement, the focus should be therapeutic intervention rather than containment alone. The model should provide multidisciplinary assessment, clinical support, education, cultural connection, family and kin engagement where safe, disability and mental health input, substance use support where required, and preparation for transition. The intervention should be directed to the drivers of risk, not only the behaviours that brought the child into secure care.

At the exit point, step-down support must be available. Secure care cannot succeed if the child returns to the same placement instability, unmet disability needs, school exclusion, exploitation risk or lack of therapeutic support that led to admission. Step-down options may include specialist family-based care, therapeutic residential care, intensive family or kin support, mental health or disability services, supported education re-engagement, culturally governed support, or supported transition to adulthood.

Those options need to be funded and available before the model commences. Without them, secure care will struggle to remain time-limited. Children may remain longer than necessary because there is nowhere safe to go, or they may exit prematurely into the same risks and return later. Either outcome would undermine the legitimacy of the model.

Performance should therefore be measured by safe transition and sustained stability, not bed utilisation. The key questions should be whether the child was stabilised, whether the drivers of risk were better understood, whether therapeutic intervention occurred, whether restrictive practices were minimised, whether family, kin, culture and community connections were supported, whether the child exited safely, and whether that exit was sustained.

Secure care as short-term stabilisation, not a last resort placement

CJ was 14. He had experienced significant trauma through his childhood, including exposure to physical and sexual abuse, and domestic and family violence. In his early teenage years, CJ began to show clear signs of emotional instability, including escalating self-harm, substance use and high-risk behaviour.

In the months leading up to his death, CJ's circumstances became increasingly unstable. He moved between his mother, father and informal care arrangements before being placed in the care of foster carers. During this period, he was engaging in ongoing risk-taking behaviours, including drinking alcohol, sniffing paint and recurrent suicidal behaviour, including multiple attempts to hang himself.

Despite these clear indicators of distress and risk, there was no coordinated or intensive response to stabilise CJ or address the underlying drivers of his behaviour. Referrals for specialist mental health assessments were pursued by his school and carers, but were not effectively coordinated or progressed.

In the days before his death, CJ continued to express suicidal intent. He messaged his girlfriend stating that he intended to hang himself and that he was 'not scared of dying.' Although this immediate crisis was deescalated with the support of his carers and peers, his underlying level of risk remained high.

CJ died by suicide in his foster carer's home at age 14.

This case demonstrates a period of escalating and acute risk in which CJ was engaging in repeated self-harm, expressing suicidal intent and placing himself in situations of serious danger. At that point in his trajectory, CJ was not able to keep himself safe, despite being in a stable, family-based care placement.

A short, time-limited period of intensive, therapeutically supported containment may have provided an opportunity to stabilise CJ's immediate risk, undertake comprehensive assessment and coordinate a sustained mental health and trauma-informed response.

In this context, secure care is not framed as 'placement outcome.' Rather, it represents a potential stabilisation intervention during a period of acute risk, where a young person's safety cannot be maintained in an open environment and where coordinated clinical and therapeutic response is urgently required.

6.3 Design considerations for Queensland

The cohort must be narrow. Secure care should be available only for the very small number of children whose immediate risk of serious harm to themselves or others cannot safely be managed in a less restrictive arrangement. Complex need, placement breakdown, disability-related distress, difficult behaviour or the absence of an available placement should not be sufficient.

The legal threshold must include a no less restrictive alternative test. Before a child is deprived of liberty, the decision-maker should be satisfied that other family-based and non-family based options have been considered and cannot safely manage the risk at that time.

Admission should be based on independent multidisciplinary assessment. That assessment should consider trauma, disability, neurodevelopment, cognitive capacity, mental health, substance use, exploitation, education, family relationships, culture and community. It should identify the drivers of risk and the supports required for safe transition.

Authorisation and review should be independent and judicial. The decision should be tested against a statutory threshold, with the child represented and heard. Review should occur regularly and should examine whether the threshold continues to be met, whether the child is receiving the intervention for which admission was authorised, and whether a less restrictive pathway is available.

The model should include maximum duration and strict extension criteria. Secure care should be time-limited, with any extension justified by evidence that the legal threshold continues to be met and that the placement remains therapeutically necessary. Extension should never be based merely on the absence of a suitable exit placement.

The therapeutic model should have clinical governance. Secure care should include qualified clinical input, therapeutic practice frameworks, education, disability support, cultural support, de-escalation capability, reflective supervision and workforce training. It should be capable of responding to trauma, distress, neurodevelopmental need, cognitive impairment, substance use and mental health concerns.

Restrictive practices must be regulated in legislation. The framework should define restrictive practices, identify prohibited practices, require authorisation, require recording and review, support reduction and elimination, and provide independent oversight.

The model should include independent advocacy, complaints and inspection. Children in secure care must have practical access to people outside the facility who can hear them, advocate for them and escalate concerns. Oversight should include routine external scrutiny, incident review and public reporting.

Finally, the model should be independently evaluated from commencement. Evaluation should examine who enters secure care, why they enter, how long they stay, what happens during placement, how often restrictive practices are used, whether children exit safely, whether exits are sustained, and whether particular cohorts are disproportionately affected.

The broader implication is that secure care should proceed only as part of wider reform to family-based care, therapeutic residential care, disability and mental health responses, cultural supports, education engagement and step-down pathways. Otherwise, it risks becoming the place where the system contains the consequences of its own gaps.

Recommendations

Recommendation 27: Legislated therapeutic secure care	
Executive Report (Chapter 7)	**Companion Report 3 (Chapter 3)**

RECOMMENDATION:

The Queensland Government should, within 24 months of its response to this Report, establish by legislation a therapeutic secure care capability as a narrow, time-limited stabilisation pathway for children and young people presenting with imminent serious risk of harm to themselves or others.

The legislation should provide that therapeutic secure care is not to be used as an emergency placement option, a behavioural management tool, a punitive response, or as a substitute for investment in family-based care, therapeutic residential care or integrated service responses.

The legislation should require that no child or young person may be admitted to therapeutic secure care unless:

a) the placement is authorised by the Childrens Court;

b) the child or young person has access to independent legal assistance;

c) the admission is supported by an independent multi-disciplinary assessment;

d) the child or young person presents an imminent serious risk of harm to themselves or others;

e) no less restrictive placement or support option can safely manage that risk;

f) the purpose of admission is therapeutic stabilisation; and

g) the admission is necessary, proportionate and time-limited.

The legislation should prescribe:

a) the purpose, cohort, admission threshold, authorisation process, duration, review and exit requirements;

a) a maximum initial period of 21 days before court review;

b) ongoing, mandatory review points;

c) appeal or review rights;

d) transition planning from the point of admission;

e) independent oversight and inspection;

f) approval recording, review and reporting of restrictive practices; and

g) a step-down pathway back to less restrictive care.

In addition to the required stipulated above, implementation should include development of a clinical governance framework, management of medication, use of restrictive practices, and qualified therapeutic oversight.

The model should include evidence-based therapeutic supports matched to each child's needs, qualified clinical oversight, a skilled workforce, and cross-sector involvement including from agencies responsible for health, disability, and education.

CONTEXT:

The Commission has heard evidence of a small cohort of children and young people whose immediate risks cannot safely be managed in family-based care or open residential settings. In the absence of a lawful and tightly governed therapeutic secure option, responses can include informal containment, repeated placement breakdown, crisis-driven relocation and youth justice detention being used as a de facto containment response.

The intended outcome is to create a lawful, therapeutic and accountable stabilisation pathway for the small number of children whose risks cannot be safely managed in a less restrictive setting. For children, the expected impact is safer containment where absolutely necessary, intensive therapeutic assessment and support, reduced drift into youth justice, and a planned pathway back to less restrictive care.

IMPLEMENTATION NOTES:

The Queensland Government should not commence therapeutic secure care until the legislative framework, restrictive practices framework, oversight arrangements and step-down pathways are in place.



Child Safety

Commission of Inquiry



Companion Report 4

Understanding and Reforming the Residential Care System

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Chapter 1

Introduction

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 1: Introduction

In the course of its inquiries, the Commission observed that Queensland's non-family based residential care system has been under sustained pressure from the following converging trends:

1. more children and young people are entering out-of-home care (OOHC), and particularly those children in residential care are staying for longer periods of time;
2. the children and young people entering the OOHC system appear to have increasingly complex medical conditions and behavioural challenges, necessitating a holistic therapeutic response and tailored care placements;
3. the Department of Families, Seniors, Disability Services and Child Safety (the Department) has had difficulties recruiting new foster carers and maintaining or supporting existing foster carers;
4. the overall availability of family-based care has been further constrained by comparatively low rates of kinship care in Queensland compared to other Australian jurisdictions;
5. despite these problems being well understood within the Department, the then Government failed to make a significant, upfront and sustained investment in family-based care at the scale required in the early 2020s;
6. by reason of the above matters, demand for residential care services has consistently exceeded supply and the cost of delivering those services has increased exponentially;
7. the Department has been operating in a fiscal environment whereby appropriated funding levels were not sufficient to meet existing and future commitments;
8. from at least 2019, children entering residential care were often placed with providers on expensive, short-term Individualised Placement Support (IPS) agreements;
9. this was caused by a shortfall in the supply of funded long-term residential care placements under Outsourced Service Delivery (OSD) contracts;
10. this has coincided with an increase in the number of unregulated (or underregulated) for-profit and unlicensed suppliers entering the residential care provider market;
11. there has been significant variance in procurement and contracting practices across the different child safety regions;

12. those regions have been reliant on inconsistent and outdated documents, unclear standards and processes that have not kept pace with growth in demand;
13. too few providers have been transitioned to licensed care arrangements, with significant delays becoming normalised in the child safety system;
14. these matters are emblematic of broader failings in market stewardship, oversight and long-term planning in the child safety system; and
15. assessed in totality, the Department's commissioning, procurement, contracting and licensing practices have failed to adapt to the changing market landscape.

The problem facing the child safety system is stark and ongoing. Demographic markers point to more children entering OOHC each year, with forecasts suggesting a risk of further escalation over the coming years. At the same time, Queensland is experiencing a relative decline in the number of available foster and kinship carers. Among other factors, this has been attributed to the rising cost of living (including the cost of housing and other inflationary pressures), and the decline in volunteering in the community more generally.[1] The cohort of long-term carers is retiring faster than new carers are being recruited, and the children entering care are going into residential care at a higher rate than ever before.

Owing to this confluence of factors, the reliance upon and cost of providing residential care services has increased unsustainably over the past five or so years. In the 2019-2020 financial year, the average cost of residential care was approximately $300,000 per year, per child.[2] By the 2024-2025 financial year, the average cost had reached approximately $500,000 per year, per child.[3]

In this market, private sector contracts for both IPS and OSD contracts typically command higher median prices than not-for-profits and show broader interquartile ranges, with IPS contracts exhibiting particularly pronounced variability.[4] For instance, in an internal audit of Private Providers of Child Safety Residential Services in September 2025, the Department identified that IPS-funded services are 30-40% more expensive than OSD-funded services (depending on whether the provider is a not-for-profit or for-profit entity).[5]

[1] Transcript, Evidence of Dan Jefferson (7 April 2026) 4810:41-4811:10.
[2] Department of Children, Youth Justice and Multicultural Affairs, *Placements – Residential Care* (Brief to Minister, 9 December 2020 (DFS.0397.0004.0511).
[3] PeakCare, *The future residential care workforce – Demographic analysis* (Draft Consultation Report, September 2025) (COI.0001.0001.5291) 4; Transcript, Evidence of Bernadette Harvey (17 April 2026) 5587:34-35. See also Transcript (8 April 2026) 4928:5-36.
[4] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025).
[5] Ibid 11-12.

Similarly, analysis in a report prepared by KPMG for the Commission entitled "Financial Review of Non-Family Based Residential Care" dated 2 April 2026 (KPMG Report) identified that in FY2021-2022, the median IPS contract was 29% more expensive than the median OSD contract, and by FY2024-2025, this difference had increased to 39%.[6] Whatever the precise difference may be between the prices charged by IPS and OSD providers, there can be no doubt that it is substantial.

Traditionally, there have been very few barriers to entry in the market for residential care services and minimal upfront capital was required to take on placements. This was particularly so for IPS providers who have been able to grow revenue over short periods without re-investing that income in services or infrastructure for the children in their care.[7] Further, the Commission has observed that it is common for such providers to charge hourly labour rates that exceed the relevant award rate, and to generate substantial profit margins by operating a flexible workforce model that utilises labour hire arrangements or casual staff, rather than fixed-term employment arrangements.[8]

Revenue growth for residential care providers appears to be driven by the number of placements or bed nights providers are able to procure from the Department, and the margins charged in their pricing schedules, rather than demonstrated efficiency, service maturity or measurable quality of care outcomes for children.[9] Indeed, the Commission, assisted in its investigations by KPMG, did not observe any discernible relationship between the average price charged by providers per placement day and the level of staff training or model of care provided.[10]

Perhaps unsurprisingly, the rapid and unmitigated growth of the residential care sector has also led to materially worse outcomes for children in OOHC. In the extreme, the Commission has heard that children in such placements are often exposed to high rates of trauma, physical harm, sexual exploitation, self-harm, unmet mental health needs and placement instability.[11] The Commission has also identified issues in the day-to-day running of these residential care premises, including households:

1. in which the food was either out of date, uncovered, mouldy or unlabelled;[12]

[6] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 21.
[7] Ibid 8 [ES.18].
[8] Transcript, Evidence of Dan Jefferson (7 April 2026) 4832:29-4833:5; KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026) 9, 13.
[9] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 8 [ES.18].
[10] KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026) 12.
[11] See, eg, KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 11 [BI.2] which summarises the 2024 Children in Care Census; Office of the Victim's Commissioner, Submission to Child Safety Commission of Inquiry (10 March 2026) 4.
[12] Department of Families, Seniors, Disability Services and Child Safety, *Register – 82(1)(f) Unlicensed & Add to Licence Site Inspections* (Spreadsheet, 9 September 2025) (DFS.0050.0003.1576).

2. in which medications and sharp objects were not stored securely and there were no lockable cabinets to store poisons, cleaning products and toxic substances;[13] and
3. with major maintenance issues that had been neglected by the provider in question.[14]

A further, widely acknowledged, feature of residential care is the lack of continuity in the interactions between children and young people and the staff members responsible for their day-to-day support, this is especially problematic in a context where stability and constant care is paramount.[15]

Despite the acknowledged importance of continuity and stability, the staff employed at these premises are more often than not youth workers, or support workers, who are organised into a roster of rotating carers for the household. Many, though well intentioned, have undertaken only rudimentary training and are not equipped to deal with the (increasing) complexity of children entering residential care.

These dynamics are intensified by Queensland's geography and demography, and in particular its size and the distribution of the population. As a large, decentralised jurisdiction, Queensland has limited availability of placements in many regional and remote areas, particularly for children with complex needs. For example, the Commission has heard evidence that child safety regions such as North Queensland rely heavily on a fly-in, fly-out workforce in Mackay and Townsville, and for residential care placements in Mt Isa.[16]

Augmenting this problem is that, according to recent operational data provided by the Department to the Commission, there are as many as 1,555 children in residential care who would otherwise be suitable for a family-based care arrangement, if such placements existed.[17] The data is concerning because it paints a picture of a system in which children are placed with residential care providers on the basis of availability, not suitability.

In providing this data, the Department indicated that:

(a) the number of children assessed as suitable for family-based care fluctuates from time to time depending on when family-based care placements are located (for instance,

[13] Ibid.
[14] Ibid.
[15] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 41.
[16] Transcript, Evidence of Michelle McNamara (9 April 2026) 5080:4-15; Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview - Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022).
[17] Department of Families, Seniors, Disability Services and Child Safety, *Children placed in residential care by region and whether suitable for family-based care as at 27 March 2026* (Spreadsheet, 2 April 2026) (DFS.0392.0002.0001); see letter from Department to Commission dated 30 April 2026 in response to letter dated 27 April 2026.

because kin is identified and assessed as being suitable, or a suitable foster care placement becomes available);

(b) the data was compiled by extracting and distributing a list of open residential care placements to the placement service units in each region, and asking those staff to identify the number of children who were awaiting a family-based care placement; and

(c) although the data may be used to provide information about trends, themes and emerging issues, it is not comparable with corporate data which is subject to cleansing, validation and rigorous review before publication.[18]

Even with those qualifications, the Deputy-Director General of Commissioning, Bernadette Harvey, accepted that the number of children awaiting family-based care has been increasing year-on-year since at least 2020.[19] Ms Harvey also agreed that this demonstrated the need for the Department to do more to locate and support more family-based carers.[20] The data provided by the Department reveals that, in the meantime, residential care is the ***only*** option for many children and young people (not necessarily because the placement is in that child's best interests, but rather because there is no viable alternative).

Another consequence of the growth in residential care placements has been the additional administrative burden this has imposed on the Department, especially where short-term IPS agreements are relied on in preference to long-term OSD contracts. For instance, the Commission heard evidence from the Chief Procurement Officer, Hanelie Lategan, that staff in the regions have been occupied with high volume, high frequency and highly manual processes, such as extending (or seeking approval to extend) existing placement arrangements or reconciling invoices against approved quotes for providers.[21] At least until recent reform initiatives were implemented to convert IPS-funded places to OSD-funded places, that led to an environment in which the Department was focused on simply trying to maintain the status quo, and unable to direct resources to implementing system-wide change.

The need to scrutinise the residential care model has become more urgent and critical as the continual decline of foster carers and relative decline of kinship carers has left the child protection system increasingly reliant on residential care and vulnerable to it. For instance, from 30 June 2020 to 31 December 2024, there was a decrease in foster care placements of 11.2%, an

[18] Letter from the Department to Commission with explanatory note amendment for Notice 392 dated 13 April; as supplemented by letter from Department to Commission dated 30 April 2026, in response to letter dated 27 April 2026.
[19] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5584:10-14.
[20] Ibid 5585:5-19.
[21] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5207:31-5208:19.

increase in kinship care placements of 30.2% and an increase in residential care placements of 94.7%.[22] In proportion, it is readily apparent that the growth of residential care has been to a different order of magnitude than foster or kinship care arrangements.

This is by no means a recent or unexpected development. In a strategic review of OOHC undertaken by the Queensland Treasury Corporation (QTC) in 2020, to which detailed reference is made below, there was already concern that the number of foster care families had been stagnated over the past five years (that is, throughout 2015 to 2019). QTC explained that at the same time as foster rates had stagnated, there had been a significant increase in the number of children requiring OOHC.[23]

In Phases I and II of QTC's reports (published April and August 2020, respectively), QTC concluded that transitioning children from residential care into family-based care would not only represent a significant cost saving, but would also improve the safety, health and educational outcomes for children in such placements.[24] As the former Minister for Children, Youth Justice and Multicultural Affairs, Leanne Linard put it, it was a fortunate coincidence that the most affordable placement options were also in the best interests of the child or young people.[25] However, suffice to say, the transition of children from residential care into family-based did not eventuate; to the contrary, the trend of relying increasingly on residential care placements gained even further momentum over subsequent years.

It is against that background, and within that context, that this Commission has been charged with undertaking a thorough investigation of all matters pertaining to the operation of the residential care model and the state of the market of for-profit and not-for-profit providers, including the applicable funding models, commissioning approaches and procurement practices which have manifest an exponential growth in the cost of residential care. The Commission has also been tasked with exploring quality of care in both licensed and unlicensed providers, and analysing contemporary models for licensing service providers.

The critique of the residential care model is explored below, focusing on all features of the model that reveal its shortcomings. Regrettably, those shortcomings were, and at least in part remain, manifold. The critique that follows also includes recommendations for short term and long-term

[22] Queensland Family & Child Commission, *Residential care Quarterly Data provided by Child Safety* (Spreadsheet, 20 June 2025) (COI.0001.0001.5602).
[23] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 70-71.
[24] Ibid; Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 70-73.
[25] Evidence of Leanne Linard (16 April 2026) 5463:12-25.

improvement to the model, aspects of which are already being implemented as part of the Department's Residential Care Reform Plan and a range of associated initiatives underway.[26]

The balance of this companion report is divided as follows:

Part 2 is an overview of Queensland's non-family-based care system. It includes an outline of the residential care model, a summary of recent data regarding the number and demographic profile of children and young people in residential care, an overview of the current state of the market for residential care services, some further context as to how the Department procures residential care services under IPS and OSD contracts, and a summary of workforce limitations that undermine the design intent of residential care.

Part 3 is a detailed narrative explaining the factors that have contributed to the growth of, and the State's reliance on, a billion-dollar residential care sector. Though it is "backward-looking" and diagnostic (rather than prognostic) in its focus, this part seeks to highlight the importance of making a timely, upfront, substantial, and sustained investment in family-based care for the sustainability of the child safety system. That itself represents a crucial learning for future governments.

Part 4 builds upon Part 3, by further explaining how it is that the Department came to be overly reliant on short-term IPS agreements and the consequences of that being so. This part also explores historical and contemporary approaches to converting IPS agreements to OSD contracts in order to demonstrate the importance of active market stewardship.

Part 5 analyses the way the Department forecasts and models the projected demand and cost of residential care. Modelling is integral to long-term planning and thus to reshaping the residential care market. This part focuses attention on the Department's Simulated Analytical Model (SAM) and Parameters-Based Funding Model (PBFM), with a view to providing recommendations as to how the Department can leverage the information at its disposal to optimise outcomes for the children and young people in the child safety system.

Part 6 identifies various issues with the Department's historical and contemporary approach to commissioning and procurement, focusing on what the Commission observed to be systemic failings in the way the Department made decisions internally and engaged with the market externally. This part focuses in particular on issues associated with the commissioning and

[26] CL-103, *Residential Care Reform Plan*, tendered 17 April 2026; See Transcript, Evidence of Bernadette Harvey (17 April 2026) 5537 and ff.

procurement of IPS agreements, financial reporting and transparency by providers, and the lack of training for Departmental staff involved in procuring residential care services.

Part 7 is an analysis of the licensing and regulation of residential care providers. This part explains the process by which providers become licensed, analyses the differences in monitoring and supervision of licensed and unlicensed providers, and identifies areas for reform in the current licensing framework.

This companion report concludes by pulling together a number of recommendations relevant to residential care, drawing upon the findings identified throughout each of the parts.

Chapter 2

Overview of Queensland's Non-Family Based Care System

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 2: Overview of Queensland's Non-Family Based Care System

In some instances, there is no suitable family-based care arrangement to meet the needs of a child (such as where a child has complex or extreme behavioural needs or is transitioning to adulthood) or a family-based arrangement is simply not available because all such placements have been exhausted. In those circumstances, the Department utilises non-family based care arrangements.

These placements are only permitted where the arrangement is determined to be in the best interests of the child and the placement is made in accordance with either sections 82(1)(d) or 82(1)(f) of the *Child Protection Act 1999* (Qld) (Act).[27]

Section 82(1)(d) relates to placements made by the Chief Executive of the Department (that is, the Director-General)[28] in the care of a licensee under Part 2 of Chapter 4 of the Act. These are placements made with a licensed provider.

Section 82(1)(f) allows the Chief Executive to make a placement with another entity (that is, an unlicensed provider) if satisfied that entity would be the most appropriate for meeting the child's particular protection and care needs. The Act expressly contemplates, by way of example, that a residential care facility may be the most appropriate entity for a child with a disability.

2.1 The residential care model

The most common form of non-family based care, and the focus of the Commission's inquiries, is residential care. Residential care is a form of state care provided to children and young people in residential premises by either for-profit or not-for-profit organisations that employ salaried employees, contracted workers and/or volunteers.[29]

Residential care premises are either owned or leased by non-government organisations. These premises are typically staffed 24-hours a day by carers on either a rostered, on-call or live-in-basis.[30] It is common for residential care providers to have a combination of awake and sleepover

[27] Proactive Statement of Bernadette Harvey (3 September 2025) [69].
[28] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5304:35-39.
[29] Department of Families, Seniors, Disability Services and Child Safety, *Child Protection (Placement Services) Investment Specifications* (Guide, August 2025).
[30] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220).

shifts, and to have on-call arrangements to support their workers. Residential care service providers may also have the capacity to recall staff to work where required.[31]

Under the residential care model, the organisation or service provider is responsible for the day-to-day care and support of the children, while the Department retains responsibility for the child's individual case management.[32] So much is enshrined in section 5B(d) of the Act, which prescribes that if a child does not have a parent who is able and willing to protect the child, the State is responsible for protecting the child.

For completeness, non-family based care also encapsulates a wide range of other services for the provision of supervised accommodation. These include:

1. safe houses, an integrated residential care and family support service provided to children and young people aged under 18 years old in Aboriginal and Torres Strait Islander communities;
2. supported independent living, for children aged 15 to 18 years old transitioning to independent living; and
3. therapeutic residential care, for children aged 12 to 16 years old requiring a therapeutic living environment.[33]

In the time available, and having regard to the Terms of Reference, these were not the focus of the Commission's inquiries in this companion report. However, it would be remiss of the Commission not to acknowledge the important contribution and role of such non-family based placements within the child safety system generally.

2.2 The children and young people in residential care in Queensland

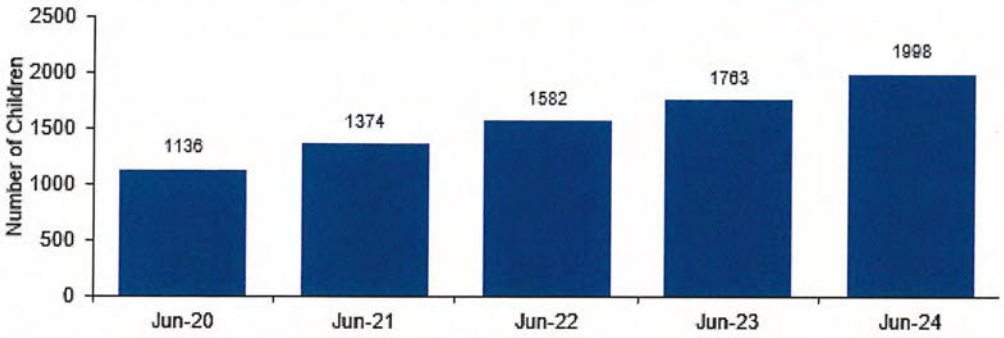
As at February 2026, there were 2,388 children and young people in residential care in Queensland, comprising 19.7% of the population of children and young people in OOHC across the state.[34] By comparison, in all of the other states and territories *combined*, there were only

[31] Proactive Statement of Bernadette Harvey (3 September 2025) [71]-[72].
[32] See, eg, overview of residential care in Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 263.
[33] Department of Families, Seniors, Disability Services and Child Safety, *Child Protection (Placement Services) Investment Specifications* (Guide, August 2025).
[34] Operational data - Care Arrangements, *'Department of Families, Seniors, Disability Services and Child Safety'* (Web Page, 18 February 2026) <https://performance.dcssds.qld.gov.au/our-performance/operational-data/care-arrangements>.

2,767 children and young people in residential care, using the latest available comparative government data from 30 June 2025.[35]

Figure A.20 below, extracted from the KPMG Report, illustrates the annual growth in residential care in Queensland across the past five financial years.[36]

Figure A.20: Children in residential care at the reference date in Queensland [49]



2,388
Individual children in residential care (as of the 18th of February 2026) [48]

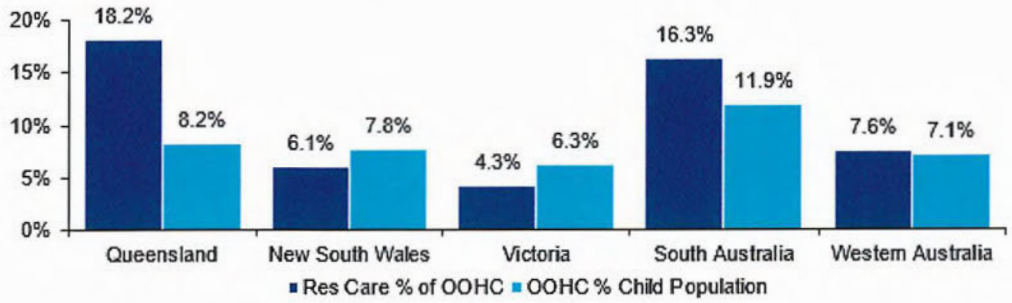
14.2%
Compound annual growth rate (period from June 2020 to February 2026) [48] [49]

Queensland now has the highest rate of non-family-based care use of any state and territory in Australia. By way of comparison, the proportion of children and young people in residential care is, according to recent government data, approximately 7% in New South Wales, 5% Victoria and 8% in Western Australia.[37] Put differently, in relative terms, Queensland's residential care population accounts for almost 50 per cent of Australia's total residential care population, despite having only about 20 per cent of the nation's children in OOHC.[38]

Figure A.22, extracted from the KPMG Report, includes an analysis of residential care as a percentage of OOHC, which shows the marked difference between Queensland (on the one hand) and Victoria, New South Wales and Western Australia (on the other hand).[39]

[35] Table 16A.23, 16 Child protection services data tables, *'Australian Government Productivity Commission'* (Web Page, 29 January 2026) <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/>.
[36] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 35.
[37] Publicly available ROGS data synthesised in Department of Families, Seniors, Disability Services and Child Safety, *The Child Safety Care Continuum Framework* (Draft Discussion Paper, November 2025) (DOT.0006.0001.2323).
[38] Queensland Family & Child Commission, *Buyer Beware: How Economic Forces are Shaping Queensland's Residential Care Market* (Report, August 2025).
[39] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 35.

Figure A.22: Residential care proportion of OOHC and OOHC rate by state jurisdiction in 2024 [20]



Overuse of residential care has diluted the design intent of this placement type and contributed to worse outcomes for children who would better have their care needs in an alternative, family-based care arrangement.[40]

For instance, a specific feature of residential care, in its design and intent, is that it is primarily intended for children and young people between the age of 12 to 18 with moderate, high, complex and/or extreme needs.[41] To that end, the Commission repeatedly heard evidence that residential care was never designed for children under the age of 12.[42]

However, in practice, its use is not so confined. As at March 2026, operational data provided by the Department, which was subject to validation and cleansing, indicated that:

- 1,095 children and young people living in residential care were 12 years of age or less (being approximately 33% of the children and young people in residential care); and
- of that cohort of children under 12, 182 were 5 years of age or less (being primarily children part of a sibling group or with a significant disability or medical needs).[43]

It is apparent from data published by the Department, including the Children in Care Census, that the profile of children entering OOHC in Queensland has also shifted in recent years, with children increasingly entering the system after prolonged exposure to multiple forms of adversity, including instability, violence, neglect, and unmet health and developmental needs.[44] The evidence heard by the Commission suggests that these issues often manifest as heightened

[40] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 47; 16 Child protection services data tables, *'Australian Government Productivity Commission'* (Web Page, 29 January 2026) <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/child-protection/>.
[41] Proactive Statement of Bernadette Harvey (3 September 2025) [70].
[42] See, eg, Transcript, Evidence of Bernadette Harvey (17 April 2026) 5592:3-22.
[43] Department of Families, Seniors, Disability Services and Child Safety, *Children placed in residential care by region, Aboriginal and Torres Strait Islander status and age group* (Spreadsheet, 27 March 2026) (DFS.0392.0003.0002).
[44] See, eg, Department of Children, Youth Justice and Multicultural Affairs, *Children in Care Census 2024* (Report, 2025) 4, 5.

distress, difficulty regulating emotions, challenges forming trusting relationships with adults, and behaviours that carers and systems may perceive as difficult to manage.[45]

For more data in relation to the number of children placed in residential care, the demographic breakdown of those children and the proportion of such children relative to those in family-based care placements, the Commission commends the 'Buyer Beware' report published by the Queensland Child and Family Commission (QFCC) in August 2025.

For a detailed exposition of the changing market for residential care services, and an analysis on the modelling on the present and projected demand, the Commission refers to the KPMG Report, which is included as Appendix 1 to this report and available on an ongoing basis on the Commission's website.

2.3 An assessment of the current state of out of home care

The increase in the number of children in OOHC in Queensland, including residential care, has occurred within the context of a deliberately mixed-provider market, comprising a combination of family-based organisations, small non-government organisations, large national charities and for-profit providers. This market configuration was intended to introduce flexibility, innovation and responsiveness into the delivery of OOHC, particularly in circumstances of acute need and system pressure. In theory, a mixed-provider environment can enable diversity of models and allow services to respond to varying local and cohort-specific needs.

However, in the Commission's assessment, the system has developed over several years as an emergency placement response to increasing demand for tertiary child safety services. The system has been further influenced by the decline in family-based care, the increasingly complex needs of children and young people, the rapid emergence of private providers and the lack of a sufficient mix of residential care services. Until very recent times, there has been a shift away from long-term funding contracts with licensed providers to individual placement arrangements, which are more often than not entered into with unlicensed and for-profit providers. This has seen the levels of funding in IPS agreements escalate to unsustainable levels.[46]

[45] See, eg, Transcript, Evidence of Witness C (8 September 2025) 49, 75; Transcript, Evidence of Witness H (8 September 2025), 132; Transcript, Evidence of Dr Fraser (16 September 2025) 1934.
[46] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform Project* (Director-General Briefing Note, 1 August 2025) (DFS.0186.0030.0147).

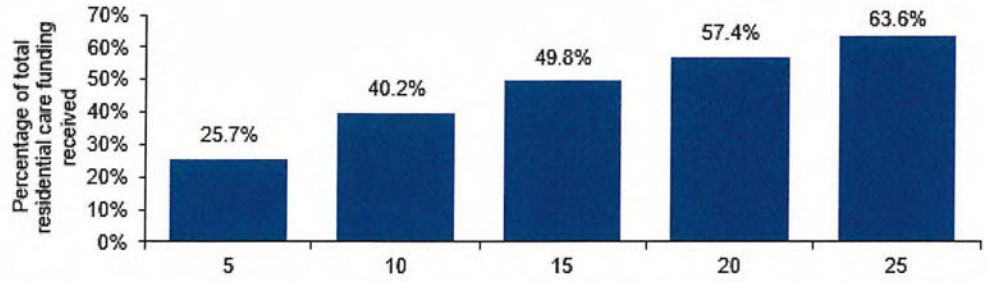
The residential care market itself is reasonably concentrated, notwithstanding some of the largest service providers (including high-profile providers such as Churches of Christ and Mercy) leaving the sector in recent years. In or around April 2020, the top ten suppliers of residential care made up 75% of the Department's OSD expenditure, and 68% of fee-for-service agreements, pointing to a concentrated market.[47]

Data from the Department's IPS Redesign Project Reference Group, which first met in mid-August 2022, similarly indicated that while the market remained concentrated, there was by this point more competition in the market. Specifically, as at around mid-2022, the top ten suppliers received only approximately 50% of the total expenditure on fee-for-service agreements.[48]

More recently, market and demand analysis shows a continued reliance on a small number of providers, notwithstanding the increasing demand for residential care services due to the complex needs of children and young people.[49] For instance, Figure A.3 in the KPMG Report includes data in respect of FY2024-25,[50] which demonstrates that:

- 5 providers (being 3% of market participants) received more than 25% of the Department's total funding for residential care services;
- 20 providers (being 12% of market participants) received almost 60% of the Department's total funding for residential care services.[51]

Figure A.3: Percentage of total residential care funding received by the largest providers FY2024-25 [1]



According to Dan Jefferson, Lead Partner at KPMG for Health, Ageing and Human Services in Australia, who gave evidence at public hearings, this is not unusual in markets for the delivery of

[47] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 41.
[48] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign Project Procurement Strategy* (Presentation, 17 August 2022) (DFS.0186.0037.0052) 2.
[49] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 1-2.
[50] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 18.
[51] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 18-19.

human services. In fact, Mr Jefferson said this is often seen as advantageous in terms of ensuring consistency of quality of care across the system.[52]

To address the need for a balanced supply chain, the Department has indicated that it will embed a strategic commissioning approach that is dynamic, responsive to emergent market conditions, and capable of delivering quality care placements within tight timeframes. However, the Commission was not directed to any initiatives *specifically* designed for that purpose, and in the interim there is a high-risk of placement instability for children and a risk that the Department will be beholden to a small number of organisations when the market is so concentrated.[53]

Further, in response to a series of queries put to the Department by the Commission, regarding expected future demand, the risk of providers exiting the market and plans in place to enhance competition and supply, the Commission was left with the impression that the Department is not taking adequate steps to shape and lead the market.

For instance, the Department confirmed that it has no specific plans to address the risk of for-profit providers choosing to exit the market,[54] even though there is a risk of that occurring as the Department progresses the IPS to OSD conversion (as to which, see Part 4 below), introduces further regulation and insists upon providers becoming licensed. The Department said, in response to a Notice issued by the Commission that in its view, there are already sufficient providers in the market offering residential care services. Accordingly, the Department has no plans in place to enhance the supply of providers in the market.[55]

2.4 Funding and licensing of residential care providers

In order to understand the issues that exist within the residential care sector that are the focus of the balance of this companion report, it is important to identify two matters for context.

The first contextual matter is the conceptual and practical differences between OSD funding and IPS funding. The second contextual matter is the usual licensing status of OSD and IPS providers (including, in brief overview, the process for becoming licensed).

[52] Transcript, Evidence of Dan Jefferson (7 April 2026) 4812:4-25.
[53] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign Project Procurement Strategy* (Presentation, 17 August 2022) (DFS.0186.0037.0052) 5.
[54] Statement of Danny Short (25 November 2025) [10].
[55] Ibid [11].

2.4.1 Different funding methods for residential care (IPS and OSD funding)

Residential care placements in Queensland are funded through either:

1. OSD funding; or
2. IPS funding.[56]

OSD funding involves contracts spanning multiple years for general service provision, with payment made to the service provider quarterly in advance.[57] Before entering into such contracts, a financial delegate from the Department must be able to certify that there is a funding source from which the funding may be drawn.[58] In the simplest terms, that means there must be funds allocated to the Department in its annual budget, or the financial delegate must otherwise have sufficient comfort that funds will be available, for instance, by way of an assurance from the government of the day.

The alternative to OSD funding is fee-for-service funding via IPS agreements. These are funding arrangements intended for specific children and young people who may be assessed as having particular care and support needs that cannot be provided through contracted OSD or for whom no OSD funded placement is available (for instance, because all of the contracted OSD placements are being fully utilised).[59]

Payment under a fee-for-service agreement is made by the Department to the service provider only *after* the services have been delivered and an invoice is raised. IPS or fee-for-service funding is also known as "Child-Related Costs – Placement and Support" or "CRC-PaS" funding.[60]

In substance, OSD agreements are broader in nature and typically involve the outsourcing of standardised services to external providers on an ongoing basis of three to five years duration, whereas IPS agreements are intended for cases where standard placement options are unsuitable due to the complexity of the child or young person's needs.[61]

To ensure compliance with financial delegation policies, procurement procedures, and accountability standards, OSD providers are required to submit to the Department annual financial statements (AFS) for the organisation as a whole, and annual acquittal statements (AAS)

[56] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 11.
[57] Statement of Belinda Drew (17 September 2025) [9]; Statement of Bernadette Harvey (18 December 2025) [6](a)-(b).
[58] Transcript, Evidence of Danny Short (10 April 2026) 5155:43-47.
[59] Proactive Statement of Bernadette Harvey (3 September 2025) [20]. m
[60] Statement of Belinda Drew (17 September 2025) [9]; Statement of Bernadette Harvey (18 December 2025) [6](a)-(b).
[61] Explanatory note to Notice 24 provided by the Department (COI.0001.0010.0010).

for each OSD funded service.[62] The efficacy of, and compliance with, these reporting obligations are matters explored in greater detail below in Part 6 of the companion report.

Importantly, the standard contract terms for OSD agreements include a range of contractual mechanisms that are not found in the standard form IPS agreement used by the Department. For example, under the OSD contract, the Department has powers:

- to conduct a performance review of the provider or nominate auditors to conduct such a review;[63]
- recover unspent funds or reduce future payments to take into account unspent funds;[64] and suspend or cease funding,[65] or terminate the agreement in accordance with different notice periods (including with six months' notice without cause, if the Department merely wishes to re-test the market).[66]

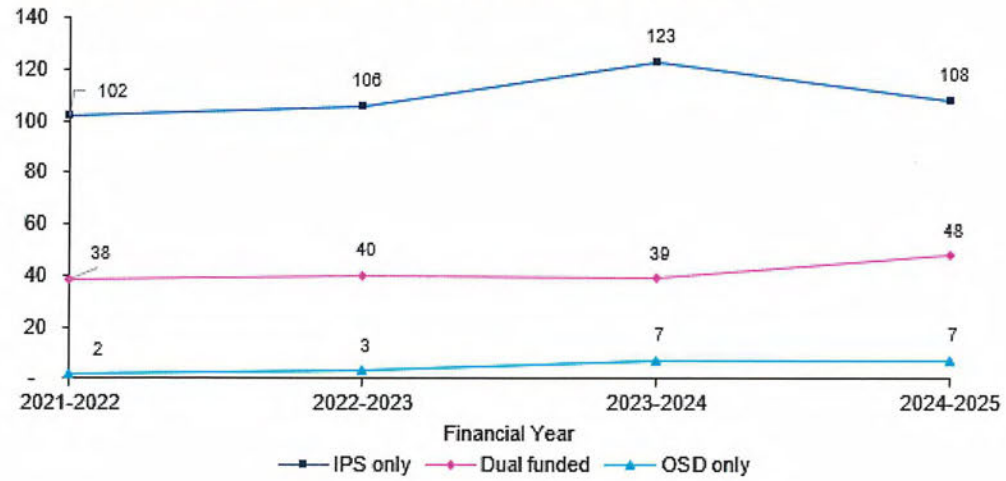
The inadequacy of the IPS standard form agreement, and the issues with associated policies and procedures used to procure such services, are also explored in Part 6 of this companion report, which focuses on deficiencies in the Department's approach to commissioning and procurement.

Relevantly, by way of further context, it is important to understand that OSD and fee-for-service funded arrangements have different procurement and contracting processes. However, both arrangements are guided by the investment specifications, which outline the priorities, objectives, requirements and performance expectations for services procured under those specifications. This is intended to ensure that investments are targeted effectively to support the safety and wellbeing of children in care. By their stated objective, the investment specifications also help align service delivery with legislative requirements, departmental strategies, and evidence-based practices.[67]

Figure A.9 of the KPMG Report shows the number of IPS only, dual funded and OSD only funded providers from FY2021-22 to FY2023-2024.[68]

[62] Statement of Bernadette Harvey (29 August 2025) [17].
[63] Service Agreement - Standard Terms (July 2025) (DFS.0006.0003.0032) cls 5, 12.
[64] Ibid cl 7.3.
[65] Ibid cl 13.
[66] Ibid cl 15.
[67] Proactive Statement of Bernadette Harvey (3 September 2025) [22]-[23].
[68] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 21.

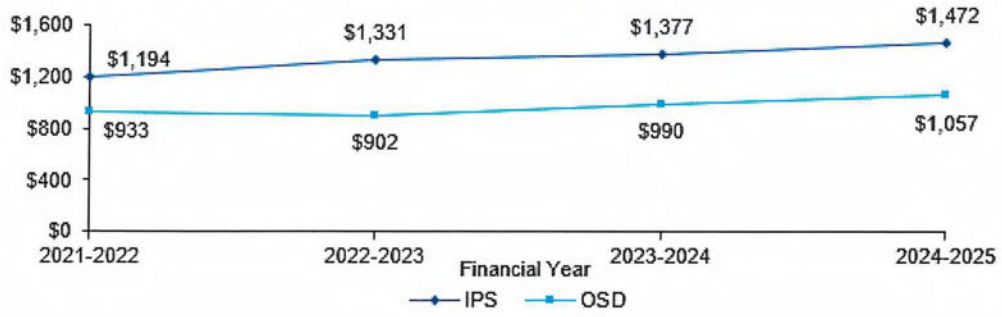
Figure A.9: Number of providers by types of contracts they deliver [1]



Across those years, most providers have been funded on an IPS *only* basis. Further, of those providers that receive OSD funding, a significant proportion also receive IPS funded placements. The apparent explanation for this is that IPS contracts generate a larger (and widening) profit margin for such providers. The Commission has thus come to discover that some providers operate a business model whereby they are "essentially breaking even on the OSD funding" and then rely on generating fee-for-service income via IPS agreements that is conducive to increased profitability.[69]

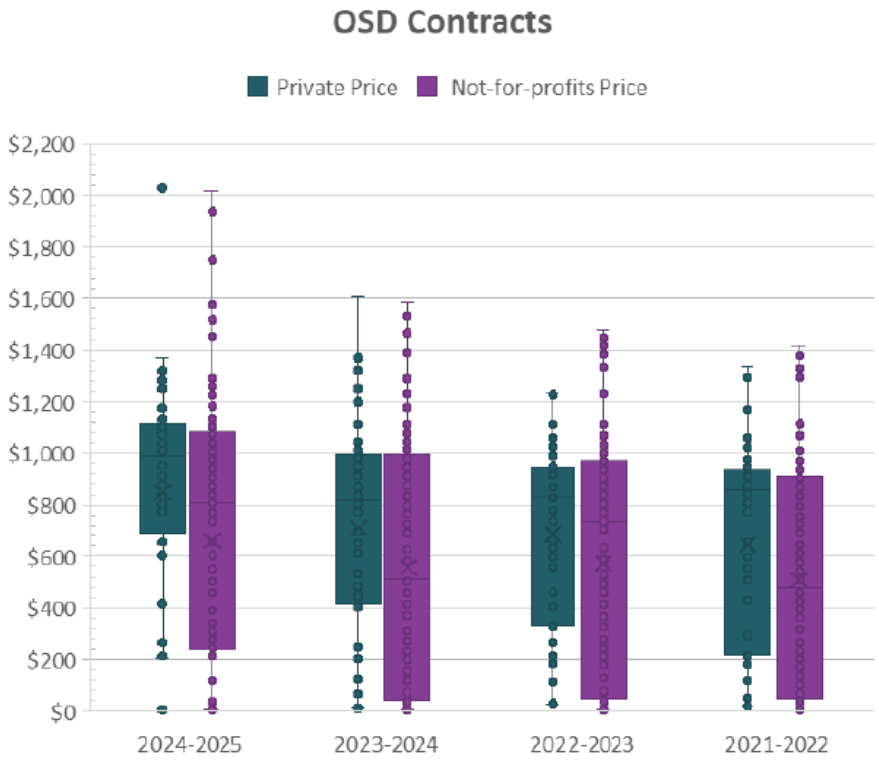
For instance, the KPMG Report concluded that in FY2021-22 the median IPS contract was 28% more expensive per day than the median OSD contract; in FY2024-25 this difference rose to 39%.[70] So much so is recorded in Figure A.10 of the KPMG Report.

Figure A.10: Median of daily cost by contract type [1]

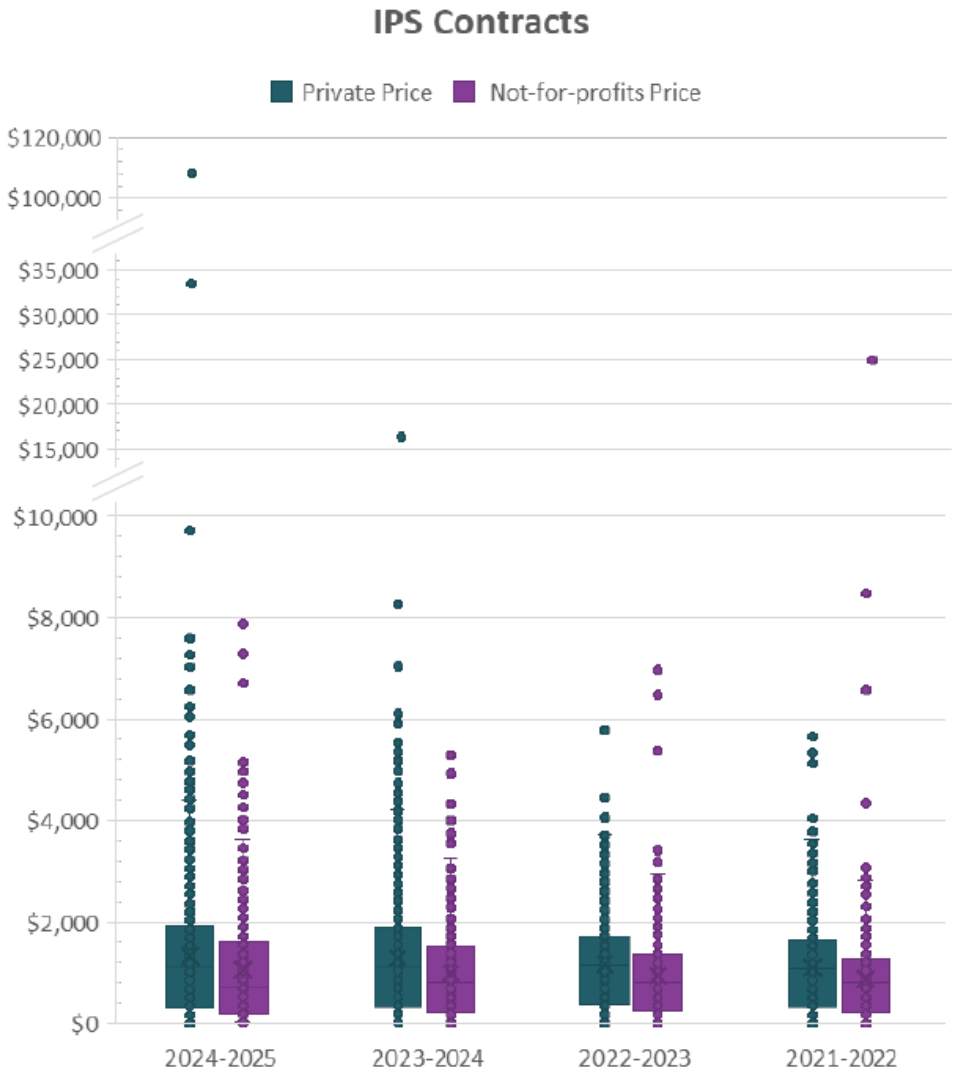


[69] See, eg, PKF audit of provider (March 2023) (DFS.0001.0002.2615) 8-9, 21.
[70] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 21.

KPMG undertook further analysis of a cross-section of 20 individual providers, the detailed findings of which were included in a confidential annexure that was only made available to the Commission. In that annexure, KPMG recorded that IPS-only providers generate higher contract margins than dual-funded providers, but even those dual-funded providers tend to extract greater profits from IPS contracts.[71] KPMG also concluded that not-for-profit providers have lower contract and staff margins than for-profit providers.[72] This is consistent with the conclusions in an internal audit finalised by the Department in September 2025, entitled "Private Providers of Child Safety Residential Services". Those findings are usefully encapsulated in the box and whisker charts extracted below.[73]



[71] KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026) 9.
[72] Ibid.
[73] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025) 11-12.



2.4.2 Licensing of IPS and OSD providers

In theory, both OSD and IPS funded arrangements may be provided by licensed and/or unlicensed service providers.[74] The licensing process starts once a supplier is: (a) delivering care services; (b) is deemed to be in-scope for licensing; and (c) has been certified for the provision of child protection placement services under the Human Services Quality Framework (HSQF).[75]

Importantly, however, the standard form service agreement for OSD providers specifies that such providers are automatically "in-scope of licensing" and must meet the practical requirements in the HSQF within 18 months.[76] The practical effect of this is that OSD providers either tend to be already licensed or on their way to becoming licensed.

[74] Proactive Statement of Bernadette Harvey (3 September 2025) [21].
[75] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 7.
[76] Ibid; see also Email to Bernadette Harvey, 2 July 2025 (DFS.0001.0002.2472) 2.

There is no equivalent requirement for IPS providers to be licensed. Instead, the process by which a fee-for-service funded organisation might become licensed is as follows.

The Child Safety Licensing Team within the Investment and Commissioning division of the Department (assisted by the staff working in the regions) review data on a quarterly basis to determine if any service providers contracted under IPS agreements are suitable for an "in-scope of licensing assessment".[77] Factors relevant to that assessment include:

1. the provider's continuity of placement service delivery;
2. whether the number of placements with the provider have increased over the past 6-12 months; and
3. whether any placements with the provider have been maintained for longer than 12 months.[78]

The Child Safety Licensing Team then notifies the relevant region of the service provider that they have been determined to be suitable for an in-scope of licensing assessment. From there, the staff in the regions determine whether an in-scope of licensing assessment will be conducted. If a service provider operates across multiple regions, the region with the most placement takes the lead in conducting the assessment and liaises with the other regions during the process.[79]

The assessment, endorsed by the Regional Executive Director, is then reviewed by Child Safety Licensing, endorsed by the Child Safety Licensing Manager and progressed to the State-Wide Licensing Panel where the recommendation is made to the licensing delegate who decides if the service provider is deemed to be in-scope of licensing.[80]

Once a provider is deemed in-scope, they will need to achieve HSQF accreditation prior to making an application to be licensed by the Department. It is only at that point that they are invited to apply to become licensed by the Department.[81]

The Commission heard evidence from the Acting Senior Executive Director of Investment and Commissioning, Natalie Wilson, that because of the various steps involved in this process, an IPS-only provider will often remain unlicensed for at least 30-36 months before they have a

[77] Statement of Natalie Wilson (25 March 2026) [102].
[78] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 5; Ibid.
[79] Statement of Natalie Wilson (25 March 2026) [103].
[80] Ibid [104].
[81] Transcript, Evidence of Natalie Wilson (9 April 2026) 5037:17-22.

demonstrated history of providing services, progress through the in-scope assessment and achieve HSQF certification.[82]

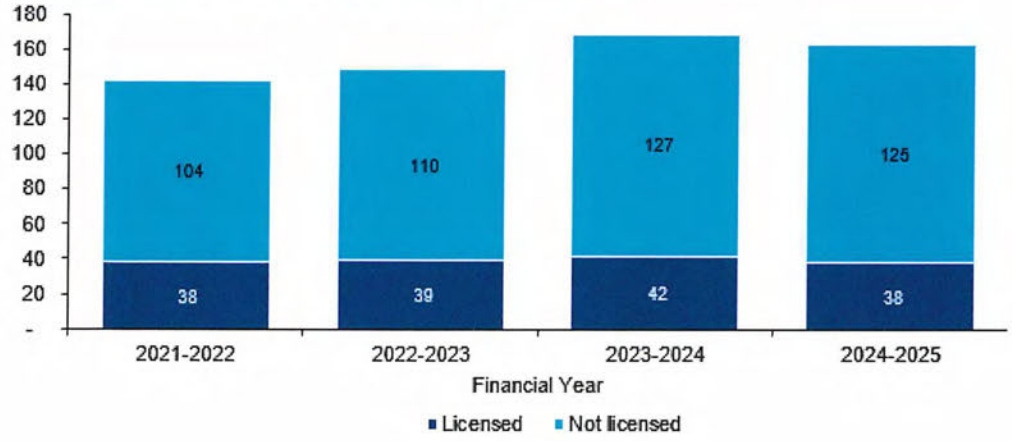
If, having progressed through the aforementioned steps, a service provider is invited to apply for a care service licence:

1. the supplier must apply, in the approved form, for a care service licence within 30 days of the invitation to apply; and
2. the application must be granted by the Department,

before such a provider is deemed to be licensed.[83]

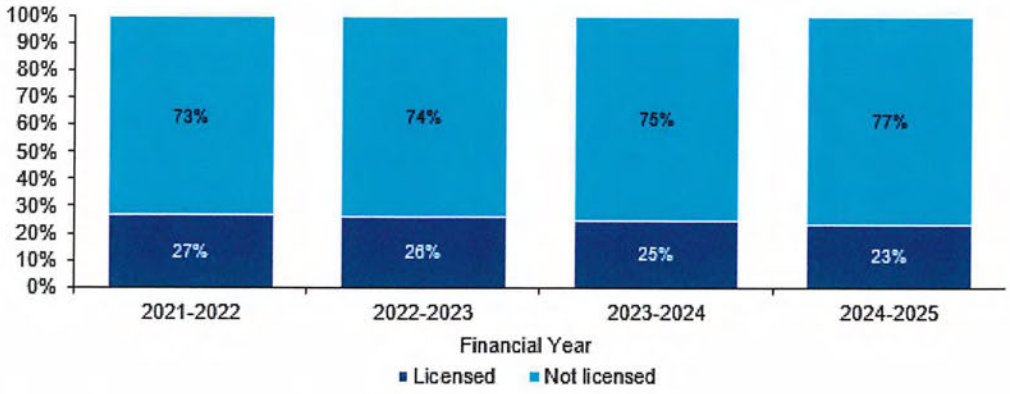
As it has eventuated in practice, the number of unlicensed providers increased substantially across the previous four financial years. During that period, unlicensed providers made up approximately 75% of the residential care market.[84] So much can be seen from Figures A.6 and A.7, which have been extracted from KPMG's Report.

Figure A.6: Number of providers by licensing status [1]



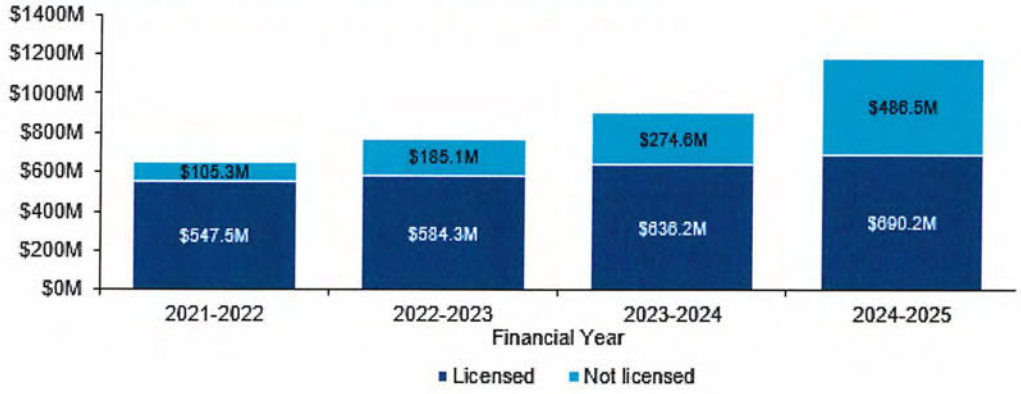
[82] Ibid 5038:16-24.
[83] Statement of Bernadette Harvey (10 November 2025) [67].
[84] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 20.

Figure A.7: Relative proportion of providers by licensing status [1]



That being said, it warrants mentioning that while there were significantly more unlicensed providers than licensed providers from FY2021-22 to FY2024-25, most of the expenditure on residential care services continued to flow to licensed providers.[85] Figure A.8 from the KPMG Report shows that to be so, notwithstanding the shifting proportion over time. This reflects the fact that many of the largest providers in the market are dual-funded, including multiple providers that receive funding in excess of $50m from the Department.[86]

Figure A.8: Total funding to providers by licensing status [1]



2.5 Workforce instability and model limitations

A final feature of the residential care model that warrants mentioning at the outset is how workforce instability among residential care providers represents one of the most persistent and structurally significant limitations of the system in Queensland.

[85] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 20.
[86] See, eg, providers B.13, B.14, B.18 in the KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026).

The findings of the QFCC's Statutory Systems Workforce Survey highlight the extent of workforce fragility across child protection and OOHC services, including residential care.[87] The survey identifies a workforce that is disproportionately young, heavily casualised, and characterised by high turnover and frequent movement between residential care locations. Important elements such as supervision, reflective practice and access to professional development are inconsistent, and opportunities to build specialist expertise are limited. As was observed in QFCC's Buyer Beware Report, these conditions are not simply the result of individual organisational decisions; they are the predictable outcome of funding and commissioning arrangements that prioritise flexibility, rapid deployment and cost containment over workforce stability and professionalisation.[88]

This is corroborated by regional feedback collated by the Department in relation to the residential care system. The sector experiences a high turnover rate due to many factors, including the difficulty of the work involved, the perceived lack of opportunities for career progression and the relatively low renumeration compared to other sectors.[89] In addition, the sector is not seen as desirable to work in for new graduates, reducing the overall permanent workforce.[90]

This has encouraged providers to look at options such as labour hire. These workers are employed by the labour hire agency rather than the residential care provider, allowing organisations to fill staffing gaps quickly and flexibly.[91] To be sure, there are advantages to such arrangements. However, an overreliance on labour hire has led to predictable challenges such as inconsistencies in the quality of care provided, limited continuity in relationships with young people, and variability in staff training and qualifications.[92] The KPMG Report also concluded that this has led to labour inputs becoming a key driver of provider profitability, and consequently of burgeoning costs in the OOHC for the Queensland taxpayer.[93]

In its review of the residential care workforce in Queensland, PeakCare (one of the peak bodies for child and family services in Queensland) has canvassed at length the advantages and challenges associated with utilising labour hire providers.[94] In summary form, the principal advantage of enabling providers to utilise labour hire arrangements is that it creates flexibility for

[87] Queensland Family & Child Commission, *Statutory systems workforce survey* (Research Report, June 2025).
[88] Queensland Family & Child Commission, *Buyer Beware: How Economic Forces are Shaping Queensland's Residential Care Market* (Report, August 2025).
[89] Department of Child Safety, Seniors and Disability Services, *Residential Care System Review Workshop Insights August-September 2023* (Presentation, September 2023) (COI.0001.0009.0041) 4, 10.
[90] Ibid 3.
[91] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 42.
[92] Ibid.
[93] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 8.
[94] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 43-44.

employers to fill short-term needs such as covering emergency placements and unexpected staff absences.[95] It also provides scalability to organisations to match the size of their workforce to uncertain placement demand, and reduces the administrative burden associated with recruitments, payroll and administrative tasks, mitigating the risk of inadvertent non-compliance with employment laws and regulations.[96]

However, it warrants mentioning that some of those perceived advantages, particularly in relation to workforce flexibility and demand elasticity, are in effect temporary fixes for a Department that fails to adequately forecast demand and contract accordingly. In line with the Commission's preliminary views, and the extensive work already underway within the Department, a system built around contracted OSD supply, with accurate modelling of residential care placements, has the ancillary benefit that providers are less dependent on temporary workforce patches.

Further, as alluded to above, utilising labour hire arrangements often results in frequent staff changes, which can disrupt service delivery and hinder the development of relationships with young people in care. That is paramount and cannot be overlooked. The quality of workers can also vary, leading to inconsistent performance and challenges with cultural integration, which can affect teamwork and collaboration.[97] There is also a risk that the competency, morale and loyalty of the residential care workforce will be further degraded if labour hire models are normalised, with workers more likely to transfer to allied occupations that are more lucrative or less demanding.[98] In that respect, the KPMG Report identified that the average funding per placement per day received by organisations that relied on labour hire arrangements was greater compared to those relying on casual or fixed-term staff, essentially because of the need to pass on agency fees to the Department.[99]

Crucially from the Commission's perspective, workforce instability is particularly problematic when assessed from a developmental and trauma-informed perspective. Children and young people in residential care have typically experienced repeated disruptions in attachment relationships, including instability in caregiving, schooling and community connections. The Commission has observed, unsurprisingly, that consistent, emotionally attuned relationships with reliable adults are central to supporting emotional regulation, building trust and restoring a sense of safety. Where their residential care placement is characterised by frequent staff

[95] Ibid 43.
[96] Ibid.
[97] Ibid.
[98] Ibid 44.
[99] KPMG, Provider Financial Analysis (Part B) (Report Confidential Annexure, 2 April 2026) 9.

changes, rotating shifts and limited relational continuity, these developmental needs are difficult to meet.

As currently configured, residential care often reproduces rather than repairs relational fragmentation. Shift-based staffing models, high turnover and organisational cultures oriented toward risk management and compliance can result in care environments in which adults appear transient and interchangeable. These workforce realities also raise fundamental questions about the extent to which residential care in Queensland can legitimately be described as 'therapeutic'. Therapeutic residential care requires far more than the presence of caring adults and basic routines. It is predicated on a stable, skilled and well-supported workforce; clear and consistently applied models of practice; low staff-to-child ratios; regular clinical supervision; and close integration with external therapeutic and specialist services. It also assumes that staff have the training, time and relational continuity necessary to understand and respond to trauma-related behaviour in developmentally appropriate ways.

There is limited evidence that these conditions and standards are being met consistently across Queensland's residential care sector. That is not to say it does not exist; however, it is not a prominent feature of the evidence produced to the Commission. In any event, what is clear is that while some providers articulate therapeutic intentions and employ elements of trauma-informed practice, workforce instability significantly constrains the feasibility of delivering therapeutic care to a high standard and at scale.

Without structural changes to how the workforce is funded, trained, supported and regulated, expectations that residential care services will consistently provide relationally rich, healing-oriented care in Queensland are unlikely to be realised. The result is a system in which children's complex needs are acknowledged rhetorically, but the conditions required to meet those needs reliably are not embedded in workforce design. In this context, residential care risks functioning less as a therapeutic intervention and more as a managed environment of containment, shaped by system constraints rather than developmental imperatives.

Chapter 3

The Growth of and Reliance on a Billion-Dollar Residential Care Sector

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 3: The Growth of and Reliance on a Billion-Dollar Residential Care System

3.1 Introduction

By 2024-25, the annual cost of placing children in residential care in Queensland had reached in excess of 1.1 billion dollars.[100] In that context, the Terms of Reference tasked the Commission with investigating the factors that contributed to the growth of, and the State's reliance on, a residential care sector of that extraordinary size.[101]

The growth in the cost of the residential care sector was the focus of public hearings held over two weeks in Brisbane in April 2026. During that hearing block, the Commission heard evidence from:

(a) the Honourable Leanne Linard MP, the Minister for Children, Youth Justice and Multicultural Affairs from November 2020 to May 2023;

(b) relevant past and present Departmental officials, including:

(i) Deidre Mulkerin, the Director-General of the Department from February 2020 to December 2024;[102]

(ii) Arthur O'Brien, the Deputy Director-General of Corporate Services from November 2020 to September 2025;[103]

(iii) Danny Short, the Chief Finance Officer;

(iv) Bernadette Harvey, the Deputy Director-General of Commissioning;

(v) Michelle McNamara, a Director of the Reform Implementation Office;

[100] Data provided of expenditure on each provider for FY2023-24 and FY2024-25 in Department of Families, Seniors, Disability Services and Child Safety, *Detailed service provider list* (Spreadsheet, 16 July 2026) (DFS.0001.0001.0272); Statement of Danny Short (30 March 2026) [55]; Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Demand and Complexity* (Brief to Minister, 10 November 2020) (DFS.0397.0004.0222); Department of Children, Youth Justice and Multicultural Affairs, *Placements – Residential Care* (Brief to Minister, 9 December 2020) (DFS.0397.0004.0511).
[101] 'Commissions of Inquiry Order (No. 1) 2025' in Queensland, Queensland Government Gazette - Extraordinary, Vol. 399 No. 16, 23 May 2025, 137 [3](a).
[102] In that role, Ms Mulkerin was also the "accountable officer" under the *Financial Accountability Act 2009* and therefore the person invested with ultimate approval authority over the expenditure of the Department's funds, and responsible for achieving "reasonable value for money".
[103] Prior to this, Mr O'Brien had also been the Chief Finance Officer from February 2012 to May 2018 and Assistant Director-General responsible for financial services, legal services, and audit and compliance from May 2018 to November 2020.

(vi) Natalie Wilson, the Acting Senior Executive Director of Investment and Commissioning;

(vii) Hanelie Lategan, the Chief Procurement Officer; and

(c) Dan Jefferson, the National Lead Partner of Health, Ageing and Human Services at KPMG.

The Commission has also been assisted by a large body of relevant documentary evidence produced to it by the Department, the Department of Treasury, Queensland Treasury Corporation, PeakCare, QFCC and various residential care providers, as well as submissions received from a range of stakeholders.

3.2 The factors that drive cost in OOHC

There are four main factors which drive the overall cost of Queensland's OOHC sector.[104]

3.2.1 Demand-side factors

The first two are demand-side: the ***volume*** of children entering the OOHC system, and the ***complexity*** of their needs and behaviour. The ***volume*** of children drives cost because there is a cost associated with every placement. The ***complexity*** of the children's needs and behaviour drives costs for two reasons: children with complex needs and challenging behaviour may be less suited for low-cost, family-based care; and a small cohort of children with very high complex needs may only ever be suited to expensive, highly individualised, IPS placements. Evidence before the Commission suggested that this cohort comprised less than a third of all children on IPS placements.[105]

The Department has very little control over either of the demand-side factors.[106] This reflects the fact that, by its very nature, the market for residential care services in Queensland is inelastic, every child that enters the care of the State requires a placement and demand is therefore relatively unresponsive to fluctuations in price. The Queensland Government, as the sole buyer, will continue to purchase residential care services in line with its legislative responsibilities regardless of rising input costs, including housing, utilities and insurance costs.[107]

[104] Transcript, Evidence of Danny Short (10 April 2026) 5141:1-30, 5142:4-17.
[105] Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 20; Department of Child Safety, Seniors and Disability Services, *Queensland Residential Care Review* (Final Report, November 2024) (COI.0001.0009.0075) 10.
[106] Transcript, Evidence of Danny Short (10 April 2026) 5143:9-33.
[107] Transcript, Evidence of Dan Jefferson (7 April 2026) 4809:27-39.

These two demand-side factors contribute not only to the service delivery cost of OOHC, but also to the Department's staffing costs across a variety of activities.[108] That is, the Department requires a range of staff in the regions and in its service delivery, commissioning and corporate services teams to supervise and manage those child safety placements. Those costs are reflected across the care continuum, including in terms of the costs associated with employing frontline and head office staff.[109]

3.2.2 Supply-side factors

The third and fourth factors that drive the cost of OOHC are supply-side. The third is ***supply mix*** that is, whether there is sufficient supply to allow children entering care to be placed in the most cost-effective form of care suitable to their needs. The fourth is ***market engagement,*** that is, whether, when required to contract for residential care, the Department does so in a way that represents value for money.[110]

Getting the ***supply mix*** right is critically important.

Principally, it is important for welfare reasons. As explained above, for a child who is suited to family-based care, being placed in residential care instead is associated with much worse outcomes,[111] including high rates of trauma, self-harm, suicide attempts, unmet mental health needs, placement instability, children going missing from care, and exposure to further abuse.[112] For a child who is suited to an OSD-funded residential care placement, being placed in residential care under an IPS agreement instead means that the child is not necessarily under the care of a licensed provider and does not have the continuity of care associated with a longer-term OSD arrangement.[113]

Getting the supply mix right is also critically important for economic reasons. There are very significant cost differences between the main forms of placements. Specifically:

(a) residential care placements are on average around 10-15 times more costly that family-based care;[114] and

[108] Transcript, Evidence of Danny Short (10 April 2026) 5142:31-41; 5143:27.
[109] Ibid 5142:4-41.
[110] Ibid 5139–5141, 5140–5141.
[111] Ibid 5138:35-5139:9; Transcript, Evidence of Leanne Linard (16 April 2026) 5463:6-25.
[112] Transcript (7 April 2026) 4793:37-41; KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 11.
[113] Transcript (7 April 2026) 4797-4799; Transcript, Evidence of Dan Jefferson (7 April 2026) 4814:40-43, 4832:36-39, 4850:15-40; Transcript, Evidence of Leanne Linard (16 April 2026) 5455:4-12; Transcript, Evidence of Hanelie Lategan (9 April 2026) 5111 6-13, 5208.
[114] Transcript, Evidence of Danny Short (10 April 2026) 5138:37-42; Evidence of Deidre Mulkerin (14 April 2026) 5314:10-20.

(b) even among residential care placements, IPS placements are about 30 to 40 per cent more expensive than the equivalent OSD-funded residential place.[115]

As a result, if the State lacks sufficient supply of family-based placements for children suited to family-based care, a cohort of those children will "overflow" into residential care. When that occurs, the State pays an economic premium for a placement which is, by any measure, worse for those children. The economic consequences of the failure to have sufficient supply of family-based care in place are stark: for every 120 or so children who are suited to family-based care but "overflow" into residential care instead, the State pays an additional $50m annually for their care.[116] All of that additional cost is wasted.[117]

Accordingly, the single most important thing that the Department can do to control the cost of the OOHC system is to ensure there is a supply of family-based care sufficient to place all (or as many as reasonably possible) of the children suited to family-based care with families.[118] If that objective is achieved, the State will avoid the expenditure associated with placing children suited to families in residential care facilities. The closer the State comes to achieving this objective, the lower its wasted costs will be.

Regrettably, the evidence before the Commission was that the State has not come close to achieving this objective since at least 2019. The cohort of children suited to family-based care who were instead placed in residential care facilities was concerningly high in 2019; and since then, the size of the cohort has only increased.[119] Now, more than half of the children in residential care are suited to family-based care but remain in residential care because of the Department's failure to generate or maintain adequate supply of family-based care placements.[120] Indeed, evidence before the Commission suggested that there are currently around 1,555 children who are suited to family-based care but are instead in residential care. That represents roughly $650 million in wasted annual cost to the State, and its taxpayers.[121]

Similarly, if the State lacks sufficient supply of OSD-funded residential care placements for children suited to such arrangements, a cohort of those children will instead need to be placed in short-term IPS placements. When that occurs, the State also pays a 30 to 40 per cent premium for a placement for which the child is not suited. Again, that additional cost is entirely wasted

[115] Transcript, Evidence of Danny Short (10 April 2026) 5140:1-8.
[116] Transcript, Evidence of Danny Short (10 April 2026) 5164-5165.
[117] Ibid 5164:35.
[118] Ibid 5162:28-39; 5164:30-35.
[119] Transcript, Evidence of Leanne Linard (16 April 2026) 5465:14-19.
[120] Transcript (7 April 2026) 4793:42-47; 4794:1-3; Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 24; Transcript, Evidence of Bernadette Harvey (17 April 2026) 5549:12-19.
[121] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5583–5591.

cost, insofar as it could be avoided by long-term planning and commissioning. Accordingly, the second most important thing that the Department can do to control the overall costs of the OOHC system is to reduce, to the extent possible, the number of children suited to OSD-funded residential care placements who "overflow" into IPS-funded residential care placements.[122]

There is no reason in principle why both of these things, increasing the supply of family-based care and increasing the supply of OSD funded residential placements, cannot be done in tandem.[123] While arranging supply to meet the demand for family-based care should be the Department's primary objective, as it presents the greatest opportunity to improve outcomes for children and avoid wasted cost, arranging adequate supply of OSD residential places remains an important complement to that objective, for two reasons.[124]

First, there will always be a cohort of children entering care who are not suited to family-based care but do not require highly specialised or individualised care over the long-term. Evidence before the Commission suggested that this cohort, for whom OSD-funded residential care is the most cost-effective placement suitable to their care needs, is substantial, and includes between a third and a half of all children who end up in IPS placements.[125] Having a supply of OSD-funded placements for that cohort avoids the wasted cost associated with these children "overflowing" into less suitable and more expensive IPS placements.

Secondly, ensuring adequate supply of OSD residential places is an important failsafe. Even the best-executed attempts to ensure adequate supply of family-based care may not, or may not immediately, make up the gap between funded family-based supply and demand. This might be because of, for example:

(a) the time-lag associated with bringing new family-based carers online;

(b) factors that frustrate the recruitment of family-based carers; or

(c) unanticipated surges in demand driven by disruptive events, such as a recession, or a public health crisis.

While some gap between supply of family-based care and demand remains, it is both better for the relevant children and the finances of the State that the gap is met, so far as possible, with better value, long-term, OSD placements delivered by licensed providers.

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[122] Transcript, Evidence of Danny Short (10 April 2026) 5164:30-35.
[123] Cf Transcript, Evidence of Arthur O'Brien (13 April 2026) 5269.
[124] Pursuing both was, for example, recommended by: Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 20-24. Cf Transcript, Evidence of Arthur O'Brien (13 April 2026) 5268-5269).
[125] Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 20.

When the Department is required to pay for residential care placements, the fourth factor, ***market engagement*** influences the price it pays, and the quality of care it receives in exchange for the price it pays. Effective market engagement includes: (a) clearly communicating price expectations to the market; (b) promoting competition between providers, where possible; (c) contracting in a way which allows the Department to know, precisely, what services it is paying for, and to assess the quality of those services; (d) the Department acting as an "informed purchaser" with a sophisticated understanding of the providers with which it contracts; and (e) proactively shaping the market by ensuring there is sufficient supply in thin-markets and by supporting a diversity of providers to remain profitable.[126] As several Departmental officials accepted, the price the State pays may also be affected by whether the State enters, or is at least open to enter, the market for the provision of residential care services.[127]

The ways in which the Department's approach to commissioning and procurement have enabled, or failed to arrest, the burgeoning expenditure on residential care are explored further in Part 6 below.

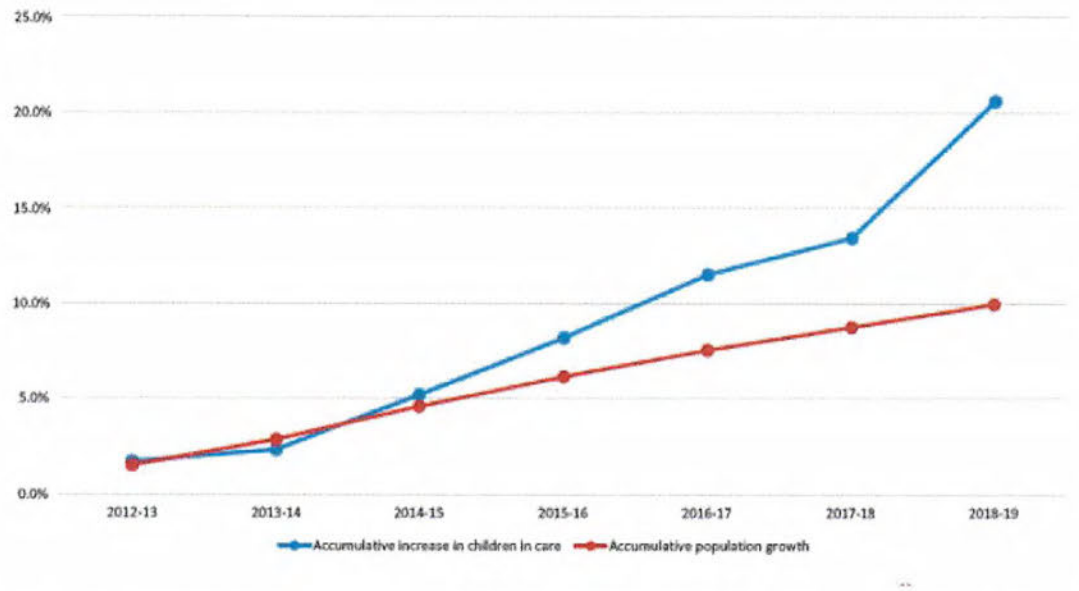
3.3 A gap emerges between funded supply and demand

In the years immediately after the Carmody Inquiry, it appears that the demand-side factors were relatively stable. The number of children in OOHC grew at a manageable rate.[128] At that time, the Department's appropriated budget funding for child safety placements was indexed to population growth.

However, by the 2015-16 financial year, the growth in children entering care had begun to exceed population growth. Then, over the next three financial years, the growth in children entering care began to significantly outpace population growth. As a result, by early 2019, a significant gap had emerged between funded places, in family-based care, or OSD residential care, and demand for places. The increasing gap is shown in the following graph prepared by the Department for the

[126] Transcript, Evidence of Danny Short (10 April 2026) 5138:37-42, 5140:1-8. See also supply constraints discussed in KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 8 [ES.11], 39-40 [A.51]-[A.55].
[127] Transcript, Evidence of Michelle McNamara (9 April 2026) 5109-5110; Transcript, Evidence of Hanelie Lategan (13 April 2026) 5217–5221; see also Transcript, Evidence of Arthur O'Brien (13 April 2026) 5248-5251.
[128] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 14, Figure 3; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5316:25-37.

Department of Treasury in October 2019, which mapped increases in children entering care against population growth in the years 2012 to 2019:[129]



Over the coming years, that gap continued to grow as demand for OOHC continued to exceed growth in the Department's budget.[130]

Notably, the increased growth in demand, and the emergence of a gap between demand and supply, *preceded* the COVID-19 pandemic. Several witnesses suggested that COVID-19 was one of the main reasons the supply mix had failed.[131] However, the objective evidence before the Commission demonstrated, unambiguously, that the supply mix was failing *before* COVID-19 commenced. For example, the Department had internally diagnosed a "market failure" on the basis of its supply and demand analysis of the 2018-19 financial year.[132] It may well be that the COVID-19 pandemic further *exacerbated* the gap between demand and supply, but it plainly did not create it.[133]

[129] Department of Child Safety, Youth and Women, *Demand for Child Protection Placement Services - Briefing for Treasury* (Presentation, 22 October 2019) (DOT.0011.0002.9421) 4.
[130] Transcript, Evidence of Danny Short (10 April 2026) 5154:44-47.
[131] See Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5325-5331; Transcript, Evidence of Leanne Linard (16 April 2026) 5437, 5439, 5449-5451.
[132] See Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 8; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5317, 5319:42.
[133] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5331:12. See also Transcript (8 April 2026) 4948:44-4950:5.

3.4 IPS placements are used to cover the gap between funded supply and demand

From the 2018-19 financial year onwards, the growing gap between funded places and demand was overwhelmingly met by very expensive, largely unfunded, IPS placements. That was a very substantial failure in commissioning and procurement.

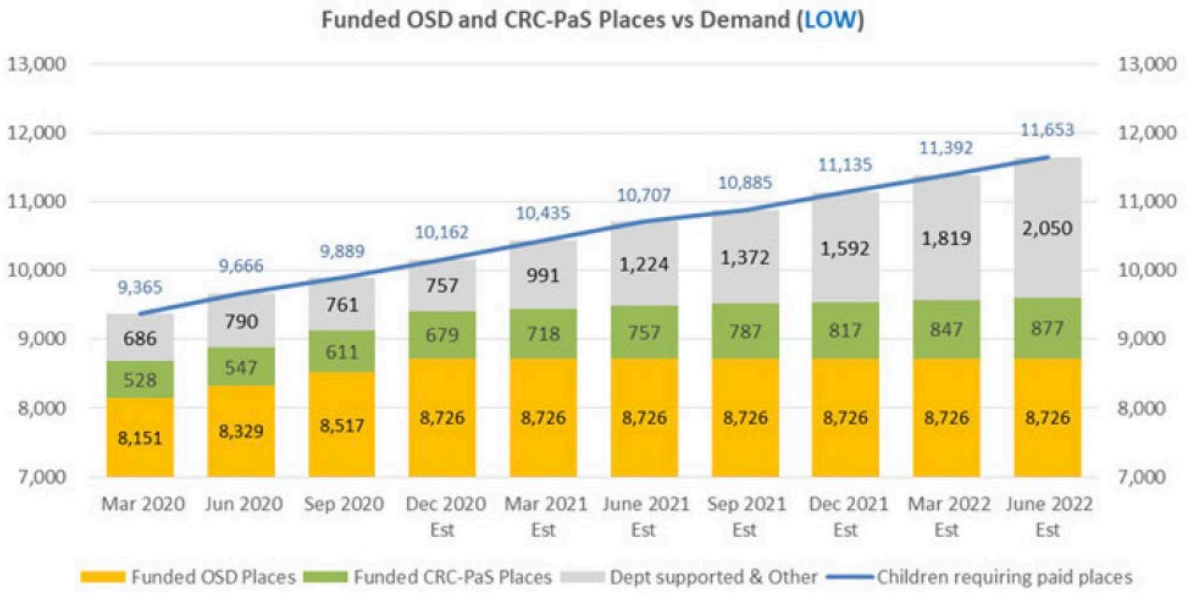
IPS placements are intended to be used for essentially two purposes. The first is to provide a short-term emergency placement for a child while a longer-term placement is located. The second is to provide an ongoing, bespoke placement for a small cohort of very high complex needs children, who require highly specialised, and individualised, support.[134]

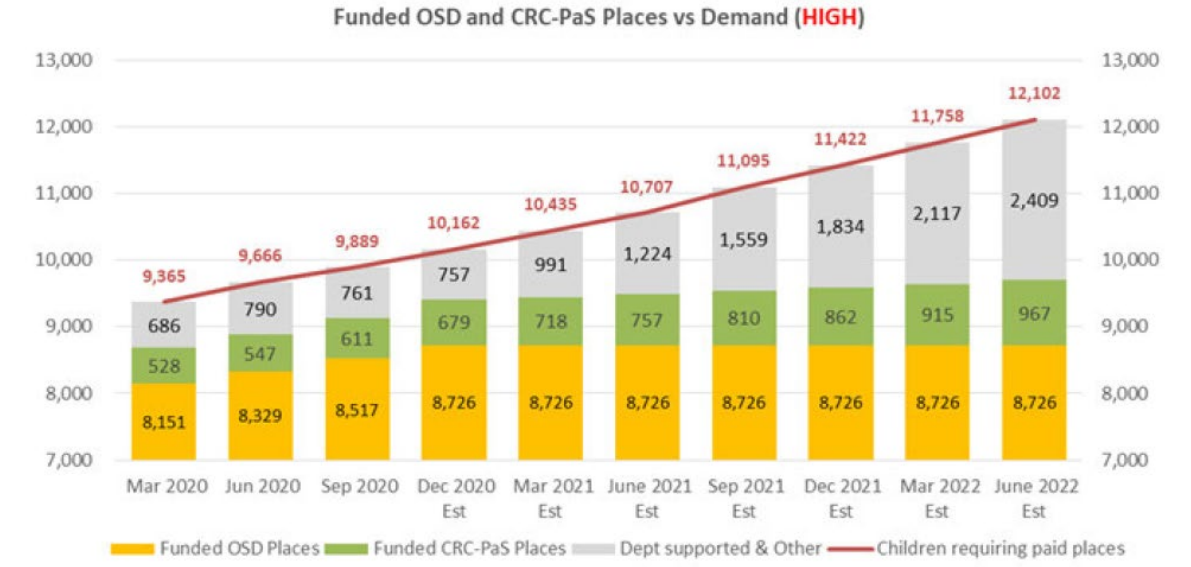
It is because of this first purpose (use as an emergency placement) that IPS placements alone can be purchased by the Department irrespective of whether funds are available to cover the purchase. Specifically, IPS placements can be purchased using the Child Related Costs, Placement and Support (CRC-PaS) funding source, an emergency funding source available to the Department to ensure that all children requiring placements are able to be safely placed somewhere, even where no funded option is available.[135] By contrast, leaving aside some matters of detail that are not presently relevant, more cost-efficient family-based care and OSD-funded residential care placements cannot be purchased by the Department unless budgeted funds sufficient to cover the placement cost are available in the forward estimates.

From 2018-19 onwards, IPS placements were increasingly used for a purpose very different to their intended purposes, namely, to bridge the growing gap between the supply of funded placements and overall demand. For example, Mr O'Brien (the former Deputy-Director General of Corporate Services) accepted that the following graphs, prepared by the Department in March 2021 to inform deliberations in the Cabinet Budget Review Committee (CBRC), showed the increasing gap between funded places and demand being filled by unfunded IPS placements. In the graphs, the yellow and green bars collectively represented budgeted places in family-based and residential care (whether IPS or OSD funded). The grey bars represented the unfunded gap, which Mr O'Brien accepted would "mostly be filled by emergency IPS placements". As the graphs

[134] Transcript, Evidence of Danny Short (10 April 2026) 5136:42-5137:24; Transcript, Evidence of Michelle McNamara (9 April 2026) 5006:1-9, 21-35; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5313-5315.
[135] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 8.

demonstrate, without appreciable growth in funded placements, unfunded IPS placements would need to increase very rapidly simply to keep pace with linear growth in demand.[136]





As several Departmental officials accepted, in the years that followed 2018-19, IPS placements went from being an emergency and/or specialist placement option to being primarily an "overflow service". Mr Short neatly encapsulated this point in his evidence when he said that because there were not "available placements in family-based care or indeed OSD, [children] have overflowed … to those higher cost short-term [IPS] contracts."[137] Children who were placed in IPS

[136] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5270-5272.
[137] Transcript, Evidence of Danny Short (10 April 2026) 5154:43-5155:7.

placements for this reason then tended to stay there for long periods, because there was rarely any surplus funded family-based or OSD-funded placements to which they could be moved.[138]

Even though IPS placements were by 2018-19 being used essentially as an overflow service, the Department's funding and financial delegation rules continued to reflect the original, emergency purpose. Perversely, this meant that under financial delegation rules designed to ensure the "accountable, efficient, effective and economic use of public resources"[139] only IPS-funded placements, the least economical of all options, could be entered into when appropriated funds were exhausted or inadequate to fund a family-based or OSD residential care placement.[140] As mentioned, this is because only these placements could be purchased using the CRC-PaS funding source, which was all that remained available to the Department without a forward-looking budget appropriation.

3.5 Unfunded IPS placements drive exponential cost and deficit growth

For obvious reasons, the use of very expensive, unfunded IPS placements to service the growing gap between funded supply and demand caused the Department's costs, and deficits, to start growing exponentially.[141] Across the 2016-17 to 2018-19 financial years, the Department's expenditure on IPS placements had begun to grow by more than 30 per cent per annum, albeit that at that time the child safety budget was substantially smaller in aggregate terms.[142] However, the latter fact only served to obscure the problem that was emerging. Because those IPS placements were largely unfunded places, purchased using the CRC-PaS funding source, the Department's overspends, and deficits, began to grow exponentially as well.[143]

A further, and related issue, was that the Department had not been able to increase the supply of family-based care arrangements to offset the additional placements required. Such placements were not being generated or maintained notwithstanding that it was well understood that promoting kinship care initiatives, and recruiting, training and retaining additional foster carers,

[138] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5313:31-46.
[139] Transcript, Evidence of Danny Short (10 April 2026) 5131:19-24.
[140] Ibid 5155:23-26, 5156:6-12, 5156:26-35, 5157:30-35, 5170:24-30; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5347:19-37.
[141] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5316:25-37.
[142] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008).
[143] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) records the 32% annualised increase in IPS costs; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5316:25-37.

would substantially reduce demand on residential care, improve quality of care for children in the OOHC system and produce a net financial benefit.[144]

This dynamic, exponentially rising costs, and deficits, driven by the use of IPS placements to cover a gap between demand and funded supply of placements (whether in family-based care or non-family based care), was clearly identified in two reports from early 2020 (one internal, the other external), which laid a roadmap for what was to follow.

That being said, the Commission of course recognises that the ease with which these issues can be articulated belies the complexity of their resolution. Understanding this tension is essential to any critical examination of the issues that led to the emergence of a billion dollar residential care sector.

3.5.1 The Care Systems Investment Plan

The first report was the Care Systems Investment Plan (conveniently, the CSIP), which was prepared and finalised by the Department in January 2020. The CSIP succinctly identified the supply mix problem facing the Department: "There are not enough planned funded places for children in care. Therefore, kids are accessing high cost short term care models."[145]

The CSIP identified further that current supply of OSD funded placements was fully utilised, leading to reliance on emergency high-cost arrangements to meet demand. In particular, as at September 2019, the CSIP recorded that there were already 777 more children requiring placement than there were funded places, and that demand gap was being bridged by placing those children in IPS placements. It also recorded, in a foreshadowing of what was to come, that the use of IPS placements to cover the demand gap had:

> ...resulted in $115M overspend in the Child Related Costs-Placement and Support [CRC-PaS], emergency funding for placements. The department is forecasting an overall overrun of $70M primarily, due to these high cost arrangements.[146]

The takeaway message from the CSIP was that a failure to invest in new care options will continue to result in over expenditure on IPS agreements in the coming years.[147] So much was apparent from supply and demand modelling prepared for that report, which projected that expenditure on unfunded IPS placements would all but double between the 2018 and 2020 financial years, just

[144] See, eg, Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 34.
[145] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 5.
[146] Ibid.
[147] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 6.

as it had all but doubled between the 2017 and 2019 financial years. The former Director-General, Ms Mulkerin, who commenced in that role in early 2020, recognised during her evidence that this was an exponential growth curve.[148]

The CSIP also identified the solution to arresting exponential cost and deficit growth. What was needed was an "immediate investment" in "less intensive and cost efficient models of support, creating a dividend on current expenditure".[149] Among other things, the CSIP recommended a significant and immediate upfront investment in both new foster and kin carers, to create an additional 874 care options. The cost-benefit modelling showed that, over four years, those investments in foster and kinship carers would generate net savings nearly three times larger than the initial investment.[150]

3.5.2 The QTC Report(s)

This was not an isolated prophecy. The second report, published shortly thereafter, was the Queensland Treasury Corporation's ***Review of Out of Home Placement Services*** (conveniently, the QTC Report or Reports), which itself comprised multiple phases. The Queensland Treasury Corporation (QTC) is a statutory corporation. It is the central financing authority for the Queensland Government and, among other things, provides financial analysis and modelling services to the State.

The first phase of that report was delivered on 6 April 2020, although interim findings and early drafts of the report were circulated to key Departmental officials in February and March.[151] The second phase of that report was finalised on 18 August 2020, following a presentation to senior executives of the Department, the Department of Premier and Cabinet and Queensland Treasury.[152] A briefing of the Phase II Report was also prepared for the Director-General, which was in effect a synthesis of the more detailed conclusions in the body of the report.[153]

The QTC Report was commissioned at the insistence of the CBRC. During the 2019 Mid-Year Fiscal and Economic Review (MYFER), the Department had revealed to the CBRC that it was expecting its second successive annual deficit, and that the 2020 financial year deficit was

[148] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5316:25-37.
[149] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 5-6.
[150] Ibid 32-34.
[151] See, eg, Transcript, Evidence of Arthur O'Brien (13 April 2026) 5260:11-17].
[152] See Department of Child Safety, Youth and Women, *2020-21 Budget Deficit* (Cabinet Budget Review Committee Policy Submission, August 2020) (DFS.0397.0005.0116) 2.
[153] See Queensland Treasury Corporation, *Child Safety Phase II Report - Briefing to Director-General* (Presentation, 18 August 2020) (DFS.0288.0327.0164).

projected to be more than triple the $20m deficit recorded in the 2019 financial year. The projected deficit would be driven by a more than $132m overspend on IPS placements.[154]

As a condition of funding the projected deficit, the CBRC insisted that QTC independently analyse the factors driving the steep cost and deficit growth and identify the measures that might most cost-effectively arrest that growth.[155] As part of that engagement, QTC was also asked to analyse the CSIP, which has been drafted for the 2020-21 budget process, but was seemingly shelved due to the COVID-19 pandemic. QTC was asked to provide its findings in time to inform consideration of the Department's main budget submission for the 2020-21 financial year.[156] There was broad consensus among the relevant Department witnesses that the QTC Report was credible and rigorous and that the conclusions reached were correct.[157]

Ultimately, through the QTC Reports, the Department received advice, conveyed in unambiguous terms, that:

1. growing demand and challenges in the investment and commissioning of OOHC services was putting the Child Safety budget under considerable and increasing pressure, and likely delivering sub-optimal outcomes for children;[158]
2. the Department had to collaborate with Treasury in relation to constraints around long-term contracting and budget certainty, to ensure that it was appropriately committed to long-term contracting for known demand and complexity of the children entering OOHC;[159] and
3. failing a shift in the Department's approach to commissioning and procurement, the increasing demand for and complexity of placements would continue to outstrip supply, with the likelihood that such placements would need to be funded under expensive fee-for-service arrangements.[160]

Further, in its review, QTC warned that the lead time required to facilitate an increase in the number of family-based placements and procure sufficient market capacity meant immediate

[154] Department of Child Safety, Youth and Women, *Incoming DG Brief* (Brief, 21 January 2020) (DFS.0288.0327.0770); Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Deficit - Overview of additional funding provided to address the child safety deficit* (Figures, March 2026) (DFS.0376.0001.0001).
[155] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5259-5260.
[156] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5260:19-24.
[157] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5274:29-37; Transcript, Evidence of Danny Short (10 April 2026) 5172:2-7; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5331:1-3, 5332:12-24.
[158] Department of Children, Youth Justice and Multicultural Affairs, *2021-22 Budget Submission* (Cabinet Budget Review Committee Policy Submission, 10 June 2021) Submission Attachment No 1, 1.
[159] Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 9.
[160] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 24.

action and careful monitoring were required.[161] If the Department did not obtain authorisation and support from Treasury to make a sustained commitment to identifying, supporting and retaining family-based carers, the gap in the market would be filled by short-term IPS expenditure on residential care placements, in which value for money is seldom achieved and placement instability is common.[162]

At a level of granularity, the QTC Reports also identified that:

(a) the steep increase in OOHC costs in the previous two financial years had been largely driven by a 32 per cent annualised increase in IPS expenditure;

(b) the Department's deficits in the 2019-20 financial year, and in later years, were likely to be worse than the Department's forecasts;

(c) capacity in family-based and OSD residential care was "full", resulting in the utilisation of high-cost IPS placement options to pick up the overflow; and

(d) current "budget constraints" had resulted in "perverse outcomes, with short term contracts being purchased (which are far more expensive in the long-term).[163]

The overall conclusion was that failures in information and data collection had resulted in a placement system lacking the ability to strategically plan, develop sufficient insight into children's outcomes, clarify system pressure points, and improve service provision.[164] The Department's procurement practices were inflexible, it was not in a position to attract sufficient family-based placements to meet demand, and consequently there were material risks to the ability of the Department to deliver OOHC services within budget across the coming years.[165]

The QTC Reports also largely validated the CSIP. For instance, Phase I of the QTC Report described the CSIP as "credible and evidence based".[166] It showed that the key investments, in foster care, kinship care, and tailored support would, by moving 1,059 children that would otherwise be in residential care into family-based care, deliver a net financial benefit of around $181m on an investment of $85.3m.[167] There was an apparently unanimous view that in the medium and long-term, the Department had opportunities to avoid substantial costs - and by

[161] Queensland Treasury Corporation, *Child Safety Phase II Report* (Report, August 2020) (DFS.0288.0327.0051) 41.
[162] Ibid 21-22.
[163] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 5-6.
[164] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 28.
[165] Ibid 28-29.
[166] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 38.
[167] Ibid 32-34, 38.

extension, substantial deficits, by making an upfront investment in family-based, developing a better understanding of the services the Department purchases from providers and proactively shaping the market.[168]

3.6 The window of opportunity to arrest exponential cost and deficit growth

The key officials with financial responsibility for the Department at the relevant time, including those that gave evidence at the hearings: Ms Mulkerin, Mr O'Brien and Mr Short, understood the CSIP and the QTC Reports to clearly identify both the relevant problem and solution. The relevant problem was exponential cost and deficit growth driven by the use of unfunded IPS placements to cover the gap between funded supply and demand. The relevant solution was investment to increase funded supply, and particularly the funded supply of low-cost family-based care.[169] To solve the problem, the investment in the supply of funded, lower-cost, places needed to have three features: it needed to be ***substantial***, ***upfront***, and ***immediate***.

It needed to be ***substantial*** because, by early 2020, there was already a very significant gap between funded supply and demand, which was forecast to continue increasing in the coming years. Ms Mulkerin explained that it was by then clear that a "substantial investment in lower-cost forms of care" was required because a "smaller investment would not produce the scale of change required to ease placement pressures".[170]

The investment needed to be ***upfront*** because, for reasons already explained, lower-cost forms of care could only be purchased by the Department with appropriated funds (budgeted in advance). As Ms Mulkerin explained, changing the contracted supply mix and arresting the growing reliance on IPS placements required "long-term committed locked-in funding" to increase the supply of lower cost placements.[171] Because the investment needed to be ***upfront***, simply increasing the "deficit funding" provided to the Department was incapable of solving the problem. "Deficit funding" is the appropriation of amounts to the Department simply for the purpose of covering actual or projected deficits that is, the amounts spent in excess of the funds appropriated to the Department.

As mentioned, the Department's deficits were, in the relevant period, overwhelmingly driven by the purchase of IPS-funded placements using the unfunded CRC-Pas funding source. There is

[168] See Queensland Treasury Corporation, *Child Safety Phase II Report - Briefing to Director-General* (Presentation, 18 August 2020) (DFS.0288.0327.0164) 5-9.
[169] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:1-5.
[170] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5319:21-42.
[171] Ibid 5321:10-27.

therefore a critical functional distinction between the provision of ***upfront*** and ***deficit*** funding. The provision of ***upfront*** funding affords the Department the opportunity to adjust the supply mix in a way which reduces reliance on unfunded IPS agreements. ***Deficit funding*** affords the Department no opportunity to adjust the supply mix. It simply funds the consequences of overreliance on unfunded IPS agreements.[172]

Ultimately, the key financial executives from the Department accepted that the running and funding of consecutive deficits produced a "vicious cycle" that operates, in escalating financial terms, as follows:

> *if the department is not funded upfront to get the supply mix right, the overflow goes to IPS, IPS drives deficits, and then deficits make it more difficult for [the Department] to have the upfront funding [it needs] to get the supply mix right next year.*[173]

Ms Mulkerin, similarly and colourfully, described cycles of deficit funding as simply "chasing your tail" or "just treading water", where the longer you delay "more and more effort has to go into treading water."[174]

Finally, the investment needed to be ***immediate*** for several important reasons. One reason that investment needed to be immediate was that the logic of an exponential growth curve means that any delay drastically increases the cost of action. As Ms Mulkerin explained during the hearings, "as the problem grows exponentially the cost to meet the problem grows exponentially as well".[175] Another reason is that investments in lower-cost forms of care take some time to translate into additional placements. For example, a new foster carer may take six-to-nine months before they are approved to accept a placement; a kinship carer may take longer.[176] Another reason that the investment needed to be immediate was because the significant net costs savings of upfront investments in lower-cost forms of care would often only start to be realised in the third or fourth year after the investment.[177]

As a result, the key Departmental witnesses each accepted that there was a narrow window of opportunity for the Department to arrest the exponential cost and deficit growth by making the investment necessary to reset the supply mix. Mr Short accepted that the "window of opportunity" spanned the period 2019 to 2021. Mr O'Brien and Ms Mulkerin each accepted that

[172] Transcript, Evidence of Danny Short (10 April 2026) 5161:38-46.
[173] Ibid 5161:3-26; see also Transcript, Evidence of Arthur O'Brien (13 April 2026) 5272:18.
[174] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5347:22-24.
[175] Ibid 5342:7-24.
[176] Ibid 5317:32-38; 5318:12-23.
[177] Ibid 5318:8.

the window of opportunity was one or two budget cycles after the QTC Report was delivered in early 2020.[178]

3.7 The window of opportunity was missed

The window of opportunity was missed. The Department needed a ***substantial***, ***upfront***, and ***immediate*** investment in lower-cost care in either the 2020-21 or 2021-22 budget. In neither of those years (nor indeed in the following year's budget) did it receive ***any*** new upfront funding for OOHC placements.[179] All it received in those years was deficit funding to ensure the Department's liquidity.

3.7.1 The first budget cycle (2020-21)

On 20 February 2020, the Department submitted its budget proposal for the 2020-21 annual financial year budget. At that time, the responsible Minister was Di Farmer, and the Director-General of the Department was Michael Hogan.[180] By that proposal, the Department sought something akin funding for the ***substantial***, ***upfront***, and ***immediate*** investment in lower-cost forms of care called for by CSIP and the QTC Report.[181]

In particular, the Department proposed a credible funding package for the OOHC system, which exceeded $400m.[182] Aside from $70m to cover the projected deficit for the 2020 financial year, the funding sought was all upfront funding. The centrepiece of the proposal was more than $150m in upfront funding to implement the CSIP; that is, by funding an additional 874 family-based places and additional supports designed to "reduce reliance on residential care". The balance of the proposal included measures to improve payments and provide other additional supports to family-based carers.

It does not appear that this proposal was ever considered by the CBRC, though Ms Linard was not able to say one way or another, as she was not the Minister responsible for the Department at that time.[183] Either way, it is clear from the public record that not long after the February 2020 submission, the then-Treasurer decided to defer the budget that had been scheduled for late April

[178] Transcript, Evidence of Danny Short (10 April 2026) 5173:38-42; Transcript, Evidence of Arthur O'Brien (13 April 2026) 5275:47-5276:5; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5320:38-47.
[179] See Transcript, Evidence of Leanne Linard (16 April 2026) 5523:27-5524:39, where the former Minister accepted that the Department never received anything more than deficit funding; that is, an appropriation above and beyond historic and forecast deficits.
[180] Due to the expedited hearing timetable, neither Ms Farmer nor Mr Hogan were called to give evidence at the public hearings.
[181] See Department of Child Safety, Youth and Women, *2020-21 Budget Submission* (Cabinet Budget Review Committee Policy Submission, February 2020) (DFS.0406.0001.1014) with CSIP as Attachment 1.1; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5323:30-5324:4; Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:37-46.
[182] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5324:30-5325:4; the underlying document is Department of Child Safety, Youth and Women, *2020-21 Budget Submission* (Cabinet Budget Review Committee Policy Submission, February 2020) (DFS.0406.0001.1014) with CSIP as Attachment 1.1; Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:37-46.
[183] See Transcript, Evidence of Leanne Linard (16 April 2026) 5497:14-30.

2020 because of the COVID-19 pandemic. Following a change in Treasurer, in May 2020, the incoming Treasurer announced that the government would publish a COVID-19 Fiscal and Economic Review later in the year. It appears that the Department was then given an opportunity, in August 2020, to submit a policy submission ahead of the delivery of the main budget in December 2020.[184] By that time, Ms Mulkerin had replaced Mr Hogan as Director-General. Di Farmer remained the relevant Minister.

In that submission,[185] dated 25 August 2020,[186] the Department simply requested that the CBRC "note" that:

(a) the Department projected a deficit for 2020-21 between $171.1m and $193.3m that was projected to increase to $183.9m in 2021-22, $288.4m in 2022-23 and $440.9m in 2023-24;

(b) the Department would, in early 2021, seek deficit funding of between $171.1m and $193.3m for the projected 2020-21 deficit; and

(c) further consideration of funding requirements for 2021-22 onwards and "options to address longer-term strategies for mitigating costs and managing demand will be required".[187]

It appears that, at some point between the February and August 2020 CBRC submissions, the original budget proposal, seeking substantial upfront funding for the OOHC system, was "shelved", that is, that the Department and the Minister chose not to (or were directed not to) propound it again in the August 2020 submission. That was Mr Short's recollection.[188] Neither Mr O'Brien nor Ms Mulkerin had any different recollection,[189] and Mr O'Brien saw no reason to doubt Mr Short's recollection.[190] The Commission has not seen any documentary evidence that falsifies Mr Short's recollection.[191]

It is not entirely clear why the original budget proposal was not renewed in the August 2020 submission. On one view, the budget proposal ought to have been a compelling proposal to put

[184] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5322:28.
[185] See Transcript, Evidence of Leanne Linard (16 April 2026) 5500:13-19.
[186] Relevantly, Emails to Deidre Mulkerin and Arthur O'Brien with DCSYW Budget Deficit CBRC Submission, 25 August 2020 (DFS.0397.0005.0001–0002).
[187] Department of Child Safety, Youth and Women, *2020-21 Budget Deficit* (Cabinet Budget Review Committee Policy Submission, August 2020) (DFS.0397.0005.0116) [37], [39], [46], [56], [60]-[61] and Recommendations.
[188] Transcript, Evidence of Danny Short (10 April 2026) 5174:21-35.
[189] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5325:8-25.
[190] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:20-35.
[191] Indeed, some documentary evidence is consistent with that recollection: Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 6.

to the CBRC in August, given that it had by then been validated by the rigorous and independent QTC analysis,[192] and which showed that an initial investment in lower-cost care would avoid far greater IPS-driven costs to the State in the long term.

No witness could precisely recall the reason the budget proposal was shelved, although several hypotheses were put forward.[193] The most likely is that the CBRC pre-emptively indicated and / or the Department and the Minister assessed, at some point prior to the August 2020 submission, that large requests for new funding not connected with the State's COVID-19 response would have no real prospect of being approved in that first budget following the outbreak of COVID-19.[194] That is consistent with the documentary record. For example, a plan prepared by the Department in late 2021 described the CSIP as having been "drafted for the 2020-21 budget process" but not proceeding due to "pandemic related budget pressures".[195]

As it occurred, the main budget was delivered on 1 December 2020. The Department received no new upfront child safety funding. Instead, it received only $98.3m toward the projected deficit.[196] Despite that outcome, a press release was issued with a quote attributed to the then Minister, Ms Linard, in terms that there was a "record investment of 1.475 billion to support the child protection system and its reforms."[197]

However, to compound matters, the budget was accompanied by a Government Savings and Debt Plan "in response to the COVID-19 impacts on the State Budget". As part of the plan, government departments were assigned "savings allocations". The Department's savings allocation for 2020-21 was $11.196m. That amount was taken from the Department's budget, and the Department introduced various austerity measures in response, such as not filling vacant positions, reducing staff travel, freezing new IT projects, and reducing the use of office supplies.[198]

In short, at a time that the Department was desperately in need of an urgent and substantial increase in its appropriated funds to seek to arrest an exponential cost growth in residential care, its budget was reduced. While it took difficult decisions to trim its internal expenses to meet an allocated savings target, it was, as a result, entirely unable to stem the use of unfunded IPS

[192] It will be recalled that this was done at the CBRC's insistence.
[193] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5324, 5332-5333.
[194] Ibid 5332:30-38.
[195] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 6.
[196] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:38-5277:35; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5332:30-38.
[197] CA-76, *Media Statement — 2020 Budget caring for Queensland Communities,* tendered 16 April 2026.
[198] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5277:38-5279:18; Department of Children, Youth Justice and Multicultural Affairs, *DCYJMA Savings and Debt Plan* (Brief to Minister, 10 December 2020) (DFS.0397.0004.0295).

placements to service the growing gap between supply and demand, let alone reverse the relative decline in the availability of family-based care. As a result, the steps the Department took to achieve its internal savings allocation of $11.96m yielded only a pyrrhic victory. Despite those efforts, the Department nonetheless returned an IPS placement-driven deficit that year of a further $98.3m (that is, above the existing $98.3m in deficit funding it had already been allocated), which needed to be funded in the next year's budget.[199]

3.7.2 The second budget cycle (2021-22)

The second cycle was not materially different. Mr Short's evidence was that the 2021-22 Budget remained "focused on" whole-of-government post-COVID economic recovery. The Department's submission in that year did not propound the CSIP, or any other similar upfront investment in the funded supply of lower-cost placements.[200] Rather, the Department's 2021-22 submission to the CBRC requested a package of approximately $1.5 billion over the forward estimates to fund projected deficits driven by the shortfall in family-based care and cost-controlled OSD-funded residential care placements.[201]

The 2020-21 budget submission was accompanied by modelling that showed an increasing gap between funded places, which remained stagnant, and demand, which continued to rise as it had in previous years. The submission warned that "the key issue is, if … funded places do not increase in line with demand then more expensive CRC-PaS placement packages are required to meet the shortfall.[202] By then, the shortfall was at least 1,372 funded places. The shortfall was projected to more than double, to somewhere between 2,972 and 3,376 by June 2022.[203] Accordingly, the submission forecast steeply increasing deficits over the forward estimates, with the deficit expected to approach $600m by the 2024-25 financial year.[204]

The Department received less than a fifth of what it asked for: $184.3 million of funding for the forecast deficit for the 2021-22 financial year, plus $98.3M to fund the remaining deficit from the prior year.[205] Like the previous financial year, the funding for the forecast deficit in 2021-22 again

[199] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:38-5277:35; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5332:30-38.
[200] Transcript, Evidence of Danny Short (10 April 2026) 5175:13-19.
[201] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5279:46-5280:5; Department of Children, Youth Justice and Multicultural Affairs, *2021-22 Budget Submission* (Cabinet Budget Review Committee Policy Submission, 10 June 2021) Submission Attachment No 1.
[202] Department of Children, Youth Justice and Multicultural Affairs, *2021-22 Budget Submission* (Cabinet Budget Review Committee Policy Submission, 10 June 2021) Submission Attachment No 1, 4.
[203] Ibid.
[204] Ibid, 3.
[205] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5279:36-47, 5280:12-19; Department of Children, Youth Justice and Multicultural Affairs, *2022-23 Budget Submission* (Cabinet Budget Review Committee Policy Submission, 13 May 2022) Submission Attachment No 6, 1.

proved insufficient. The Department's child safety deficit for 2021-22 was around $384.3m. The $170m shortfall was funded in the next financial year's budget.

For the second successive budget cycle, the Department had received no new upfront funds. The window of opportunity to reverse the exponential cost of residential care and associated deficit growth had all but closed.

3.7.3 The third budget cycle (2022-23) — the uplift arrives, but too late and only in the form of deficit funding

In the third budget cycle after QTC, the 2022-23 Budget, the Department sought an even larger package: $3.2 billion across the forward estimates. The submission to the CBRC in late February 2022 again highlighted that the Department was facing significant budget pressures arising from increased demand for placement services associated with the increasing number of children and young people requiring care, and increasing complexity of families and children in contact with the child protection system.[206] The submission observed further that it had been informed by work undertaken by QTC during Phases I and II of their engagement, notwithstanding that by this point that work had aged at least 18 months, and two budget cycles.

The submission urged CBRC to commit to a substantial investment in child safety, on the basis that there was, at that time, significant pressure on Queensland's OOHC system.[207] That analysis was supported by QTC modelling and forecasts, which laid bare that forecast over-expenditure in child safety would be driven by two factors: (1) the cost difference between placing children in residential care compared to family-based care; and (2) the premium paid to place children under more expensive IPS-funded residential care placements rather than OSD contracts.

In the outcome, the Government committed $2.2 billion over five years, with a recurrent $500 million in projected deficit funding per annum from 2022-23 to 2025-26.[208] There was some evidence that the committed funding for future years improved the Department's ability to enter into longer-term arrangements.[209] But the amount allocated, substantial as it was, was insufficient by then to pull the Department out of its vicious cycle of deficit spending. Indeed, the $500 million in recurrent funding, large as it was, was already being outpaced by cost growth: the Department ran a further $202.3 million deficit in 2023-24, and $461 million deficit in 2024-25.[210]

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[206] Department of Children, Youth Justice and Multicultural Affairs, *2022-23 Budget Submission* (Cabinet Budget Review Committee Policy Submission, 13 May 2022) Submission Attachment No 6, 2.
[207] Ibid 7.
[208]Transcript, Evidence of Arthur O'Brien (13 April 2026) 5276:5-9, 5280:20-5281:3; Transcript, Evidence of Leanne Linard (16 April 2026) 5464:18-19, 5487:34-5488:14; 5516:1-11.
[209] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5280:34-45.
[210] Ibid 5281:32-46.

3.8 Conclusion

The consequences of missing the window of opportunity are by now well-known. Deficit funding, even when ultimately supplemented by a more substantial appropriation, is inapt to produce the scale of change required to ease placement pressures in the child safety system. The consequences for the children and young people in the system, who would have been suitable for family-based care, if placements were available were materially worse, and the fiscal impact on the Queensland budget was demonstrably significant.

The conclusion is inescapable. The only way to avoid unsustainable growth in residential care is to make a timely, upfront, substantial and sustained investment in the Department. That funding should be directed towards prioritising the recruitment and retention of family-based carers as a first order of priority and, acknowledging that some surplus capacity in residential care is required, involve a commitment to long-term, therapeutic OSD-funded placements that are both cost-controlled and stable, where required.

3.9 Recommendations

Recommendation 28: Sufficient funding to support Department's placement strategy	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 3)**
RECOMMENDATION: That the Queensland Government, within its MYFER 2026/27 budget cycle, ensure that sufficient ongoing funding is provided to the Department in its annual budget and across the forward-estimates to meet anticipated demand for out-of-home care placements, with additional funding available as necessary to build an appropriate 'buffer' or 'surge' capacity of additional family-based care placements and OSD-funded residential care placements.	
CONTEXT: Adequate funding and a buffer of family-based care placements to meet unexpected demand will enable the Department to implement initiatives that promote family-based care and support financial delegates to primarily use long-term and cost-effective Outsourced Service Delivery-funded contracts with confidence, rather than being limited to high-cost Individual Placement and Support agreements.	
IMPLEMENTATION NOTES: The government should not restrict itself to an arbitrary target for residential care capacity, but rather should ensure the use of placement types is responsive to the confirmed and projected needs of the children in out-of-home care, and is governed with rigour.	

Chapter 4

The Historical Overreliance on IPS Agreements

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 4: The Historical Overreliance on IPS Agreements

4.1 Departure from the original intent of IPS agreements

As alluded to above, the original intent of IPS agreements was to have a small allocation of funds to top up OSD arrangements with additional support and to care for children and young people who were not suited to family-based care.[211] However, as was detailed in the preceding section, the use of IPS agreements departed from that original intent in recent years, largely because investment in OSD-funded placements did not keep pace with demand for OOHC, thereby leading to a significant reliance on ad-hoc, unfunded IPS packages to make up the shortfall.[212]

Historically, residential care services were provided by large statewide organisations (often not-for-profit entities) operating multiple sites or premises across Queensland. These entities would tender for residential care services and, if successful, enter into OSD contracts with the Department of three or more years in duration.[213] However, from June 2018 to June 2020, expenditure on IPS agreements almost doubled, with the number of placements increasing by a similar order of magnitude.[214]

Since at least the beginning of 2020, internal Department records suggest that OSD-funded residential care providers have consistently been at full capacity.[215] By mid-2021, a majority of the new residential care services purchased by the Department were via IPS packages delivered by for-profit providers. Indeed, as at 31 July 2021, approximately 41% of all residential care service providers to the Department were for-profit organisations.[216]

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[211] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0039).
[212] Ibid.
[213] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 12.
[214] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 14.
[215] See, eg, Department of Child Safety, Youth and Women, *Incoming DG Brief* (Brief, 21 January 2020) (DFS.0288.0327.0770); Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 5; Department of Children, Youth Justice and Multicultural Affairs, *Strategy for IPS Redesign* (Deputy Director-General Briefing Note, March 2023) (DFS.0001.0002.2398); Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 7 May 2024) (DFS.0234.0002.0162); Email from Director Placements, Investment and Partnership, 7 May 2025 (DFS.0001.0002.2542).
[216] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 13.

Throughout the subsequent years, there was an awareness within the Department as to the magnitude of the problem emerging. Not only was there an overreliance on IPS agreements but, moreover, there were a number of financial and operational risks associated with the procurement, contracting and commissioning practices that had developed around the entry into and management of those agreements.

Those findings prompted the development and approval of a Significant Procurement Plan (SPP) in late 2021, the purposes of which included to:

(a) effectively address placement pressures;
(b) reduce reliance on residential care; and
(c) assist the regions in their investment decisions to generate quality care arrangements and ensure these arrangements provide optimal value for money.[217]

These are themes that remain as relevant today as they were almost five years ago. In no small part, that is because despite setting ambitious goals in the SPP to (among other things) halve the number of children and young people placed in residential care arrangements by 30 June 2026 and double in the proportion of children placed in a care arrangement with kin by 30 June 2026, there was no new funding to accompany these initiatives.[218] The Department had to make do with the funds already at its disposal, notwithstanding that by this point it was already entrenched in a structural fiscal deficit.

4.2 Establishment of internal audits and working groups

In February 2022, in response to the Department's growing reliance on IPS-funded placements, an internal financial due diligence audit was finalised (IPS Financial Due Diligence Audit). The background to the audit included that the number of young people supported by IPS packages had been increasing at an exponential rate (from 800 in August 2020 to 1,311 in August 2021).[219]

The IPS Financial Due Diligence Audit identified (among other matters) a number of high risk issues related to the Department's use of IPS agreements. These issues included circumstances where:

(a) no agreement was formally in place between the Department and providers;

[217] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 5.
[218] Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5344:12-22.
[219] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support (IPS) Final Due Diligence Audit* (Final Internal Audit Report, February 2022) (DFS.0186.0040.0006) 3.

(b) the agreement had been signed retrospectively; and

(c) financial approval limits had been misunderstood and/or exceeded.

The IPS Financial Due Diligence Audit also noted the lack of a centralised database for managing IPS demand and contracting.[220] That warrants mentioning because, remarkably, the Commission observed in documents and heard from witnesses that this issue persists today, augmenting the challenges associated with variability in practice and process across different child safety regions.[221]

Shortly thereafter, in August 2022, the IPS Redesign Reference Group was created to provide advice and endorse practical solutions to implement the recommendations from the IPS Financial Due Diligence Audit and undertake a substantive re-design of existing IPS arrangements.[222] When introducing attendees to the inaugural meeting of the group, the then Senior Executive Director, Investment and Commissioning observed that the Department was disproportionately reliant on IPS packages to meet demand for child placements, at least in part because of the lack of investment in OSD-funded supply.[223]

An accompanying presentation for members of the IPS Redesign Reference Group included a slide which asked "where are we now?" That slide identified a number of issues with the procurement of IPS agreements, which proceeded to plague the Department over the years that followed. With minor amendments for syntax, those issues were:[224]

- burdensome processes for procuring and managing IPS agreements;
- the Department is investing beyond increasing budgets;
- there are disparate processes between regions;
- despite multiple audits, practice within the Department is still not aligning with policy and process;
- placement services unit and frontline staff are not contract managers or negotiators;

[220] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support (IPS) Final Due Diligence Audit* (Final Internal Audit Report, February 2022) (DFS.0186.0040.0006).
[221] See Transcript, Natalie Wilson Witness Conference (27 February 2026) 80-81; Transcript, Evidence of Hanelie Lategan (13 April 2026) 190:35-40.
[222] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support – Redesign Reference Group* (Terms of Reference, August 2022) (DFS.0186.0037.0048) 1.
[223] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0039).
[224] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign Project Procurement Strategy* (Presentation, 17 August 2022) (DFS.0186.0037.0052).

- suppliers are not incentivised to transition children and young people to preferred support options (including family-based care placements) or to enter into OSD contracts;
- there is a high number of unlicensed IPS providers;
- unplanned demand leads to reactive procurement; and
- suppliers are driving the market, which creates a high risk given that a small number of suppliers provide half the budgeted services.

Over the subsequent 12-24 months, the Department sought to implement some of the recommendations from the IPS Financial Due Diligence Audit (with the guidance of the IPS Redesign Reference Group), including addressing issues such as the absence of a central computerised system for managing IPS placements, concerns regarding the retrospective approval of IPS packages, and issues with the approval of IPS agreements on a rolling basis in a way that exceeded cumulative delegation approval limits.[225]

However, at least part of the issue being experienced by the Department was that the cumulative financial value of residential care packages was increasing due to higher unit costs and the extended duration of child placements.[226] The Commission heard evidence from the Chief Procurement Officer, Ms Lategan, that those issues became more pronounced over time, with some IPS contracts being funded on a recurrent basis for anywhere up to seven years, and at cumulative values that sometimes exceeded $5 million.[227]

The Commission has also heard and observed that, in recent times, information gaps and data issues continue to persist. For instance, in an internal audit report entitled "Private Providers of Child Safety Residential Services", finalised in September 2025, it was explained that the Service Type Aggregated Records (STAR) dataset serves as the primary consolidated data source for contract-level information, crucial for managing both OSD and IPS arrangements.[228] The Commissioning Oversight team is responsible for compiling the STAR dataset, which involves integrating OSD data from the Procure2Invest (P2I) system alongside manually submitted data for IPS contracts.[229]

[225] Department of Families, Seniors, Disability Services and Child Safety, *Tracking worksheet for IPS reform* (Spreadsheet, 18 November 2025) (DFS.0186.0040.0032).
[226] Department of Children, Youth Justice and Multicultural Affairs, *Strategy for IPS Redesign* (Deputy Director-General Briefing Note, March 2023) (DFS.0001.0002.2398).
[227] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5195-5196.
[228] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025) 20.
[229] See also Transcript, Michelle McNamara Witness Conference (26 February 2026) 48 and ff.

Once data is collected, it undergoes cleansing, validation and a multi-layered endorsement and quality assurance process before being released as the final endorsed STAR dataset for stakeholder use.[230] However, given all the checks, the process results in the most current available data being at least three weeks old at the time of use, hindering the Department's decision-making and reporting accuracy. Timeliness is critical and any lag may lead to outdated insights, affecting strategic planning and operational efficiency. Consequently, there is a risk that decision-makers might rely on incomplete or inaccurate data, posing risks to effective resource allocation and contract management.[231]

4.3 Persistent overreliance on IPS agreements

The evidence before the Commission revealed that the persistent overreliance on IPS agreements was a notorious and well understood problem. Further, it was a problem that the Department knew, in the moment, could be met with a series of reasonably simple solutions: utilise data to inform demand growth over next four to five years to identify and design service models based on the type of future demand; build a market of suitable residential care providers through market signalling; and enter into competitive OSD contracts with those providers, adopting a degree of consistency to pricing (subject to regional variations and the specific needs of individual children).[232]

Despite exploring, discussion and ultimately approving initiatives to properly model demand and to transition unsustainable IPS agreements to long-term OSD contracts, the Department failed, over several years, to implement reform proposals with sufficient urgency and purpose. Further, even where implemented, the reforms overseen by the IPS Redesign Reference Group did little to abate the Department's ever-growing reliance on IPS agreements. For instance, by March 2023, expenditure on IPS agreements exceeded the investment in OSD-funded placements.

At or around the same time, the then Acting Director, Investment and Commissioning, prepared a briefing note for the then Deputy-Director General of Strategy in relation to the overreliance on IPS agreements.[233] The briefing note identified that:

(a) due to a range of contributing factors, IPS agreements were increasingly being utilised to manage capacity issues with OSD-funded placements;

[230] Ibid.
[231] Ibid.
[232] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Minutes, 16 May 2023) (DFS.0186.0037.0216) 4.
[233] Department of Children, Youth Justice and Multicultural Affairs, *Strategy for IPS Redesign* (Deputy Director-General Briefing Note, March 2023) (DFS.0001.0002.2398).

(b) expenditure on IPS agreements had exceeded budget year-on-year and was already, by that point, costing the Department more than OSD funded placements;

(c) in addition to the growth in the aggregate number of IPS agreements, the value of those packages was increasing due to higher unit costs and the extended duration of such placements; and

(d) as part of the IPS redesign, Investment and Commissioning would continue to progress the conversion of IPS agreements to OSD contracts and explore the creation of alternative procurement models such as preferred supplier panels.

The fact that this trend was allowed to take place is even more concerning given that the Department was aware at all relevant times that:

(a) the number of children entering residential care was on a consistent upward trajectory, so the use of IPS funding could not be rationally justified as necessary to meet a short-term spike in demand;

(b) if the majority of non-family based placements purchased through IPS agreements were moved to OSD contracts, at a competitive OSD market rate, there would be a material cost saving by the Department; and

(c) there was limited evidence to support that the additional costs associated with IPS agreements led to the Department purchasing higher levels of intervention, specialist responses, specific assessment or treatment interventions.[234]

In the Commission's assessment, there was an insufficient investment and prioritisation of foster and kinship carers in a way that would enable the Department to meet the surge in demand for OOHC, without resorting to the expensive and sub-optimal outcomes often associated with residential care. Given the convenient reality that those family-based care arrangements are in almost all instances preferable for the child, and materially less expensive, the rational justification for investing in and prioritising family-based care ought to have been self-evident. Once it became apparent that family-based placements would not be available, the Department should have pivoted to a strategy that prioritised long-term OSD placements (or pursued such a strategy in parallel).

As it eventuated, the Department instead resorted to utilising IPS agreements to manage capacity constraints in residential care services, as family-based care arrangements failed to keep pace

[234] Ibid.

with demand and there was no measured way to supplement OSD contracted placements.[235] The cost of convenience, ultimately borne by the taxpayers of Queensland – proved to be substantial. Over the subsequent years, the Department came to rely on high-cost fee-for-service placements to supplement the absence of cost-controlled OSD placements.[236] This has had material consequences for expenditure on child safety, with the Department operating by this point in what appeared to be a constant cycle of budget deficits. An overview of the additional funding required by the Department in each financial year from 2018-19 to 2025-26 is included below.[237]

	2018-19 $000s	2019-20 $000s	2020-21 $000s	2021-22 $000s	2022-23 $000s	2023-24 $000s	2024-25 $000s	2025-26 $000s
Demand Management and Critical Reforms in the Child Protection System	20,000	..	..	..	..	..	..	..
The future strategic direction for the family support and child protection system 2019-20 to 2023-24	..	20,000	..	..	..	..	..	..
CBRC Decision 1012 - Operational and Cash Deficit	..	50,000	..	..	..	..	..	..
Children, Youth Justice and Multicultural Affairs - 2020-21 Operational and Cash Deficit	..	-	98,381	..	..	..	..	..
2021-22 Budget Outcomes - Child and Family Services Budget Deficit CBRC Decision 1228	..	..	98,300	184,329	..	..	..	..
2022-23 CBRC-Child & Family Services Budget Deficit (including Parameter Based Funding Model report back)	..	..	..	170,000	500,000	500,000	500,000	500,000
2023-24 MAY FE - CFS (PBFM) - Parameter-Based Funding Model (PBFM) - Deficit & EPCS	..	..	..	..	..	212,300	..	..
2024-25 CBRC Decision 21 - CS - Child Safety - Funding injection to ensure continued liquidity	..	..	..	..	..	..	461,000	-
2024-25 CBRC 2025-26 BUDGET OUTCOMES - CS- Child Safety Deficit (Out of Home Care)	..	..	..	..	..	..	..	200,000
MYFER 2025-26	..	..	..	..	..	..	..	100,000
	20,000	70,000	196,681	354,329	500,000	712,300	961,000	800,000

That the situation unfolded in this way is not surprising when one takes into account the premium charged by providers under fee-for-service contracts. For example, data compiled for the Department's Reform Implementation Office (RIO) in July 2025 suggests that for service providers receiving both OSD and IPS funding to deliver non-family based residential care placements, known as dual-funded providers, the average daily rate for IPS placements was almost *double* the average daily rate for OSD contracts entered into with the same provider.[238]

When the Commission made inquiries of the Department in relation to this issue, the Department indicated that it prefers to enter into OSD contracts, and that it will only make a referral directly to a fee-for-service provider where: (i) OSD capacity has been exhausted; or (ii) if the capacity is assessed as not being the most appropriate care arrangement for a particular child or young person.[239]

Without seeking to be critical of those senior executives that authored witness statements, the Department's response to the Commission was rather unhelpful. It failed to acknowledge that

[235] Ibid.
[236] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 5.
[237] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Deficit - Overview of additional funding provided to address the child safety deficit* (Table, March 2026) (DFS.0376.0001.0001).
[238] Dual Funded Residential Care Mapping dashboard created by the Reform Implementation Office (DFS.0186.0030.0012) - to be precise, the IPS Average Daily Rate is ~$1,700 per night; the OSD Average Daily Rate is ~ $959 per night.
[239] Statement of Bernadette Harvey (29 August 2025) [8](a); Statement of Belinda Drew (17 September 2025) [12].

the Department has an important role to play in that assessment because OSD-capacity should only be exhausted in exceptional or limited circumstances. In this regard, there was reference in documents produced to the Commission and during the course of public hearings to suggest that the Department should consider holding a buffer of OSD placements up to 20 per cent for surge capacity or vacant placements to enable that to be so.[240] Far from this being so, the environment in which the Department operated following the Carmody Inquiry, and especially across the past five or so years, was one in which the prevailing market dynamic was insufficient OSD capacity to meet demand and an acceptance that the shortfall would be covered by expensive IPS agreements.

4.4 Market composition consequences of overreliance on IPS

By 2024-2025, the market had been fundamentally reshaped. There were 156 organisations that delivered residential care services to the Department under IPS funding packages and/or OSD contracts across Queensland. Of those suppliers, internal documents suggest that:

1. 106 received IPS funding only (67.9%);
2. 4 received OSD funding only (2.6%); and
3. 46 received both IPS and OSD funding (29.5%).[241]

Of these 156 organisations, only 45 were classified as not-for-profit (28.8%), with the balance of 111 providers (71.2%) operating for profit.[242] This itself reflected a broader trend of not-for-profit providers exiting the market and being replaced by, generally speaking, more expensive for-profit providers.[243]

The shifting market dynamic has been attributed to a range of factors, ranging from factors that are largely beyond the Department's control (including the fact that more children entering OOHC than exiting the system, the increasing complexity of child and family support needs and longer placements in the system) to factors that are, at least to some extent, within the Department's control (including issues with the Department's approach to forecasting supply and demand for

[240] See, eg, Transcript, Evidence of Natalie Wilson (9 April 2026) 5010; Transcript, Evidence of Hanelie Lategan (13 April 2026) 5220.
[241] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 16.
[242] Ibid.
[243] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025) 6.

residential care services,[244] and a failure to recruit sufficient foster or kinship carers who can provide family based care.[245]

The Commission recognises that the issues are multifaceted and nuanced, but that only made an upfront and sustained investment in OOHC more urgent. In the outcome, the Commission has concluded that the overreliance on unfunded, ad-hoc IPS placements was one of the main factors that contributed to higher (and evidently unsustainable) costs of delivering residential care in Queensland.[246]

In the financial year ended 30 June 2025, the Department's expenditure on IPS funded individual and group residential care exceeded $764m (67% of overall expenditure),[247] whereas the Department's expenditure on OSD funded residential care was approximately $365m (33% of overall expenditure).[248] In aggregate, approved contract funding (including both OSD and IPS arrangements) grew consistently between 14-20% each financial year from FY2021-2022 to FY2024-2025, with costs escalating in a particularly pronounced way over those years.

4.5 Historical attempts to convert IPS to OSD

In October 2018, the Department commenced the Care Enhancement Project (CEP), which was aimed at delivering a number of initiatives and actions to increase placement options for children and young people and achieve cost efficiencies in the utilisation of CRC-PaS funding.[249] By January 2020, the Department had converted a number of CRC-PaS placements to OSD-funded placements or procured additional OSD-funded placements[250] via a two-stage process that involved:

1. Pathway One – A direct negotiation for children and young people to convert stable IPS placements to OSD-funded places with existing suppliers, which resulted in the conversion of 54 placements; and

[244] Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008) 25.
[245] See also Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057) 7.
[246] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 11.
[247] Calculated from Department of Families, Seniors and Disability Services, *Detailed service provider list 2023-24 and 2024-25* (Spreadsheet, 16 July 2025) (DFS.0001.0001.0272).
[248] Ibid; Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview - Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022) 43.
[249] See discussion of CEP in Department of Child Safety, Youth and Women, *Child Related Costs - Placement and Support Services (CRC-PaS) Follow-up Internal Audit Review* (Internal Audit, January 2020) (DFS.0004.0001.0208) 23.
[250] Department of Families, Seniors, Disability Services and Child Safety, *The economic benefit for investment into the care system within Queensland: Care System Investment Plan 2020-2024* (Confidential Report, January 2020) (DFS.0234.0008.0220) 20.

2. Pathway Two – An open tender, which ultimately resulted in an additional 73 residential care placements and 3 supported independent living placements (although this was not formally a conversion or transition of existing arrangements).

By August 2022, there is no question that the Department understood the urgent need to shift investment in residential care services from IPS agreements to OSD contracts.[251] In fact, at or around that time, the IPS Redesign Reference Group was created to provide advice on and endorse practical solutions to implement the recommendations from the IPS Financial Due Diligence Audit and undertake a substantive re-design of IPS arrangements.[252]

In one of its inaugural meetings, the IPS Redesign Reference Group noted that OSD contracts were much more cost effective than relying on rolling IPS arrangements, and that the Department had an important function to play in influencing supplier behaviour by encouraging suppliers to enter into OSD contracts.[253]

No doubt spurned by that logic, the Department commenced a statewide IPS to OSD conversion procurement activity in 2022.[254] In particular, one of the critical purposes of the SPP was to establish an environment that supported the implementation of responsive investment initiatives including the statewide IPS to OSD conversions in early to mid-2022.[255] The statewide initiative, and later procurement initiatives relating to IPS to OSD conversions, were implemented to improve placement stability for children and to reduce both financial and administrative costs.[256]

In a memorandum noted and approved by the then Director-General, Ms Mulkerin, dated 6 April 2022, the Department approved a negotiation strategy for the conversion of 97 non-family based care places from IPS packages to OSD funding, at a saving of $2.3m per annum.[257] Across 2022-2025 those 97 placements were transitioned from fee-for-service arrangements to OSD-funded contracts, with conversions in each of the child safety regions. The Department also progressed

[251] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0132) 1-2. See also Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 14 September 2022) (DFS.0186.0037.1180) 2.
[252] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Annotated Agenda, 17 August 2022) (DFS.0186.0037.0045).
[253] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign Project Procurement Strategy* (Presentation, 17 August 2022) (DFS.0186.0037.0052) 5. See also Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 14 September 2022) (DFS.0186.0037.1180) 2.
[254] See explanatory note to Notice 234 provided by the Department (COI.0001.0003.7957).
[255] Department of Children, Youth Justice and Multicultural Affairs, *Reducing Pressures on the Care Service System 2021-2026* (Significant Procurement Plan, November 2021) (DFS.0234.0008.0057); see also Supplementary Statement of Bernadette Harvey (10 February 2026) [9].
[256] Supplementary Statement of Bernadette Harvey (10 February 2026) [10].
[257] See Department of Children, Youth Justice and Multicultural Affairs, *Funding Approval for OSD Contracts* (Director-General Briefing Note, 6 April 2022) (DFS.0234.0003.0004).

a *further* 97 placements (that is, 194 in total) throughout that period, the majority of which were in the South East and North Queensland regions. [258]

Reflective of these initiatives, by May 2023, the IPS Redesign Reference Group noted that over the preceding six months, the Placement Reform team had been supporting the regions to transition the bulk of IPS packages into OSD contracts to reduce the administrative churn associated with that process.[259] However, so much appears to have been overstated; the "bulk" of such packages continued to be procured via IPS agreements and discernible trend to the contrary can be discerned from the data that has been made available to the Commission.

It is relevant to pause here to note that in the same meeting, in May 2023, the Reference Group observed that the next stage of its project would be to look at issues such as how to utilise IPS arrangements with the rigour and quality of an OSD contract.[260] For reasons explained below in Part 6, that remains an unfulfilled aspiration rather than a reality within the Department.

Regardless, by this point at least, the importance of converting IPS agreements to OSD contracts was well understood within the Department at that time. For instance, in discussions between senior members of the strategy and commissioning teams, it was recorded that:

1. if the Department could better manage the IPS to OSD conversions, it had a theoretical hold over the market, and could take control of who it contracts with and what services it buys;
2. the Department should consider increasing resourcing levels to manage the number of new OSD contracts;
3. the Department should consider transitioning IPS agreements to flexible OSD contracts that can scale up and scale down; and
4. the Department should start to settle on specific providers long-term, noting there are challenges in that respect when agencies are holding vacancies and not accepting referrals.[261]

In those circumstances, it is not apparent why the conversion of IPS funded placements to OSD contracts was not pursued at greater scale or intensity until recently, putting to one side the question of whether there was political support to allocate upfront funding to such proposals (as

[258] Ibid [14], [19].
[259] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Minutes, 16 May 2023) (DFS.0186.0037.0216) 4.
[260] Ibid.
[261] Ibid 5.

to which, see the preceding Part 3). One explanation appears to be that at least some child safety regions, including Far North Queensland, were advised by 'Investment and Commissioning' to pause conversions until the Residential Care Review process was completed.[262]

In recent times at least, there is an apparent consensus that the IPS funding model in Queensland's residential care system is financially unsustainable and fails to consistently deliver high-quality outcomes for children and young people.[263] To that end, the Commission repeatedly observed or heard evidence that it was necessary to return the IPS funding model to its original intent.[264] As explained in Part 4.6 below, that process is now well and truly underway through a comprehensive initiative to convert IPS agreements to OSD contracts.

4.6 The recent IPS to OSD conversion

Despite the longstanding nature of this problem, it is only over the past 6 to 12 months that the Department has re-emphasised the process of transitioning high-cost individual support to more cost effective outsources service delivery.[265] This has been facilitated by approval from the Queensland Government to transition high-cost IPS arrangements to OSD contracts in the Queensland State Budget 2025-2026.[266]

Importantly, apropos earlier initiatives to convert IPS agreements to OSD contracts, the scale of the transition work that commenced in July 2025 was influenced by a clear direction from the Government to undertake that exercise at scale. This has also created an authorising environment that balances the requirements of the Act with the Department's financial accountability obligations.[267]

The transition forms a key part of the Residential Care Reform Plan, which itself is guided by three principles: (1) decision-making driven by the best interests of child; (2) quality and outcome-oriented services, delivered through fit-for-purpose regulation, licensing and commissioning practice; and (3) fiscally disciplined action.[268]

[262] Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 31 August 2023) (DFS.0234.0002.0107).
[263] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview – Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022) 43.
[264] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign – Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0039); Transcript, Evidence of Natalie Wilson (8 April 2026) 4993-4999; Transcript, Evidence of Michelle McNamara (9 April 2026) 5096-5097; Transcript, Evidence of Bernadette Harvey (17 April 2026) 5564.
[265] Email from Danny Short regarding guidance to decision-makers for placement contracts, 11 July 2025 (DFS.0001.0002.2687).
[266] Statement of Bernadette Harvey (25 November 2025) [22].
[267] Statement of Michelle McNamara (25 March 2026) [62].
[268] Statement of Bernadette Harvey (25 November 2025) [22].

At the time the Department commenced this project, IPS funding comprised approximately 67% of all the investment in residential care, with the balance attributable to OSD funding.[269] The Commission heard evidence from a Director of the RIO, Michelle McNamara, and Deputy-Director General of Commissioning, Bernadette Harvey, that:

1. the Department has converted more than 715 IPS placements to OSD funded placements in a period of approximately six months;[270]
2. as a result of transitioning those arrangements, more than 55% of the Department's funding for residential care is now allocated to OSD providers (compared to less than 33% less than a year ago);[271] and
3. the factors that have enabled the Department to convert these contracts, at scale, were as simple as:
    a. having a mandate from Government to undertake that exercise, which includes the Government committing to underwrite any overspend on OSD-funded contracts by ensuring there is adequate funding in the forward-estimates;[272] and
    b. reaching a consensus on a form of wording to ensure financial delegates can balance their legislative obligations under the Act, the *Financial Accountability Act 2009* (Qld) and the *Financial and Performance Management Standard 2019* (Qld), the substance of which is that those delegates are endorsing a proposal that is the most efficient and effective use of the Department's financial resources.[273]

Suffice to say, no compelling reason was offered as to why these steps could not have been taken earlier.

This transition has resulted in a significant state-wide re-commissioning of residential care services, allowing the Department to substantially redesign the non-family based care system. In the end, the Department has a stated objective of transitioning between 50 and 75 per cent of IPS

[269] See Department of Families, Seniors, Disability Services and Child Safety, *Transition of Investment Procurement Approach* (DFS.0186.0030.0109), Current overview of IPS v OSD graph; Department of Families, Seniors, Disability Services and Child Safety, *Care Continuum Framework* (Minister Briefing note, 27 October 2025) (DFS.0186.0030.0204).
[270] Transcript, Evidence of Michelle McNamara (9 April 2026) 5115:31-5116:8; as supplemented by Transcript, Evidence of Bernadette Harvey (17 April 2026) 5562.
[271] Transcript, Evidence of Michelle McNamara (9 April 2026) 5118:1-44, as adjusted to account for the fact there have been further conversions since then, according to Ms Harvey's evidence referenced above.
[272] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5553:26-5554-17.
[273] Email from Danny Short regarding new IPS templates, 30 June 2025 (DFS.0186.0002.3365) 4.

funding to longer term OSD contracts to establish statewide consistency in pricing and service delivery while improving outcomes for children and young people in care.[274]

The Commission endorses the initiatives currently underway within the Department to progress this procurement strategy. The Department is to be commended for its attention and considerable efforts to convert IPS agreements to OSD contracts in a manner that is data-driven and fiscally responsible. The Commission recommends that the Department explore a long-term solution to ensure that the proportion of children in IPS arrangements is restored and maintained at around 5-10 per cent of all placements (as a bespoke and emergent accommodation option), with the balance of placements to be provided by OSD funded providers.[275]

To ensure adequate oversight of new OSD contracts, the Department is also in parallel tracking key service metrics, including: unoccupied placement nights; the number of children under six years of age; those accommodated with siblings; those who exited upon turning 18; and those who exited as part of a planned change in the care arrangement.[276]

Further, the Department appears to be developing qualitative metrics to capture quality of care considerations, such as: staff ratios to children and young people, including sleep shift, awake shift and overlay; outcomes where children and young people demonstrate improved safety and nurturing environments, community connections, achieving person goals and increased health and resilience; and in relation to children and young people with disability or on a National Disability Insurance Scheme plan.[277]

Each of these recent initiatives is integral to the reforming the residential care system in a manner that is sustainable over the long term.

[274] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 1.
[275] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5564:9-15.
[276] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 2.
[277] Ibid 3.

4.7 Benchmark pricing and the Residential Care Costing Model (RCCM)

For several years now, the Department has recognised that more work was required to benchmark costs within residential care settings and according to different models of care.[278] For instance, documents produced to the Commission revealed that (historically):

1. there was no clear understanding of what was driving cost inconsistencies within and across the different child safety regions;[279]
2. different regions had developed benchmark pricing that was neither consistent with statewide guidance nor particularly instructive;[280] and
3. benchmarks were not closely adhered to by staff in the regions when negotiating with providers.[281]

The absence of clear guidance and up-to-date benchmark pricing led to inconsistencies in the price at which services are contracted for, and exposed the Department to paying a premium for services as it lacked a reference price to anchor negotiations. The significant variability in providing pricing was apparent in the fact that even the same providers often charge differently within their own organisation in different regions, even where the model of care is comparable.[282]

The Commission acknowledges that the Department has recently implemented significant reforms in this regard, by developing a Residential Care Costing Model (RCCM). The RCCM is a practical tool designed to estimate indicative placement costs in residential care arrangements. By generating cost estimates based on user-defined inputs, the RCCM supports informed planning and effective resource allocation.[283]

The RCCM was developed by the Investment and Commissioning team within the Department, in conjunction with Queensland Treasury, and has been tested against a statistically significant sample of contracts.[284] Self-evidently, the assumptions within, and outputs of, the RCCM are

[278] See Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign Reference Group* (Meeting Minutes, 18 January 2023) (DFS.0186.0037.0202) 2; Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 9 April 2024) (DFS.0234.0002.0119); Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview – Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022) 13; Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 7.
[279] Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 9 April 2024) (DFS.0234.0002.0119).
[280] See, eg, Department of Families, Seniors, Disability Services and Child Safety, *Variation to contracts for non family-based care services – Sunshine Coast and Central Region* (Director-General Briefing Note, 19 June 2024) (DFS.0214.0006.0001).
[281] Department of Families, Seniors, Disability Services and Child Safety, *IPS Business Rules Review Current State Analysis* (Memo) (DFS.0377.0001.0001) 3.
[282] Ibid.
[283] Statement of Danny Short (25 November 2025) [28].
[284] Ibid [27].

matters of commercial sensitivity. The Commission will thus abstain from substantive commentary in relation to such matters. However, suffice to say for present purposes that the RCCM is currently being utilised by the Department to:

1. provide a baseline cost estimate for residential care placements, serving as a starting point for financial planning;
2. support the Department's decision-making by allowing users to explore cost implications across different parameters and scenarios; and
3. enable customisation to reflect unique funding arrangements, urgent placements, or the specific needs of children in care.[285]

The Commission recommends that the Department continue to invest in and refine the RCCM, so that it may be used as a quantifiable and objective verification tool to assist the Department in its procurement, investment and commissioning processes more generally. A necessary aspect of the ongoing development of this model will be implementing metrics and refining inputs to ensure that the model tracks inflationary pressures within the industry, accommodates to different models of care and is operationalised in a way that recognises benchmark pricing must be used as a guide rather than becoming a prescriptive tool.

The Commission further recommends that the RCCM, or an equivalent costing tool, be deployed across the State to those working in the regions to assist with negotiations. Evidence given by the Chief Procurement Officer, Ms Lategan, indicated that for staff working in the regions, the negotiation process was more explanatory than assertive.[286] Unassisted by such tools, staff are often focused on seeking to understand why a particular placement might be expensive, but are rarely engaged in what one might regard as a genuine commercial negotiation and have little bargaining power with providers. Having a baseline costing model is essential if those staff are to negotiate contracts with residential care providers in a way that reflects value-for-money for the Department (and, by extension, taxpayer).

[285] Ibid [28].
[286] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5205:34-5206:11.

4.8 Recommendations

Recommendation 29: Demand and Cost Modelling	
Executive Report (Chapter 7)	**Companion Report 4 (Chapters 4 and 6)**
RECOMMENDATION: That the Queensland Government, within 12 months of the government's response to this report, design and implement a funding model suitable to enable the Department to deliver its services and implement system reforms.	
CONTEXT: The Commission endorses, without limitation, the following aspects of KPMG's Report. *The SAM should be adapted or expanded to:* *include a driver-based intake module that links intake volumes to observable drivers, reducing the reliance on trend-only inflows;* *include a supply/capacity module to make placement mix and substitution dynamics explicit within the model (such as carer recruitment, retention or burnout);* *include a standard set of sensitivity ranges for materially significant parameters that affect the demand for child safety services; and* *establish formal governance over probability distributions to ensure pathways within the SAM remain representative of system behaviour.* *The PBFM should be adapted or expanded to:* *accommodate two standard reporting outputs: a 'base case', reflecting approved target-driven parameter settings; and a 'reference case' used for planning and risk analysis, drawing on the enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model; and* *establish formal governance over cost escalation assumptions to ensure cost parameters remain reflective of reality.* These reforms to the PBFM will enable the Department to seek appropriations from the Cabinet Budget Review Committee properly informed by both actual and aspirational projections.	
IMPLEMENTATION NOTES: The Commission suggests that a working group be established to consider the findings in KPMG's Report in relation to the SAM and PBFM to ensure that the Department has a model that is fit-for-purpose in terms of enabling the Department to implement critical reforms with confidence.	

Chapter 5

Forecasting the Future State of Residential Care

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 5: Forecasting the Future State of Residential Care

A further critical feature of reforming the child safety system is being able to predict, accurately and reliably, the future state of residential care. In particular, the Department will only be able to implement the Commission's recommendations if it is guided by a clear picture of the likely demand for and cost of residential care into the future. That is why Part 5 of this companion report focuses on how the Department currently forecasts demand and cost, and how this be improved.

5.1 The development and use of the Simulated Analytical Model (SAM)

In 2015, shortly after the Carmody Inquiry, the Department developed the Simulated Analytical Model (SAM) to assist with forecasting demand for child protection services.[287] It was anticipated that the SAM would provide a more sophisticated and flexible approach to forecasting than traditional analytical models. The outputs of the SAM are projected annual demand for: intakes; investigations; ongoing intervention; and OOHC.[288]

The SAM relies on historical data collected by the Department and projected population growth rates provided by the Queensland Government Statistician's Office. This was initially the basis on which the Department determined the likely demand for child protection services. However, in contemporary times, the outputs from the SAM are utilised in the Department's Parameter-Based Funding Model (PFBM), which was implemented from 1 July 2023. The PBFM is explored in further detail below, as this is the principal mechanism by which funding is sought by the Department for tertiary child protection services.[289]

In late 2022, QTC engaged ACIL Allen to conduct a review of the SAM due to its perceived inability to account for the impact of broader systemic shocks, such as the pandemic, on demand for child safety services. The review found, among other matters, that: the functions and features of SAM were not configured or optimised for cost forecasting; the complexity of the SAM and its background calculations impeded the ability of stakeholders to easily understand how changes in inputs affected outputs; the SAM relied heavily on historical data and failed to readily

[287] Statement of Carina Muller (14 January 2026) [6]-[8]; ACIL Allen, *Review of the Simulated Analytical model (SAM)* (26 October 2022, Report) (DFS.0243.0004.0001) 2.
[288] Ibid.
[289] Statement of Carina Muller (14 January 2026) [11]; ACIL Allen, *Review of the Simulated Analytical model (SAM)* (26 October 2022, Report) (DFS.0243.0004.0001) 5.

incorporate the impact of external shocks such as the pandemic or legislative changes; and the functions and capabilities of the SAM were being underutilised by the Department.[290]

The Department ought to have known that its systems were inadequate to model and forecast demand, and that would have consequences for its capacity to forecast residential care placements, because of the findings of the ACIL Allen review. So much so was apparent from the proposals put forward by ACIL Allen, which included: (a) redevelop or expand the SAM, this being most costly and technically complex solution to implement; (b) modify the SAM to decouple it from the assumptions related to the Carmody Inquiry and review the current "levers" to ensure they are appropriate, this being a more straightforward and cost-effective option; or (c) replicate the SAM in a more accessible platform such as Excel, flagged as a cost-effective alternative to Option A, but with limitations that would likely render itinsufficiently sophisticated given the complexity of the services contracted by the Department.[291]

By this point, at the very latest, it was likely apparent to the Department that its approach to forecasting was deficient and, consequently, the Department had limited certainty to forecast demand for residential care (and associated costs). That was a system deficiency which left the residential care system prone to systemic miscalculation of demand, and thereby added to the conditions in which IPS agreements would need to be relied on to supplement the failure to adequately forecast contracted OSD supply.

For example, the Commission has observed that throughout the early 2020s, much emphasis was placed on the impact that methamphetamine use, domestic and family violence, and drug or alcohol problems, had on the apparent unpredictability as to the number of children entering OOHC and the complexity of their placements.[292] However, those are known drivers and risks for the Department, which ought to have been capable of factoring into forecasting of demand. Indeed, analysis in the KPMG Report suggests that such factors are capable of being taking into account as part of an intake model simulation that measures how causal factors such as the cost of living, domestic and family violence and substance misuse affect the number of children requiring the protection of the State.[293]

[290] ACIL Allen, *Review of the Simulated Analytical model (SAM)* (26 October 2022, Report) (DFS.0243.0004.0001) ii, 10-11.
[291] Ibid 13-15.
[292] See, eg, Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Demand and Complexity* (Brief to Minister, 10 November 2020) (DFS.0397.0004.0222) 2; Department of Children, Youth Justice and Multicultural Affairs, *Child Safety Demand and Complexity* (Brief to Minister, 10 June 2021) (DFS.0397.0004.0753) 2.
[293] See, eg, KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 60.

5.2 The Parameters Based Funding Model (PBFM)

As mentioned above, in 2020, contemporaneously with the surging demand for out-of-home services, QTC completed a review into OOHC, including a review of cost drivers. This review helped to identify the need for more sophisticated cost forecasting with respect to OOHC.[294]

The importance of Phases I and II of that review are addressed above, in the context of the factors contributing to the growth of the billion dollar residential care sector. There was, however, a Phase III to QTC's review, which involved the development of a Parameters-Based Funding Model (PBFM).[295]

In or around March 2021, at a time when the Department was experiencing escalating budget deficits, parameter-based funding was identified by Treasury as an option for providing the Department with regular funding adjustments aligned with changes in demand.[296] Accordingly, in late 2021, QTC were engaged by the Department and Treasury to prepare a PBFM for use by the Department and Treasury.[297]

Over the subsequent 18 months or so, the Department worked closely with Queensland Treasury and the Department of the Premier and Cabinet (DPC) to develop the PBFM.[298] The development of the PBFM was overseen by a working group and a steering committee comprising senior executives from Treasury, the Department and the Department of Premier and Cabinet.[299] Discussions though this committee and papers from the committee progressed to a Director-General (or equivalent level) oversight committee for decision-making. It was that committee which was responsible for making decisions in relation to the scope of the model, inclusions and exclusions from the model, base year funding, demand, price, supply and projected growth parameters.[300]

The final design of the model was presented to and approved by the Government as part of the 2023-24 budget cycle. In that context, the PBFM was approved to be implemented from 1 July 2023 and is one of the mechanisms by which funding is now allocated to the Department for

[294] Statement of Glenn Miller (14 January 2026) [36]-[37]; Queensland Treasury Corporation, *Review of Out of Home Care Placement Services* (Report, 6 April 2020) (DFS.0288.0002.0008).
[295] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5264:1-14.
[296] Statement of Glenn Miller (14 January 2026) [38].
[297] Statement of Carina Muller (14 January 2026) [11].
[298] Department of Children, Youth Justice and Multicultural Affairs, *Placement Reform and Commissioning Support* (Presentation, May 2023) (DFS.0234.0001.0068).
[299] Statement of Glenn Miller (14 January 2026) [44]-[46]; Statement of Arthur O'Brien (1 April 2026) [40].
[300] Statement of Arthur O'Brien (1 April 2026) [41].

tertiary child protection services.[301] The purpose of the model is not only to enable funding to vary in accordance with actual demand, but also to incentivise placement reform efforts.[302]

The PBFM provides for yearly growth in funding for child and family frontline services and includes data in relation to:

(a) demand across the five past years and for the five future years for OOHC;

(b) supply actuals for the past five years and five years of projected supply for OOHC bed nights by region and by type of placement, overlaid by delivery targets; and

(c) OOHC placement costs based on the previous year's actual costs and with costs indexed for next five years.[303]

The PBFM aims to assist the Department with projecting costs of care and demand for services that were not in line with modelled forecasts.[304] The PBFM does this by utilising the levers at its disposal, being demand (the output of SAM), supply mix (projections about the estimated proportion of children in family-based care and non-family based care) and cost (average/assumed cost of care for each type of care service, informed by analysis undertaken by the QTC).[305]

Notwithstanding the implementation of the PBFM, due to unrealistic assumptions about the supply mix and unit price parameters, the Department was not (and has not been) sufficiently funded to meet the projected demand for child protection services.[306] These issues with forecasting have further contributed to an increased reliance on IPS funding to meet temporary demand and also limited the ability of regions to enter longer term OSD contracts to buy the capacity needed where there was a lack of a confirmed funding source.[307]

More recently, the Department has recommended to cease aligning supply mix targets to an aspirational target and align to actual performance. The past practice of doing so has led to anomalies whereby the PBFM simulation in February 2025 assumed only 9.4% of the OOHC population would be in residential care, when that figure more closely approximated 18%.[308] In

[301] Statement of Carina Muller (14 January 2026) [11].
[302] Statement of Arthur O'Brien (1 April 2026) [43].
[303] Department of Children, Youth Justice and Multicultural Affairs, *Placement Reform and Commissioning Support* (Presentation, May 2023) (DFS.0234.0001.0068).
[304] Statement of Glenn Miller (14 January 2026) [47]; Statement of Helen Dogan (14 January 2026) [10].
[305] Statement of Glenn Miller (14 January 2026) [42]; Statement of Helen Dogan (14 January 2026) [11].
[306] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview - Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022).
[307] Ibid.
[308] Department of Families, Seniors, Disability Services and Child Safety, *Investment and Partnerships Operational Governance Group – Parameter Based Funding Model Update* (5 and 6 February 2025) (DFS.0186.0037.0002).

addition, until at least very recently, unit prices set by the PBFM have been lower than the actual funding required to deliver services, meaning that the regions have not been funded to meet the actual cost of residential care.[309]

A degree of caution is required not to conflate forecasting with aspiration. The Department has nevertheless continued to explain to each of the child safety regions, quite properly, that they should continue to implement the reform agenda to increase number of young people in family-based care.[310] However, while reforms are implemented to prevent children from entering the residential care system altogether,[311] there is continued logic in the Department updating placement unit rates to reflect the contracted costs of service provision, including by reference to the additional costs associated with wage indexation, increases in the costs of information technology and administration expenses and having regard to general cost of living pressures.[312] Those adjustments, and a realistic recalibration of the supply mix are essential pre-requisites to reforming the residential care system.

In this regard, KPMG has recommended among its proposed enhancements to the PBFM outputs that the Department develop alternative "base case" and "reference case" scenarios.[313] A reference case is a causal-model driven cost forecast, whereas a base case refers to a goal-based driven cost forecast. The idea, in general terms, is that the Department should model different scenarios for different purposes. For instance, the Department could model a scenario based on the existing supply mix and actual unit cost for residential care services, for the purposes of seeking approval for its annual budget, and an alternative scenario with different demand drivers, supply mix settings and cost escalation rates to understand upside potential and downside risks consequent upon achieving (or failing to achieve) reform initiatives.[314]

5.3 Enhancements to the SAM and PBFM

As mentioned above, KPMG has examined the underlying model methodology of the SAM and PBFM, identified opportunities for further sensitivity testing of key demand and cost drivers to

[309] Department of Families, Seniors, Disability Services and Child Safety, *Child Safety Investment and Commissioning Data Overview - Data as at end of April 2025* (Presentation, April 2025) (DFS.0186.0002.0022) 13.
[310] Department of Families, Seniors, Disability Services and Child Safety, *Investment and Partnerships Operational Governance Group – Parameter Based Funding Model Update* (5 and 6 February 2025) (DFS.0186.0037.0002).
[311] As to which see Companion Report 3: Models of Care.
[312] Ibid.
[313] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 60.
[314] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 60, 74.

strengthen forecasts, and provided commentary on the reliability of projections in those models, including key uncertainties and risks.[315]

The Commission endorses KPMG's analysis, with the caveat that given time and access constraints, it was undertaken in circumstances where KPMG did not have direct access to live or executable versions of the models, and without the ability to run alternative scenarios or sensitivities. Accordingly, KPMG's review does not validate model outputs or independently confirm model logic or parameter interactions. Instead, it assesses whether the methodologies and stated assumptions, as documented, support the level of reliance implied for the projections. The Commission recommends that the Department develop a working group to consider the findings in KPMG's Report,[316] and if necessary or desirable, work further with KPMG to ensure that the Department has a model that is fit-for-purpose in terms of enabling the Department to implement critical reforms with confidence.

[315] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 60.
[316] Specifically at pages 59 and 71-74.

5.4 Recommendation

Recommendation 30: Revised procurement documentation	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 5)**
RECOMMENDATION: That the Queensland Government, within three months of the Government's response to this report, revise and update standard form contracts and procurement documentation for all service delivery types (with a particular focus on the Individualised Placement and Support (IPS) standard form agreement and IPS Business Rules) and include a mechanism for periodic review.	
CONTEXT: The Commission heard evidence that the current standard form contracts used by the Department are out of date and inadequate for their intended purpose. The Department has been intending to review these for some time.	
IMPLEMENTATION NOTES: First, the standard form contract for IPS agreements should be revised to promote visibility over the services provided by residential care providers, measure and improve quality of service delivery, and align boilerplate clauses in IPS agreements with protections in Outsourced Service Delivery contracts, to the extent practical (or permissible) under the *Child Protection Act 1999*. Second, the Department should embed periodic review practices in respect of its critical procurement documentation (both internal and external facing), including the benchmark pricing in the IPS Business Rules and IPS Supplier Guidelines.	

Chapter 6

Commissioning and Procurement within the Department

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 6: Commissioning and Procurement within the Department

6.1 Commissioning and procurement at a conceptual level

The structure of the residential care market, and the way residential care has been commissioned and procured in Queensland, are matters that have profoundly shaped provider behaviour and system outcomes. At a conceptual level, the Department's commissioning framework has prioritised the purchase of capacity rather than the achievement of outcomes. Indeed, commissioning and procurement settings have often discouraged providers from delivering therapeutic care, offering stable placements and prioritising child wellbeing.

In this regard, the Commission has observed that Queensland's residential care services are largely funded on the basis of how many beds are occupied, the ratio of residential care staff to child residents and compliance with minimum service specifications.[317] In most instances, the Commission observed the Department is driven by processes that buy from the investment specifications, follow traditional commissioning cycles, use internal data only, default to open tender procurement and apply consistent, rigid contract management processes which tend to allow contracts to roll over year-on-year.[318] While some of these inputs are necessary (indeed, important) components of service delivery, they are poor proxies for the outcomes that matter most to children and young people, including relational continuity, emotional safety, cultural belonging, educational engagement, and progress toward reunification or other permanent arrangements.[319]

When funding is tied primarily to the availability and utilisation of beds, and pro-forma contracting and procurement methodologies, residential care is treated as a scalable service response rather than as a tertiary, time-limited intervention the growth of which should prompt system scrutiny. Under such conditions, constant expansion of the model becomes normalised, and volume becomes a marker of responsiveness rather than a signal of system stress. A critical

[317] See, eg, Department of Child Safety, Seniors and Disability Services, *Far North Queensland PBFM Budget Pack* (Brief, 13 July 2023) (DFS.0234.0001.0065).
[318] Department of Child Safety, Seniors and Disability Services, *First Nations Investment Strategy* (Presentation) (DFS.0234.0001.0002).
[319] Queensland Family & Child Commission, *Buyer Beware: How Economic Forces are Shaping Queensland's Residential Care Market* (Report, August 2025).

component of any future reform will be repositioning residential care in a manner that conforms to its original service intent.

As presently constructed, the Department's commissioning process creates unintended, yet predictable, responses. Providers are rewarded for maintaining occupancy and for their capacity to absorb placements quickly, particularly in crisis contexts. Conversely, there are few, if any, financial or contractual incentives to invest in practices that might reduce the need for residential placements over time, such as intensive family engagement, step-down planning, or collaboration with community-based supports. Similarly, providers are not meaningfully rewarded for achieving stability, reducing placement duration, or supporting successful transitions out of residential care. In effect, residential care is funded as a volume-sensitive service in a system that rhetorically positions it as a last-resort response.

The QFCC's 'Buyer Beware' report provides a detailed analysis of how these economic forces have shaped the residential care market.[320] It describes a system in which government procurement in this area has been characterised by short-term contracts, limited outcome accountability and weak differentiation between models. That has contributed to rapid sector growth alongside substantial variation in quality. Providers with the organisational scale and the flexibility to mobilise their workforces quickly are advantaged, while those seeking to develop smaller, highly specialised, therapeutically intensive or culturally grounded models face heightened financial risk and uncertainty.

For instance, the Commission came to learn of one provider that delivers a family-centric, culturally rich and genuinely therapeutic residential care in areas where there is considerable demand for child safety services.[321] That provider was able to demonstrate a history of reinvesting operating surpluses within the business, including in the setup and fit-out of residential homes and specialised clinical staff.[322] Notwithstanding, that provider reported frustration in relation to its dealings with the Department, which included the following issues (among other things).

1. There is a tendency for the Department to prioritise short-term cost containment over the actual needs of young people entering care, which in the long-term in fact has the effect of increasing costs.

[320] Queensland Family & Child Commission, *Buyer Beware: How Economic Forces are Shaping Queensland's Residential Care Market* (Report, August 2025).
[321] Provider's statement to Commission (COI.0001.0005.7093).
[322] Ibid.

2. The Department's internal structure and operational processes are highly fragmented and inefficient. Rather than operating as a coordinated system, teams function independently, with limited visibility of decisions made by other core areas.
3. Ongoing communication breakdowns and slow decision-making within the Department have resulted in persistent and severe payment delays for service providers, particularly in relation to IPS pricing schedules and approvals for a model of care change.
4. Despite making multiple proactive attempts (over a number of years) to engage with the Department in relation to the licensing process, the provider was initially told that they had to await an invitation from the Department and subsequently that new licensing applications were on hold pending the Commission of Inquiry.
5. In aggregate, this provider has observed recurring patterns in Departmental decision-making that appear to prioritise administrative or funding transitions over the stability, wellbeing, and best interests of young people in care.[323]

Over time, this has contributed to the replication of standardised residential care models that meet minimum compliance thresholds but offer limited therapeutic differentiation.

Importantly, and as is illustrated by some of the observations above, this dynamic is often not the result of poor intent on the part of individual providers. Rather, it reflects the rational reaction of organisations to a commissioning environment that values responsiveness to immediate demand over long-term investment in capability. In such an environment, innovation is risky, workforce development is difficult to sustain, and model fidelity can be undermined by the imperative to maintain staffing ratios and occupancy levels. The result is a market that tends toward homogeneity rather than diversity, and strays from the intended purpose of residential care services. The provision of care to children risks becoming a mere profit-making enterprise, in which the Department is adapting to the preferences and convenience of service providers, rather than vice versa.

6.2 The absence of market stewardship

These effects are compounded by the State's limited role as an active steward and shaper of the market.[324] In well-governed human services markets, the government does more than purchase services. It plans supply in line with anticipated need, shapes provider behaviour through incentives and contract design, monitors quality and outcomes in real time, and intervenes

[323] Ibid.
[324] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 8, 11.

decisively when services drift from policy intent.[325] Effective stewardship also requires a willingness to constrain capacity where growth is inconsistent with system objectives, and to support alternative responses where tertiary services are being used to compensate for failures elsewhere in the system.

As residential placements have become harder to source, particularly for children with complex needs or in regional and remote areas, the system has increasingly relied on ad hoc IPS arrangements and high-cost placements. These arrangements, while often necessary in the moment, further reinforce a focus of the commissioning process on immediacy and capacity; and this entrenches residential care as the default response to system pressure rather than as a carefully constrained intervention.

The Department has limited capacity to shape provider behaviour in the residential care market. This manifests in different ways. For example, in 2023 the Department approached one of the largest providers in the market, proposing an amendment to the IPS agreement then in place. The proposed revision was that the Department would reduce payments being made to the provider while a young person or child was in school full-time. The provider in question refused to agree to the Department's proposal, and minutes from a meeting of the regional IPS panel in question record that, rather than insisting upon the amendments, the Department relented to the provider's demands. The stated rationale was that there was nothing the Department could do about it because this was the provider's "business model".[326] This is but one of many examples that illustrates the Department's lack of bargaining power, notwithstanding that it is the sole buyer in the market.

The consequences of current commissioning arrangements are visible in the fragmentation of residential care services, the limited availability of genuinely therapeutic or culturally specific models, and the significant constraints on the ability of the system to meaningfully assess and compare provider performance. Without clear, consistent output and outcome measures linked to funding and contract renewal, it is difficult for the Department to distinguish between services that are merely compliant and those that are demonstrably effective in achieving outcomes that enhance the wellbeing of children and young people in residential care. Over time, this weakens accountability, inhibits learning, and obscures early warning signs of declining quality or escalating risk. In such a system, residential care growth becomes self-reinforcing, not because

[325] Queensland Family & Child Commission, *Buyer Beware: How Economic Forces are Shaping Queensland's Residential Care Market* (Report, August 2025).
[326] Department of Children, Youth Justice and Multicultural Affairs, *IPS Panel Agenda – April 2023* (Spreadsheet, 3 May 2023) (DFS.0186.0044.0009).

it is delivering better outcomes for children and young people, but because the market has been designed to respond to demand rather than to resolve it.

A further manifestation of the Department's underdeveloped market stewardship function can be observed in its modelling of placements and demand for residential care services. In that context, supply has frequently been driven by immediate demand, rather than by a longer-term strategy configured to meet defined cohorts, geographic need or therapeutic purpose. Though the Commission has seen considerable evidence of forecasted demand through the SAM and the utilisation of a PBFM (as to which see Part 5 above), historically these prognostic tools have relied on flawed assumptions or otherwise not been operationalised or interpreted by the Department in an effective manner.

The most obvious example of this is that the way the Department has used aspirational targets to forecast demand under the PBFM. Under assumptions embedded in the model, the assumed supply mix of family-based and non-family based placements varied markedly from the true picture. The Chief Finance Officer, Mr Short, and the former Deputy Director-General of Corporate Services, Mr O'Brien, explained in their evidence that these aspirational targets were set at the time the PBFM was introduced in July 2023. However, both Mr Short and Mr O'Brien also said it was understood within the Department that those would need to be reviewed regularly through ongoing monitoring of actual experience and adjusted accordingly. [327]

In and of itself, there is nothing objectionable about having or relying on aspirational targets, especially if they are generally understood to be precisely that. However, targets alone are ineffective to promote change if not supported and accompanied by market stewardship. As a result, the Department has found itself in a position where the current modelling in the PBFM does not allow for informed budgeting, workforce planning and intervention testing, and does not have available to it alternative modelling.[328] That is why, moving forward, Mr Short said that the PBFM should reflect not only aspiration, but also reality.[329] The Commission embraces that recommendation.

The proposed approach is also consistent with a recommendation in the KPMG Report that the PBFM incorporate "Base Case" and "Reference Case" scenarios.[330] A "base case" could be used as a control scenario, reflecting approved target-driven parameter settings; and a "reference case

[327] Transcript, Evidence of Danny Short (10 April 2026) 5172:17-20; Transcript, Evidence of Arthur O'Brien (13 April 2026) 5284:40-5285:20, 5285:42-5286:9.
[328] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 9.
[329] Transcript, Evidence of Danny Short (10 April 2026) 5172:30-35.
[330] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 58-60.

or cases" could be used for planning and risk analysis, drawing on an enhanced intake model and a forecasted, driver-based, constraint-aware supply mix and capacity model.[331] When giving evidence before the Commission, Mr O'Brien, went so far as to say that he read this aspect of KPMG's Report with a bit of "quiet satisfaction". He explained that using a base case and reference case scenario was something that could be incorporated into the PBFM with relative ease, and that making this change would produce a "whole range of information that would be very useful".[332]

6.3 The intersection between procurement issues and IPS overreliance

The Commission has explored the commissioning and procurement issues within the Department, and associated opportunities to improve efficiency, transparency and accountability, through the lens of its historical overreliance on IPS agreements (as to which, see Part 4 of this report). As observed earlier, the original intent of such agreements was to have a small allocation of funds to top up arrangements with support, an option for emergency placements and to care for children and young people who were not suited to family-based care. However, over time, investment in family-based care and OSD-funded contracts did not keep up with demand, which led to significant and disproportionate reliance on IPS packages.[333]

As explained above in Part 3 of this companion report, as a result of the overreliance on IPS agreements, the Department soon became mired in a problem whereby its approach to procurement led to a proliferation of financially unsustainable residential care arrangements.[334] The extent of that problem was exacerbated by a series of failures in commissioning and procurement, broadly encapsulated as an inflexible and unsophisticated approach to contracting with providers, which is explored in detail further below by reference to deficiencies in the IPS Business Rules and IPS standard form contract used for procuring such arrangements.

6.3.1 Process for procuring IPS funded services

In order explore the failings in IPS procurement practice, it is necessary to first explain how such agreements come to be entered into by the Department. That process was helpfully explained by the Chief Procurement Officer, Ms Lategan, and Deputy Director-General of Commissioning, Ms

[331] Ibid.
[332] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5289:28-5290:9.
[333] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0132) 1.
[334] Email from Deputy Director-General, 15 July 2025 (DFS.0186.0030.0001).

Harvey, in witness statements produced to the Commission. In effect, it involves a four-step process.

The ***first step*** is that the Department will issue a Request for Quote (RFQ) detailing the specifics of the care package required from the provider.[335] The RFQ includes various sections to be populated by the Department, namely:

- **Child details**, which identifies the child's name, date of birth and gender, and includes information about the level of complexity of the child or young person's needs;[336]
- **Requirements**, which outlines the dates required for the placement, the preferred placement type, the preferred staffing model and care roster, and information about allowable contingency hours and damage repairs;[337]
- **Child outcomes**, which outlines specific activities and services the department wants to purchase as part of this package. The guidance in the pro-forma RFQ indicates these specific activities should contribute to the child or young person's case plan goals; provide clear contractual expectations; and reduce the risk of duplicating services e.g. therapeutic and counselling services;[338] and
- **Conditions**, which outlines in general terms the requirements suppliers are to meet. This notifies providers, among other things, that the contractual arrangement is governed by the Individualised Placement and Support Agreement and they are required to obtain current insurance policies for public liability (of not less than $10m), contents insurance and comprehensive motor vehicle insurance.[339]

The Chief Procurement Officer, Ms Lategan, gave evidence that this RFQ is usually sent to suppliers via email, after initially making a call to ascertain their availability to take on a child placement. Rather than an open tender, in many instances specific providers are contacted based on the Placement Services Unit's regional knowledge about vacancies, and often there are only one or two providers (if any) with available placements, particularly in rural and remote regions.[340]

The ***second step*** is that any service providers wishing to submit a response to the RFQ are required to provide quotes for the proposed care package alongside a pricing schedule to the

[335] Statement of Bernadette Harvey (1 December 2025) [8]; Proactive Statement of Bernadette Harvey (3 September 2025) [24].
[336] Department of Child Safety, Seniors and Disability Services, *Individualised Placement and Support Package Request for Quote* (Template, October 2020) (DFS.0001.0001.1424) 1.
[337] Ibid 2.
[338] Ibid 3.
[339] Ibid 4.
[340] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5192:17-43.

Department.[341] The evaluation criteria for such responses includes four factors: service delivery methodology and framework; organisational experience and capability of personnel; model of business, governance structures and financial viability; and Aboriginal and Torres Strait Islander Cultural Capability.[342]

The ***third step*** is for the service provider's pricing schedule to be assessed against:

(a) the requested and approved model of care to ensure alignment with funding requirements; and
(b) established pricing benchmarks outlined in the Individualised Placement and Support Packages – Supplier Guidelines.[343]

Relevantly, for the purposes of the discussion that follows in this part, the pricing benchmarks in the Supplier Guidelines are equivalent to those in Attachment 1 of the Individualised Placement and Support (CRC-PAS) Business Rules (IPS Business Rules).[344]

Ms Lategan explained that at this stage of the process, procurement's role is to review the procurement pathway, supporting documentation, value for money considerations, compliance with the IPS Business Rules and relevant delegations, and to provide procurement assurance before the arrangement is finalised.[345]

However, as was noted by Ms Lategan, that is only relevant in respect of higher value contracts because the Department's financial delegation limits provide that:

1. contracts of less than $3m on a whole-of-life (or cumulative) basis are approved exclusively at a regional level, and not reviewed by anyone within the Department's central procurement function;
2. contracts of more than $3m but less than $5m on a whole-of-life (or cumulative) basis are approved by the Deputy-Director General of Commissioning; and
3. contracts of more than $5m on a whole-of-life (or cumulative) basis, are approved by the Director-General of the Department.[346]

[341] Statement of Bernadette Harvey (1 December 2025) [8]; Statement of Hanelie Lategan (30 March 2026) [25].
[342] Department of Families, Seniors, Disability Services and Child Safety, *Request for Information Supplier Response* (Template) (DFS.0050.0003.1570) 4.
[343] Ibid; Transcript, Evidence of Hanelie Lategan (13 April 2026) 5193:7-27.
[344] See, eg, Department of Families, Seniors, Disability Services and Child Safety, *Individualised Placement Support Business Rules* (September 2025) (DFS.0186.0039.0007) 23-24; Department of Families, Seniors, Disability Services and Child Safety, *Individualised Placement Support – Supplier Guidelines* (September 2025) (DFS.0346.0002.0001) 8.
[345] Statement of Hanelie Lategan (30 March 2026) [26].
[346] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5193:47-5194:46,

If the financial delegate is either the Deputy-Director General of Commissioning or Director-General of the Department, then the procurement function will provide a recommendation as to whether the proposal is consistent with the 2026 Queensland Procurement Policy, Supplier Code of Conduct and other similar requirements.[347]

The ***fourth and final step*** is that upon conclusion of the procurement process and a supplier being selected, an IPS fee-for-service agreement (IPS Agreement) is entered into between the provider and the Department.

That IPS Agreement comprises the following parts:

(a) IPS Standard Form Agreement;
(b) RFQ;
(c) Supplier Response; and
(d) Pricing Schedule.[348]

It is important to understand that, in practice, IPS procurement is heavily influenced by the need for urgent placements due to the lack of family based or OSD funded residential care placements, seemingly ever-increasing demand, and complexity of need for the children and young people in care (including children with disabilities and/or behavioural challenges). There are also constraints in provider capacity and workforce availability, some of which are explained in Part 2.5 above. Though the Government is, in effect, the sole buyer for residential care services in this unusual marketplace, the inelastic nature of demand and the supply-side constraints limit the scope for assertive bargaining. Collectively, those factors materially affect procurement timing, pricing, market testing, provider responsiveness, documentation and, ultimately, the Department's ability to apply a more structured or streamlined procurement processes.[349]

6.3.2 IPS Business Rules

An important feature of the IPS procurement landscape is the IPS Business Rules. The first version of the IPS Business Rules (then called the CRC-PaS Business Rules) was introduced on 6 March 2018.[350] These Business Rules were introduced to guide and support the consistent application of policy and procedure associated with expenditure utilising funds from the IPS

[347] Ibid 5197:3-39.
[348] Statement of Bernadette Harvey (1 December 2025) [9]; Statement of Hanelie Lategan (30 March 2026) [29].
[349] Statement of Hanelie Lategan (30 March 2026) [28], [33].
[350] Transcript, Evidence of Natalie Wilson (9 April 2026) 5008:16-19; Department of Child Safey, Youth and Women, *Child Related Costs – Placement and Support Business Rules* (March 2018) (DFS.0369.0043.0183).

budget.[351] These Business Rules are integral to the Department's procurement, approval and administration practices for fee-for-service funded care arrangements across the Department.[352]

However, documents produced by the Department to the Commission revealed that senior employees within the Department regard these rules as entirely unfit for purpose. In a particularly scathing assessment from May 2025, the then Senior Executive Director of Investment and Commissioning observed that "the IPS [Business] Rules have been flagged for improvement since they were developed because they do not make sense."[353]

Further, in a detailed current state analysis of the IPS Business Rules, prepared by the Chief Procurement Officer (Ms Lategan) and thereafter provided to the Chief Finance Officer (Mr Short) and Deputy Director-General of Commissioning (Ms Harvey),[354] Ms Lategan observed that:

> across regions, staff report that [the] IPS [Business] [R]ules are not fit for purpose, heavily reliant on manual tracking, and difficult to interpret or apply consistently. The current framework does not reflect the operational reality, the pace at which placements occur, or the complexity of the children supported under IPS.

Having undertaken a detailed process of seeking to understand how IPS arrangements were operating in practice, Ms Lategan identified the following challenges experienced by the regions in her current state analysis:

(a) IPS agreements are procured and managed in a high pressure and largely manual environment, with variability in practice across regions.[355]
(b) There is inconsistency across regions in processes for intake, triage, confirmation that alternative placement options had been exhausted, escalation pathways, market engagement, pricing assessments, approval practices and contract administration.[356]
(c) As discussed further below, existing benchmarking tools are outdated and are not consistently relied upon by regional staff in practice.[357]
(d) Staff undertaking IPS related procurement activities are often balancing multiple responsibilities and may not always have access to specialised commercial, costing or contract management capability.[358]

[351] Transcript, Evidence of Natalie Wilson (9 April 2026) 5008:21-31; Statement of Bernadatte Harvey (31 March 2026) [9].
[352] Statement of Bernadatte Harvey (31 March 2026) [18].
[353] Email from Senior Executive Director, Investment and Commissioning to Bernadette Harvey, 9 May 2025 (DFS.0001.0002.2465).
[354] Statement of Hanelie Lategan (30 March 2026) [42]-[44]; Department of Families, Seniors, Disability Services and Child Safety, *IPS Business Rules Review Current State Analysis* (Memo) (DFS.0377.0001.0001).
[355] Statement of Hanelie Lategan (30 March 2026) [44].
[356] Ibid [45].
[357] Ibid [46].
[358] Ibid [47].

(e) Invoicing and payment processes are highly manual, with no purchase order system. In practice, this creates reconciliation difficulties, contributes to payment delays, and results in a significant administrative burden for staff and service providers. It also limits the Department's ability to achieve efficient and consistent financial control across IPS arrangements.[359]

(f) Contract management practices are not consistently applied across IPS arrangements and system wide visibility of supplier performance, risk and financial exposure is limited.[360]

Each of these perceived issues represent opportunities to improve procurement consistency, timeliness and value for money when contracting with providers.

During public hearings, the Commission focused on one of the issues identified by Ms Lategan, which reflected the issues with procurement in the Department; namely, the failure to update the benchmark pricing in the IPS Business Rules over a period spanning approximately six years and continuing into the present day.

The IPS Business Rules have been through many revisions since their introduction in March 2018. In September 2018, the then CRC-PaS Business Rules were substantially revised and renamed the IPS Business Rules (Version 2). At that time, the IPS Business Rules were co-designed through workshops with Departmental stakeholders, including regional Placement Services Units (PSU) / Placement Support Services (PSS), Regional Directors and Child Safety Service Centre (CSSC) staff, including Managers, Senior Practitioners, Child Safety Officers, Business Officers and Administration Officers.[361]

Over the following years, there were then various further iterations of the Business Rules, with substantive variations effective from April 2019 (Version 3.0), August 2020 (Version 4.0) and December 2022 (Version 5.0). Relevantly for present purposes, there was also a minor update to the IPS Business Rules on September 2025 (Version 5.1), which it seems involved merely fixing broken intranet links and updating the Department's branding on the IPS Business Rules.[362]

It appears that costing benchmarks were embedded as part of the IPS Business Rules (as "Attachment 1" of those rules) from the August 2020 (Version 4.0) onwards, with the stated

[359] Ibid [48].
[360] Ibid [49].
[361] Statement of Bernadatte Harvey (31 March 2026) [13].
[362] Ibid [15].

purpose of providing guidance to staff negotiating contracts in the regions.[363] At that time, the Business Rules included benchmark pricing as follows:

- For a support worker – $51.32 per hour (including hourly rate, on-costs, superannuation and penalties);
- For a sleepover worker – $61.53 per hour (calculated on the same basis as above, but excluding penalties);
- Operating costs – To be calculated at 14% of salaries and wages;
- Training and development – To be calculated at 2% of salaries and wages;
- Property and energy – $95.15 per day (on the assumption of a four-bedroom house);
- Motor vehicle – $24.87 per day (on the assumption of a mid-range vehicle); and
- Child daily expenses – $45.10 per day.

By mid-2021, the IPS Action Group had convened to initiate a deep dive review of the operational costs in the IPS Business Rules, including but not limited to, property and energy, motor vehicles, establishment costs and daily child expenses should occur. According to Ms Wilson, who gave evidence at the public hearings and was at that time the Director of Tertiary Care and Support, the IPS Action Group proposed that the benchmarks either be removed or recalculated.[364]

In the outcome, the Commission has observed that the IPS Business Rules were neither recalculated nor removed. According to the Deputy-Director General of Commissioning, Bernadette Harvey, "a review of available records has been undertaken however, the reason/s that these recommendations did not progress any further has not been able to be ascertained."[365] Ms Wilson, now the Acting Senior Executive Director of Investment and Commissioning, initially suggested in her evidence that this was not an issue because staff working in the regions may rely on guidance "at a local level". However, she ultimately acknowledged that it was an issue that the documentation said to be relied on to support and guide decision-making had not been updated centrally.[366] Ms Wilson went further to concede that this rendered the current version of the IPS Business Rules "outdated and unclear."[367]

The failure to embed processes for regularly updating and revising the IPS Business Rules meant that staff working in the regions had limited objective guidance (or benchmarks) by which to

[363] See Department of Child Safety, Youth and Women, *Individualised Placement and Support Business Rules* (August 2020) (DFS.0369.0043.0212).
[364] Statement of Natalie Wilson (25 March 2026) 11.
[365] Statement of Bernadatte Harvey (31 March 2026) [29].
[366] Transcript, Evidence of Natalie Wilson (9 April 2026) 5015:11-32.
[367] Ibid 5011:10-23.

assess whether pricing schedules produced in response to requests for quotes represented value for money. The guidance that one would expect to be available was either non-existent, inconsistent or outdated, which created an environment in which the Department was at high risk of overpaying for residential care services or entering into inconsistent pricing arrangements across and within regions.[368]

Even if it was the case that those regions were relying on separate regional guidance or experience, that itself poses risks from a procurement perspective, including of inconsistent pricing. An astute provider might, for instance, realise that there is an opportunity to extract a greater profit margin by operating in some regions rather than others, distorting the nature of the market. This is symptomatic of the fragmented operation of the Department, which the Commission has observed tends to operate in silos at times.

Some of these risks are not merely theoretical. In her current state analysis, Ms Lategan noted high variability in the application of the Social, Community, Home Care and Disability Services (SCHADS) award rate, training and development costs, motor vehicle rates, rent expenses, energy costs, and management or administrative overheads.[369] Similarly, a key finding in the KPMG Report was that provider profit margins varied considerably in respect of labour costs, although non-staff related margins (property, training, vehicles and other such expenses) tended to be reasonably uniform.[370] The sample of providers analysed by KPMG included a broadly representative mix of for-profit and not-for-profit, licensed and unlicensed, large providers and small providers, as well as providers from a diverse geographical and cultural spread, and with different focus areas and models of care.[371]

Ms Lategan did clarify, however, that initiatives are underway to update the benchmark pricing in the IPS Business Rules.[372] Suffice to borrow from Ms Lategan's evidence that there is a manifest urgency and importance to that initiative being prioritised, given that staff in the regions, though no doubt well intentioned and diligent in performing their duties, lack the requisite experience, skills and tools to negotiate effectively with providers in the absence of suitable benchmark pricing, particularly in a high inflationary environment.[373]

[368] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5203:3-9.
[369] Department of Families, Seniors, Disability Services and Child Safety, *IPS Business Rules Review Current State Analysis* (Memo) (DFS.0377.0001.0001) 3.
[370] KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026).
[371] Transcript, Evidence of Dan Jefferson (7 April 2026) 4828:17-21.
[372] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5201:35-41.
[373] Ibid 5201:43-5202:10.

The risks posed by not updating these Business Rules over the course of several years is put starkly into focus when one appreciates that by September 2025, prior to the Department commencing the recent IPS to OSD transition that has now re-shaped the market, the Department was procuring services valued at more than $750m per annum in reliance on the outdated guidance in the IPS Business Rules.[374] It is difficult for the Commission to understand why the staff negotiating those contracts were not better equipped with guidance or tools to do so, given the extent of public funds being expended and the associated risk of the Department overpaying.

6.3.3 IPS standard form contract

The standard form contract used to enter into IPS agreements was last updated in July 2025.[375] Prior to the revisions made in July 2025, which appear to relate to a clause concerning information privacy,[376] the standard form IPS agreement had not been updated since April 2020.[377]

In the current version of the template IPS contract used by the Department, the relevant terms and conditions are approximately two pages. In and of itself, that is not necessarily problematic. However, in substance, the terms and conditions are surprisingly scant and, in the Commission's assessment, lacking in material respects (if not wholly unfit for purpose). So much so appears to have come to the attention of the Director-General of the Department, Belinda Drew, in or around August 2025, when Ms Drew undertook a review of the standard form contract and sought clarification from senior Departmental staff in relation to a number of aspects of that agreement.[378]

In September 2025, in response to that request from the Director-General (which by this point had been escalated to then Senior Executive Director of Investment and Commissioning), the Chief Procurement Officer, Ms Lategan, undertook a review of the template IPS agreement from a "procurement and contract management perspective".[379] [redacted]

[374] Department of Families, Seniors, Disability Services and Child Safety, *Transition of Investment Procurement Approach* (DFS.0186.0030.0109).
[375] Department of Families, Seniors, Disability Services and Child Safety, *Individualised Placement and Support Agreement* (Template, July 2025) (DFS.0186.0039.0001) 3.
[376] See what appears to be the amendments made to the April 2020 version: Department of Child Safety, Seniors and Disability Services, *Individualised Placement and Support Agreement* (Template, April 2020, with revisions from July 2025) (DFS.0186.0023.0687).
[377] See April 2020 version: Department of Child Safety, Seniors and Disability Services, *Individualised placement and Support Agreement* (Template, April 2020) (DFS.0001.0001.1415).
[378] See Deputy Director-General comments on the April 2020 version: Department of Child Safety, Seniors and Disability Services, *Individualised Placement and Support Agreement* (Template, April 2020, with comments from August 2025) (DFS.0186.0042.2380).
[379] [redacted]



In evidence before the Commission, the Deputy-Director General of Commissioning agreed that it was important and indeed urgent to ensure the standard form agreement was updated.[383] That, of course, begs the question as to why the standard form agreement was not updated earlier.

Throughout late 2025, it appears that Ms Lategan sought quotations from external lawyers to rewrite the standard form agreement and navigated internal bureaucracy in relation to the same. On 15 January 2026, Ms Lategan formally sought budget approval from the Chief Finance Officer, Mr Short for the "urgent review" and rewrite of the standard form terms and conditions.[384] In her email to Mr Short, Ms Lategan explained that:

[380] Ibid.
[381] Ibid.
[382] Ibid.
[383] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5267:40-43.
[384] Email from Hanelie Lategan to Danny Short, 15 January 2026 (DFS.0369.0046.0001).

> The current standard terms and conditions and short form contract require urgent update to ensure they are compliant with current legislation, policy settings, and risk management expectations.

There is an email in response from the Chief Finance Officer, also dated 15 January 2026, in which Mr Short seemingly approved the expenditure from the Whole of Department (WOD) Budget.[385]

Neither the documents nor the evidence at public hearings reveal exactly what occurred next, save to say that over the subsequent months – despite Mr Short's apparent sign-off – this "urgent" work was not formally approved. In March 2026, the Deputy-Director General of Commissioning, Ms Harvey, produced a witness statement to the Commission indicating that the quote was "pending approval from the financial delegate".[386] The Chief Procurement Officer, Ms Lategan, also gave evidence at the public hearings, on 13 April 2026, that she was still awaiting an update from the Commissioning team, and despite having followed up multiple times, she understood financial delegate approval to rewrite the standard form agreement was still pending.[387]

Whatever the reason may be for the delay, the Commission considers that this "urgent" work was not prioritised in the manner that would be expected given its self-evident importance to the way the Department procures services. So much appears to have been realised by the Department. By the time the Deputy-Director General of Commissioning gave evidence at the hearings, on the final day of the April hearing block (17 April 2026), it was confirmed that approval had been given two days earlier, that is, on or around 15 April 2026, for the engagement of external solicitors to provide advice in relation to updating the standard form agreement.[388] Given the lengthy delays already experienced, it is unclear when the Department will receive advice in relation to an updated agreement and arrange for that to be put in place.

6.3.4 Onboarding and pre-qualification of providers

A further issue observed by the Department concerns the onboarding process for new IPS funded service providers. According to the Department, each of the child safety regions use place-based processes to assess, approve and onboard new IPS service providers.[389] Relevant considerations for the Department are said to include whether: (i) a service provider is licensed or unlicensed; (ii) whether a service provider is OSD funded (including for other service types); and (iii) whether a service provider offers models of care that are designed to meet the needs of the individual

[385] Email from Danny Short, 15 January 2026 (DFS.0369.0046.0038).
[386] Statement of Bernadette Harvey (6 March 2026) 2.
[387] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5211:46-5212:3.
[388] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5268:8-40.
[389] Statement of Bernadette Harvey (18 December 2025) [19].

child or young person, such as a child or young person with complex behavioural needs or disability.[390]

However, the Commission was subsequently informed that none of these "place-based processes" for assessing, approving and onboarding IPS funded providers are documented.[391] The Department's explanation for this was that each child safety region has its own distinct circumstances and complexities. Therefore, this approach gives them the autonomy to address their unique needs and implement processes that suit their specific contexts, provided (of course) they comply with the Department's procurement and contract management processes.[392]

The Commission considers this to be an inadequate framework within which to operate because it is prone to variability and inconsistency. Moreover, it misapprehends that having an organised, documented and criteria-driven process for onboarding suppliers is *not* mutually exclusive with the notion of different child safety regions being permitted a degree of latitude or regional variability when determining which IPS funded service providers are suitable. To the contrary, there is self-evident utility in giving guidance to the child safety regions as to the factors that might make a provider suitable for providing residential care services – leveraging the wealth of accumulated data and experienced held by the Department – albeit with express permission for that criteria to be applied flexibly based from region-to-region.

Though the Department is now developing and implementing a framework for residential care services to support faster engagement of pre-qualified service providers,[393] that framework is well overdue and was neglected for far too long. Indeed, as explained in further detail below, the Deputy Director-General was briefed in March 2023 (as part of the IPS Redesign) as to the necessity and utility of creating a panel of preferred suppliers.[394] Some regions, such as Far North Queensland, in fact took steps to develop a preferred supplier list, so as to have a standardised supplier due diligence process to assist the Placement Services Unit with a list of regionally preferred and approved suppliers for urgent placements of children and young people.[395]

Ultimately, the Far North Queensland Region ceased using a preferred supplier list in 2025, as this gave way to a statewide systems level framework for pre-qualification of suppliers.[396] In this

[390] Ibid.
[391] Supplementary Statement of Bernadette Harvey (10 February 2026) [3].
[392] Ibid [4].
[393] Ibid [5].
[394] Department of Children, Youth Justice and Multicultural Affairs, *Strategy for IPS Redesign* (Deputy Director-General Briefing Note, March 2023) (DFS.0001.0002.2398).
[395] Statement of Bernadette Harvey (18 December 2025) [23].
[396] Ibid [24].

regard, Ms Lategan's evidence was that the development of a pre-qualification framework was akin to the notion of a "preferred supplier list" based on a series of provider-level, employee-level and site-level considerations.[397]

In response to issues identified before and during the Commission's inquiries, the following actions are thus underway within the Department to identify and respond to IPS commissioning and procurement risks:

(a) a review of the benchmark pricing in the IPS Business Rules, which it is anticipated will be supplemented by the deployment of more sophisticated pricing tools such as the RCCM, discussed above at Part 4.7;
(b) a review of the IPS agreement standard form template from a procurement, contract management and legal perspective; and
(c) the development and implementation of a pre-qualification framework for residential care service providers (and other types of services) that aligns with the Department's move toward an agile procurement model.[398]

The Commission regards the development of pre-qualification criteria as a particularly worthwhile reform. As Ms Lategan explained in her evidence, the pre-qualification framework is intended to provide a more structured and consistent statewide process for assessing whether suppliers are suitable, capable and ready to provide services *before* they are engaged for placements.[399] It will enable the Department to identify a subset of providers that the Department regards as preferable or desirable to engage with based on considerations such as performance, staff qualifications and pricing.[400] In this context, the Department should consider requiring suppliers of IPS placements to provide additional supporting documentation to justify their pricing schedule such as payroll information, rental lease contracts and energy or utility bills.[401]

The Department has indicated that the pre-qualification criteria is still being developed, a process that has been ongoing for at least 12 months already. At present, the following criteria are under consideration for all service types:[402]

(a) financial transparency and viability;
(b) type of organisation;

[397] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5213:35-5214:6.
[398] Statement of Bernadette Harvey (1 December 2025) [18].
[399] Statement of Hanelie Lategan (30 March 2026) [120].
[400] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5214:1-16.
[401] See, eg, Department of Families, Seniors, Disability Services and Child Safety, *IPS Panel Agenda – July 2025* (Spreadsheet, 30 July 2025) (DFS.0186.0044.0110) in this regard.
[402] Statement of Hanelie Lategan (30 March 2026) [122].

(c) insurance;
(d) reference checks for senior executives;
(e) workplace health and safety systems;
(f) implementation and compliance with Child Safe Standards;
(g) compliance with relevant;
(h) working with children requirements; and
(i) organisational structure.

The Department is also considering additional pre-qualification criteria for residential care suppliers, including:[403]

(a) whether the provider has policies and procedures specific to residential care;
(b) whether the provider is appropriately certified or licensed where relevant;
(c) whether the provider is a suitable entity to provide residential care;
(d) whether the provider has appropriate insurance; and
(e) whether the provider has adequate staff training and structure.

In aggregate, this detailed vetting process will reduce the risk of a service provider being engaged before the Department has sufficient visibility of that service provider's suitability, capability, financial position and compliance settings.[404] It also aims to support faster engagement of pre-qualified providers while maintaining probity, transparency, and value-for-money outcomes.

As Ms Lategan explained in her evidence, the pre-qualification process will allow the Department to sign providers up to a standard and comprehensive set of terms and conditions *before* engaged to provide services.[405] This demonstrates the ways in which reform is a multifaceted and interrelated undertaking. It is not sufficient to have a pre-qualification framework. That framework must also be supported by a robust documentation suite of standard form agreements and a compliance team that assesses, monitors and tracks performance against the designated criteria.

The development of a pre-qualification framework also aligns with the recommendations in the report prepared by Ernst & Young (EY) in August 2025 for the Department entitled "Unlicensed Residential Care – Contract Management Review" (EY Report). In that report, EY identified that the Department had not developed a vendor evaluation/pre-qualification process for unlicenced providers, and that it should do so to assess whether the organisation and its employees were

[403] Ibid [123].
[404] Ibid [125].
[405] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5207:23-39.

suitable to work with children and be engaged by the Department. EY noted that the regions have developed their own processes to undertake this; however, they are inconsistent and are a 'one off' activity, undertaken at the commencement of the use of the provider.[406] It is for that reason that EY recommended a pre-emptive assessment for all unlicenced providers who have an active placement, to determine their suitability to provide services for the Department and to provide a risk assessment against them.[407]

To date, the Department has not implemented the pre-qualification framework, nor has it committed to a timeframe for doing so.[408] The Commission recommends that this be given high-order priority, given that it informs and is relevant to a wide range of operational and financial risks the Department has to navigate.

6.4 Additional opportunities to improve efficiency, transparency and accountability in commissioning and procurement processes

6.4.1 Financial reporting obligations (IPS and OSD providers)

A further opportunity for the Department to improve the efficiency and transparency of its procurement and contracting practices arises with respect to the financial reporting obligations imposed on OSD and IPS funded providers, respectively.

At present, every OSD-funded residential care provider is required to submit to the Department an audited annual financial statement (AFS) at the organisational level and an annual acquittal statement (AAS) for each OSD-funded service every year.[409]

The AFS must be in the form of either a General Purpose Financial Report or a Special Purpose Financial Report. It must also be prepared in accordance with the applicable Australian Accounting Standards.[410]

The AAS must be in the form of a Special Purpose Financial Report, apply the same Australian Accounting Standards as the AFS and include:

(a) a statement of profit and loss;

(b) a statement of assets and liabilities;

[406] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 13.
[407] Ibid.
[408] Statement of Bernadette Harvey (18 December 2025) [24].
[409] Statement of Bernadette Harvey (10 November 2025) [70].
[410] Ibid [70](a).

(c) a directors' statement/declaration; and

(d) an independent audit report.[411]

In the first instance, the Budget and Contracting Coordination team in Investment and Commissioning (I&C) review the submitted documents to ensure they are complete, in the sense of including a cash flow statement and an independent audit report.[412]

The Financial Services team within Corporate Services then reviews those financial statements to determine the provider's financial viability using an assessment tool which includes a number of financial indicators.[413] These financial indicators include operating earnings before interest, taxes, depreciation, and amortisation (EBITDA) margin, and ratios relating to operating cashflow adequacy, adjusted debt, gearing, interest coverage, and debt serviceability coverage.[414]

Based on its review of the financial indicators, the Financial Services team records a binary outcome. The outcome is binary insofar as an entry is recorded of either "concerns" (where financial viability concerns exist) or "no concerns" (where no financial viability concerns exist). This determines whether a further assessment and deeper evaluation of the service provider is required.[415]

If a provider is identified as having financial concerns, the NGO Financial Risk Oversight team then undertakes an in-depth analysis to determine next steps.[416] The assessment includes:

(a) making adjustments to the initial analysis conducted by the Finance team (where required);

(b) thoroughly reviewing audited financial statements, including disclosure notes and audit reports;

(c) reviewing additional contextual information as available, whether on the provider's website or regulatory databases held by entities such as the Australian Securities and Investments Commission (ASIC), Australian Charities and Not-For-Profit Commission or National Disability Insurance Scheme (NDIS) Quality and Safeguarding Commission;

(d) reviewing total funding in relation to departmental funding; and

(e) considering regional feedback.

[411] Ibid [70](b).
[412] Statement of Bernadette Harvey (6 March 2026) [7](a).
[413] Statement of Bernadette Harvey (10 November 2025) [72].
[414] Statement of Bernadette Harvey (6 March 2026) [7](b).
[415] Ibid [8].
[416] Statement of Bernadette Harvey (10 November 2025) [73].

Where financial concerns require further action by the Department, the NGO Financial Risk Oversight team works with regional Investments, Planning and Partnership (IPP teams to support their engagement with the service provider and/ or leads engagement with the service provider if contracted across multiple regions. Where significant financial concerns are identified, the NGO Financial Risk Management team escalates advice to the Senior Executive Director (SED), I&C. Briefings may also be provided to other departmental senior executives, such as Regional Executive Directors and the Deputy Directors-General of Service Delivery and Commissioning, as required.[417]

The Commission has identified a range of issues associated with this process for OSD providers.

First, for a new organisation, the timing of the current process results in the first assessment of their financial viability occurring up to 18 months into the contractual engagement. The absence of a timely preliminary financial assessment of the organisation poses risks in terms of both risk management and compliance. It increases exposure to financial instability among providers, potentially affecting service delivery and increasing liability risks.[418] There is also a risk that because payments are made to OSD providers quarterly in advance, that if a service provider becomes insolvent or unsuitable for further placements, the Department may have to take legal action to recover unspent funds (or, even worse, may simply be unable to recover unspent funds).

A related issue is that if any financial assessments are conducted by the procurement team during the sourcing phase, these evaluations are not being effectively communicated to the finance, compliance or contract management teams. This lack of information sharing can lead to a fragmented understanding of a provider's financial position, increasing the risk of engaging with financially unstable providers. Ensuring that all relevant assessment results are systematically shared across these teams is essential for cohesive risk management and strategic decision-making.[419]

In giving evidence before the Commission, the Chief Procurement Officer, Ms Lategan, agreed that the fact OSD providers may not be audited for up to 18 months after they commence service delivery poses issues in terms of risk management and operational compliance. Ms Lategan also agreed that it was important for there to be a timely financial assessment of those providers, and that such matters should be dealt with in the pre-qualification framework.[420]

[417] Statement of Bernadette Harvey (6 March 2026) [12]-[13].
[418] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025) 23.
[419] Ibid.
[420] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5222-5223.

The Commission endorses the recommendation in an internal audit finalised in September 2025, and by the Chief Procurement Officer, that the Department should undertake a preliminary financial evaluation of all providers as part of the initial sourcing process. The internal audit further observed, and the Commission agrees, that this should be documented through a procedure, with defined roles and responsibilities across functions and timelines, that governs the process prior to the contract being awarded and during subsequent contract management.[421]

Second, despite all providers being required to submit their AFS each year, the Commission has become aware that not all of those financial statements are reviewed by the Department. According to evidence from the Deputy Director-General of Commissioning, Ms Harvey, only approximately two-thirds of AFS received are assessed in any given year using a risk-based sampling methodology, with each service provider assessed at least once every two years.[422]

When pressed by counsel assisting as to why the Department adopted that approach, the Deputy Director-General of Commissioning said she could not "answer that question definitively".[423] Ms Harvey later conceded that if the only reason was a resourcing issue, and no alternative explanation was proffered, then that was not a particularly compelling reason and it would be prudent for the Department to review *all* of the AFS submitted to the Department each year.[424]

The importance of this occurring was apparent from a cursory analysis of data produced by the Department in relation the AFS review process, which indicated that in respect of the 2024-25 financial year:

- the Financial Services team had assessed 90 AFS provided by OSD-funded service providers;
- of those 90 AFS, more than 25% (being 23 in total) were identified as having financial concerns and escalated to the NGO Financial Risk Oversight team;
- of those providers identified as having financial concerns, only five were identified as low risk following further review; and
- in respect of the remaining providers (being 18 in total):
    - one had been issued a show cause letter;
    - another had been sent a formal request for further information as to their financial position;

[421] Department of Families, Seniors, Disability Services and Child Safety, *Private Providers of Child Safety Residential Services* (Final Internal Audit Report, September 2025) (DFS.0271.0001.0025) 26.
[422] Statement of Bernadette Harvey (6 March 2026) [8].
[423] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5598:18-21.
[424] Ibid 5598:27-41.

- several had attended or arranged meetings with the Department to discuss their financial position and performance; and
- several had submitted plans to manage or improve their financial position and performance.[425]

As for IPS providers, the Department seemed to suggest that such rigorous financial monitoring was not required because, as distinct from OSD-funded contracts, funding for IPS agreements is only provided after services have been delivered and an invoice rendered.[426] The Department also seemed to suggest that financial viability would, for those IPS providers that are licenced, also be assessed as part of their application for a care service licence.[427] As part of that process, applicants are required to provide either: an annual audited financial statement; a statement from an accounting firm that states the corporation is a going concern; or a letter from a company director stating that the company is viable.[428]

The fact alone that IPS providers are paid after-the-fact for services rendered does not obviate the need for prudent and careful financial management. It is important for the Department to be aware of financial solvency risks in that scenario because, among other things, it might indicate the Department should minimise or limit the number of placements with the provider.[429] In such scenarios, the Department should also be astute to monitor carefully for complaints or failures in delivering the standard of care required, as there is a greater risk of providers taking 'shortcuts' to minimise on costs.

The Deputy Director-General of Commissioning, Ms Harvey, ultimately acknowledged in her evidence that there was utility in also having IPS providers submit audited financial statements on a regular basis, moving forward (noting that in the changing residential care landscape, it was envisaged such providers would have a much smaller footprint).[430]

The importance of this proposed reform recommendation was also brought into sharp focus by KPMG's Report. In that report, KPMG identified a range of issues in respect of IPS-only providers based on a desktop review of their financial statements. Those matters included that providers:

1. often extract economic value through a variety of mechanisms, including above-market remuneration, management fees, acquisition of non-core assets (including speculative

[425] Statement of Bernadette Harvey (6 March 2026) [20]-[21].
[426] Statement of Bernadette Harvey (1 December 2025) [12].
[427] Ibid [16].
[428] Ibid [16](a)-(c).
[429] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5215:34-38.
[430] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5602:12-22.

investments such as gold or cryptocurrency), dividends and related-party transactions, rather than through reported profit;[431] and

2. may have on their balance sheet substantial debts, unsecured loans, tax liabilities or uncommercial transactions that raise questions or concerns about financial viability.[432]

These are matters that would not be transparent to the Department without access to financial statements. This only further highlights the importance of requesting audited AFS in respect of all providers, not merely OSD-funded providers, and doing so in a timely manner.

Addressing these issues with the contracting and procurement of residential care services is integral to the Department taking back its role as a market steward.

6.4.2 Training and professional development requirements for Departmental staff

Another issue with the Department's approach to commissioning and procurement concerns the training of Department staff entrusted with those functions. The Chief Procurement Officer, Ms Lategan, elegantly summarised this concern in the following propositions:

1. procurement and contract management are specialised disciplines requiring structured capability, formal training and clear professional standards;
2. at present, staff involved in negotiating OSD or IPS funded arrangements are often balancing operational responsibilities with procurement, commercial and contract management tasks and may not always have access to specialised training or support; and
3. the qualifications and training required for staff working in procurement and/or contract management should reflect the complexity, risk profile and financial significance of the work they are undertaking.[433]

The nub of Ms Lategan's evidence was that for Departmental staff working in high-risk or high-value procurement and contract management environments, it is important to have recognised professional development and accreditation pathways.[434]

With those observations in mind, the Commission was surprised to learn that, at present, the Department has no mandated procurement or contract management training for contract

[431] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 8 [ES.17], 50 (Finding 2).
[432] Synthesis of issues in KPMG, *Provider Financial Analysis (Part B)* (Report Confidential Annexure, 2 April 2026).
[433] Statement of Hanelie Lategan (30 March 2026) [106]-[108].
[434] Ibid [109].

officers, nor are they required to hold any formal qualifications.[435] This represents a substantial operational and financial risk for the Department, given that financial delegations for such staff include contracts of up to $3 million (in cumulative value).[436]

At its highest, Department witnesses explained that contract officers have the option to complete a mix of whole-of-government training and internal online learning modules on topics such as an introduction to procurement, probity in procurement, contract management and emergency procurement.[437] Procurement Services encourage staff to complete these modules, but they are not mandatory and risk becoming, in any event, a merely formulaic exercise.[438] It was equally little comfort to the Commission to learn that the Department supposedly encourages staff to complete relevant LinkedIn Learning courses in procurement and contract management to support ongoing capability uplift.[439]

Ms Lategan explained to the Commission that the procurement modules that do exist are "very high level" and that it would "be difficult to perform the role" of negotiating and executing contracts with providers if that was the only training available.[440] Ms Lategan further observed that the existing training was insufficient and that, in her view, staff should be encouraged and supported (if not mandated) to pursue professional development opportunities and formal accreditations in procurement and contract management.[441] Ms Lategan went so far as to say as to recommend the World Commerce and Contracting Association Accreditation.[442]

To the extent that Department staff are required to complete mandatory corporate training, it is broadly with respect to topics that might arising in any workplace such as record-keeping, safety at work, information security awareness and emergency procedures.[443] Further, training records provided to the Commission indicated that for a number of staff employed by the Department in commissioning, procurement and service delivery (including contract officers), they had not enrolled in, not attempted, partially completed or failed training modules.[444]

The Department has only recently started developing a procurement and contract management capability framework that will outline staff roles and responsibilities and recommend specific

[435] Statement of Bernadette Harvey (1 December 2025) [34].
[436] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5230:29-47.
[437] Statement of Bernadette Harvey (1 December 2025) [29].
[438] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5230:29-27.
[439] Statement of Bernadette Harvey (1 December 2025) [32].
[440] Transcript, Evidence of Hanelie Lategan (13 April 2026) 5231:11-17.
[441] Ibid 5231:19-41.
[442] Statement of Hanelie Lategan (30 March 2026) [109].
[443] Statement of Bernadette Harvey (1 December 2025) [37].
[444] See, eg, spreadsheets provided by the Department of employees and the enrolment status for procurement training modules (DFS.0214.0008.0001, DFS.0214.0008.0002, DFS.0214.0008.0003).

training for each role across the end-to-end process.[445] This an opportunity for the Department to drastically reimagine the training provided to its contract procurement and management staff, so that it has the internal competency to efficiently administer such substantial public funds.

For staff working in high-risk and high-value procurement and contract management environments, the Commission considers that recognised professional development and accreditation pathways are essential.

In the time available, the Commission has not undertaken a deep dive assessment to determine what enhanced training might look like, but there is plainly an identified gap. The Commission thus recommends that the Department undertake such a review, focusing on how professional competencies can be enhanced through clearer role expectations, more structured internal training, stronger mentoring and capability support, and greater use of recognised professional accreditation pathways for staff undertaking procurement and contract management responsibilities.

If the residential care system is to be reformed and overhauled in a way that quantifies value not by bed nights, placements or in unit costs, and rather by the quality of care provided to children and young people, the Department will require frontline staff with the training, experience and aptitude to implement these reforms in each of the varied and complex child safety regions services are provided.

6.5 Exploring prospect of direct Government service delivery

A final aspect of commissioning and procurement explored by the Commission concerned whether the Department should engage in direct service delivery. By way of context, in some Australian states and territories, non-family-based care services, such as residential care, are delivered through a mix of direct government delivery and outsourcing to non-government organisations (NGOs).[446]

According to a Director within the RIO, Ms McNamara, in other jurisdictions this mixed approach is often used where:

(a) there are not enough available placements being provided by the non-government sector, particularly in remote areas;

[445] Statement of Bernadette Harvey (1 December 2025) [36].
[446] Statement of Michelle McNamara (25 March 2026) [68].

(b) children or young people, or specific groups of them, require more intensive or specialised care that the non-government sector is not equipped to provide; and/or
(c) a care provider exits the market unexpectedly, requiring short-term or emergency care arrangements.[447]

Mr Jefferson, of KPMG, similarly gave evidence, by reference to his sector experience and expertise, that direct service delivery may be used in human services:

(a) for the purposes of providing care as an option of "last resort" where that care is unable to be provided by existing market participants;
(b) to test and trial new models of service delivery, which providers may not have sufficient capital themselves to invest in; and
(c) as a means of supporting the labour market, by facilitating employment opportunities that support workforce retention.[448]

Ms McNamara explained that the advantages of internal delivery of residential care compared to external contracting include greater control over service quality, standards, and consistency, as the Department can directly manage and enforce care practices. Internal delivery also allows for improved integration with other government services, such as health, education, and therapeutic support, enabling a more holistic approach to meeting the needs of children and young people.[449]

Additionally, direct service delivery reduces reliance (indeed, dependence) on external providers, which can mitigate risks associated with market failures, provider exits or limited-service availability in rural and remote areas. Internal delivery may also offer cost efficiencies through economies of scale and streamlined operations.[450]

Conversely, however, Ms McNamara explained that if the Department were to engage in direct service delivery, that would require an investment in infrastructure, workforce, and ongoing operational costs, which can pose challenges for scalability and flexibility compared to external contracting.[451]

To these disadvantages, Mr Jefferson added the common refrain that government is not always best placed to deliver social services, and whether that would be prudent depends on the availability and track record (from a quality of care perspective) of providers in particular geographic areas. Mr Jefferson also mentioned that direct government service delivery may run

[447] Ibid.
[448] Transcript, Evidence of Dan Jefferson (7 April 2026) 4826:24-41.
[449] Statement of Michelle McNamara (25 March 2026) [69].
[450] Ibid.
[451] Ibid [70].

counter to the initiatives underway to transition Aboriginal and Torres Strait Islander children to First Nations providers and community-controlled organisations.[452]

All of the witnesses that gave evidence for the Department agreed that at no time since the Carmody Inquiry has the Department ever given specific or detailed consideration to the possibility of entering the residential care market (even to a limited extent).[453] Plainly enough, the Department would need to carefully consider a balanced approach between internal and external delivery if it were to explore intervening in that way.

In the time available, the Commission was not able to exhaustively canvas the competing views as to whether the Department should be involved in direct service delivery. Accordingly, the Commission recommends that the Department commission or undertake a feasibility review in relation to the same, focusing on the potential for government intervention in thin markets (such as regional areas or specialised services) or as a provider of last resort. Such a review could focus on the infrastructure and workforce planning required, include a cost-benefit analysis to guide policy decision-making, and explore the consequences of a mixed-market approach for smaller, medium and large providers in the market.[454]

[452] Transcript, Evidence of Dan Jefferson (7 April 2026) 4827:2-17.
[453] Transcript, Evidence of Arthur O'Brien (13 April 2026) 5248:10-29; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5361:43-5362:7.
[454] Transcript, Evidence of Michelle McNamara (9 April 2026) 5110:12-29.

6.6 Recommendations

Recommendation 32: Risk-based monitoring of funded services	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within six months of the Government's response to this report, develop a system for appropriate, risk-based financial monitoring of all services funded by the Department, including residential care providers, regardless of funding type. Those providers receiving above a determined threshold level of funding should be required to produce to the Department, on an annual basis: audited statements at the funded organisation level; audited acquittal statements for each service or contract; and a signed statement confirming compliance with any contract conditions.	
CONTEXT: The Department requires service providers funded under outsourced service delivery (OSD) agreements to disclose certain financial documentation annually. However, there are no similar requirements for service providers funded under other arrangements, including Individual Placement and Support (IPS) agreements, despite these agreements being widely used by the Department. Further, even where submitted, not all of that financial documentation is reviewed on an annual basis.	
IMPLEMENTATION NOTES: All financial statements lodged with the Department, whether at the organisation level or service level, should be subject to an independent review by a qualified accountant employed by the Department each year, with appropriate pathways and processes for escalation where financial risks are identified.	

Recommendation 33: Minimum role-specific training for procurement and contract staff	
Executive Report (Chapter 7)	**Companion Report 4 (Chapter 6)**
RECOMMENDATION: That the Queensland Government, within six months of the Government's response to this report, should develop mandatory minimum, role-specific training to be required for all staff involved in procurement, contract management and/or regulatory activities including licensing.	
CONTEXT: The Commission observed there was a lack of training for key Department staff involved in procuring and managing contracts, creating a significant risk for the Department. However, training itself will not be sufficient. The Commission recommends that a Department-wide costing tool that can be deployed to assist those in the regions responsible for negotiating with suppliers.	
IMPLEMENTATION NOTES: The Department should also explore opportunities for professional development and formal accreditation in relation to these same roles, as ongoing learning opportunities.	

Recommendation 34: Pre-Qualification Framework for residential care providers	
Executive Report (Chapter 7)	**Companion Report 4**
RECOMMENDATION: That the Queensland Government, within three months of the Government's response to this report, develop a pre-qualification framework and associated criteria for residential care providers. This framework and criteria should include, at a minimum: preliminary financial assessments; incentives for providers to become licensed ; pre-contracting with the Department with improved instruments; and any other criteria that would be necessary to ensure the Department is procuring value for money.	
CONTEXT: The Department has foreshadowed that it intends to develop a pre-qualification framework and associated criteria, but that has not been implemented to date and there is no commitment to a date by which that would be operational. The Commission recommends that this be given high-order priority, and that elements be built into the framework that align with other recommendations.	
IMPLEMENTATION NOTES: The pre-qualification framework should include, at a minimum, preliminary financial assessments, incentives for providers to become licensed and pre-contracting with the Department with improved instruments. In this context, the Department should also give consideration to requiring suppliers to provide additional supporting documentation to justify their pricing schedule (in the context of Individual Placement and Support agreements) such as payroll information, rental lease contracts and energy or utility bills.	

Chapter 7

Licensed and Unlicensed Providers

Companion Report 4

Understanding and Reforming the Residential Care System

Chapter 7: Licensed and Unlicensed Providers

Given the vulnerability of children and young people placed in residential care settings, licensing is an important safeguard to ensure not only that minimum standards are met, but also that service providers are capable of delivering consistent, relationally stable and culturally safe care.

In Queensland, the current licensing framework has struggled to keep pace with the scale, complexity and rapid expansion of the residential care sector. These issues have been brought sharply into focus by the increased reliance on IPS agreements, the causes of which are explored in detail in Parts 3 and 4 above.

Until recently, children and young people in residential care were increasingly being placed with providers who were: (a) not receiving OSD funding; and (b) not therefore required to meet any licensing requirements nor to be audited for compliance with the HSQF, at least until deemed "in-scope" for licensing and invited to apply for a licence by the Department.[455]

Absent the oversight afforded by the licensing regime, the Department has been operating in an environment where it had limited visibility over children and young people placed in the care of unlicensed providers.

7.1 Contextual information and overview of licensing process

Under the current system for engaging residential care service providers, an organisation may be either licensed or unlicensed.

If an organisation is to be licensed, it must meet the legislated requirements in s 126 of the Act, which relevantly include that:

- the licence applicant is a suitable entity to provide care services, being either a director of the applicant, the nominee for the licence, or the person who will be (or is) responsible for directly managing the care service or for performing a risk-assessed role for the care service: ss 126(a) and (b) of the Act;

[455] Department of Children, Youth Justice and Multicultural Affairs, *Individualised Placement and Support Redesign - Reference Group* (Meeting Minutes, 17 August 2022) (DFS.0186.0037.0132) 3; Proactive Statement of Bernadette Harvey (3 September 2025) [96].

- the applicant will comply with Chapter 7 of the *Working with Children Check Act 2000* (Qld) in carrying on a regulated business or employing persons in regulated employment under that Act: s 126(d) of the Act;
- the standard of care provided complies, and will continue to comply, with the statement of standards: s 126(e) of the Act; and
- methods for the selection, training and management of people engaged in providing the services are suitable: s 126(f) of the Act;
- the applicant's primary function is a function relating to the care of children in need of protection who are in the custody or guardianship of the chief executive: s 126(g) of the Act; and
- any accommodation provided by the applicant to children in need of protection is, and will continue to be, at a place that the applicant has a suitable right to occupy (for example, a residential premises leased, rented or owned by the applicant): s 126(h) of the Act.

Moreover, before a service provider is invited by the Department to apply for a care service licence with the Department, they must be: (i) incorporated; (ii) delivering care services; (iii) deemed to be in-scope of licensing; and (iv) certified under the HSQF.[456] In follows that the process of obtaining certification under the HSQF for child protection placement services only commences *after* the provider has already commenced providing services and been deemed "in-scope" for licensing.[457]

In this way, the licensing framework does not operate as a prerequisite (or authorisation) to providing care services, but rather as a regulatory scheme applicable to some residential care service providers and not others. There is thus a risk that the way licensing has been utilised by the Department, it functions less as a precondition for service delivery and more as a deferred regulatory objective; with few incentives for providers to become licensed, weighed against substantive disincentives (including a financial, administrative and oversight burden) to do so.

The Department's current licensing framework (Organisation Level Licensing (OLL)) was implemented in 2013 and has not undergone a full review since that time.[458]Under the OLL

[456] Proactive Statement of Bernadette Harvey (3 September 2025) [85].
[457] Ibid [83]; revised in light of observation by Natalie Wilson in a witness conference (Transcript, Natalie Wilson Witness Conference, 27 February 2026) 88-89.
[458] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 5.

framework, a supplier can apply for and maintain a single licence for all its care services in Queensland, regardless of location or service delivery type.[459]

The OLL framework is implemented by the Child Safety Licensing (CSL) team, the regional Investment & Partnerships (I&P) team, the State-wide Licensing Panel (SWLP) and the Department's Licensing Delegate (the Senior Executive Director, Investment and Commissioning). In accordance with s 282 of the *Public Sector Act 2022* (Qld), decisions relating to the granting and refusal of care service licences are delegated by the Chief Executive to the Senior Executive Director of Investment and Commissioning.[460]

The CSL team is centrally based within the Investment and Commissioning team. The CSL team is responsible for the oversight of licensing non-government organisations including coordination of care service licence applications, compiling and providing information to support decision-making and monitoring compliance with licensing requirements. The CSL team is also responsible for the development and maintenance of licensing forms, templates, guides and manuals.[461]

The SWLP has been established by the Department to provide support and guidance to the Licensing Delegate in making informed decisions regarding "in-scope of licensing" assessments and care service licence applications. The SWLP provides recommendations to the Licensing Delegate as to whether a licensing application should be granted or refused, or whether further information is required to make a decision.[462]

Collectively, the CSL, I&P and SWLP teams ensure that both licensed providers, and those that are in the process of becoming licensed, meet licensing requirements.[463]

The licensing process starts in earnest once a supplier is delivering care services and is deemed to be in-scope for licensing.[464]

If an unlicensed provider is deemed "in-scope" of licensing, they are invited by the Department to work towards becoming licensed.[465] A provider may be deemed in-scope of licensing if they

[459] Ibid.
[460] Department of Child Safety, Seniors and Disability Services, *Instrument of Delegation, Authorisation and Appointment* (Delegation, 5 June 2023) (DFS.0178.0001.0001).
[461] Statement of Bernadette Harvey (2 April 2026) [12].
[462] Ibid [13].
[463] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 5.
[464] Ibid 7.
[465] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 5.

have continuity of placement service delivery, placements have occurred over six to 12 months and placements have been maintained for over 12 months.[466]

As explained below, a provider also comes in-scope of licensing when they enter into a Service Agreement subject to the *Community Services Act 2007* (Qld) and receive OSD funding. In-scope providers will need to achieve HSQF accreditation prior to making an application to be licenced by the Department.[467]

It follows that providers receiving OSD funding to deliver care services are automatically deemed in scope of licensing; whereas, the Licensing Delegate determines whether IPS suppliers are in-scope of licensing and communicates their decision to the supplier in writing.[468]

OSD and IPS funded contracts include a condition that care service suppliers are required to achieve and maintain certification under the HSQF within 18 months of the funding schedule start date (for OSD-funded services) or from the date of being deemed in-scope (for IPS-funded services).[469] The provider must apply for a care service licence within 30 days of being invited to apply by the Department.[470]

The HSQF is the quality assurance system administered by the Department and used by a number of Queensland Government departments to improve the quality of funded services. It incorporates:

(a) a set of quality standards, known as the HSQF, in relation to governance and management, service access, responding to individual need, safety, wellbeing and rights, feedback, complaints and appeals, and human resources;
(b) an assessment process to review the performance of suppliers against the standards, through either:
    (i) third-party certification by an independent auditing body (for higher risk, higher funded providers); or
    (ii) self-assessment (for lower risk, lower-funded providers); or
    (iii) recognition of organisations' accreditation under another quality system; and
(c) a continuous improvement framework.[471]

[466] Ibid.
[467] Ibid.
[468] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 7.
[469] Ibid.
[470] Ibid.
[471] Statement of Bernadette Harvey (10 November 2025) [16].

Once a region has decided to undertake an in-scope of licensing assessment, they will advise the fee-for-service provider that they are doing so, and that the outcome will be communicated in due course.[472] The region will then complete the "In Scope of Licensing Assessment for IPS/CRC-PaS Funded Organisations" (Assessment Form), which evaluates the following matters for each organisation:

1. whether the organisation applying for a licence is a corporation;
2. whether they meet the primary purpose requirement of providing care services to children;
3. whether they have achieved HSQF certification and any findings from the HSQF audit;
4. whether they are certified under another regulatory scheme;
5. whether they have an extended history of child safety placements;
6. whether they have a secure funding source and viable long-term outlook;
7. any organisational strengths, such as the model of care utilised, governance values, service delivery history, favourable outcomes in caring for children and their engagement with the Department;
8. whether they have had any Standards of Care Concerns (SoCC) over the past 12 months, for example in relation to inappropriate behaviour management practices; and
9. whether any complaints have been made to the Department over the past 12 months (either via regional staff or directly with the Department's Complaints Unit).[473]

Once an in-scope of licensing assessment is completed by the region and endorsed by the Regional Executive Director, the assessment is submitted to the CSL team.[474] The in-scope of licensing assessment will be reviewed and endorsed by the CSL Manager and the Director of Data Insights, Value, Assurance and Regulation for progression to the SWLP, who will then make a recommendation to the licensing delegate.[475]

The licensing delegate will provide written advice of their decision to the service provider as well as a copy of the decision to the region or regions in which the provider is delivering care services.[476]

[472] Statement of Bernadette Harvey (2 April 2026) [31]-[32].
[473] Department of Families, Seniors, Disability Services and Child Safety, *Risk profile and mitigation guidance for suppliers deemed in scope of licensing* (Guide, March 2024) (DFS.0393.0001.0001).
[474] Statement of Bernadette Harvey (2 April 2026) [35].
[475] Ibid.
[476] Ibid [42].

If the funded service provider is deemed to be in-scope of licensing, the following advice will be provided:

(a) the in-scope assessment has been reviewed, and the service provider has been deemed to be in-scope of licensing;
(b) the next step in becoming a licensed service provider is to achieve third-party certification against the HSQF for child protection placement services within 18 months; and
(c) the CSL team will contact the service provider upon receipt of confirmation that the HSQF certification has been issued.[477]

The relevant region will subsequently provide the service provider with additional information relating to the HSQF and licensing requirements.[478] Following receipt of a successful certification for child protection placement services against the HSQF, the Department will invite a service provider to apply for a care service licence.[479]

The application for a care service licence must be received by the Department within 30 days of the service provider being invited. The Department will accept a licence application as properly made if it is compliant with s 125 of the Act.[480] The Chief Executive may refuse a care service licence application. In that event, s 129 of the Act requires the Chief Executive to give notice within 10 days of the decision, stating the reasons for the decision and explaining the licence applicant's rights to review the decision or have the operation of the decision stayed.[481]

If the Chief Executive decides to grant an application for, or renewal of, a care service licence, the licence may be issued subject to the reasonable conditions the Chief Executive considers appropriate, and such licences are valid for three years, pursuant to ss 127 and 128 of the Act.[482]

If the application for a care service licence (or its renewal) is granted, a licensee must ensure that:

(a) care services provided by a licensed care service operated under the licence comply with the standards of care stated in the statement of standards;
(b) each person performing a risk-assessed role for a licensed care service operated under the licence is a suitable person; and

[477] Ibid [43](a)-(c).
[478] Ibid [44].
[479] Ibid.
[480] Ibid [46]-[47].
[481] Statement of Bernadette Harvey (10 November 2025) [18].
[482] Ibid [17].

(c) it complies with Chapter 7 of the *Working With Children (Risk Management and Screening) Act 2000* (Qld) (WWC Act) when carrying on a regulated business or employing persons in regulated employment.[483]

The Department monitors a licensee's compliance with licensing requirements and organisational governance and individual care services covered by the licence. For that purpose, the CSL team develops annual licence monitoring schedules in consultation with regional I&P teams. The I&P team members are authorised officers under s 146 of the Act and are therefore able to enter and inspect licensed premises to ensure compliance with the Act.[484]

Specifically, the CSL team conduct annual reviews to assess a licensed organisation's overall compliance with legislative requirements, and monitoring occurs through announced and unannounced visits and assessment of records by authorised officers. At a minimum, one announced and one unannounced inspection must occur at each licensed residential care service during a 12-month period.[485]

Under the HQSF framework, a mid-term maintenance audit conducted approximately 18 months after initial certification or recertification against a sample of the standards may also replace a scheduled announced licence monitoring inspection for non-family based services where the HSQF maintenance audit is conducted within 3 months before or after the date of the scheduled inspection and the premises to be inspected is included in the HSQF audit sample.[486]

Finally, once granted, the Chief Executive may suspend or cancel a care service licence on certain grounds as set out in s 139 of the Act.[487] Without limitation, a licence may be suspended or cancelled because (among other reasons):

(a) the licensee is not meeting the standards required under the authority or another condition of the authority;
(b) the licensee has contravened a provision of this Act; or
(c) the licence was issued because of a materially false or misleading representation or declaration (made either orally or in writing).

The five phases of the licensing process are thus as follows: application; assessment; decision; monitoring; and renewal.[488]

[483] Ibid [19](a)-(c).
[484] Proactive Statement of Bernadette Harvey (3 September 2025) [87].
[485] Ibid.
[486] Statement of Bernadette Harvey (10 November 2025) [21].
[487] Ibid [22].
[488] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 37-38.

First, an OSD funded organisation, or an IPS funded organisation deemed by the Department as in scope of licensing, is invited to apply for a licence, following: (a) successful certification of relevant child protection placement services against the HSQF; and (b) assuming the applicant meets legislated requirements outlined in s 125 of the Act. The Department gathers, reviews and analyses information to assess the application including HSQF audit report, details of complaints, financial compliance concerns, standards of care concerns, regional feedback and suitability of people associated with the provision of care services.

Second, there is an opportunity for organisations to respond to regional feedback and the HSQF audit report before their application is progressed to the Department's Licensing Delegate to make a decision.

Third, the Department's Licensing Delegate grants the licence application if none of the restrictions in s 126 of the Act apply (see above at Part 7.1).

If each those first three requirements are met, then the organisation is issued a licence.

Fourth, the CSL team develops annual licence monitoring schedules in consultation with I&P team members. It thereby monitors organisational governance and individual care services covered by the licence. The CSL also conducts annual licensing reviews to determine the organisation's overall compliance with licensing requirements. During the monitoring phase, each residential care service provider is subject to a minimum of one unannounced and one announced inspection annually.[489]

Fifth, licences are subject to renewal every three years.[490] Through that process, providers are required to demonstrate ongoing compliance through recertification against the HSQF and address any areas for improvement identified during previous assessments.

As explained in further detail below, some providers expressed frustration with the Department's process for determining whether a provider is suitable for an in-scope licensing assessment and the subsequent licensing application processes. For example, one provider mentioned that they had been proactively seeking to become licensed with the Department since at least July 2024 and had undertaken extensive preliminary work required under the HSQF. Notwithstanding their interest and willingness to commit financial resources to the licensing process, the provider has

[489] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 8.
[490] Department of Children, Youth Justice and Multicultural Affairs, *Organisation Level Licensing Manual* (Manual, October 2022) (DFS.0393.0001.0008) 7.

been told it is "very long and detailed process"[491] and that any new licensing process is on hold pending the work of the Commission.[492]

7.2 Licensing for OSD and IPS providers

It is a contractual requirement for OSD-funded service providers delivering care placement services to be licensed or to be in the process of becoming licensed.[493] OSD-funded providers have 18 months from the date they commence providing services to the Department to achieve HSQF certification.[494] It follows that every such provider is either: (a) licensed, that is, having completed the HSQF certification and licensing process; or (b) in-scope for licensing, which includes providers that are either: (i) working towards HSQF certification; (ii) already certified but awaiting an invitation from the Department to apply to be licensed; or (iii) has received an invitation and is undergoing the licensing process.[495] For providers that are not yet licensed, failure to meet this requirement can lead to suspension or termination of funding for the service provider.[496]

The position for IPS providers is slightly more complex. It is not mandatory for service providers delivering care placement services under IPS agreements to be licensed and, unlike OSD-funded providers, they are not automatically deemed in-scope for licensing.[497] Therefore, as a first step in the licensing process, a licensing delegate from the Department determines whether an IPS-funded provider is within scope of licensing. If so, they will generally be working towards licensing, at the invitation of the Department.

The standard form agreement used for procuring IPS-funded services provides that the Department may require such providers to hold a care service licence or be actively working towards an application for a licence.[498] Accordingly, once such a provider is deemed in-scope, the Department has a contractual mechanism to insist upon that occurring. If, however, an IPS-only provider is not in-scope of licensing or has not been invited to apply for a licence by the

[491] Email from the Department to service provider, 13 February 2025 (COI.0001.0005.7072).
[492] Statement from service provider (COI.0001.0005.7093).
[493] Department of Children, Youth Justice and Multicultural Affairs, *Service Agreement – Funding and Service Details* (Template, Version 1.3) (DFS.0006.0003.0003) cl 4.8; Proactive Statement of Bernadette Harvey (3 September 2025).
[494] Department of Children, Youth Justice and Multicultural Affairs, *Service Agreement – Funding and Service Details* (Template, Version 1.3) (DFS.0006.0003.0003) cl 4.3.
[495] Explanatory note to Notice 1 provided by the Department (COI.0001.0006.0005).
[496] Proactive Statement of Bernadette Harvey (3 September 2025) [84].
[497] Department of Families, Seniors, Disability Services and Child Safety, *Individualised Placement and Support Agreement* (Template, July 2025) (DFS.0186.0039.0001) cl 4(a).
[498] Ibid cl 4(b).

Department, they may continue to operate indefinitely as an unlicensed provider, with the only consequence being that they are excluded from consideration for OSD-funded contracts.[499]

7.3 Main pathways for IPS providers to become licensed

There are two ways in which an IPS-*only* funded service provider is identified and determined to be suitable for an in-scope of licensing assessment. The primary way is a quarterly review of placement data relating to IPS Agreements undertaken by the CSL team, based on data it receives from the regions (Pathway 1).[500]

The CSL team will review the placement data and consider the following factors in whether a service provider is suitable for an in-scope of licensing assessment:

1. the continuity of placement service delivery;
2. if the number of placements provided has increased over a 6 to 12 month period; and
3. if any placements have been maintained for longer than 12 months.[501]

The CSL team then notifies the relevant Child Safety region of any IPS-only providers who have been determined to be suitable for an in-scope of licensing assessment.[502]

Once an IPS-only funded service provider is identified as suitable by the CSL team, the region determines whether an in-scope of licensing assessment will be undertaken. If a service provider operates across multiple regions, the region within which the service provider delivers the most placements takes the lead in conducting the assessment, and liaises with the other regions during this process.[503] Each region is responsible for undertaking in-scope of licensing assessments, having regard to the criteria and process mentioned above in Part 7.1.[504]

The other way an IPS-only fee-for-service funded service provider can be identified and determined to be suitable for an in-scope of licensing assessment is a proactive nomination by one of the child safety regions (Pathway 2).[505]

The regions will consider the same three factors mentioned above (continuity of placements; the number of placements increasing over a proximate period and the number of placements

[499] Explanatory note to Notice 1 provided by the Department (COI.0001.0006.0005).
[500] Statement of Bernadette Harvey (2 April 2026) [20]-[21].
[501] Ibid [22].
[502] Ibid [23].
[503] Ibid [24].
[504] Ibid [25].
[505] Ibid [26].

sustained over a proximate period), as well as local market need. The region also considers whether a service provider has and will continue to meet an identified market need, whether placements will be maintained for the foreseeable future, and/or if there is any intention to grow the service provider's placement numbers.[506] The regions must then consult with the CSL team prior to advising the service provider and commencing the licensing assessment.[507]

7.4 Market composition of licensed and unlicensed providers

Having regard to the licensing process set out above, in most instances, unlicensed placements are therefore provided by:

1. newly funded unlicensed OSD and/or IPS suppliers deemed in-scope of licensing, that are in the process of obtaining HSQF certification or a care service licence;
2. licensed suppliers in premises that have not yet been added to the provider's care service licence; or
3. unlicensed suppliers that are not in-scope of licensing, including because the organisation:
    a. only sporadically provides residential care services to the Department, such that it does not meet the continuity thresholds;
    b. only receives such limited funding from the Department that licensing is perceived as an unnecessary administrative burden;
    c. provides specialised services to the Department (such as disability services), and otherwise holds another relevant accreditation (such as NDIS registration), which the Department is satisfied provides an adequate safeguard and quality assurance; or
    d. is awaiting an in-scope licensing assessment by the Department or has made an application to be licensed and is awaiting the outcome.[508]

In FY2024-25, placements with unlicensed providers made up approximately 52% of all IPS agreements, an increase from 47% in FY2023-24.[509] Put differently, in respect of the provision of

[506] Ibid [27].
[507] Ibid [27].
[508] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 10; Email to Bernadette Harvey regarding funding arrangement for this provider, 2 July 2025 (DFS.0001.0002.2472).
[509] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 5.

residential care services by way of IPS agreements, there were more children and young people in the care of unlicensed providers than licensed providers in the last financial year.[510]

Across the 156 organisations that provided residential care services in FY2024-25, 36 were licensed (23.1%), 22 were in-scope for licensing or deemed suitable for an in-scope assessment but not yet licensed (14.1%) and 98 were unlicensed (62.8%).[511] This included 14 unlicensed providers that received funding of between $5m-$10m, 6 unlicensed providers that received funding of between $10m-$20m, 1 unlicensed provider that received funding in excess of $20m and 1 unlicensed provider that received funding in excess of $30m.[512]

In respect of the unlicensed provider that received approximately $35m in funding in FY2024-25, data produced by the Department to the Commission demonstrated that:

1. the service provider first commenced delivery of residential care services on 9 December 2022;
2. the service provider was deemed suitable for an in-scope licensing assessment almost two years later, on 26 August 2024, by which time 54 children were placed with the provider;
3. the Licensing Delegate deemed the provider in-scope of licensing on 23 April 2025, by which time 78 children were placed with the provider;
4. on 29 April 2025, the Licensing Delegate provided written advice to the service provider indicating that they were in-scope of licensing;
5. on 15 January 2026, the service provider achieved their HSQF certification after completing the audit process; and
6. on 2 March 2026, the provider was invited to apply for a care service licence. However, as at 31 March 2026, the provider had not yet applied for a licence.[513]

In total, only two unlicensed providers became licensed in the 2023-24 financial year, and in the 2024-25 financial year, no unlicensed providers became licensed.[514] Indeed, focusing more narrowly on IPS-only providers, over the 14-year period spanning from January 2013 to March

[510] Department of Families, Seniors, Disability Services and Child Safety, *CRC-PaS Placement Report – Monitoring of Unlicensed Organisations* (Spreadsheet, 30 September 2025) (DFS.0186.0031.0043).
[511] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 16.
[512] Department of Families, Seniors, Disability Services and Child Safety, *Residential care providers and funding across 2023-24 and 2024-25* (Spreadsheet, 23 June 2025) (DFS.0186.0031.0215).
[513] Department of Families, Seniors, Disability Services and Child Safety, *Last 20 IPS funded service providers whow were not a party to any OSD funded contracts who were deemed in-scope of licensing* (Spreadsheet, 31 March 2026) (DFS.0393.0002.0001).
[514] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 12.

2026, only eight IPS-only providers became licensed with the Department.[515] This is particularly problematic having regard to the evidence before the Commission as to a historical and systemic overreliance on IPS placements over recent years.

Importantly, however, the Commission also heard that the composition of licensed and unlicensed providers has been shifting significantly over the past few months. Based on evidence given by the Deputy-Director General of Commissioning, Ms Harvey, the Commission understands that:[516]

1. 67% of children and young people are now placed with licensed providers;
2. 33% of children are placed with unlicensed providers, of which:
    a. approximately 16% are placed with unlicensed providers who are not yet in-scope for licensing;
    b. approximately 8% are placed with unlicensed providers who have been invited to apply for a licence; and
    c. approximately 8% are placed with unlicensed providers who are in-scope of licensing and working towards HSQF certification.

Taken collectively, and having regard to Department's intention that only 5-10% of placements will be delivered by IPS agreements,[517] this suggests that by the end of the calendar year, the breakdown of providers will continue to trend towards more licensed rather than unlicensed providers. In that context, Ms Harvey recognised that it may be necessary to provide more resourcing to the CSL and I&P teams to monitor compliance by licensed providers.[518] The Commission endorses that approach, failing which there is a risk that even licensed providers will not be subject to adequate oversight and supervision.

7.5 Conceptual issues with licensing regime

In theory, licensing is intended to operate as a gatekeeping mechanism so that only providers with appropriate governance arrangements, workforce capability, clinical oversight and physical environments are permitted to operate in the residential care sector. However, the effectiveness of licensing as a protective threshold has been diluted in this context, both by the proliferation of

[515] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5611:9-20.
[516] Ibid 5612:17-47.
[517] Ibid 5602:24-43.
[518] Ibid 5618:18-24.

IPS agreements, under which providers may operate without a licence, and by arrangements that allow OSD funded providers to operate while '*working towards*' licensing.[519]

In practice, the rapid expansion of residential care has placed sustained pressure on the State's regulatory capacity. The sector has grown more quickly than the systems designed to oversee it. Reports of delays in licensing processes, extended periods of provisional operation, and insufficiently frequent audits raise serious questions about the extent to which licensing has been able to function as a robust safeguard. Where providers are permitted to operate for prolonged periods without a licence, regulatory oversight becomes overly reactive rather than preventative. This is of particular concern in a system in which placement urgency and scarcity of placement options already constrain decision-making.

Further, the Commission has heard that, at least historically, if providers were not interested in entering into OSD contracts (a position that has been enabled by the Department's procurement practices over the past decade), there was little incentive to become a licensed provider under the current regulatory and contracting frameworks. The tendency of providers to therefore remain unlicensed in turn restricts the Department's understanding of the extent to which organisations providing residential care services are complying with regulatory frameworks, and potentially places children and young people at greater risk.[520]

However, if properly utilised, the Commission has found that the licensing process is an effective tool to identify and manage organisational deficiencies with particular providers. For example, in or around November 2024, during the pre-HSQF process for a particular provider, the Department identified that: staff were not fully trained or supervised; and basic care and safety needs not being met from the time children enter placement (e.g., no hygiene items, missing medication and records, inadequate or expired first aid kits and lack of care planning).[521] Having identified those concerns, the Department was able to work proactively with providers to improve standards of care in residential care placements.

Conversely, without the supervision enabled by the licensing regime, there is a risk that providers are able to operate effectively unregulated. The Department itself is no doubt aware of that,

[519] Department of Families, Seniors, Disability Services and Child Safety, *Residential Care Reform - Transition of investment to outsourced service delivery for residential care services in accordance with the Child Protection Act 1999 (Qld)* (Director-General Briefing Note, 26 September 2025) (DFS.0186.0030.0159) 16.
[520] PeakCare, *Insights and opportunities - Queensland Residential Care Workforce* (Detailed Report, March 2025) 40.
[521] Email from Senior Executive Director, Investment and Commissioning, 29 November 2024 (DFS.0186.0031.0386).

having identified that a lot of issues regarding "standard of care" were being raised in unlicensed houses during the course of IPS Panel Meetings and in other internal contexts.[522]

The reliance on IPS arrangements further compounds these risks. IPS agreements are traditionally used in circumstances of acute pressure or specific need for care, and when no licensed placement is immediately available. While such arrangements may be necessary in the short term, they create a paradox: children with the highest levels of need and risk are frequently placed in settings subject to the least rigorous regulatory assurance. Structural barriers and limited incentives for providers to transition from IPS arrangements to fully licensed OSD models further entrench this pattern.

Regulation in residential care is also inherently challenging because of the nature of the service itself. The quality of care experienced by children depends on staff continuity, supervision, organisational culture, and the capacity of services to respond to children's distress by providing therapeutic services. Compliance-based regulation, focused primarily on adherence, through documentation, to policies and regulatory standards setting out procedures, struggles to capture these dimensions. As a result, services may appear compliant on paper while significant issues related to outcomes (emotional safety, relational harm or mental health) or outputs (inappropriate practice) remain undetected. Without monitoring mechanisms such as frequent on-site inspection, independent observation and systematic feedback from children and young people, regulatory systems are poorly positioned to identify emerging risks before harm occurs.

The QFCC has repeatedly highlighted the importance of timely, transparent and proportionate regulatory oversight in residential care, noting that weaknesses in this area undermine public confidence and expose children and young people to unnecessary and preventable risk. In recognition of similar challenges, some jurisdictions have strengthened inspection regimes, increased the frequency and intensity of oversight, and made inspection findings publicly accessible. These approaches reflect an understanding that the intensity of regulatory scrutiny must be proportionate to the vulnerability of those protected by regulation, and that residential care, by its nature, requires more than minimal compliance monitoring.

7.6 Licensing reform

It is apparent that there is much scope for reform to the licensing framework. That reform ought properly be informed by the previous consideration of issues in respect of the OLL and unlicensed

[522] Observation made by Senior Team Leader: Department of Children, Youth Justice and Multicultural Affairs, *IPS Panel Agenda – April 2023* (Spreadsheet, 3 May 2023) (DFS.0186.0044.0009).

providers, as considered by the Department in the Draft Licensing Options Paper dated December 2024 and in a report prepared by EY for the Department entitled "Unlicensed Residential Care – Contract Management Review" dated August 2025.

7.6.1 Licensing Options Paper

On 20 December 2024, then then Senior Executive Director within the Department, Ellenah Mackie, provided the Acting Deputy Director-General of Commissioning, Ms Harvey, a draft version of an Options Paper entitled "Improving the Regulation of Care Services".[523]

The Options Paper was developed by a team internal to the Department, comprising a Principal Program Officer and the Manager of the Child Safety Licensing team.[524] The purpose of the Options Paper was to outline regulation of care requirements currently applied to care services, with a view to identifying options to strengthen the legislative and departmental framework for regulating care provided by these services.[525]

The Options Paper was also developed having regard to insights gathered as part of the Residential Care Review, preliminary statewide consultation and the Department's understanding of and access to licensing materials.[526] It canvassed, in impressive detail, the obstacles and issues with the current system for licensing and regulating residential care providers, as well as a myriad of options for reform.[527]

In response to a request from the Commission as to whether the Options Paper was ever finalised or substantively implemented, the Department indicated that it remained in draft form, has not been through internal or external consultation processes, and has not been through the refinement and approval processes ordinarily expected of an internal review. As a result, the Department has cautioned that the Options Paper may contain a level of subjective opinion and use of anecdotal evidence that has not been rigorously vetted.[528]

One of the witnesses who gave evidence in relation to the Options Paper was the Acting Senior Executive Director of Investment and Commissioning, Ms Wilson. Ms Wilson's recollection was

[523] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779).
[524] Statement of Natalie Wilson (25 March 2026) [53].
[525] Ibid [52].
[526] Explanatory note to Notice 186 provided by the Department (COI.0001.0001.7038) 9.
[527] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779).
[528] Explanatory note to Notice 186 provided by the Department (COI.0001.0001.7038) 9.

similarly that while there were some verbal briefings in relation to the content of the Options Paper, it had not progressed beyond a draft and its distribution had been quite limited.[529]

Ms Harvey, the Deputy-Director General of Investment and Commissioning, also gave evidence in relation to the Options Paper. Ms Harvey's recollection was that she received a draft of the Options Paper in December 2024, only a few days into commencing as the then Acting Deputy-Director General of Investment and Commissioning.[530] Subsequently, in or around February 2025, Ms Harvey had a briefing with the Senior Executive Director of Investment and Commissioning and the Senior Manager of the CSL Team, in which she suggested that it would be useful to further refine some aspects of the Options Paper before briefing the Director-General.[531]

Ms Harvey said that in or around November or December 2025, a briefing was prepared for the Director-General in relation to a condensed version of the Options Paper.[532] Ms Harvey's explanation during the public hearings was inconsistent and irreconcilable with the explanation provided by the Department in its formal response to the Commission. Perhaps there was an innocent explanation for that being so, such as the timing of Notices issued to the Department and the date on which the briefing note was in fact circulated to the Director-General. Either way, the Commission did not have access to any subsequent version of the Options Papers, and thus relied on the draft from December 2024.

Even with all of the caveats that were attached to this document, the Commission considers that that the Department's obvious reluctance to engage with the Options Paper was not only an inefficient use of Departmental resources but also, more fundamentally, misconceived.

Ms Wilson gave evidence that at the time of the Options Paper being developed, Child Safety Licensing was part of her responsibility as Director, Tertiary Care and Support.[533] Ms Wilson explained that while she was on leave during the early stages of the Options Paper, she was consulted during the final drafting stages, and ultimately reviewed and endorsed the Options Paper for progression to the Senior Executive Director of Investment and Commissioning for consideration.[534]

[529] Transcript, Evidence of Natalie Wilson (9 April 2026) 5057:14-22.
[530] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5615:43-45.
[531] Ibid 5615:45-5616:6.
[532] Ibid 5616:8-14.
[533] Statement of Natalie Wilson (25 March 2026) [54].
[534] Ibid.

During her evidence, Ms Wilson was taken to a number of the issues and recommendations in the Options Paper and provided observations in relation to the same.

The first issue was that although the Child Safety Practice Manual (CSPM) includes a requirement for CSOs to visit individual children in their place of residence at least once per month, the s 82(1)(f) assessment process does not ensure regular monitoring of the service, including components assessed in the initial s 82(1)(f) assessment.

The Options Paper further observed that it was unclear whether s 82(1)(f) assessments or visits to premises by CSOs are consistently occurring due to the considerable workload demands placed on CSOs and regional staff, and varying practices between regions regarding who is responsible for undertaking s 82(1)(f) assessments.

Ms Wilson initially sought to downplay the fact of there being no scheduled inspections of unlicensed providers as unimportant, by suggesting that CSO would be regularly visiting children in such arrangements and monitoring unlicensed providers.[535] However, the difficulty of Ms Wilson's explanation was thereafter exposed.

For one, Ms Wilson ultimately conceded that the announced and unannounced inspections conducted by the I&P Team are focused on compliance with licensing requirements, including an assessment of the physical environment and compliance with standards, whereas CSOs have many different responsibilities and matters to take into account.[536] Moreover, Ms Wilson's observation failed to meet the very concern identified in the Options Paper, namely that there are no centralised departmental oversight mechanisms to monitor completion or consistency of these CSO assessments or visits, at least as concerns compliance with licensing requirements.[537]

In this regard, the Options Paper recommended that the Department consider adding the following conditions to funding contracts (whether IPS or OSD), to ensure regular inspection and screening requirements for all providers (not merely licensed providers):

- services should be inspected by the Department (via staff who are officers authorised to conduct licensing inspections, not CSOs) on a quarterly basis to ensure care provided meets the Statement of Standards;

[535] Transcript, Evidence of Natalie Wilson (9 April 2026) 5039:33-47.
[536] Ibid.
[537] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 13.

- suppliers must ensure compliance with the WWC Act for all staff undertaking regulated employment; and
- the department should conduct Queensland Child Safety and Personal History (CSPH) Screening for all staff engaged in providing care services (by consent).

Ms Wilson was asked specifically about the recommendation for quarterly inspections. She said that she regarded that as the type of reform the Department should consider and explore.[538] Ms Harvey was less equivocal in her support of the proposed reform, observing that she thought there would be benefits to all service providers, whether licensed or unlicensed, being subject to a combination of announced and unannounced visits and for their staff to be subject to CSPH Screening.[539]

The Commission's view is that if the Department regards those regulatory measures as necessary for licensed providers, who often have a history of providing services to the Department and have been already been subject to a third-party HSQF audit, there is no rational basis not to impose the same requirements on unlicensed providers. Indeed, neither Ms Wilson nor Ms Harvey were able to identify any obvious impediments or compelling reasons not to do so.[540]

It is telling, in this regard, that the Carmody Inquiry itself recommended that the Department ensure that all residential care placements (whether "transitionally funded" or "grant-funded") be subject to the same level of oversight. Despite that recommendation being accepted by the then Government, too few steps have been taken to ensure that occurred over the subsequent decade.

The second issue raised in the Options Paper, which was also the subject of evidence by Ms Wilson and Ms Harvey during public hearings, concerned the CSPH Screening requirements. As the draft Options Paper explained, unlicensed suppliers can engage persons to provide care if they have a current Blue Card, which can be obtained before seeking employment. In contrast, licensed suppliers must ensure that persons have both a current Blue Card and CSPH Screening before engagement. Currently, there is no legal mechanism for individuals to apply for CSPH Screening before securing employment.

The delay in receiving a CSPH Screening recommendation from the Department, or linking previous screening to a different licensed supplier can lead to potential employees seeking alternative employment. It also has the paradoxical consequence that someone can be

[538] Transcript, Evidence of Natalie Wilson (9 April 2026) 5053:2-5.
[539] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5617:24-35.
[540] See, eg, evidence of Ms Harvey who was asked squarely about this (Ibid 5617:37-40).

employed at an unlicensed provider, over which the Department has less oversight as compared to a licensed provider, even if they have a history of personal offending (such as traffic offences and domestic or family violence offences) that would preclude them from working with a licensed provider.[541]

The Act does not require or provide a means for suppliers or the Department to ensure the suitability of persons engaged by unlicensed suppliers, such as the ability to apply for and consider a CSPH recommendation. Consequently, individuals who are no longer employed by, or are never engaged by licensed suppliers due to a negative CSPH Screening recommendation may be (and are) subsequently engaged by unlicensed suppliers. In part, this is because the unlicensed suppliers are not privy to the previously identified risks and have no legal right to obtain the CSPH recommendation from the Department to ensure suitability of persons engaged to provide care.[542]

This problem is compounded by the fact that although CSPH Screening has been in place prior to 2005, there is no operational policy or procedure underpinning the process. Similarly, there is no publicly available information specifying how the department assesses personal history, child protection history, or changes to these histories when formulating a CSPH Screening recommendation.[543]

Further yet, despite the significant consequences of an adverse CSPH Screening outcome, a person does not have a right of appeal should the Department refuse to make a recommendation following review of a person's child protection and personal history. This is complicated by the fact that the outcome is notified to the licensee, as opposed to the person themselves. Accordingly, the process as constructed, does not ensure that individuals affected by significant Departmental decisions are afforded a right of an independent review after a decision has been made, in accordance with the principals of natural justice.[544]

Ms Wilson was not able to give evidence in relation to why the CSPH Screening could not be extended to unlicensed providers, nor as to whether the related reforms proposed to the CSPH Screening were achievable.[545] She did, however, agree that there was no justifiable reason to

[541] Department of Families, Seniors, Disability Services and Child Safety, *Improving the Regulation of Care Services* (Draft Options Paper, December 2024) (DFS.0001.0002.2779) 15.
[542] Ibid 13.
[543] Ibid 16.
[544] Ibid 16.
[545] Transcript, Evidence of Natalie Wilson (9 April 2026) 5055:33-39.

differentiate between licensed and unlicensed providers in this context; that is, genuine consideration should be given to extending the CSPH to all residential care workers.[546]

7.6.2 EY Report

The Commission infers, although so much has not been explained by the Department, that perhaps part of the reason the Options Paper appeared not to proceed further is because EY was engaged six months or so thereafter, on 1 June 2025, to carry out a current state assessment of unlicensed providers of residential care services as part of the Department's initial response to the Government announcing the Commission of Inquiry.[547] Ms Wilson's evidence was that EY had a copy of the Options Paper, and that it "would have factored into" their thinking. Beyond that, she appeared to have no specific recollection.[548]

EY was engaged to examine the Department's control environment relating to a variety of key risks including:

1. unlicensed providers not complying with or not required to maintain a HSQF certification;
2. limited mechanisms to check compliance with Working with Children Worker Screening Checks;
3. executive officers of residential care providers not being required to have Worker Screening Checks; and
4. insufficient placement checks and monitoring of young people in their placement.[549]

The EY Report concluded that there are gaps in the design of the procurement and contract management process for unlicenced residential care providers. The consequence of this is that the Department is not able to proactively and consistently confirm child safety and quality standards are being met, nor that contractual requirements are being fulfilled adequately during placements with unlicensed providers.[550]

The issues identified in the EY Report can be broadly grouped as follows.

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[546] Ibid 5056:33-47.
[547] Department of Families, Seniors, Disability Services and Child Safety, *Approval to engage EY to carry out a risk assessment of contract arrangements with unlicensed providers of residential care services* (Director-General Briefing Note, 1 June 2025) (DFS.0042.0001.1618).
[548] Transcript, Evidence of Natalie Wilson (9 April 2026) 5059:26-34.
[549] Department of Families, Seniors, Disability Services and Child Safety, *Approval to engage EY to carry out a risk assessment of contract arrangements with unlicensed providers of residential care services* (Director-General Briefing Note, 1 June 2025) (DFS.0042.0001.1618).
[550] Ernst & Young, *Unlicenced Residential Care - Contract Management Review* (Report, August 2025) (DFS.0042.0001.1567) 6.

First, EY identified that the procurement processes used for unlicensed providers (including for both Immediate Care Agreements (ICAs) and IPS agreements) do not enable the Department to adequately assess a residential care provider for suitability, capability and capacity to undertake a placement.[551]

Second, EY identified the absence of a 'whole-of-Department' contract management practice or process, which would enable the Department to track performance indicators and provide ongoing access and oversight of unlicensed residential care service providers, their employees, their sites and, most importantly, the children and young people placed in their care.[552]

Third, and relatedly, EY remarked of the absence of a central management system to support oversight of unlicensed providers. Such a system should, in theory, enable the Department to monitor the number of active placements and their value on a rolling basis, so that the Department can readily identify outliers (such as placements where prices are disproportionate). Having such a database is particularly important given that a number of unlicenced residential care providers have sites across multiple regions with stakeholder consultations, and yet the Department is acting in silos, with no shared view of the unlicenced residential providers they are engaging, nor the employees working at each location.[553]

Fourth, in a conclusion that is unsurprising based on the Commission's other preliminary findings, EY observed that employees in the Placement Services Unit (PSU) do not have the bandwidth, capacity or capability to be preoccupied with procurement and contract management activities. Indeed, such staff are not required to have procurement and contract management qualifications, and it is not mandatory for them to undertake Departmental procurement and contract management training (as to which see the discussion below in Part 6).[554]

It is of considerable concern to the Commission that many of these issues have been identified in prior assurance activities and yet, to the Commission's understanding, remain unresolved.[555] The priority reforms identified in the EY Report included: undertaking a statewide review of all residential care service providers to understand the current state of the market; identifying preferred lists of suppliers and benchmark pricing; developing revised contract management and

[551] Ibid.
[552] Ibid.
[553] Ibid.
[554] Ibid.
[555] Ibid.

procurement processes; and developing a system to manage contract evaluation and financial agreements.[556]

With respect, these are neither novel nor revolutionary proposals. For many years, there had been discussions within the Department, in briefing notes, regional forums and internal communications, to the effect that:

1. As part of the Department's IPS Redesign Reference Group in 2023, the Department would:
    a. identify unlicensed IPS agreements that could be transitioned to OSD contracts, and review the benchmark pricing for residential care services to support that process;[557] and
    b. explore the creation of alternatives that safeguard quality of care, including the creation of preferred supplier panels.[558]
2. Similarly, concerns were being raised by at least mid-2023 that the standard of care in unlicensed providers was inadequate, with contract or agency staff having difficulty managing the behaviour of children and young people in such settings.[559]

The EY Report has since been entered into the Department's Internal Audit Register for follow-up and progress reporting to the Audit and Risk Committee. The Chief Finance Officer of the Department has indicated that it is still considering EY's recommendations and mapping the findings to the Department's internal audit of private providers of child safety residential care services, where appropriate.[560]

Ultimately, the absence of publicly accessible information about provider performance, licensing status, incident trends and regulatory enforcement action limits the capacity of communities, families and young people to hold the system to account. It also constrains government's ability to act as an informed and active steward of the sector. In the context of a rapidly expanding residential care market, regulatory opacity not only weakens accountability but also obscures early warning signs of system stress, allowing risk to accumulate until it manifests in crisis or harm. The Department should give serious consideration to the feasibility and utility of

[556] Ibid 7-8.
[557] Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 20 April 2023) (DFS.0234.0002.0074).
[558] Department of Children, Youth Justice and Multicultural Affairs, *Strategy for IPS Redesign* (Deputy Director-General Briefing Note, March 2023) (DFS.0001.0002.2398).
[559] Department of Child Safety, Seniors and Disability Services, *Far North Queensland Out-of-Home Care Strategy Meeting* (Minutes, 6 February 2024) (DFS.0234.0002.0123).
[560] Statement of Danny Short (25 November 2025) [23]-[24].

developing a central repository (whether public or otherwise) to monitor compliance by licensed and unlicensed service providers, and their contracts with the Department.

7.7 Delays in the licensing process

The Department identified four factors that contribute to the period of time between an IPS-only funded provider being deemed in-scope of licensing and that IPS provider being issued with a care service licence.

7.7.1 HSQF certification process

The first (and perhaps most important) factor that contributes to delays is the HSQF certification process, which itself involves two stages.

The first stage of the HSQF certification process involves the collation and submission of documentation by the service provider, which has a focus on the development of policies and procedures that meet the requirements outlined in the HSQF User Guide for Certification. At this stage, an independent audit is conducted to review the submitted policies and procedures.[561]

The second stage involves an on-site auditing of every care service premises to ensure that the policies and procedures are effectively implemented by the service provider in practice, with the auditor requiring evidence to confirm compliance.[562]

Independent audits are prepared by a Joint Accreditation System of Australia and New Zealand (JASANZ) accredited certification body. These audits, which are conducted against the HSQF, are used in the licensing process to meet the legislative requirement for an independent evaluation.[563]

7.7.2 Invitation to Apply for Care Service Licence

The second stage at which there may be delays arises at the point of providers being invited to apply for a care service licence.

Once the HSQF certification has been successfully achieved, the Department indicated that it will invite a service provider to apply for a care service licence as soon as possible. When the Department invites a service provider to apply for a care service licence will turn on the following factors, which may impact the decision-making timeframe:

[561] Statement of Bernadette Harvey (2 April 2026) [50].
[562] Ibid.
[563] Ibid [51].

(a) when the SWLP is due to sit (noting that it sits monthly);
(b) public holidays;
(c) extenuating circumstances for service providers such as Sorry Business or natural disasters; and
(d) ensuring there is sufficient time to complete CSPH screening checks for every staff member of a service provider.[564]

7.7.3 Child Safety and Personal History (CSPH) screening checks

A third factor contributing to delays in the process of undertaking CSPH screening checks. The CSPH screening checks involve background history checks including domestic violence, traffic infringements and child protection history for all persons seeking to undertake specific roles within a licensed care service. These checks are a key requirement for determining suitability, and are a requirement for the nominee, directors, managers and persons performing a risk-assessed role for a licensed organisation.[565]

According to the Department, delays can occur when an application has been properly submitted, and the applicant has a large number of people in risk-assessed roles requiring screening. The delays may involve waiting for Queensland domestic violence checks, traffic and child protection histories from interstate or New Zealand, or when a person has a relevant history that requires a review by the Central Screening Unit within the Department.[566]

7.7.4 Care service licence applications

A service provider must apply for a licence within 30 days of the Department's invitation to apply, in the approved form for a care service licence. Delays can arise at this stage as a result of applications not being completed by relevant persons (i.e. the proposed nominee) and submitted by the service provider in a timely manner.[567]

Following an application, the Department then has 90 days to assess the application and make a decision. Further, under s 143A of the Act, the Chief Executive and the applicant may, at any time before the end of the 90-day period after the application is properly made, agree in writing to extend the period within which the application must be decided. This period of extension may be an additional 90 days.[568]

[564] Ibid [53].
[565] Ibid [54].
[566] Ibid [55].
[567] Ibid [56].
[568] Ibid [58]-[59].

In summary, the assessment process involves:

(a) the CSL team undertake an initial assessment of the licence application to determine whether additional information is required to assist the licensing delegate to be satisfied that the application will meet the criteria in s 126 of the CP Act;
(b) the CSL team will send licensing reference reports to relevant regions to seek feedback on an organisation's local service delivery performance;
(c) the CSL team will progress CSPH screening checks and working with children (blue card/exemption card) checks for an organisation's nominee and directors, if required;
(d) the CSL team will provide the service provider with copies of the HSQF audit report and regionally completed licensing reference reports, and allow the service provider 14 days to respond if they wish to do so;
(e) the CSL team will collate all the information relevant to the licence application and prepare a summary report, which will contain the most recent information available and progress the report to the SWLP for consideration; and
(f) the SWLP will consider the application and make a recommendation to the licensing delegate.

7.7.5 Minimising future delays

The Deputy-Director General of Commissioning, Ms Harvey, gave evidence that an 18-month period for funded service providers is appropriate having regard to the potential for delay outlined above.

However, the Commission recommends that the Department explore the utility of expediting the process in the following ways:

1. liaise collaboratively and proactively with providers to provide guidance concerning the policies and procedures required to achieve HSQF certification as part of the pre-qualification process; and
2. establish processes to assess licence applications within 30 days, given that the Department should be able to anticipate the timing of such applications in advance and resource accordingly.

7.8 Minimum Qualification Standards

A further issue with the current licensing arrangements concerns the Minimum Qualification Standards (MQS) applicable to residential care staff and their supervisors. Under the MQS, the Department requires employees of *licensed* providers to:

1. hold a current Queensland Working with Children Check (a Blue Card);
2. have completed the core modules of the Hope and Healing Framework; and
3. be enrolled to undertake a recognised and relevant qualification (being a Certificate IV in Child, Youth and Family Intervention (Residential Care) or other equivalent certificates).[569]

Compliance with the MQS is assessed through the HSQF auditing process, which is coordinated for each service provider by the regional Investment and Commission teams.[570]

However, the MQS do not apply for unlicensed providers who, at least in recent times, have made up a significant proportion of the total number of providers in the residential care market.[571] No compelling explanation was proffered for that being so.

Further, while employees of unlicensed providers are required to have a Blue Card, that provides little assurance that staff and supervisors have the necessary skills and qualifications to care for what the Commission has repeatedly heard is an increasingly complex cohort of children entering residential care.

The Deputy-Director General of Commissioning, Ms Harvey, was at pains to point out that some unlicensed providers may nevertheless offer specific or specialised training to their staff.[572] So much may be accepted, but it remains the position that there are no mandated, Department-imposed minimum qualifications for those employees working with unlicensed providers. Given that, Ms Harvey ultimately accepted that the Department has limited line of sight as to the qualifications of those employees in unlicensed residential care premises and that it was difficult to justify why the MQS should not be extended to unlicensed providers also.[573]

[569] Department of Families, Seniors, Disability Services and Child Safety, *Strengthening the Queensland Residential Care Workforce – Minimum Qualification Standards* (Information Sheet, October 2021) (DFS.0041.0002.0106); See also Statement of Bernadette Harvey (29 August 2025) [13]-[22].
[570] Statement of Bernadette Harvey (29 August 2025) [22].
[571] PeakCare, *Beyond a Checklist – Guiding the Road Forward for Queensland's Residential Care System* (Report, December 2023) 10; Transcript, Evidence of Bernadette Harvey (17 April 2026) 5625:2-39.
[572] Transcript, Evidence of Bernadette Harvey (17 April 2026) 5623:33-46.
[573] Ibid 5624:34-37.

In this context, the Commission recommends that the Department undertake a review to determine:

1. whether the MQS are still fit for purpose in the modern environment in which residential care services are delivered; and
2. whether it would be prudent and desirable to extend the MQS (in their current form or a modified form) to unlicensed providers also.

The Commission is reticent to express a concluded view as to those questions, as that will require further and careful consideration as to how the MQS are operating in practice and whether they might exacerbate the workforce limitations or constraints discussed in Part 2.5 above.

The Commission recommends that in the context of exploring the suitability of the existing MQS, the Department consider whether those standards should also include mandatory:

(a) water safety assessment training;
(b) safe sleeping for infants training;
(c) non-violent crisis intervention training
(d) first aid qualifications, including anaphylaxis and asthma management training; and
(e) child protection training.

As concerns water safety assessment training, this is mandatory for both foster and kinship carers.[574] The Commission could not identify any compelling reason why it should not be extended to all residential care workers, particularly given the recommendation in the Coroners Court of Queensland (2021/1526) in relation to a child that drowned at Cedar Creek Falls while in the care of a residential care service provider.[575]

As concerns non-violent crisis intervention training, such training is required to be completed by Child Safety Officers (CSOs). The stated rationale for that being so is that it enables CSOs to develop:

(a) increased awareness of contemporary perspectives on the dynamics of aggression;
(b) an understanding of crisis intervention and how it relates to the management of aggression;
(c) familiarity with general safety principles, workplace health and safety legislation, departmental policy and procedures relating to personal safety;

[574] See Department of Child Safety, Seniors and Disability Services, Water Safety Awareness Training Module (DFS.0025.0001.0873).
[575] Findings of the Inquest into the death of a 13-year-old child (Coroners Court of Queensland, Coroner Lee, 26 February 2024).

(d) an understanding of the basic skills and techniques required for effective tactical communication and active de-escalation; and
(e) an awareness of practical approaches to non-violent crisis intervention.[576]

By parity of reasoning (if not with even more reason), staff employed in residential care are in effect living with the children and young people in residential care settings. Again, if such training is regarded as necessary to CSOs, the Commission could not identify any reason why it should not be extended to all residential care employees.

As concerns first aid qualifications, it is well understood that early childhood centres and schools are required to have staff with first aid qualifications on site.[577] Given that those staff employed in residential care settings are often working with children who have physical or mental health conditions which make them more susceptible to medical issues, and that workers may only have limited background knowledge about the children in their care, there appears to be a compelling case for having first aid qualified staff onsite in that context also.

As concerns child protection training, such training is also often required in early childhood centres and of school teachers. Such training ordinarily involves:

(a) identifying, reporting and responding to child maltreatment through trauma informed practice;
(b) differences in behaviour and responding appropriately, along with identifying grooming behaviour in children and adults around them;
(c) understanding the difference between developmentally expected sexual behaviour and concerning or harmful behaviour by children or between children; and
(d) effective supervision and behaviour guidance, including the offence of using inappropriate discipline.[578]

The Commission has received a significant body of evidence about children in residential care settings being subject to grooming behaviour and/or being victims of sexual crimes.[579] There appears, accordingly, also to be a compelling case for mandatory child protection training for residential care employees.

[576] Department of Families, Seniors, Disability Services and Child Safety, *Mandatory courses for a Child Safety Officer – current as at August 2025* (Presentation, 20 August 2025) (DFS.0025.0001.0058) 36.
[577] *Education and Care Services National Regulations 2011* (Qld) div 6 pt 4.4.
[578] See, eg, training delivered by the Australian Centre for Child Protection.
[579] See, eg, Submission No 84 to Child Safety Commission of Inquiry (27 November 2025); Office of the Victim's Commissioner, Submission to Child Safety Commission of Inquiry (10 March 2026) 5; Transcript, Evidence of Witness S (16 February 2026) 4127-4129.

7.9 Primary function requirement

As mentioned above, one of the pre-conditions to licensing is that the chief executive must not grant an application unless satisfied the applicant's primary function is a function relating to the care of children in need of protection who are in the custody or guardianship of the chief executive.[580]

Ms Wilson gave evidence that a provider who did not have the care of children as their primary function would be "out of scope of licensing".[581] This precludes some of the Department's specialised providers, many of whom are contracted through more tailored IPS agreements, from becoming licensed. Ms Wilson gave the example of a disability support provider, who is likely to be registered with the NDIS Quality and Safeguards Commission, as being a provider whose primary function might not be the care of children.[582]

The only explanation offered by the Department as to why it might be justified to retain the "primary function" requirement in the Act is that organisations for whom the care of children is not the primary function ought not be put to the burden of becoming licensed and implementing the associated policies, procedures and compliance measures required. However, Ms Wilson stopped short of describing this as a compelling reason and suggested this was something the Department needed to consider further.[583] In the time available to finalise its inquiries, the Commission has not been able to access information concerning how many providers might be precluded from licensing because of this "primary function" requirement, nor whether there is a compelling basis to recommend legislative reform. In those circumstances, the Commission recommends that the Department undertake further analysis in relation to such matters, as part of a broader exercise of analysing the current state of the market (of licensed and unlicensed providers) and the extent of overlap with other human services standards or regulatory regimes.

7.10 Licensing into the future

In aggregate, the Commission recommends that the Department should:

1. undertaking a mapping exercise to determine which unlicensed providers are subject to other human services standards or regulatory regimes;

[580] Statement of Natalie Wilson (25 March 2026) [99].
[581] Transcript, Evidence of Natalie Wilson (9 April 2026) 5040:45-57.
[582] Statement of Natalie Wilson (25 March 2026) [100].
[583] See, eg, Transcript, Evidence of Natalie Wilson (9 April 2026) 5045:44-5046:21.

2. assess whether there is any scope to streamline the licensing process by recognising, in whole or in part, compliance with those other accreditations or regulatory standards;
3. determine whether the "primary function" requirement is inadvertently rendering providers out of scope for licensing;
4. maintain a central repository of licensed and unlicensed providers to monitor the current number of active placements and their value, the outcomes of initial site assessments and visits, and concerns in relation to compliance with standards of care;
5. implement measures to better supervise and monitor unlicensed providers, including via mandatory quarterly inspections (announced and unannounced) inspections;
6. apply the CSPH screening process to all providers, whether licenced or unlicensed (with associated policies and procedures to communicate and review such decisions);
7. give priority to licensed suppliers as part of the pre-qualification framework being developed, in an effort to encourage licensing; and
8. seek to minimise delays in the licensing process, so as to ensure the Department has continual oversight over the market of residential care providers.

If those reforms directed towards enhanced monitoring and oversight are implemented, the Commission acknowledges that there is scope for the Department to retain a small and limited pool of unlicensed providers, in the interests of maintaining and promoting a diverse supplier mix and minimising the regulatory burden on new entrants to the sector to the extent possible.

7.11 Recommendations

<table>
<tr><td colspan="2">Recommendation 35: Review of Licensing Framework</td></tr>
<tr><td>Executive Report (Chapter 7)</td><td>Companion Report 4 (Chapter 7)</td></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this report, review its licensing framework and associated policies and procedures for non-family based care providers to ensure the delivery of at least the following:

Repository of providers: The Department should maintain a central repository of licensed and unlicensed providers to monitor the number of active placements and their value, the outcomes of initial site assessments and visits, and concerns in relation to compliance with standards of care

Monitoring and oversight of providers: The Government should ensure the delivery of quarterly inspections (announced and unannounced) for all providers, regardless of whether they are licensed or unlicensed. The Government should also develop and maintain a central repository of information about licensed and unlicensed providers.

Mapping of providers and regulatory regimes: The Department should undertake a mapping exercise to determine which other regulatory regimes apply to licensed and unlicensed providers and explore opportunities for cross-accreditation or streamlining of processes to encourage providers to become licensed.

CSPH Screening: The Department should introduce mandatory Child Safety and Personal History (CSPH) Screening for all persons delivering direct care services at non-family based residential care services. Allied to this, the Department should consider what reforms are required so that CSPH Screening decisions are communicated to affected persons and so that there are avenues of revenue or appeal.

Delays in licensing process: The Department should seek to minimise delays in the licensing process by undertaking activities relevant to licensing prior to engaging providers and during the pre-licensing phase.

Primary function requirement: The Department should explore the utility or otherwise of limiting the licensing process to those providers who have the care of children as their primary function and consider avenues for legislative reform if required.</td></tr>
<tr><td colspan="2">CONTEXT:

The Department's current licensing framework was implemented in 2013 and has not undergone a full review since that time. Evidence before the Commission indicates that the Department's licensing regime is operating in a manner which does not allow sufficient oversight, expediency, and may be inconsistent with its policy intent.</td></tr>
<tr><td colspan="2">IMPLEMENTATION NOTES:

Licensing reform should be implemented as a collaborative exercise involving the Child Safety Licensing team, the regional Investment & Partnerships team, the State-wide Licensing Panel and the Department's Licensing Delegate.</td></tr>
</table>



Child Safety

Commission of Inquiry



Companion Report 5

Corporate Parenting and the Youth Justice Interface

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders

Phone: 13 92 76

https://www.13yarn.org.au/

Lifeline – Crisis support

Phone: 13 11 14

https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people

Phone: 1800 650 890

https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling

Phone: 1800 737 732

https://1800respect.org.au/

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Chapter 1

Permanency

Companion Report 5

Corporate Parenting and the Youth Justice Interface

Chapter 1: Permanency

Abstract

This chapter examines the permanency framework in the *Child Protection Act 1999* (Qld) (CP Act) and considers the data, as well as evidence and submissions from carers and children, on whether the Department is meeting its statutory obligations to provide permanency to children in OOHC. It concludes that the Department is not complying with the permanency hierarchy in the CP Act – in practice or in spirit, and recommends changes to the approach to assessment of guardians and s 51VAA permanency reviews with the aim of increasing the quality of permanency outcomes achieved for children in care who cannot safely return home.[1]

1.1 Introduction

The concept of permanency within the child safety system involves three dimensions:

- ***Relational permanency*** referring to the experience of having positive, loving, trusting and nurturing relationships with people important to the child which support a child's sense of belonging and wellbeing.
- ***Physical permanency*** referring to safe, stable (i.e. long term) living arrangements with connections to the child's community and meet the child's developmental, educational, emotional, health, intellectual and physical needs.
- ***Legal permanency*** referring to legal arrangements for a child's care which provide a child with a sense of permanency and long-term stability.[2]

These concepts are reflected in the permanency principles set out is s 5BA. For the purposes of the CP Act, **permanency**, for a child, means the experience of having these three interrelated things.

The Department is obligated to actively plan to achieve relational, physical, and legal permanency for a child in care, so that the child has the best opportunity to form healthy

[1] This Chapter does not deal with adoption. Adoption is addressed in Chapter 2.
[2] See CP Act ss 5BA(2) and (3). Also see s 5BA(4): *For this Act, **permanency**, for a child, means the experience by the child of having the things mentioned in subsection (2)(a) to (c)* See also CL-44, *CSPM: Permanency*, tendered 26 November 2025, 4.

attachments, have a sense of stability and security in their life, and is in an environment which will foster their development and growth as they mature.[3] The foundational principle for the administration of the CP Act is that the safety, wellbeing and the best interests of the child, *both through childhood and for the rest of the child's life*, are paramount.[4] All permanency related decision-making must flow from this overarching 'paramount principle'.[5]

1.1.1 The Permanency Framework

The current permanency framework was introduced to the CP Act on 29 October 2018[6] (and amended in May 2021[7]), in response to concerns identified in the Carmody Report over the number of children subject to multiple short-term orders without achieving reunification with their families or long-term OOHC.[8]

In relation to permanency planning, the Explanatory Memorandum provided the rationale and policy objective of legislating this process:

> *The Bill introduces provisions that require a permanency goal to be in place for each child from the time a case plan is developed. In circumstances when reunification of a child with their family is the case plan goal, an alternative permanency goal will be required to be in place to meet the child's need for long-term stable care in the event that timely reunification is not possible.*[9]

1.1.1.1 The permanency hierarchy: s 5BA of the CP Act

The CP Act mandates a hierarchy of preferences for achieving permanency.[10] For deciding whether an action or order best achieves permanency for a child, the following principles apply, in order of priority:

- the child to be cared for by the child's family;
- the child to be cared for under the guardianship of a person who is a member of the child's family, other than a parent of the child, or another suitable person;

[3] CP Act ss 5A, 5B(g) and 5BA; see also CL-40, *Child Safety Policy: Permanency Planning,* tendered 26 November 2026.
[4] CP Act s 5A. Note that, for reasons discussed in Companion Report [2}, the Commission recommends that the words in italics be removed.
[5] Ibid.
[6] Explanatory Memoranda, *Child Protection Reform Amendment Bill* 2017 (Qld) 5.
[7] *Child Protection and Other Legislation Amendment Act* 2021 (Qld).
[8] *Child Protection Reform Amendment Bill 2017* (Qld); Explanatory Memoranda, *Child Protection Reform Amendment Bill* 2017 (Qld)
[9] Explanatory Memoranda, *Child Protection Reform Amendment Bill* 2017 (Qld) 5.
[10] Ibid s 5BA(4).

- if the child is not an Aboriginal or Torres Strait Islander child, the child to be adopted under the *Adoption Act 2009*;
- the child to be cared for under the guardianship of the chief executive; and
- if the child is an Aboriginal or Torres Strait Islander child - the last preference is for the child to be adopted under the *Adoption Act 2009*.

1.1.1.2 Permanency planning (including concurrent planning)

The CP Act also embeds concurrent planning, the simultaneous pursuit of a primary and an alternative permanency goal as a statutory requirement.[11] Permanency planning, as part of the case planning process, is the process of making stable, long-term care arrangements for children in care.[12] A case plan must include the goal for achieving permanency for the child and the actions to be taken to achieve the goal.[13] If returning the child to their family is the goal, there must also be an alternative goal, if timely return of the child to their parent is not possible.[14] The main benefit of concurrent planning is to encourage consideration of permanency from the beginning of the placement, reducing short-term thinking and thus multiple placements. Concurrent planning has been associated with expedited timeframes in some jurisdictions and aims to avoid the time lags associated with sequential planning.[15]

The Department's approach to permanency planning is anchored in Policy 594 Permanency Planning[16] and given practical expression through the Permanency Practice Kit[17] within the Child Safety Practice Manual.[18] Decisions about which alternative permanency option to pursue are subject to practice panel review. The intended purpose of these reviews is to providing rigour and objectivity to decisions about how best to achieve permanency for a child, by critically examining the information available including how the child has been provided with ongoing opportunities and support to meaningfully participate in decisions about the best option for meeting their

[11] Ibid ss 51B and 51D.
[12] Claire Tilbury and Jennifer Osmond, 'Permanency Planning in Foster Care: A Research Review and Guidelines for Practitioners' (2006) 59(1) *Australian Social Work* 4-5, 2.
[13] CP Act s 51B(2)(a).
[14] Ibid s 51B(2)(b).
[15] Claire Tilbury and Jennifer Osmond, 'Permanency Planning in Foster Care: A Research Review and Guidelines for Practitioners' (2006) 59(1) *Australian Social Work* 4-5, 10; Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2882:31-41, 2886:31-33, 2906:11-23.
[16] CL-40, *Child Safety Policy: Permanency Planning,* tendered 26 November 2026.
[17] CL-44, *CSPM: Permanency*, tendered 26 November 2025.
[18] The Child Safety Practice Manual (CSPM) supports the delivery of child safety service in Queensland through operational policies, procedures, and practice guidelines.

permanency needs.[19] Guardianship to the chief executive is therefore, as a matter of policy, intended to be a residual 'last resort' outcome rather than the default.

1.1.1.3 Section 51VAA reviews

Permanency planning is intended to be an ongoing obligation. The CP Act requires ongoing review of case plans to ensure permanency planning remains active. Section 51VAA of the CP Act is of particular significance in this regard. It requires that if a child has been the subject of a long-term guardianship order to the chief executive for two years, a review of the case plan must be undertaken with specific consideration as to whether permanency for the child can be better achieved through an alternative arrangement as set out in s 5BA of the CP Act. This review is intended as a critical check and balance to ensure that permanency planning continues even after a long-term guardianship order is made to the chief executive. As the legislation currently stands, a s 51VAA review is a 'one-off'. There is no requirement for a review every two years where the child has remained on LTG-CE orders.

1.1.1.4 Limits on short term orders

The CP Act imposes a hard limit on short-term orders to prevent children drifting in care. If a child has been in the continuous care of the Department under a custody or short-term guardianship order for two years or more, the court must not make a further custodial or short-term guardianship order unless satisfied it is in the best interests of the child and reunification is reasonably achievable in the longer period.[20] These time limits were imposed to provide structure around reunification and timeframes for achieving permanency for the child, including alternative arrangements.[21]

1.1.1.5 Forms of legal permanency

When reunification cannot be achieved within an appropriate timeframe, the CP Act provides for three forms of long-term legal permanency: long-term guardianship to a suitable person or the chief executive, and permanent care orders.[22] These are to be pursued in line with the

[19] Analysis of permanency planning records has led the Commission to be concerned that these reviews lack of objectivity and have an insufficient focus on the paramount principle. This issue is explored further in the Jarred case study (Appendix B). It is also raised in the analysis section below in respect of s 51VAA reviews.
[20] CP Act ss 62(4)-(5).
[21] See Explanatory Note, *Child Protection Reform Amendment Bill* 2017 (Qld).
[22] CP Act ss 61(e)-(g).

permanency hierarchy as set out in s 5BA of the CP Act. All three orders are made by the Children's Court once the court is satisfied that there is no parent able and willing to protect the child within the foreseeable future and/or that the child's need for emotional security will be best met in the long term by the order.[23] They differ in who holds guardianship, how much the Department remains involved, and the degree of permanence they provide for the child.

1.1.1.6 The Guardianship Assessment Process

If a potential guardian is identified, her or she must be assessed by the Department before they can be recommended for guardianship. The assessment of a proposed guardian is "a structured, multi-part process" designed to determine whether it is in the child's best interests for the proposed person to hold full parental responsibility for the child's long-term care, wellbeing and development.[24]

The information-gathering stage requires the assessor to consult a range of sources including relevant documents (such as prior carer assessments, NDIS plans and departmental records), the views of the child, the views of the child's parents, the views of other significant people, and the views of the proposed guardian themselves.[25] Children, parents and family members have express statutory rights to participate in the process,[26] and specific obligations apply with respect to Aboriginal and Torres Strait Islander families to ensure their meaningful engagement, including through an independent person to help facilitate their engagement in the decision making process.[27]

The substantive assessment evaluates the proposed guardian across six domains: their suitability as an individual (including safety checks and history of care); their capacity to support family connection and relational permanency; their ability to preserve the child's cultural identity; their capacity to affirm the child's identity and diversity; their ability to meet the child's support needs and provide physical permanency; and their willingness and ability to fulfil the guardian's statutory obligations to the chief executive.[28] Importantly, the assessment is intended to be

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[23] Ibid s 59(6).
[24] Department of Families, Seniors, Disability Services and Child Safety, *Assess a Proposed Guardian* (Practice Guide, August 2024). The assessment is organised into five parts: administrative details (Part A), information gathering (Part B), substantive assessment across six domains (Part C), a recommendation (Part D), and approval by the Child Safety Service Centre manager (Part E).
[25] Department of Families, Seniors, Disability Services and Child Safety, *Assess a Proposed Guardian* (Practice Guide, August 2024) 104 (Part B); Transcript, Evidence of Witness A (3 February 2026) 3896-3897.
[26] By virtue of CP Act ss 5B(2)(b) and (d).
[27] Ibid s 5F(2)(b).
[28] Department of Families, Seniors, Disability Services and Child Safety, *Assess a Proposed Guardian* (Practice Guide, August 2024) 4-7 (Part C).

grounded in demonstrated actions and concrete examples rather than mere expressions of willingness. At the conclusion of the assessment, the Child Safety Service Centre manager, not the assessor, holds the decision-making power on whether to approve or reject the recommendation.[29] A related topic concerns the constraints imposed by the Blue Card requirement.

1.1.2 Permanency in Practice – What the Data Shows

Given the express legislative preference for LTG-O and PCO over LTG-CE, one might expect the data on long-term guardianship applications to reflect a genuine effort to identify suitable guardians before defaulting to the chief executive. The data does not support that expectation.

1.1.2.1 Applications for long-term guardianship

In financial year 2024-25, the Director of Child Protection Litigation (DCPL) received 1,302 referrals in which the Department assessed that an order granting Long-Term Guardianship to be the most appropriate intervention for the subject child.[30]

a) LTG-CE – 1,061 referrals (81.5%);
b) LTG-O to a suitable family member – 61 referrals (4.7%);
c) LTG-O to another suitable person – 69 referrals (5.3%); and
d) PCO – 111 referrals (8.5%).[31]

Of the 1,302 referred matters, the DCPL filed in line with the Department's assessment in 1,271 matters (97.6%).[32] The DCPL did not file in line with the Department's assessment in 31 matters:[33]

a) LTG-CE – 18 matters (out of 1,061);
b) LTG-O to a suitable family member – 3 matters (out of 61);
c) LTG-O to another suitable person – 5 matters (out of 69); and
d) PCO – 5 matters (out of 111).

[29] Ibid 7 (Part E).
[30] Statement of Nigel Miller (7 November 2025) [220].
[31] Note: a Permanent Care Order may only be made in favour of a suitable person (including a family member), it cannot be made in favour of the Chief Executive pursuant to CP Act s 61(g).
[32] Statement of Nigel Miller (7 November 2025) [220].
[33] Ibid [220].

1.1.2.2 Applications determined by the court

In the same period, the court made final orders in respect of 1,047 LTG applications:[34]

a) LTG-CE – 763 applications (72.9%);
b) LTG-O to a suitable family member – 92 applications (8.8%);
c) LTG-O to another suitable person – 75 applications (7.2%); and
d) PCO – 117 applications (11.2%).

This data shows two key trends.

First, there is a significant discrepancy between the number of referrals and applications for LTG-O and PCOs, when compared to LTG-CE orders being sought. Specifically, referrals for LTG-O orders comprise only 18.5% of LTG referrals to DCPL. Thus, roughly 4 out of 5 applications are for LTG-CE, despite this type of order providing the least permanency approach for a child, and despite the CP Act establishing a clear hierarchy that favours guardianship to a suitable person or family member.

Secondly, in dealing with the referrals, there is a very high rate of 'compliance' by DCPL. Regarding LTG-CE referrals in particular, the DCPL almost always files in line with the assessment of the Department (98.3% compliance). There is a lower degree of compliance with filing for LTG-O orders, however compliance overall is still high. The trend shifts, albeit slightly, when looking at matters determined by the court. Notwithstanding the initial assessment of the Department and DCPL, a higher proportion of matters are finalised as LTG-O (27.1%).[35]

1.1.2.3 Data regarding all child protection orders

Data provided by the Department, comprising a breakdown of all child protection orders as at 31 March 2025, showed that there were 6,106 children on LTG-CE, 1,569 children on a LTG-O and 441 children on a PCO.[36] As at 31 March 2025, approximately 24% of children subject to long-term guardianship orders were under an LTG-O or PCO, with the remaining 76% under LTG-CE.

However, this data is of little assistance in understanding current Departmental practice as to seeking long-term guardianship orders as it captures all children on orders, irrespective of when

[34] Ibid [240].
[35] It is noted that this data does not necessarily reflect a contest – rather, it may indicate a tendency of the DCPL to amend its application throughout proceedings.
[36] CL-51, *Table – statistics about children subject to child protection orders as at 31 March 2025*, tendered 27 November 2025.

those orders were made. Greater insight on long term order preferences is gained from the dataset prepared by the DCPL:[37]

Applications for long-term guardianship orders across Queensland								
Order type	2021–2022		2022–2023		2023–2024		2024–2025	
	Application	Order	Application	Order	Application	Order	Application	Order
LTG – Family member	69 (5.96%)	83 (7.61%)	73 (5.15%)	110 (9.23%)	76 (6.05%)	118 (10.50%)	58 (4.56%)	92 (8.79%)
LTG – Other suitable Person	51 (4.41%)	73 (6.69%)	46 (3.25%)	71 (5.96%)	56 (4.46%)	69 (6.14%)	64 (5.04%)	75 (7.16%)
LTG - Chief Executive	963 (83.23%)	855 (78.37%)	1,192 (84.12%)	866 (72.65%)	1,032 (82.10%)	836 (74.38%)	1,043 (82.06%)	763 (72.87%)
PCO	74 (6.40%)	80 (7.33%)	106 (7.48%)	145 (12.16%)	93 (7.40%)	101 (8.99%)	106 (8.34%)	117 (11.17%)
Total	1,157	1,091	1,417	1,192	1,257	1,124	1,271	1,047

This data demonstrates that approximately four out of every five applications for a long-term order are sought in favour of the chief executive, despite LTG-CE being the least preferable form of long-term guardianship in the permanency hierarchy. The pattern is striking in its consistency. Across all four financial years captured in the data, LTG-CE accounted for between 82% and 84% of applications and between 75% and 79% of orders made. There is no improving trend. The rate of applications and orders for LTG-O or PCO remains consistently low.

The DCPL Annual Report 2024/2025 provides a further breakdown of order types made per Child Safety Region.[38] The analysis reveals that in each of the Child Safety Regions, except Far North

[37] CL-52, *Extract of DCPL Annual Report 2023-2024 – tables of types of applications and orders made*, tendered 27 November 2025; Office of the Director of Child Protection Litigation (Qld), *Annual Report* (Report, 2024-2025) 112.
[38] Office of the Director of Child Protection Litigation (Qld), *Annual Report* (Report, 2024-2025) 129 –149.

Queensland (FNQ)[39] the rate of different long-term guardianship orders being made is broadly consistent with the Statewide averages.

Child protection applications determined in the Far North Queensland Child Safety Region			
Order type	2022–2023	2023–2024	2024–2025
Long-term guardianship to a suitable family member	20	23	13
Long-term guardianship to another suitable person	4	0	4
Long-term guardianship to the chief executive	86	92	82
Permanent care order	5	0	0

[39] Ibid 141.

In Far North Queensland, while the rate of LTG-O to a family member is broadly consistent with the rest of Queensland, the rates of LTG-O to another suitable person and PCOs are significantly lower. For example: in 2023–2024, no orders of either type were made; and in 2024–2025, no PCOs were made. It is not possible from the data supplied to discern why FNQ is out of step with the rest of the State. Notably, the rate has been consistent across all four years captured in the data, ranging from 82% to 84% of applications and 72% to 78% of orders made, with no evidence of an improving trend. An order placing guardianship with a family member or other suitable person will not always be possible. However, the data demonstrates that the Department is approximately four times more likely to seek an LTG-CE than the combined alternatives of LTG-O or PCO, which warrants close examination.

1.1.2.4 Permanency reviews – section 51VAA

The Commission sought from the Department data in relation to 100 children who were placed on an LTG-CE between January and March 2023, who would have had their s 51VAA review conducted during 2025. A random sampling was undertaken with a view to gaining a cross-section of information to help identify any trends in Departmental practice.

Given the time constraints brought on by the shortened date for the delivery of the report, a more extensive data analysis was not possible. This data is set out and discussed in the following section of the Chapter.

The data that has been produced by the Department is both instructive and concerning, as from the 100 children sample:[40]

- Only 9 out of the 100 children had a s 51VAA review conducted;
- Of the 91 children who did not have a s 51VAA review conducted, 61 of these children were in either kinship or foster care;
- Of the 41 children in foster care who did not have a review conducted, 34 had been in their placement for over one year at the time of the review requirement and 21 had been in their placement over three years;

[40] Department of Families, Seniors, Disability Services and Child Safety, *Spreadsheet of s.51VAA reviews* (4 August 2026) (DFS.0394.0002.0001).

- Of the 20 children in kinship care who did not have a review conducted, 18 had been in their placement for over one year at the time of the review requirement and 14 had been in their placement over 3 years;
- Less than 10% of the children in the sample had the required s 51VAA review conducted. Of the 61 children in kinship or foster care who did not have the s 51VAA review conducted, 57% of these children had been in their placement for over three years and 85% had been in their placement over one year. While it is unable to be discerned from the data whether these children would be suitable for a PCO or LTG-O, those orders are ordinarily suitable for children who have been in long-term stable family-based placements.

What this sample demonstrates is that the Department is failing to conduct the legislated permanency reviews. As a consequence, children in long-term family-based care are not having their permanency needs reviewed through timely review of their LTG-CE orders and consideration of better permanency options.

On the nine s 51VAA reviews that were conducted, the Practice Panel Notes detailed:

- Carers concerns as they, '*Have previously wanted guardianship but were told that because they were not First Nations they wouldn't be guardians'*.[41] This is consistent with evidence heard by the Commission that non-indigenous carers are routinely not considered for guardianship for indigenous children;[42]
- In one case, a group of three siblings were placed with a foster carer. The children all had high needs and were doing well in the placement. Both parents have acquired brain injuries, and their parenting was therefore unlikely to improve. The children are not indigenous. The Child Safety Officer (CSO) had concerns that there may be issues with family contact should the children be placed on an LTG-O or PCO, and on that basis no guardianship assessment was undertaken of the carers and the children remained on LTG-CE;[43]

[41] Department of Families, Seniors, Disability Services and Child Safety, *Practice Panel Notes, s.51VAA review* (1 August 2025) (DFS.0394.0001.0001) 2.
[42] Transcript, Evidence of Witness O and P (11 September 2025) 496; Transcript, Evidence of Witness AB (12 September 2025) 603.
[43] Department of Families, Seniors, Disability Services and Child Safety, *Practice Panel Notes, s.51VAA review* (14 August 2025) (DFS.0394.0001.0004) 2-5.

- An indigenous child had been placed with their grandmother since birth, being a period of over four years.[44] The grandmother already held a PCO for the child's older sibling. The review recommended the grandmother be assessed for a PCO. It is unclear why it took four years for this carer to be considered for guardianship. This is an unnecessary delay in achieving permanency for the child;
- Two children had been placed with foster carers for over five years. During that time there had been several failed attempts at reunification with the mother. In January 2025, the Department established that one of the children was indigenous through their father's side (five years after coming into care). Because of this, as at the time of the s 51VAA review (28 February 2025), the Department had only just become aware of the child's indigenous status, they decided that an LTG-O or PCO was not appropriate and they would commence looking for new kin. This is notwithstanding the child had been living with the carers for six years and they had expressed interest in obtaining guardianship.[45] The Department would not consider PCO or LTG-O for the non-indigenous child because they determined it was not appropriate for the children to be on different orders; and
- A sibling group of two were placed with two different foster carers. One child had been with the carer for five years, the other for two years. The children are indigenous. One carer thought an LTG-O was the best option for the child in their care but didn't think this was an option because the child is indigenous and she is not. Both children were thriving in their placements. The panel concluded that an LTG-CE was the most appropriate order due to concerns over cultural connection, though this is not explained. The Department appeared to want to continue attempts at reunification, despite the children having been in care for over five years. The practice panel seems not to have given proper consideration to whether the carers should be the guardians of these children, not withstanding their long-term stable placements.[46]

The practice panel notes are suggestive of a resistence in practice pursuing the granting guardianship of Aboriginal and Torres Strait Islander children to non-indigenous carers, delays of several years in seeking guardianship for suitable carers, and a reluctance to assess carers for

[44] Department of Families, Seniors, Disability Services and Child Safety, *Practice Panel Notes, s.51VAA review* (25 August 2025) (DFS.0394.0001.0009) 1-12.
[45] Department of Families, Seniors, Disability Services and Child Safety, *Practice Panel Notes, s.51VAA review* (28 February 2025) (DFS.0394.0001.0030) 1-7.
[46] Department of Families, Seniors, Disability Services and Child Safety, *Practice Panel Notes, s.51VAA review* (13 August 2025) (DFS.0394.0001.0038) 1-13.

guardianship despite the children being in long-term stable and thriving placements. These issues are explored in the case study of Witness AB, set out in Appendix B.

1.1.2.5 Expiry of short-term custody or guardianship orders

Under Notice to Produce, the Department provided information in relation to the children who had a short-term custody or guardianship order expiring between 1 July 2025 to 31 December 2025. The intention of this data was to review the Department's decision-making at the point in time when a decision is made to apply for a long-term guardianship order of some type.

During this period, 144 children had a short-term order expiring for whom an LTG-CE order was recommended. Of these, the barriers to having an LTG-O or PCO included:

- 39 children who had carers who would be suitable for guardianship had not had a guardianship assessment completed (it is unclear if this was to be undertaken);
- 39 children had concerns over ability of carer to maintain family contact;
- 4 children had concerns over the ability of the carer to maintain cultural connection (3 of these were kin placements); and
- 13 children needed to have kin explored (12 of these children had been in care over three years).[47]

Even in cases where a prospective guardian had been identified, the guardianship assessment had not been undertaken, and the Department sought LTG-CE orders, though in principle those orders may be amended at a later stage to an LTG-O or PCO application. This is a failure in concurrent planning. Such assessments ought to be completed to enable long-term guardianship orders to be made in favour of others at the expiry of the short-term orders.

The prolonged periods of searching for kin are consistent with the practice observed by the Commission that the Department fails to conduct timely kin searches when a child is already in a long-term, stable placement. However, this practice has a self-perpetuating effect especially if the child is Aboriginal or Torres Strait Islander, namely the opportunity for long-term guardianship in favour of another person is impeded because finding kin has not been exhausted. The concerns ostensibly about meeting family contact and cultural needs were raised in the evidence of

[47] Department of Families, Seniors, Disability Services and Child Safety, *Short term order expiry spreadsheet* (1 July 2025 to 31 December 2025) (DFS.0394.0006.0001).

Witness A.[48] This evidence raises some incongruencies. Assuming a child has been placed on a long-term basis with a carer, in principle it should be assumed the child's needs have been met.

1.2 Perspectives of children and carers

1.2.1 Past and present children in care evidence

Throughout the Inquiry the Commission received evidence from many past and present children in care through public and private hearings, youth forums, private meetings and youth surveys. The views of children who have lived within the child safety system carry particular weight; it is their lives, their stability, and their futures the permanency framework is designed to protect.

The Commission asked children in care what permanency arrangement they wanted for their future. Their responses were direct:

- *I want mum [carer] to have permanent care order I don't want the government to be my parent.*[49]
- *PCO so I don't have to stress about child safety and just be normal.*[50]
- *Long-term guardian ship [sic] with current kinship carer (strongly want).*[51]
- *Adopted by my foster parents.*[52]

The consistency of these responses reflects a common desire for settled, family-based arrangements that do not depend on the ongoing involvement of the Department.

One child described the experience of being a foster child and the feeling of having less autonomy than peers:

- *Being a kid feels like everyone else is always telling you want to do. Being a foster kid is way worse because strangers come to your house and tell you want to do or tell your foster parent to do things a way that isn't right for you.*[53]

[48] Transcript, Evidence of Witness A (3 February 2026) 3900-3901, 3931.
[49] Youth survey response No 110 from child in care (23 October 2025).
[50] Youth survey response No 69 from child in care (6 October 2025).
[51] Youth survey response No 9 (23 October 2025).
[52] Youth survey response No 4 from child in care (2 October 2025).
[53] Youth survey response No 46 from child in care (2 October 2025).

Many children told the Commission how a lack of permanency affects them in their daily lives.[54] Some described the practical burden of Departmental involvement in everyday decisions, the kind of decisions that children in functioning families take for granted:[55]

- *Unfortunately, every small thing has to go through my child safety officer, meaning that the things my kinship care has access to providing me with, such last minute holidays on the weekends or signatures on consent form for activities, is limited.*
- *Gets annoying have to ask child safety for everything!!*
- *My Aunty has to get permission for everything I do.*
- *We should always be listened to if we dont want to go back to birth families and want to go pco or ltgo doesn't matter if we indigenous our safety and happiness comes first, the government needs to stop controlling us.*
- *Pco so I dont have to stress about child safety and just be normal.*
- *When things take too long it feels like I'm not getting what I need, but then I get it. I need a forever family like my friends. I don't get that.*

These responses reveal children who understand, in concrete and immediate terms, what guardianship would mean for their daily lives. They reveal that they are impliedly reminded that they do not possess the comfort and reassurance of permanency.

Overwhelmingly, the Commission was told that children in care want permanency, either through returning home to their parents, or having guardianship granted to a carer so that they feel like they truly 'belong': to know there is a person and a place they can always return to.[56] This is often expressed by children as a desire for the Department to have less involvement in their lives, as this involvement singles them out as 'different' to others.[57]

> I and my carers have been promised PCO, LGTO etc. My bio family support this, 10+ CSO say they are 'trying' to do the paperwork. My older brother has aged out of care, he is now 21, they promise and never deliver. I love having to argue with CSO and plead my case as to why i need essential school supplies, and then they want me to put it in writing, yep fantastic legal guardians. My carers have provided everything, department pays for nothing, would not even pay for school camp.[58]

[54] See Youth Survey responses (October 2025 to February 2026) where submissions were received from 45 young people and children in care who spoke about permanency.
[55] See various Youth survey responses from children in care (October 2025 to February 2026).
[56] Transcript, Evidence of Witness AG (11 September 2025) 539-540; see Case Study of Jack at Appendix B.
[57] Youth Survey response No 4 from child in care (10 January 2025).
[58] Youth Survey Response No 25 from child in care (2 October 2025).

1.2.2 Carer evidence

The themes emerging from the children's evidence were reinforced and elaborated on by the evidence of carers, who experienced the same system challenges from a different vantage point. The Commission heard from many carers during both public and private hearings as well as in private meetings, carer forums and through submissions. Across different regions and circumstances, carers consistently reported that the Department does not prioritise the granting of guardianship to carers for a variety of reasons, and the consequences of this failure fall most heavily on the children in their care.

> There were multiple opportunities where permanency could have been progressed, yet each time the process stalled due to staff changes, administrative delays, lack of follow-through, poor communication and no accountability from child safety… This prolonged uncertainty had a profound impact on my son.[59]

Many carers described their frustration at delays or refusals in respect to guardianship applications, and the impact this has on the children in their care.[60]

One carer submission spoke to the day-to-day experience of the Department in pursuing permanency for children, seen in small, painful moments felt by the child and carers who care deeply for them.

> Our current caseworker, the fifth this year, recently entered our home and asked Mr 10 what he calls me. He looked confused, then quietly replied, "She is my mum." A heartbreaking reminder that despite being raised in a loving home, he is still seen as a child in care—even in the only home he's ever known.[61]

There are also practical impacts for children and carers where the Department retains guardianship. The Commission was given some accounts of the practical impacts, including carers not being able to make decisions (including medical and educational) on behalf of the child without seeking permission from the Department,[62] often a very time-consuming process.[63]

The submission of one foster carer from Central Queensland also spoke to this issue:

Noah's story

[59] Submission No 329 to Child Safety Commission of Inquiry (24 March 2026).
[60] Approximately 38 submissions from carers addressed the issue of permanency.
[61] Submission No 42 to Child Safety Commission of Inquiry (17 July 2025).
[62] Ibid 55.40; Transcript, Evidence of Witness O and P (11 September 2025) 497-498.
[63] Ibid 498.13.

Noah[64], 13, has given permission to share his story...[W]hat he wants you to know is this:

"Just let me live in my family and be a normal kid"

We are his family. I've been his Mum for nearly 12 years.

Now imagine being raised by someone for over a decade, your primary caregiver, your safe place, yet that person has no control over the most basic decisions in your life: what school you attend, where you can stay overnight, whether you're allowed to go on a school camp with your friends.

At 13, Noah is still treated differently. Still living under restrictions that make him feel like an outsider. Still forced to justify why his life doesn't look like his peers.

Does he know his biological family? Yes and we talk about them openly. But Noah carries deep trauma, trauma that will never fully fade. His biological father passed away when he was an infant. His mother was incarcerated for seven years from the time he was four. Contact with her has been assessed as unsafe. Noah still bears the emotional scars of forced contact visits imposed by the Department in his early years.

Why should this young man continue to suffer for the choices of others? Why should he be trapped in a system that ignores his voice and his needs?

Noah is now old enough to speak for himself, and he is speaking clearly.

Listen to him. Let him choose. He makes us proud every single day."

The Commission heard a consistent message from non-indigenous carers that they were told that the Department considered them ineligible to seek guardianship for their Aboriginal or Torres Strait Islander foster children because they themselves were non-Indigenous, even where the carer had been the primary caregiver in the child's life for many years and would continue to be so.[65]

[64] A pseudonym.
[65] Transcript, Evidence of Witness C (8 September 2025) 56-57; See Ellen Case Study in Appendix B; Transcript, Evidence of Witness O and P (11 September 2025) 496.

Murphy – eight years in care, no guardianship assessment completed

Murphy is an Aboriginal child who has spent most of their life in the care of Witness AB, an experienced foster carer and trained nurse. Their case illustrates how the Department's failure to discharge its statutory obligation to pursue permanency, and its subordination of the paramount principle to identity-based placement assumptions, can leave a child in prolonged legal uncertainty despite a stable, committed and long-standing placement.

Murphy came into Witness AB's care in October 2017. A long-term guardianship order to the Chief Executive was made in February 2019. Within weeks, the Department committed to assessing Witness AB as a prospective permanent guardian, with the assessment to be completed by September 2019.

Nothing happened. Over the fifteen months that followed, Witness AB wrote to the Department repeatedly. She received acknowledgements, promises, and explanations that other priorities had intervened. No assessment was commenced.

A Practice Panel was convened in June 2020 before any assessment of Witness AB had been undertaken, which the Department's own witness, Witness A, described as unusual. The Panel declined to support a permanent care assessment on the ground that kin had not yet been explored. That failure of kin exploration was the Department's own: apart from one contact in July 2017, no steps had been taken to identify kin for nearly three years. The consequence of that inaction was then used to justify deferring the permanency outcome it had caused to be delayed.

At a meeting in July 2020, a Departmental manager stated on the record that she did not agree with permanent care orders for Aboriginal children being made to non-Aboriginal carers, and that this would never have been a discussion point under her oversight. Witness A was unequivocal: there is no legislative or policy basis for that position; it is contrary to both; and it is a view capable of being contrary to the best interests of a child. The Regional Director confirmed that the position was contrary to the legislation and raised serious concerns that privately held views were impermissibly influencing permanency decisions.

The Department then moved Murphy from Witness AB's care and placed her with her elderly grandmother without any assessment of whether that move was in Murphy's best interests, without providing the assessing agency with Murphy's child protection history, case plan or strengths and needs assessment, and without seeking Witness AB's views, despite Witness AB's three years of detailed and direct knowledge of Murphy's history and needs. The grandmother had herself expressed the view that she was not suited to taking on another child's full-time care. The placement broke down. Murphy was returned to Witness AB care in April 2022.

In the four years that have elapsed since Murphy's return, the Department has taken no steps to assess Witness AB for a permanent care order. Witness A confirmed that the assessment should have been revisited upon Murphy's return to Witness AB's care. She also confirmed that in her experience, it is generally the foster carer who raises the question of permanency, rather than the Department, an inversion of the statutory obligation that was precisely what occurred throughout Murphy's case.

The practical consequences are felt daily. Murphy has since developed additional needs requiring NDIS support. Without a guardianship order, Witness AB cannot navigate that system on Murphy's behalf; every decision must pass through the Department. Murphy has spent eight years in the care of a devoted and capable carer, a carer assessed as suitable for ongoing placement, but never assessed for guardianship. The law contemplates otherwise.

For the more extended version of the case study of Witness AB, see Appendix B.

Other carers described not being informed by the Department that there is even the prospect of becoming a guardian[66], and a significant number spoke to the length of time it took to receive an answer about permanency, leaving the children in a state of uncertainty and lack of normalcy, with a revolving door of adults coming into their life.[67] For example, a submitter to the Commission[68] who had cared for over 50 children described how it took over eight years to obtain guardianship over two children whom they had cared for since infancy.[69] Others spoke about

[66] Transcript, Evidence of Witness H (8 September 2025) 124-125.
[67] Transcript, Evidence of Witness E (19 February 2026) 4411.
[68] Submission No 329 to Child Safety Commission of Inquiry (17 February 2026 and 24 March 2026).
[69] Ibid.

being told told the Department would not seek an LTG-O or PCO to them for reasons including workload, because they are non-indigenous or bcause they did not have the support of, or relationships with, the child's biological family.[70]

The Commission heard from carers, through submissions and evidence at hearings, of the Department perfunctorily moving children from long-term care placements(at times upwards of 8 years)to place them with kin unknown to the child in order to comply with the Aboriginal and Torres Strait Islander Placement Principle (ATSICPP).[71] Another issue raised was carers being refused as long-term guardians for unstated reasons, despite being impliedly considered assessed as suitable to provide ongoing care for their foster children.[72]

Submission No 329 to Child Safety Commission of Inquiry (17 February 2026 and 24 March 2026)

"*As I write to you today my boys are [both teenagers]. The 15yr old has now lost all hope in the system. He is so jaded and his hatred for the dept is warranted. All he wants is to be parented by us his parents rather than a government dept. We never thought we would be here with him at this age and still not able to legally call him our own... Next year it will be 13yrs. How can we still not have guardianship after all these years! It's so disappointing and so unfair to this young man.*"

A consistent message from carers was that the Department does not prioritise guardianship to carers. This approach is inconsistent with the statutory permanency hierarchy.

1.3 The Department does not follow the permanency hierarchy in practice

Regional Director, Corinne Porta (Ms Porta) gave evidence to the Commission that, in her experience, the Department does not, in practice, follow the permanency hierarchy required by the CP Act.[73] Instead, the Department skips over LTG-O and adoption and seeks LTG-CE when a child is identified for long-term guardianship.[74] She also agreed with two propositions put to her:

[70] Submission No 387 to Child Safety Commission of Inquiry (30 September 2025); Submission No 42 to Child Safety Commission of Inquiry (17 July 2025).
[71] Transcript, Evidence of Witness E (19 February 2026) 4415; Ellen Case Study, see Appendix B.
[72] Transcript, Evidence of Witness E (19 February 2026) 4409; Ellen Case Study, see Appendix B.
[73] Transcript, Evidence of Corrine Porta Transcript (21 November 2025) 2481.
[74] Ibid.

firstly, that "the Department has decided upon its own set of priorities, not consistent with the prescription"[75] in s 5BA of the CP Act; and secondly, that this Commission could assume that "this practice is approved at the highest level within the Department."[76] Witness A, a Child Safety Service Centre Manager also acknowledged that that the Department is not always actively pursuing the permanency hierarchy.[77]

The Commission acknowledges that these witnesses were from one Child Safety Region. However, the Commission notes that their evidence is consistent with State-wide data provided by the DCPL demonstrating that LTG-CE is the most frequently sought long-term order, sought in approximately 80% of applications across 2020 – 2023 financial year periods. It is also consistent with the Department's data on adoption.

Carers identified as suitable for assessment face lengthy delays in having their guardianship assessment undertaken.[78] The Department's explanation was to the effect that workload pressures prevented CSOs from conducting the assessment. Turnover of CSOs, workload associated with legal proceedings and the pressures of other urgent work deadlines, and the lack of support and training for CSOs.[79] However, the weight of the evidence, particularly the data referred to above leads to a strong inference that the Department does not give sufficient weight to complying with the permanency hierarchy in s 5BA(4) in terms, or in spirit.

Evidence presented to the Commission highlighted that long term guardianship to the Chief Executive is sought by default once reunification is deemed unviable without searching for a suitable 'other', and carers who are willing to become guardians of children in care are facing significant resistance from the Department.[80]

1.4 Implications for reform

The weight of the material assessed by the Commission in the form of data, submissions, witness statements and evidence at hearings, demonstrates a systemic and longstanding failure by the Department to give practical effect to the permanency hierarchy legislated in the CP Act. That

[75] Ibid 2428:26.
[76] Ibid 2482:11.
[77] Transcript, Evidence of Witness A (3 Feburary 2026) 3899.
[78] Transcript, Evidence of Corrine Porta (21 November 2025) 2477.
[79] Ibid 2477:24; Department of Children, Youth Justice and Multicultural Affairs, *Permanency Strategy Phase 2* (Director-General Briefing Note, 6 April 2021) (DFS.0280.0004.0202).
[80] Transcript, Evidence of Corrine Porta Transcript (21 November 2025) 2482.11; Transcript, Evidence of Witness A (3 February 2026) 3899.

failure is not simply the product of individual error, workforce pressure, or isolated poor practice, it is the product of a practice culture that has normalised LTG-CE as the default outcome, and a system that provides no structural accountability for that normalisation.

1.4.1 Mandatory and enforceable timeframes for guardianship assessments

1.4.1.1 A direct right for carers to seek assessment as guardians

The evidence has demonstrated that it is generally the carer, rather than the Department, who raises the question of guardianship to a suitable other. Reform is required to facilitate long-term carers having a direct right to seek assessment as a guardian. South Australia has recently enacted a materially similar model. Section 125 of the *Children and Young People (Safety and Support) Act 2025* (SA) gives approved carers who have had a child in their care for at least two years a direct right to apply to the Chief Executive to seek a specified person guardianship order. Once an application is received, the Chief Executive is under a mandatory obligation to commission a suitability assessment and make a determination as to suitability, An equivalent provision should be enacted in Queensland.

1.4.1.2 Mandatory periodic reviews of LTG-CE orders

The current s 51VAA framework requires only one mandatory permanency review, within six months of the second anniversary of an LTG-CE order. If that review does not produce an alternative permanency outcome, the question of whether a better permanency option is available need never be revisited, even where a child remains on LTG-CE for many years thereafter. A child's circumstances, placement stability, and available supports evolve over time. A periodic review obligation, requiring the Department to reassess every two years whether a better permanency option is available for as long as the child remains on LTG-CE, would address the design flaw in the existing provision. A once-only obligation cannot provide adequate structural assurance.

1.4.1.3 Powers for the Court and DCPL to direct guardianship assessments

The evidence demonstrates that both the DCPL is currently reliant on the Department to identify and assess prospective guardians before long-term guardianship applications are filed. The DCPL makes applications in accordance with the Department's assessment in approximately 98% of cases involving LTG-CE. Where either the DCPL or the Court considers that a prospective

guardian has not been identified or assessed, the DCLP or the Court on its own motion, should have power to direct the Department to undertake that assessment.

The above recommendations are premised upon the present litigation model continuing. The Commission considers that it is likely that many of the impediments to permanency to persons other than the Chief Executive will be resolved by the litigation model recommending in Companion Report 2. Accordingly, these recommendations are conditional upon the Government deciding not to implement the restructure of the litigation model. If the Government accepts the recommendations concerning the litigation model, the Commission accepts that it would be reasonable and prudent to defer implementation of the present recommendations pending an assessment of the necessity having regard to the working out in practice of the suggested new litigation process.

1.5 Recommendations

Recommendation 37: Full consideration of permanency options for all children	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 1)**
RECOMMENDATION: That the Queensland Government, within three months of the Government's response to this report, review and address the policies, practices and organisational culture of the Department to ensure that the priority order for considering permanency options as required under section 5BA of the *Child Protection Act 1999* is met in all cases, including consideration of adoption for all children.	
CONTEXT: The evidence before the Commission shows that the Department has significant shortfalls in delivering on its responsibilities as a corporate parent under the paramount principle to prioritise the best interests of the child, and more specifically, to effectively provide permanency for children in care in accordance with the permanency hierarchy in section 5BA of the Child Protection Act. Despite previous recommendations and the Government's acceptance of those recommendations, the Department has systemically failed to consider the full range of permanency options for children in care as required by the Child Protection Act. In particular, the Department has failed to consider and pursue adoption for children for whom reunification is no longer a possibility, despite: (a) on more than one occasion being recommended to do so; and (b) the Department continuing to assert or claim that it was in fact doing so. This reform addresses the urgent need of children in care to experience belonging to a family, in order to have the best possible chance of reaching their full and best potential.	
IMPLEMENTATION NOTES: It will not be sufficient to merely report that this has been implemented. Identifiable changes will need to be shown to Department practices, policies, processes, and training to overcome current personal and organisational culture barriers and deliver on the intent of this recommendation, as required by the Child Protection Act.	

Recommendation 38: Improving permanency through guardianship	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 1)**

RECOMMENDATION:

That the Queensland Government, within three months of the Government's response to this report, introduce measures to improve permanency for children in care through improved assessment of guardian, including at a minimum:

a) amend the *Child Protection Act 1999* to confer a right on carers to seek assessment as guardians after two years of continuous care for a child.
b) amend section 51VAA(3) of the *Child Protection Act 1999* to require a permanency review to be undertaken every two years for as long as a child remains on an LTG-CE order.
c) amend the *Child Protection Act 1999* to confer power on the DCPL and the Court to direct the assessment of prospective guardians.

CONTEXT:

Evidence before the Commission demonstrated the assessment of carers as suitable guardians was not being prioritised, leading to extraordinary delays in assessments of many years, or assessments not being conducted. Further evidence demonstrated that only 10% of section 51VAA reviews were being conducted.

Legislative amendment is required to ensure assessments are conducted in a timely manner in the best interests of s child who has a prospective guardian willing to care for them, and that children on LTG-CE orders have the benefit of having this arrangement periodically reviewed to determine if their permanency needs would be better met under an alternative arrangement.

Chapter 2

Adoption

Companion Report 5

Corporate Parenting and the Youth Justice Interface

Chapter 2: Adoption

2.1 Introduction[81]

This Chapter focuses on adoption as a permanency option within the CP Act's permanency hierarchy.[82] The chapter examines the role adoption is legislated to play under Queensland law in respect of children in care, the extent to which recommendations to increase adoptions rates were implemented with the system, and whether adoption is considered and pursued as a permanency option by the Department in practice and any factors impacting this. The chapter concludes that, despite legislative reform, recommendations have not been implemented in any real sense, and, for a variety of reasons, there has been an almost complete absence of consideration of adoption as a permanency outcome for children in care over the last 10 years.

The Commission acknowledges that adoption will not be appropriate or feasible in many cases. However, reform is required to ensure that children who cannot safely return to their families are not denied the opportunity for lifelong legal and relational belonging where this would be in their best interests.

2.2 Adoption in Queensland: Legal Position and Intended Role

Adoption is one method to provide a permanent and stable family for children who, for various reasons, cannot live with their birth families. Within the statutory hierarchy, it is the third order of preference for non-indigenous children in the permanency principles set out in s 5BA of the CP Act and the last preference for Aboriginal and Torres Strait Islander children. Adoptions are facilitated under the *Adoption Act 2009* (Qld) (Adoption Act) and are guided by the fundamental principle that the wellbeing and best interests of an adopted child, both through childhood and the rest of their life, are paramount.[83]

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[81] This Chapter builds on, and should be read alongside, the preceding Chapter on permanency, which describes other statutory permanency options in Queensland and the systemic barriers that have constrained the delivery of timely and stable care outcomes for children in OOHC.
[82] The Commission's Terms of Reference require the Commission: to review the effectiveness of Queensland's child safety system to keep children safe including tertiary child interventions which encompasses adoption (TOR 3(b)(ii)); review Queensland legislation about the protection of children, including the *Adoption Act* 2009; and make recommendations on system design to support and facilitate adoption in a modern best practice setting.
[83] *Adoptions Act 2009* (Qld) s 5(a).

Adoption is the only permanency option available under the CP Act that removes children entirely from the child safety system. It is also the only permanency option that results in orders that legally endure after the child turns 18. The adoption process in Queensland establishes a permanent, legal, parent-child relationship between the child and his or her adoptive parents. In this way, adoption may be seen to represent the highest and best permanency solution for children in State care as it represents the closest proxy for the relationship between a child and natural parent. It is certainly the most permanent legal option.

As at 30 June 2025, there were 21 households on the Suitable Adoptive Parents Register held by the Department and a further 95 expressions of interest submitted for adoptions within Queensland.[84] These numbers are supported by submissions received by the Commission, including one that noted:

> [M]any of these individuals would be willing to provide permanent homes through adoption or other long-term permanency arrangements. However, adoption pathways in Australia are extremely limited, and permanent care options are not commonly offered for many children who may benefit from them.
>
> This creates a significant gap within the current system. Australia faces a severe shortage of foster carers while many prospective adoptive families are waiting to provide permanent homes.[85]

It is clear to the Commission that there are families with a desire to adopt children within Queensland. It is also clear to the Commission that there are children in out-of-home care who seek the belonging that only adoption can give: "I wish we could be a real family". [86]

2.3 Policy Context: Adoption Reform

As the Carmody Report noted:

> Ultimately, the aim of any case planning for children and young people in the statutory system is to achieve a permanent, stable home for children.[87]

[84] Department of Families, Seniors, Disability Services and Child Safety, *Statistics on the Suitable Adoptive Parents Register* (26 February 2026) (DFS.0343.0001.0001).
[85] Submission No 725 to Child Safety Commission of Inquiry (3 May 2026).
[86] Youth survey response No 20 from child in care (2 October 2025).
[87] Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 221.

The Carmody Report's focus on adoption

Carmody's recommendation for greater consideration of adoption, particularly for children in care under the age of 3, was supported by three main evidentiary pillars:

- LTG-CE orders were not providing sufficient stability to children;
- prioritising family preservation was causing further harm to children; and
- in respect of infants in particular, there was a need to consider brain development and timeframes when permanency planning.

Carmody notably expressed doubt over the legitimacy of LTG-CE orders as a permanency goal, noting that:

> ...the rates of stability are less than ideal. Of the 3692 children and young people subject to long term orders to the chief executive as at 30 June 2012, 11 per cent (338) were aged 0-4. These children may spend many years in out-of-home care with high likelihood of multiple placements during that time.

Carmody also heard that long-term guardianship orders (whether to the Chief Executive and to others) were not having the intended effect of providing a child with sufficient stability because they may be contested in court by birth families on an ongoing basis, impeding bonding with the foster carer and their family. It was also noted that long term guardianship orders terminate on a child's 18th birthday, and that there was an alternative: legal adoption pursuant to the then-CP Act. Carmody quoted the work of Dr Jeremy Sammut, whose thinking was summarised in his report (in part) as follows:

> *...family preservation profoundly harms children by prolonging the time spent either in the custody of abusive and neglectful parents, or languishing in 'temporary foster care while awaiting family reunions that are highly prone to break down...[E]arly removal and adoption is a proven and effective response to child abuse and neglect, and that family preservation does more harm than good by exposing children to serious maltreatment, leading to attachment problems and other psychosocial disorders.*

Carmody's recommendation focused on children under three years due to submissions and evidence to that Inquiry about 'the need to consider brain development when planning for permanency.'

Following an examination of the topic of stability planning, the Carmody Report recognised that adoption may be a suitable option for some children in out-of-home care. The recommendation that followed was:

> That the [Department] routinely consider and pursue adoption (particularly for children aged under 3 years) in cases where reunification is no longer a feasible case-plan goal. (**Recommendation 7.4**)

The then-government accepted Recommendation 7.4.[88]

The Adoption Act was reviewed and in 2016, various legislative reforms were recommended, including broadening eligibility criteria to enable single persons, same-sex couples and persons undergoing fertility to express interest in adopting a child. These recommendations were subsequently legislated.[89]

Following a Coronial recommendation arising out of the inquest into the death of Mason Jet Lee, legislative changes were made requiring the Department to give express consideration to adoption as a permanency option for children in care.[90]

Despite each of these attempts at reform to boost adoption numbers from State care:

- only a handful of children were adopted from care between 2014 and 2019;
- the broadening of eligibility criteria for adoption did not have any appreciable effect on rates of adoption of children from OOHC; and
- no child has adopted from care in Queensland since 2019.[91]

In 2019, the then-Government published a recommendation closure report, asserting that it had implemented the Carmody recommendation. However, a close review of the closure report undertaken by the Commission suggests otherwise.

In late 2019, the Director-General of the Department approved a 'Recommendation Closure Report' on Recommendation 7.4 of the Carmody Inquiry. The Commission observes the following:

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[88] Queensland Government, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, December 2013) 11; Department of Child Safety, Youth Justice and Women, *Recommendation Closure Report – Recommendation 7.4: Permanency (previously known as Adoption)* (Report, 1 November 2019) (tendered as part of Exhibit CA-56, *Clair Martin tendered bundle*).
[89] On 2 November 2016 Queensland Parliament passed the *Adoption and Other Legislation Amendment Bill* 2016.
[90] The *Child Protection and Other Legislation Amendment Bill 2020* (cls 8-10) introduced amendments to the CP Act to enhance the approach to permanency, clarify that adoption is an option for achieving permanency for children in care, and clarify the importance of an promote alternative permanency options for children subject to a child protection order granting long-term guardianship to the chief executive. This was in direct response to recommendation 6(b) of Deputy State Coroner Bentley's findings (Explanatory Notes, *The Child Protection and Other Legislation Amendment Bill 2020* (Qld) 2).
[91] CA-56, *Clair Martin tendered bundle*, tendered 5 February 2026, Tab 14. From 1996 to January 2026, only 16 children were adopted from care. The 16 children were either adopted by the foster carer or a person from the Suitable Adoptive Parent Register. (Explanatory Note to Notice 227 provided by the Department) (COI.0001.0005.6825).

- Recommendation 7.4 was exclusively about adoption. Despite this, the Department rebranded the recommendation as 'Permanency'. As will be seen below, this was more than just verbiage: it denoted the apparent de-prioritisation of adoption as a permanency option, whilst maintaining a formal position that Recommendation 7.4 had been faithfully implemented as intended.
- As to implementation and delivery, the closure report asserted that the Department 'routinely considers and pursues adoption (particularly for children aged under three years) in cases where reunification is no longer a feasible case-plan goal.'[92] On the data and evidence before this Commission, it is unclear how the Government, faithfully informed by the Department, could have reasonably believed that there was a proper basis for this assertion. The data tells the story: there had been a total of 9 adoptions since Recommendation 7.4 to that point: 9 adoptions in a roughly 5-year period, 7 of whom were under three at the time of the final adoption order.[93] That is, fewer than 2 children a year were adopted during the implementation period. In her evidence to the Commission, the Department's Principal Legal Officer, Clair Martin (Ms Martin), who had been employed by the Department since prior to the Carmody Inquiry, accepted that the Department had, in fact, not done what was asserted and that the Department "could do better for all children."[94] Ms Martin's evidence, at its highest, was that the Department "considers and pursues adoption when a practitioner has deemed it may be appropriate for a child or a parent requests it."[95]
- The closure report refers to the introduction of a new permanent care order which provides a long-term care option for children "with benefits equivalent to adoption without adoption's negative effect of obscuring birth relationships." Increasing the suite of permanent long-term care options for children in care is to be encouraged. This language, which was endorsed by the then-Director-General, hints strongly of views held within the Department that adoption is to be discouraged due to perceived 'negative effects' which stem from the very permanency that adoption provides, whilst justifying

[92] Department of Child Safety, Youth Justice and Women, *Recommendation Closure Report – Recommendation 7.4: Permanency (previously known as Adoption)* (Report, 1 November 2019) (tendered as part of Exhibit CA-56, *Clair Martin tendered bundle*) 1.
[93] CA-56, *Clair Martin tendered bundle*, tendered 5 February 2026), Tab 14.
[94] Transcript, Evidence of Clair Martin (4 February 2026) 3977:4-22.
[95] Ibid 3978:6-9.

this position by conflating to the two options as equivalent.[96] To be clear, they are not, not least because adoption is for life, not simply until the child turns 18.

In her Honour's findings into the death of Mason Jet Lee, delivered in June 2020, Deputy State Coroner Bentley expressed the view that the Department had not implemented the recommendation "in any real sense" noting that only "a tiny handful" of children had been adopted from 2013-2019. As a comparison, as at 17 March 2020, 6,795 children were subject to long-term guardianship orders, that is, under the care of the Department until they turn 18 years of age on the basis that they have no parent willing and able to care for them and they will not in the foreseeable future.[97]

The Deputy State Coroner recommended that:

> *(a) The department review its policies and procedures to ensure that, in accordance with the Government's acceptance of Recommendation 7.4 of the Carmody Inquiry:*
>
> > *i. adoption is routinely and genuinely considered as a suitable permanency option for children in out-of-home care where reunification or unification is unlikely, and should be pursued in those cases, particularly for children aged under 3 years.*
> >
> > *ii. adoption is routinely and genuinely considered by Child Safety officers as one of the permanency options open to them when deciding where to place a child in out of home care.*
>
> *(b) The Government consider whether the Adoption Act 2009 (Qld) should similarly reflect the 2018 amendments to the Adoption Act 2000 (NSW), expecting children to be permanently placed through out of home adoptions within 24 months of entering the department's care.*
>
> *(c) The department report to the Coroners Court of Queensland the numbers of children adopted and the details of those matters, every six months for the next five years.*[98]

The government accepted these recommendations, and the legislative amendments to require express consideration of adoption were made. However, no adoptions have since occurred.[99]

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[96] Department of Child Safety, Youth Justice and Women, *Recommendation Closure Report – Recommendation 7.4: Permanency (previously known as Adoption)* (Report, 1 November 2019) (tendered as part of Exhibit CA-56, *Clair Martin tendered bundle*) 1.
[97] *Findings of the Inquest into the death of Mason Jet Lee* (Coroners Court of Queensland, Deputy State Coroner Bentley, 2 June 2020), [945]-[946].
[98] Ibid [953].
[99] CA-56, *Clair Martin tendered bundle*, tendered 5 February 2026, Tab 14.

2.3.1 The 2020-2024 Child Safety Permanency Strategy

Ms Victoria Van Houdt, Acting Chief Practitioner, gave evidence about the Department's Permanency Strategy 2020-2024, which arose out of a series of case reviews of children who were subject to a series of short-term child protection orders across the State, to build a set of streamlined strategies to respond to emerging barriers to achieve permanency outcomes for children in care.[100]

Through Ms Van Houdt, the Department tendered this strategy, embedded in which was a report setting out what had been achieved by it between July 2020 and 2022.[101] Two things are noticeable: firstly, the only reference to matters done in respect of adoption was to seek to recruit persons who were expressing interest in becoming, or willing to be assessed as, suitable adoptive parents to become permanent foster carers.[102] That is, to recruit potential foster carers from the pool of potential adoptive parents, the former being a form of care that keeps children in the child safety system and is a lesser form of permanency. Secondly, the 2020 recommendations of the Deputy State Coroner do not appear to be included in the Department's strategy.

Furthermore, what was envisaged to be done over the remainder of the strategy period was "strengthening practice to achieve long-term stable arrangements for children able to be reunified, including long-term guardianship order, permanent care orders and adoption."[103] When asked what this meant, Ms Van Houdt referred to "capability development in concurrent planning", and "family mapping and genogram work".[104] It was unclear how any of these related to adoption as a permanency strategy. Furthermore, the data objectively demonstrates that there were no adoptions resulting from this planning.

It was only in 2022, that the Office of the Family Child Official Solicitor (OCFOS) took on the function of progressing any adoptions matters for the Department based on instructions. Prior to this, court appearances were undertaken by a Departmental Coordinator as permitted by the Adoptions Act.[105] The Director of Child Protection Litigation, Nigel Miller (Mr Miller) gave evidence that, whilst able to, he has never been engaged to provide advice on adoption or to represent the

[100] Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2884:36-47.
[101] CL-45, *Child Safety's Permanency Strategy 2020-2024*, tendered 26 November 2025.
[102] Ibid 2.
[103] Ibid 3.
[104] Transcript, Evidence of Victoria Van Houdt (28 November 2025) 3080:6-22.
[105] Transcript, Evidence of Clair Martin (12 December 2025) 3626:45-3627:10; *Adoptions Act 2009* (QLD) s 234.

Department in an adoption matter.[106] However, as part of the Department's case planning process, he was aware of instances where natural parents were asked whether they have considered adoption and whether they would consent to it. In each of the case plans he had reviewed by way of example, the pro forma question relating to adoption had been answered in the negative.[107] Mr Miller similarly noted that he had commenced reviewing material, including the template case plans, to see whether reference to adoption had been made in the applications for long-term guardianship to the chief executive or the related legal submissions. His findings indicated he "was unable to see any reference to it."[108]

The evidence heard by the Commission did not suggest that the option of adoption was openly and fulsomely discussed with parents as a permanency option: it suggested entirely the opposite. Nor was there evidence to suggest that the Department ever considered, prior to seeking LTG-CE orders, whether an application to seek dispensation of consent was warranted in the best interests of the child, notwithstanding that there is nothing in the wording of s 5BA of the CPA that limits 'adoption' to adoption with the consent of the parents.

Further, as discussed in the previous Chapter on Permanency, another reason that is likely contributing to the lack of adoptions from care is that the Department (or parts of it) are not strictly following the permanency priority hierarchy in s 5BA of the CP Act, in effect treating the hierarchy as non-mandatory (contrary to their statutory obligations).

Whilst adoption rates have remained at zero, in the period 2019 to date, the rates of children entering care have risen; family-based care has been in decline; the cost of, and numbers of children being placed within, non-family based residential care system have increased exponentially, and children under 5 years of age are entering non-family based care (NFBC) in ever-increasing numbers.[109]

The increasing rates of children entering NFBC is occurring in circumstances where it is known:[110]

a) that non-family based residential care is not designed for children under the age of 12, let alone those aged under five;

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[106] Transcript, Evidence of Nigel Miller (10 December 2025) 3490:3-12.
[107] Ibid 3490:21-27.
[108] Ibid 3491:34-40.
[109] Queensland Family and Child Commission, *A system that Cares* (Report, April 2024) 12; Queensland Family and Child Commission and Peak Care, *The Future of Foster Care* (Report, June 2024) 7; Queensland Family and Child Commission, *Buyer Beware* (Report, 1 June 2025) 2, 13-15.
[110] See Companion Report 4 for a detailed analysis of the residential care system.

b) as a form of care, by design, NFBC does not or does not reliably provide a child with the opportunity to form an ongoing stable connection with a functioning, loving adult; and
c) the lack of family structure and discipline within this type of care is linked to the development or heightening of anti-social behaviours in the children in those placements, which may progress to criminal offending.

The Adoptions Act requires that for children subject to Child Protection Orders the Department must be in support of the adoption 'the court must not make an adoption order unless a document, signed by the chief executive (child safety), is produced to the court stating that the chief executive (child safety) considers the adoption is an appropriate way of meeting the child's need for long-term stable care.'

It is also notable that the Adoption Practice Manual sits outside the Child Safety Practice Manual, thus the contents, processes and requirements are not routinely known by CSOs in their day to day role. This may be a barrier to identifying and pursuing adoptions for children and families where it is appropriate.

Adoptions Act 2009 (QLD) s 178; and Transcript, Evidence of Victoria Van Houdt (26 November 2025) 2914:9-13.

The evident failure to consider and pursue adoption for children under three, and instead place them for long periods in NFBC placements, should be seen in the context of criticality of the first few years of a child's life for brain development and the necessity of providing permanency for that child within that short window to allow for healing and optimal development.[111]

There is a legislative mandate to consider adoption as a permanency option in a priority order, and in the context of the operation of the paramount principle. The weight of the evidence suggests that the hierarchy is not applied by the Department, or, at a minimum, tacitly regarded as non-mandatory.

This has led to a situation in which adoption has been, in effect, jettisoned by the Department insofar as children in care are concerned.

[111] National Scientific Council on the Developing Child, *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain* (Working Paper No 12, Harvard University, 2012); Yvon Gauthier, Gilles Fortin and Gloria Jéliu, 'Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: The Importance of Continuity of Care' (2004) 25(4) *Infant Mental Health Journal* 379; See also Child Death Review Board, *Timeliness and Permanency in transfer of parental responsibility* (Summary Report, 2026); Emerging Minds, Understanding the mental health and wellbeing of children in out-of-home care (Resource, March 2024) 4.

2.4 Overcoming Barriers to Adoption

2.4.1 Why Adoption is Not Being Pursued: The Legacy of Forced Adoption

I can't be adopted. I want to be adopted[112]

Evidence before the Commission suggested that the legacy of historical forced adoption practices continues to exert a significant influence on contemporary adoption practice in Queensland.

When asked whether there was an anti-adoption sentiment within the Department, the evidence of Principal Legal Officer, Ms Martin, was:

> *It's fair to say that Queensland recognises past historical practices with respect to forced adoptions. I think it's fair to say that the department and adoptions team consider the apology for forced adoptions, and I think it's fair to say that there's a reticence to consider or pursue adoption if the family are not agreeable or not supportive of that. So I think there is almost a resistance to considering adoption unless it's almost directed or supported by the family so that the department can be reflective in terms of the Queensland context with respect to adoptions.*[113]

Ms Martin's evidence candidly revealed the barriers to adoption motivating the Department which have led to the subordination of the statutory prescription in s 5BA(4) of the CP Act.

The Commission does not in any way minimise the gravity of these historical practices. However, an institutional pre-disposition against future adoptions, even where adoption would genuinely serve the best interests of a particular child, is not justified.

Contemporary adoption operates within a fundamentally different legal and ethical framework, characterised by openness, judicial oversight, and a focus on the child's best interests. Allowing historical wrongs to foreclose consideration of adoption risks involves substituting one form of harm for another, prolonging impermanence for children who cannot return home. Guidance for practitioners drawing on research into outcomes in other jurisdictions where adoption from care is more actively considered would assist in placing the option in its proper context, separating the historical wrong of forced adoption from the contemporary question of what best serves children who cannot safely return to their families.

[112] Youth survey response No 49 from child in care (3 October 2025).
[113] Transcript, Evidence of Clair Martin (4 February 2026) 3979:43-3980:10.

2.4.2 Adoption and Aboriginal and Torres Strait Islander children

Long-term guardianship orders of all types confer parental responsibility and authority on guardian parents until the child turns 18. They do not alter the child's legal relationship with the birth family, do not create a legal relationship between the child and members of the extended guardianship family, do not change the child's legal identity, do not result in any change to the child's birth certificate, and expire entirely when the child turns 18. They do not provide the same emotional, lifelong and intergenerational sense of belonging that adoption provides. One submitter, Professor Karleen Gribble (Adjunct Professor, School of Nursing and Midwifery) also drew attention to the particular significance of this for Aboriginal and Torres Strait Islander children, who in Queensland are approximately half as likely to achieve permanency via guardianship as non-indigenous children and may therefore be more exposed to the instabilities of the child safety system over longer periods.[114]

Minimising the consequences of removing any child from family and kin is plainly an important consideration for a child from any cultural background. The history of forced adoption of Aboriginal and Torres Strait Islander children has inflated the sensitivity to this consequence which should not be understated. On the other hand, focusing upon the particular child, as is, where is, and, here and now, historical errors should not be extrapolated and imposed on the child today, as if the child is to be retrospectively placed in an era which no longer exists. That is to visit the sins of past generations on the child here and now.

It is worth pausing here to note that the apparent statutory intent and the practical effect of the current permanency hierarchy in the CP Act, is that the State is preferred as a long-term guardian for an Aboriginal and/or Torres Strait Island child over an adoptive parent, even where the putative adoptive parent is Aboriginal and/or Torres Strait Islander.[115] This means that Aboriginal and Torres Strait Islander children are effectively denied the opportunity of being adopted (outside those who are the subject of traditional Torres Strait Islander adoption practices) without consideration of whether the child's best interests are better served by adoption.

Properly applied, this effect ought to be ameliorated by s 5BA(4) being read subject to the primacy, at all times, of the paramount principle in s 5A. However, the construction of s 5A is affected by specific provisions directed to particular subjects. Accordingly, a specific provision

[114] Professor Karleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 4.
[115] CP Act s 5BA(4)(e).

which inherently may come into conflict with the paramount principle in a particular case may be construed to cover the field on the particular subject, here the permanency hierarchy in s 5BA(4). Such construction would, in effect, subordinate the paramount principle to the permanency hierarchy in relation to the adoption of Aboriginal and Torres Strait Islander children.

The evidence before the Commission suggests that the Departmental officers tacitly regard the paramount principle in this context as subordinate to the permanency hierarchy in s 5BA for Aboriginal and Torres Strait Islander children in relation to adoption.

Tellingly, the Department's Child Safety Practice Manual provides as follows:

> *Adoption is the last option to be considered for achieving permanence for an Aboriginal and Torres Strait Islander child because an adoption order severs a child's legal relationship with their birth parents and family and creates an enduring (beyond the child's eighteenth birthday) legal parental relationship.*
>
> ***Adoption is unlikely to uphold the rights of Aboriginal and Torres Strait Islander children and their families or to enable Child Safety to fulfill its obligations under the Aboriginal and Torres Strait Islander Child Placement principle.***[116] *(Bold emphasis added)*

The position of adoption within the permanency hierarchy for Aboriginal and Torres Strait Islander children operates as a direct barrier to the Court ultimately granting adoption orders for Aboriginal and Torres Strait Islander children as a result.[117] The evidence suggests that, in practice, adoption is rarely, if ever, considered for Aboriginal and Torres Strait Islander children, even where it may be culturally appropriate, supported by the child, or consistent with their long-term wellbeing.

Consequently, there is a risk that the current operation of the permanency hierarchy results in adoption being functionally unavailable to Aboriginal and Torres Strait Islander children and not assessed on an individual, child-centred basis. To ensure the CP Act is operationalised with the true intent of applying the paramount principle in s 5A without racial distinction, an amendment is required to s 5BA to allow for adoption to be considered as the third preference in the permanency principles for Aboriginal and Torres Strait Islander children as well as non-indigenous children. Without such an amendment, the place of adoption in the hierarchy for Aboriginal and Torres Strait Islander children de facto subordinates the paramount principle for

[116] Department of Child Safety, Seniors and Disability Services, *Child Safety Practice Manual – Permanency* (Practice Guide, 18 June 2025) 37.
[117] *Adoptions Act 2009* (QLD) s 178.

Aboriginal and Torres Strait Islander children for whom adoption might best give effect to the paramount principle.

Finally, the Commission notes that the substantive characteristics of adoption as it presently exists in Queensland is the permanency option to which s 5BA applies. Whether adoption is in the best interests of the child must be evaluated according to its present legal characteristics. The above analysis is based on that premise. Simple adoption referred to below raises a different question, namely whether adoption with different characteristics thought to be important should also be considered.

2.4.3 Support for the introduction of simple open adoption

Since 2009, Queensland's adoption laws have provided for 'open adoptions' to allow the adopted child and the birth parents to know each other.[118] As Ms Van Houdt acknowledged in her evidence to this Commission, *'Contemporary adoption is far more open [than in the past], and identities are shared.'*[119]

Plenary adoption is the only form of adoption provided for in the Adoption Act.[120] Plenary adoption confers exclusive parental responsibility and authority on adoptive parents and creates an enduring familial relationship between the child, the adoptive parents, and the extended adoptive family. It also, however, severs the legal ties between the child and their birth parents and extended birth family. Under s 214 of the Adoption Act, the adopted child becomes a child of the adoptive parent, the adoptive parent becomes a parent of the adopted child, and the child stops being a child of a former parent. Those consequences extend to all relationships determined in accordance with those provisions. A new birth certificate is created, and the original birth certificate ceases to operate as a legal identity document.[121]

Based on the submissions made to this Commission, plenary adoption is a barrier to uptake of adoption of children from care. The Commission received submissions from individuals with experience of forced adoptions and the lasting impact that disconnection with their family of origin has had on them.

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[118] Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 227.
[119] Transcript, Evidence of Victoria Van Houdt (25 November 2026) 3037:32-33.
[120] *Adoptions Act 2009* (QLD) s 214.
[121] Transcript, Evidence of Clair Martin (4 February 2026) 3984:38-40.

> Whilst my relationship with my siblings and in particular my birth parents, has not been straightforward or easy, knowing them has been essential to my wellbeing and I have done everything in my power to show up and be present in their lives because I believe that this matters deeply, both to my wellbeing and theirs. I spent the first 18 years of my life deprived of these relationships and I have been determined that whilst I had no choice in the decisions surrounding my adoption and the legal severing of my relationship with my family and ancestors, I have a choice now and I will exercise that choice. I believe that all adopted people should be empowered and supported to do the same, from childhood.[122]
>
> I reunited with my biological mother in [year] after the death of my adoptive mother in [year]. It has been a revelatory and satisfying time with her, and the rest of the family, and both of us have been overjoyed to have found each other. But the time we lost can never be regained.[123]

Various submitters, including Professor Gribble and Jigsaw Queensland,[124] identified a fundamentally different model of adoption, known as simple adoption, as a model that submitted would better serve children in care, attract greater acceptance from birth parents, foster carers and practitioners, and remove much of the cultural resistance to adoption as a permanency option.[125]

Simple adoption exists in many jurisdictions and has been proposed in Australia since at least 1983. It is an additive rather than substitutive model.[126] This model allows adoptive parents to have full parental responsibility and to be recognised as legal parents to their adopted child, without removing the child's legal relatedness to their birth family.[127] Under simple adoption, the child legally simultaneously belongs in both the adoptive and birth families. Advocates suggest that the child loses nothing and gains a permanent legal family, while birth parents, where courts have already found that they are not willing and able to provide for the child's care and protection needs, lose nothing further. The child's original identity is preserved; an adoptive identity is added to it.

Simple adoption is available in a wide range of jurisdictions including France, Germany, Italy, Japan, Portugal, Romania, and many others. Australian authorities have had practical exposure to simple adoption through intercountry adoption programs with Ethiopia and Thailand, and the

[122] Submission No 732 to Child Safety Inquiry (7 March 2026).
[123] Submission No 549 to Child Safety Inquiry (5 December 2025).
[124] Jigsaw Queensland is a non-profit organisation that provides professional and peer support for those involved with adoption.
[125] Karleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 5-6; Jigsaw Australia, *Submission to Child Safety Commission of Inquiry* (25 March 2026) 3-4, 11.
[126] Karleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 5-6, 8.
[127] Ibid.

Queensland Adoption Act itself already contemplates the conversion of simple adoptions into plenary adoptions in sections 294 to 297, an implicit recognition that simple adoption is a legally cognisable form.

Simple adoption was first formally proposed for Australia in 1983, in the Report of the Adoption Legislative Review Committee in Victoria.[128] That Committee argued that the essence of adoption should be the establishment of the new family relationship for the child rather than the severance of previous relationships, and that this should allow for the social and legal relationship to continue between the child and the natural parent, with the natural parent continuing to be recognised as the child's birth parent.[129]

Professor Gribble's 2018 study: "Belonging in Two Families" was the first research in Australia to consider the views of people with experience of OOHC and adoption on legal frameworks for permanency. In that research, Professor Gribble canvassed the views of 1,019 participants, including foster and kinship carers, health and child welfare professionals, adoptive parents, prospective adoptive parents, adopted persons, and birth parents on four frameworks: long-term foster care, guardianship orders, plenary adoption, and simple adoption.[130]

The study found that while there were areas of significant disagreement between groups with different connections to OOHC and adoption, there was broad agreement on certain core considerations. Preservation of, or creation of, legal relatedness and identity were identified as important across all groups. The limited legal relationship between children and their caregiving family in long-term foster care and guardianship was commonly regarded negatively, but the preservation of legal relationship with birth family under those frameworks was valued. Conversely, the legal severance of children from birth family and removal of legal identity in plenary adoption were viewed as problematic, but the creation of an enduring legal membership in the adoptive family was regarded positively.[131]

Through this study, simple adoption was assessed overall as the most beneficial permanency option for children in OOHC. It addressed the deficiencies of all other frameworks simultaneously: it created an enduring legal membership in the caregiving family while preserving legal relatedness to the birth family, retained the child's original identity while adding an adoptive

[128] The report that led to the opening of adoption records in Australia.
[129] Ibid 8.
[130] Ibid 6.
[131] Ibid 7.

identity, and provided lifelong and intergenerational belonging that guardianship cannot offer.[132] Participants' responses to simple adoption were frequently strongly positive.[133] A birth parent of a child in care described it as providing the stability of a permanent placement while maintaining ties with the birth family.[134] The Commission accepts that there are good reasons for exploring the feasibility of simple adoption *as, 'No child should spend their childhood waiting to belong.'*[135]

2.4.4 Support for the introduction of integrated birth certificates (IBC)

Many children in OOHC are older children who have established and positive relationships with their birth family, including siblings and extended family. They may wish full belonging in the family caring for them, but they also want to remain a member of their family of origin to continue to be the child of their birth parents, the sibling of their birth siblings, the grandchild of their birth grandparents. Plenary adoption, which removes those legal relationships entirely, is not a framework that speaks to those children's experience of themselves or their relationships.[136] Birth parents are frequently unwilling to consent to adoption precisely because of the legal severance it entails. Many parents in the child safety system acknowledge, at least implicitly, that they cannot care for their child. What they resist is the finality of the legal excision and permanent removal of their status as the child's parent-in-law.[137] This unwillingness means that adoptions from OOHC almost invariably require consent, which is more difficult to obtain when perceived as akin to the forced adoptions of past practice. That association, though legally and ethically unfounded in the contemporary context, is a powerful inhibitor of action.

By the same measure, foster carers who have formed genuine parental bonds with children in their care are frequently reluctant to pursue adoption because they do not want those children to lose their legal membership of their birth family.

The ethical discomfort of practitioners and policy-makers with the permanent legal excision of a child from their birth family has been identified in research as one of the principal factors contributing to the unwillingness of child welfare professionals to consider adoption for children

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[132] Ibid.

[133] Ibid.

[134] Ibid 8.

[135] Submission No 329 to Child Safety Commission of Inquiry (24 March 2026).

[136] 'Adoption' *Australian Institute of Health and Welfare* (Web Page, 27 March 2026) <https://www.aihw.gov.au/reports-data/health-welfare-services/adoptions/overview>: The Australian Institute of Health and Welfare explicitly describes Australian adoption as "plenary open adoption" and defines it where the legal relationship between the child and their parent(s) are severed to create a new legal relationship with the adoptive family.

[137] Karleen Gribble, *Submission to Child Safety Commission of Inquiry* (5 November 2025) 5-6; Jigsaw Australia, *Submission to Child Safety Commission of Inquiry* (25 March 2026) 4-5.

in OOHC. As Professor Gribble noted, Tregeagle identified that the irrevocable severance of the relationship between a child and their birth family, traditionally perceived as the most profound connection of a person's life, underlies much of this reluctance.[138] The creation of a new birth certificate and invalidation of the original has been characterised in the literature as being in direct contrast to the openness of contemporary adoption work and as presenting an ethical barrier to adoption practice.

Jigsaw Queensland submitted to this Commission that IBC restores truth and completeness without altering legal parentage and recommended that Queensland adopt an IBC format (similar to that of New South Wales).[139] This was reiterated by other submissions noting that a person may have experienced an 'integration' of their families and their identity in practice and an IBC would help to formalise this legally.[140] In a submission from the Association for Adoptees, the introduction of IBC is supported. It was also recommended by the Community Affairs References Committee (February 2012) that all jurisdictions should adopt IBC.[141]

2.5 Implications for Reform

The evidence before the Commission demonstrates that adoption remains a legislated permanency option in Queensland but is not being operationalised in practice for children in OOHC. This has occurred despite repeated policy commitments, legislative amendments, and external recommendations intended to ensure that adoption is routinely and genuinely considered where reunification is no longer feasible.

A central implication of the Chapter's findings is the need to re-establish adoption as a legitimate permanency option that is actively and transparently considered as part of case planning. The evidence indicates that adoption is rarely discussed with parents, not meaningfully assessed in permanency planning, and absent from legal submissions seeking long-term guardianship orders. This has resulted in a situation where adoption exists in statute but is effectively unavailable in practice.

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[138] Ibid; Tregeagle et al, 'Are we adequately considering children's rights to a family?: The importance of open adoption to young people in long-term care' (2021) 31 *Developing Practice: The Child, Youth and Family Work Journal* 62.
[139] Jigsaw Queensland, *Submission to Child Safety Commission of Inquiry* (20 November 2025).
[140] Submission No 732 to Child Safety Commission of Inquiry (7 March 2026).
[141] Association for Adoptees, *Submission to Child Safety Commission of Inquiry* (25 November 2025); Community Affairs References Committee, *Commonwealth Contribution to Former Forced Adoption Policies and Practices* (February 2012).

Reform must therefore focus on ensuring that adoption is not treated as exceptional or inappropriate by default, but is properly evaluated where reunification is no longer viable, with clear reasons documented where it is not pursued. This does not require adoption to be the preferred outcome in all cases, but it does require that it be considered in accordance with legislative intent.

This Chapter highlights a clear misalignment between Queensland's current adoption framework and contemporary understandings of identity, openness, and relational permanence. Plenary adoption, as the sole form of adoption currently available under Queensland law, entails the permanent legal severance of a child's relationship with their birth family and the replacement of identity documentation. The evidence suggests that these features are a significant source of ethical discomfort for practitioners, resistance from birth parents, and hesitation from foster carers.

The implications for reform include the need to explore alternative legal models that better reflect contemporary practice, including simple open adoption and the introduction of integrated birth certificates. These reforms have the potential to preserve truth, identity, and connection to family of origin while still providing children with lifelong legal and relational belonging in their caregiving family.

The position of adoption within the permanency hierarchy for Aboriginal and Torres Strait Islander children raises particularly complex and sensitive issues. The evidence indicates a risk that adoption is functionally unavailable to Aboriginal and Torres Strait Islander children, regardless of individual circumstances, even where adoption may be culturally appropriate, supported by the child, or consistent with long-term wellbeing.

The Commission acknowledges that reform in this area will create concern and anxiety for certain individuals and groups in the State. However, when reform is anchored to the paramount principle under the CP Act, and requires a genuine evaluation of the best interests of the child (which will inevitably include consideration of the operation of the ATSICPP for Aboriginal and Torres Strait Islander children), stakeholders can be assured that history will not repeat. Fundamentally, this reform seeks to prevent permanency decisions being made in an environment of pre-determined assumptions that deny children access to lifelong permanency options without individualised assessment. There is a need for careful legislative and practice reform that centres the child's best interests.

The enduring impact of historical forced adoption practices, and the 2012 apology for those practices, has had a profound influence on adoption practice in Queensland. While the gravity of those historical wrongs is acknowledged, the evidence suggests that they have contributed to an institutional reticence that goes beyond what is required to ensure ethical and lawful practice in the present.

There is a need to support practitioners to clearly distinguish between past forced adoption practices and contemporary, rights-based adoption that is subject to judicial oversight and focused on the child's best interests. Without such clarity, there is a risk that historical harms will continue to foreclose consideration of adoption in circumstances where prolonged impermanence may itself be harmful to children.

Finally, the Chapter demonstrated that legislative amendments and policy statements alone have not been sufficient to change practice. Despite expressed statutory requirements to consider adoption, and repeated recommendations from inquiries and coronial findings, adoption has been ignored as a permanency outcome.

Clear practice guidance, accountability mechanisms, and appropriate oversight will be essential to ensure that adoption is neither defaulted to nor dismissed in permanency decision-making. Without operational clarity and leadership, there is a real risk that adoption will continue to exist only in law, leaving children to grow up in care without access to enduring legal and relational permanence.

2.6 Recommendations

Recommendation 39: Feasibility of simple adoption and ways to boost adoption	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 2)**

RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this report, commence a feasibility study to assess how the concept of simple adoption could be incorporated into the *Adoption Act 2009*.

Relevantly, the availability of adoption should not be limited by cultural background or ethnicity.

This feasibility study will include obtaining advice on:

(a) how best to introduce a framework to deliver 'simple open adoption' for appropriate children in Out-of-Home Care;
(b) how this framework can be best aligned with the *Child Protection Act 1999* and Department processes;
(c) how the framework can best permit suitably competent child to request or consent to their own adoption;
(d) the feasibility of introducing integrated birth certificates;
(e) the appropriate oversight and safeguards for the function; and
(f) any other appropriate changes to the *Adoption Act 2009*.

CONTEXT:

Contemporary adoption operates within a fundamentally different legal and ethical framework that past adopted practices, now characterised by openness, judicial oversight, and a focus on the child's best interests. Allowing historical wrongs to foreclose consideration of adoption entirely risks substituting one form or harm for another, and risks prolonged impermanence for children who cannot return home.

The Commission notes the strong submissions from First Nations stakeholders against adoption, however, considers it would be inappropriate to exclude one cohort of children in out-of-home care from this option.

Recommendation 40: Amend permanency hierarchy	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 2)**
RECOMMENDATION: That the Queensland Government, within 12 months of the Government's response to this report, amend section 5BA(4) of the *Child Protection Act 1999* to entrench adoption as the third permanency option for all children regardless of cultural background.	
CONTEXT: The position of adoption within the permanency hierarchy for Aboriginal and Torres Strait Islander children operates as a direct barrier to the Court ultimately granting adoption orders for Aboriginal and Torres Strait Islander children as a result. The evidence suggests that in practice, adoption is rarely if ever considered for Aboriginal and Torres Strait Islander children, even where it may be culturally appropriate, supported by the child and/or their parents, or consistent with the child's long-term wellbeing. Consequently, there is a risk that the current operation of the permanency hierarchy results in adoption being functionally unavailable to Aboriginal and Torres Strait Islander children and not assessed on an individual, child-centred basis. To ensure the CP Act is operationalised with the true intent of applying the paramount principle in s 5A without racial distinction, an amendment is required to s 5BA to allow for adoption to be considered as the third preference in the permanency principles for Aboriginal and Torres Strait Islander children as well as non-indigenous children. Without such an amendment, the place of adoption in the hierarchy for Aboriginal and Torres Strait Islander children de facto subordinates the paramount principle for Aboriginal and Torres Strait Islander children for whom adoption might best give effect to the paramount principle.	

Chapter 3

Corporate Parenting, Youth Justice and Community Safety

Companion Report 5

Corporate Parenting and the Youth Justice Interface

Chapter 3: Corporate Parenting, Youth Justice and Community Safety

3.1 Introduction

This chapter examines the Department's effectiveness as a corporate parent for children whose lives intersect with both the child safety system and the youth justice system,[142] commonly referred to as dual order youths.[143] It examines whether systemic failures within the child safety system have contributed to offending behaviour; how the Department responds when a child under its custody or guardianship has engaged in criminal conduct; and what the consequences are for both the child and the wider community when the State, as a corporate parent, falls short. This chapter draws on case studies of young people whose lives have intersected with both the child safety and youth justice systems.

It concludes that the pathway from State care to youth justice involvement reflects identifiable, recurring system failures: placement instability that disrupts attachment and trust; residential care environments that criminalise rather than contain behaviour; disability left undiagnosed until the point of detention; self-placing children driven to survival crime without financial support or sustained outreach; and emergency motel placements that expose already high-risk children to conditions directly associated with further offending. The transition from detention back to the community is a further critical point of failure that is routinely managed without adequate notice, without a plan, and without appropriate accommodation. Each of these failures, in isolation, increases a child's risk of offending. In combination, they make offending foreseeable.

It makes four recommendations directed to the points at which children are most likely to fall into crisis and, as a consequence, turn to crime: release from detention, unsafe emergency

[142] The conduct of inquiries into the matters dealt with in this chapter are supported by specific Terms of Reference whereby the Commissioner was directed to: 'evaluate the effectiveness of the Department as a corporate parent and whether it is able to meet community expectations around parenting [including by] investigat[ing], through case studies, children subject to dual Youth Justice and Child Protection Orders' (TOR 3(d)(i)); and, relatedly 'determine the failures of policy, process and practice that contributed to these children choosing a life of crime' (TOR 3(d)(i)); and make feasible and appropriate recommendations on, 'new models of care ensuring children are provided an opportunity for intervention and rehabilitation and that escalating risk or behaviours are managed in line with community safety expectations' (TOR 5(e)); and 'any reforms to ensure that Queensland's child protection system achieves the best possible outcomes to protect children and support families' (TOR 5(f)).
[143] These terms are defined in section 2 below.

placements, sexual exploitation risk, and the absence of institutional accountability when care fails with serious consequences for community safety.

Before continuing, it is important to say that the Commission vociferously rejects any global and deeply misconceived perception that children in care are 'hard cases' with a predetermined propensity towards offending. Quite the opposite, they are children and young people no different to other children; they might just as likely as anyone's children, save they find themselves placed by fate and circumstance in an environment over which they had no say. They are 'vulnerable' in the legal sense, as vulnerability is commonly understood, to the decisions and actions of all those who make decisions for them and on their behalf.

3.2 Corporate parenting in a youth justice context

As explained previously corporate parenting describes the role the State assumes when it removes a child from their family and takes on legal responsibility for their care and upbringing. In that moment, the State steps into the position of a parent, acquiring not merely legal custody but a profound obligation to promote the child's safety, wellbeing, and successful transition to adulthood.[144] The State is, by its nature, an institution. It acts through a constantly shifting cast of under-resourced frontline staff, team leaders, managers, carers, and contracted service providers, operating through the prisms of policy, procedure, statutory timelines, and bureaucratic hierarchies that have no equivalent in family life. Understanding those structural limitations is essential to any honest assessment of where the system has fallen short.

The challenge to the State in discharging corporate parenting obligations intensifies when a child in care also becomes subject to the youth justice system. At that point, the child falls simultaneously within the purview of two distinct statutory systems, child protection and youth justice, each with its own legislative framework, institutional culture, funding streams, and objectives. The child safety system is oriented toward protection from harm and the promotion of the child's best interests.[145] The youth justice system is oriented toward child accountability and community protection.[146] A further cast of actors is introduced including police, courts, and detention centre staff, who do not carry the holistic parental perspective the corporate parent is

[144] The concept of the State as 'corporate parent' is examined in the Executive Report in the context of the paramount principle. This chapter focuses on the State as corporate parent in the narrow sense — that is, in its direct relationship to a child in its care.
[145] See CP Act s 4 and 5A
[146] See *Youth Justice Act 1992* (Qld), Sch 1; Charter of juvenile justice principles, principle 1, 2 and 10(a).

meant to embody. Information does not always flow freely between these actors and the Department, despite the best intentions of all involved.

The Carmody Inquiry did not examine the youth justice interface with child safety in detail but identified systemic conditions that remain directly relevant: agency silos and fragmentation within the child protection system;[147] inadequate information sharing between agencies making decisions about children;[148] the need for greater collaboration to meet the needs of vulnerable children and families;[149] and an over-reliance on complex legal processes that were not resulting in children's best interests being met.[150]

3.3 The dual order cohort

A dual order youth is a child or young person who is the subject of a youth justice supervision order (YJO)[151] and an active child protection order at the same time. On any given day, dual order youth comprise between approximately 24% and 28% of Queensland's total youth justice client load.[152] That figure rises to 72.9% when expanded to include all young people under youth justice supervision who had prior contact with the child safety system in the preceding ten years,[153] representing the highest number nationally and the second highest proportion of any Australian jurisdiction.[154]

The younger a child is when they first come under youth justice supervision, the more likely they are to have prior child safety involvement. Of those whose youth justice supervision commenced at age 10, almost all (89.9%) had an interaction with the child safety system in the preceding decade.[155] As at September 2024, there were 388 serious repeat offenders aged 10 to 17 in

[147] Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 57-58.
[148] Ibid 486-488.
[149] Ibid 327-330.
[150] Ibid 483-485.
[151] This term encompasses both community-based supervision and youth detention.
[152] Proactive Statement of Kate Connors (1 September 2025) [14]; See also Transcript, Evidence of Michael Drane (23 February 2026) 4442:32-38 where he notes this figure can be as high as 30%.
[153] Queensland Family & Child Commission, Crossover Cohort: Young People under youth justice supervision and their interactions with the child protection system (Fact Sheet, November 2024) 2 ('Crossover Cohort Report').
[154] This figure is accurate in respect of young people under youth justice supervision during 2022-2023 who had an interaction with the child protection system (including investigated notifications, care and protection orders and/or OOHC) in the 10 years from 1 July 2013 to 30 June 2023: Australian Institute of Health and Welfare, *Young People under Youth Justice Supervision and Their Interaction with the Child Protection System 2022–23* (Catalogue No CSI 030, Australian Government, 2024) page 20, Supplementary Table S2.
[155] Australian Institute of Health and Welfare, *Young People under Youth Justice Supervision and Their Interaction with the Child Protection System 2022–23* (Catalogue No CSI 030, Australian Government, 2024) <https://www.aihw.gov.au/reports/youth-justice/young-people-youth-justice-supervision-2022-23/data>.

Queensland, of whom 111 were subject to a child protection order.[156] Serious repeat youth offenders account for 55% of all youth crime.[157]

The following table, drawn from the Department's 2024 Child in Care Census, demonstrates the stark demographic differences between children in care generally and those who are dual order:

2024 Child in Care Census — criteria for children in care who:	Children without a youth justice order	Children with a youth justice order
Have limited to severely limited intellectual functioning or developmental delay	31%	**61%**
Have been excluded from an education facility currently or in the past	25%	**72%**
Have experienced failed reunification	27%	**49%**
Have experienced placement instability with four or more placements	37%	**77%**
Have self-placed at least once (aged 10 years and over)	29%	**91%**
Have been in care for more than five years in total	48%	67%
Have attempted suicide	11%	**40%**

The data is unambiguous. Dual order youth are at least twice as likely as other children in care to experience the most significant negative system impacts across every indicator. Acting Director General Michael Drane (Mr Drane), Department of Youth Justice and Victim Safety (DYJVS)[158] described the offending of the dual order cohort as extremely visible comprising predominantly car theft, unlawful use of motor vehicles, and break and enters, with some young people filming

[156] Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence, 'Queensland's most serious young criminals housed in Labor's broken State care system' (Media Statement), 19 May 2025.
[157] Ibid.
[158] A witness statement of Mr Drane dated 12 February 2026 was tendered: Exh. #CL-90. Mr Drane also adopted the witness statement of Kate Connors, former Director General of Youth Justice and Victim Support dated 1 September 2025c: Exh #CL-91.

and uploading their offending to social media, compounding community alarm.[159] He confirmed an increase in violent offending over the last decade, both in the community and within youth detention, and identified increased methamphetamine and ice use, together with cognitive impairments and neurodisabilities, as significant contributors.[160]

These figures underscore the gravity of ensuring that effective measures within the child safety system address the needs of this cohort at the earliest point. The QFCC, in its systems advocacy and oversight role, has published data insights identifying stability and security as essential to preventing children from entering the youth justice system.[161] Those insights are consistent with the evidence before this Commission.

3.3.1 Case Studies: Witness S and YP

The case studies of Witness S and YP, set out in the boxes below, illustrate the systemic failures examined in this chapter. Long-form accounts of each are at Appendix B. The Commission draws on both throughout the analysis that follows.

Case Study: Witness S

Witness S gave evidence at the Toowoomba public hearings. Now in her twenties, she described a childhood in which the child safety system rendered her homeless, exposed her to sexual exploitation within and outside the care system, and then criminalised the survival behaviour that followed. The Department did not dispute her account.

Self-placing from age 12

- Witness S was effectively homeless from age 12, after leaving a kinship placement in which she was being physically abused and returned to a parent who had sexually abused her.
- She began couch-surfing and then lived at a bus shelter directly opposite a Child Safety Service Centre (CSSC). She attended the CSSC to charge her phone and ask for a placement.
- The CSSC response was to call the police, treating her as a trespasser for being in the building after 5pm. On at least one occasion, she slept in a skip bin for warmth.
- At 15, Child Safety assessed Witness S as **'at risk of harm due to her own deceitful and transient behaviour'** and capable of self-protecting, despite simultaneously acknowledging her family's extensive child protection history spanning nearly a decade.
- Because Witness S was subject to a child protection order (CPO), she was deemed to have a guardian **willing and able to provide a safe placement**, making her ineligible for funded

[159] Transcript, Evidence of Michael Drane (23 February 2026) 4451-4452.
[160] Ibid 4461-4462.
[161] Queensland Family and Child Commission, *Annual Report 2024–25* (2025) 13; Crossover cohort report (n 150).

homelessness services. In practice, the CPO that was supposed to protect her instead barred her from the safety nets available to other homeless young people.

• Self-placing created the conditions in which Witness S encountered those who would exploit her. As she herself observed: homelessness was the single greatest risk factor for her exposure to sexual exploitation and criminal networks.

Sexual exploitation within and outside the care system

• **Within residential care:** Witness S was sexually abused by a youth worker at a licensed residential care placement, who required sexual acts in exchange for driving her to appointments, including youth justice appointments. Witness S later made a successful application to the National Redress Scheme against this worker, who had abused multiple young people across several providers.

• There was no mechanism for information sharing between residential care providers, Blue Card Services, the National Redress Scheme, or the Department. This allowed the perpetrator to remain employed in the sector despite disciplinary findings, a situation Witness S described as **'deplorable'**.

• **Outside residential care:** Witness S's search for love and connection led her to form relationships with older men who exploited her sexually and for criminal purposes. They introduced her to methamphetamine by injection, which she interpreted as an act of care and intimacy.

• These men provided methamphetamine in exchange for sex, and ultimately sent Witness S to a local motel to be sexually exploited by strangers, from which she earned money for basic grocery items that her placement did not provide.

• **Institutional response:** When Witness S called the residential care service to collect her from the motel, the request was refused on the basis that doing so would amount to **'enabling child prostitution'** — even if she walked to the nearest CSSC for collection.

• Queensland Police Service (QPS) were aware of what was occurring at the motel and had informed the Department. On the available evidence, no meaningful intervention was attempted by any agency to support Witness S or address the exploitation.

Criminalisation of survival behaviour

• Witness S's entry into the youth justice system was a direct product of homelessness and unmet basic need. She described her early offending as **'survival crimes'**: stealing food, shoes, a first bra, and colouring pencils to relieve boredom at the bus shelter.

• She was charged multiple times with **trespass** for sleeping in locked public toilets and fire escape stairwells.

• She was charged with **possession of methamphetamine** after a residential care manager persuaded her to hand over her drugs, then took them to police and named her as the owner.

• She was charged with **armed robbery in company** following a physical altercation with another resident over her own stolen shoes.

• She was charged with **assault** after throwing a plastic cup of water at a security screen behind which a youth worker was standing.

• Witness S pleaded guilty to every charge. She said this was because **no-one had ever told her she was allowed to plead not guilty**.

• On multiple occasions, Child Safety closed her placements — sometimes directly placing her **in breach of her bail conditions**.

Case Study: YP

YP, an Aboriginal male, entered the child safety system at age 2½. Over the following 15½ years, under the custody and then guardianship of the State, he cycled through 22 foster carers, 3 kinship placements, 6 residential care placements, 1 motel placement, 778 days of self-placing, 30 days in a police watch house across 14 admissions, and 425 days in youth detention across 6 admissions. He aged out of the child safety system while on remand.

Placement instability and the failure of permanency

• By age 9, YP had cycled through 20 different foster carers. This was caused primarily by extensive use of respite carers and multiple primary placement breakdowns, including because carers were unable to manage his behaviour

• A Child Strengths and Needs Assessment at age 10 recorded a diagnosis of Reactive Attachment Disorder (RAD) and identified YP's acute need for placement permanency and stability, noting his difficulties coping with grief and loss arising from repeated placement breakdowns.

• YP's twentieth placement provided 3½ years of relative stability. During this time, an LTG-CE order was finally made — close to a decade after he entered care. The delay appears to reflect Child Safety's prolonged pursuit of reunification with his mother as the primary permanency goal, notwithstanding her failure to address substance misuse, housing instability, and lack of contact with YP.

• Despite YP having been in a stable placement for 2½ years at the time the LTG-CE order was made, there is no evidence that his foster carers were assessed for suitability as long-term guardians. At 13, YP was described in case notes as 'stable', expressing that he felt loved by his foster family and was 'curious' about the possibility of an LTG-O order to them. This desire was minimised by the Department and not explored.

• When YP was 13, a harm report was recorded in respect of the foster household. None of the notified concerns directly related to YP. YP was removed from his long-term carers under s 89 of the CP Act. The investigation found insufficient evidence that YP had suffered harm, and that the legislated standards of care had been met in respect of him at all relevant times.

• Despite the harm report being unsubstantiated as to YP, there is no record of any risk assessment being conducted as to whether he should be returned to his long-term carers, nor any evidence of discussions with YP about his removal, the outcome of the process, or what support would be provided, a significant omission given his RAD diagnosis and history of placement-related trauma.

• The primary kinship placement that followed lasted 141 days before breaking down. From that point, YP never returned to a family-based foster care placement. The loss of his long-term foster placement at age 13½ appears to have been a critical turning point in his trajectory.

Self-placing, unmet need and the escalation of offending

• YP's first contact with police, a caution for public nuisance, occurred at age 14, one day into his first period of self-placing following the kinship placement breakdown. Within a month he was charged with 12 counts of wilful damage. From age 14 onwards, the vast majority of his offending occurred during periods of self-placing.

• During periods of self-placing, YP typically stayed with extended family or kin, aunts in particular, or with community members. He was repeatedly bailed to addresses not formally assessed or approved as kinship placements. The Department's after-hours responses frequently amounted to little more than acknowledging there were no available placements.

• Financial support from the Department during periods of self-placing was minimal. A prescribed 'home visit' to his self-placing address recorded that YP was given a $50 Woolworths voucher and a sports equipment voucher. His request for clothes was deferred for approval because he had received clothes the previous month.

• A Child Strengths and Needs Assessment prepared when YP was 15 recorded: substance abuse to the point of hospitalisation (including chroming); declining mental health and emotional instability; disengagement from education; criminal activity including stealing food and essential items; and an extended family that no longer wished to have him reside with them. Despite this, Child Safety assessed his 'family connection' as a strength and identified 'significant resilience and coping skills'.

• After his first detention centre stay (53 days, age 15), YP was released to a commercial motel placement. QPS records showed he was offending, committing burglaries and stealing, during this period.

• YP's offending escalated from public nuisance and theft of essential items to wilful damage, trespass, robbery with violence causing harm to an elderly semi-disabled man, unlawful use of motor vehicles, and burglaries. On at least one occasion he slept in a police station foyer. He attended hospital voluntarily on one occasion because he had been 'trying to jump in front of cars'.

• Whilst in a Department-approved kinship care placement at approximately age 17, YP engaged in criminal conduct with others that had tragic consequences for a vulnerable member of the community. He was remanded and spent 499 days in pre-sentence detention, turning 18 in custody and aging out of the child protection system. No conviction was ultimately recorded; a reprimand only was issued.

3.4 Systemic pathways from care to youth justice

The entry of children in care into the youth justice system is not random. The evidence before the Commission identifies a set of systemic conditions recurring, identifiable, and in most cases amenable to reform that create and sustain the dual order and cross-over cohorts. Each is examined in turn.

3.4.1 Placement instability and permanency failure

Placement stability is one of the strongest and most consistent predictors of youth justice involvement for children in OOHC[162]. Children who experience multiple placement moves, short-term emergency arrangements, frequent changes in carers, schools, and caseworkers, or placement breakdowns triggered by trauma behaviour, are significantly more likely to enter the youth justice system than those in stable, enduring placements. The mechanism is well understood: instability disrupts attachment and trust; each placement move reinforces feelings of rejection, abandonment, and lack of safety; and children in unstable placements are more likely to be placed in residential care, where the conditions for criminalisation of behaviour are well-documented.

The Commission consistently heard that the consistent presence of one stable adult relationship was a critical protective factor. As the QFCC has noted, children who experience authentic relationships and feel their carers are genuinely concerned for their wellbeing are less likely to leave a placement.[163] Mr Drane expressed the same view: '*one of the greatest protective factors for a young person is a positive adult or a positive rapport relationship with a caregiver in their life*.'[164] Rachael Ham of Wuchoppheren Health Service identified what young people most need in the context of youth offending: '*loving environments, definitely; stability for young people*.'[165] The corporate parent's challenge is to create and sustain those conditions for a child whose family and care history may have made them deeply distrustful of the adults and institutions that are supposed to care for them.

A particular source of placement instability is the extended pursuit of reunification as the primary permanency goal, even where a parent has not addressed (or sufficiently addressed) the identified child protection concerns. This delays the making of long-term orders, deprives children of relational security, and prolongs uncertainty during which multiple short-term placements may occur.

YP's case illustrates this directly. He cycled through 20 foster carers by age 9, suffering multiple placement breakdowns. A Child Strengths and Needs Assessment at age 10 recorded a diagnosis

[162] Emma Colvin, Alison Gerard and Andrew McGrath, *Children in Out-of-Home Care and the Criminal Justice System: A Mixed-Method Study* (Report to the Criminology Research Advisory Council, CRG 22/16–17, Australian Institute of Criminology, September 2020) 3.
[163] Queensland Family and Child Commission, *Absent from Care* (Insights Paper, May 2024) 8.
[164] Transcript, Evidence of Michael Drane (23 February 2026) 4457:9-12.
[165] Transcript, Evidence of Rachael Ham (18 September 2025) 1138:5-6.

of Reactive Attachment Disorder and identified his acute need for permanency and stability. It was not until close to a decade after entry to care that a long-term guardianship order to the Chief Executive was made, a delay that appears to reflect the Department's prolonged pursuit of reunification with his mother, notwithstanding her failure to address substance misuse, housing instability, and absence of contact with YP. At the time that order was made, YP had been in a stable placement for 2½ years. There is no evidence his foster carers were assessed as potential long-term guardians. When a harm report was subsequently recorded against them, that was ultimately unsubstantiated, he was removed. Following a short-lived kin care placement, he cycled for years between NFBC, self-placing, watch houses and youth detention.

3.4.2 Residential care and the criminalisation of behaviour

Previous inquiries, in Queensland and across Australian and comparable jurisdictions, have consistently identified residential care as a major driver of dual order and cross-over cohort formation, independent of the child's behaviour.[166] The predominant pattern is that children in residential care are criminalised through police call-outs for behaviour that would, in a family home, be managed by parents without police involvement; for example, verbal aggression, property damage under $500, pushing, shoving, emotional dysregulation linked to trauma, conflict with peers, or refusal to comply with house rules.

Thomas Allsop, former Chief Executive Officer of PeakCare, identified a "stark and wide gap" between the training required and the time allocated to training for residential youth workers compared to the complexity of what was expected of them.[167] He noted the absence in Queensland of a trauma-informed therapeutic model capable of de-escalating heightened behaviour,[168] and observed that current training does not go to that level of detail and that a significant gap needs to be addressed.[169] Witness D, a former residential care support worker, gave evidence that: "the training's not adequate for all situations... for high risk kids... there needs to be a lot more training provided on youth worker responses."[170]

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[166] Sentencing Advisory Council (Vic), '*Crossover Kids: Vulnerable Children in the Youth Justice System*' (*Crossoveer Kids* series comprising Reports 1-3, 2019-2020); Commission for Children and Young People (Vic), *Out of Sight: Systemic Inquiry into Children and Young People Who Are Absent or Missing from Residential Care* (2021); NSW Ombudsman. (2020). Criminalisation of children living in residential care in NSW. Sydney: NSW Ombudsman; Victorian Ombudsman. (2021). Investigation into the criminalisation of children in residential care. Melbourne: Victorian Ombudsman.
[167] Transcript, Evidence of Thomas Allsop (15 September 2025) 837.
[168] Transcript, Evidence of Thomas Allsop (15 September 2025) 827.
[169] Ibid 831.
[170] Transcript, Evidence of Witness D (23 February 2026) 1305-1306.

Luke Twyford, Principal Commissioner of the Queensland Family and Child Commission told the Commission:

> It is all too common for children with backgrounds and circumstances that lead them to be in residential care that they will become involved in anti-social, defiant and criminal behaviour. Trauma is communicated through behaviour. A child with a trauma background who does not receive appropriate interventions in childhood is likely to exit the care system as an angry, confused young adult who has negative experiences at school, with adults and among peers. This behaviour is frequently associated with mental health problems, addictions, and actions that puts [sic] the safety of themselves and others at risk, including inappropriate sexual behaviours and/or involvement in criminal activities.[171]

Detective Inspector Renee Garske (DI Garske), Officer in Charge of the Child Protection Investigation Unit in Toowoomba,[172] provided data showing 228 calls for service to residential care facilities in the Darling Downs District between 1 July and 30 September 2025, the majority outside business hours.[173] She observed that if children in residential care were in a family home, many of these calls would not have been made, and that once police are involved, their rules and obligations largely govern the response rather than the interests of the child.[174] DI Garske recommended a 24/7 child safety response capacity, capable of attending on the ground where issues arise, as a means of avoiding unnecessary police involvement and the consequent criminalisation of children in care.

The Inquest into the death of Master Bailey Ezekiel Pini found that a 63-year-old residential care worker was the sole carer on duty from late on 8 June through to the morning of 9 June 2021, required to manage two teenagers who were "quite out of control."[175] The Coroner found it "should not be the case that the system is stretched to the point that one 63-year-old woman becomes the last bastion between the residents and care keys."[176] That finding speaks directly to the structural inadequacy of residential care as currently resourced and configured, and to the foreseeable consequences of that inadequacy for the children placed there.

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[171] Statement of Luke Twyford (28 November 2025) [3.72].
[172] Transcript, Evidence of Renee Garske (23 February 2026) 4501. DI Garske has a 20-year career in child protection and at the time of giving evidence held oversight of youth crime within the local district.
[173] Statement of Renee Garske (4 February 2026) [18]; Transcript, Evidence of Renee Garske (23 February 2026) 4505:23-27.
[174] Transcript, Evidence of Renee Garske (23 February 2026) 4507-4508.
[175] Inquest into the death of Master Bailey Ezekiel PINI, Coroners Court Queensland (30 June 2022) [79], [94]-[96].
[176] Ibid [112].

3.4.3 Disability, unmet needs and late diagnosis

Neurodevelopmental disability is one of the strongest predictors of a child in care entering the dual order or cross-over cohort. The most common disabilities among this group include Foetal Alcohol Spectrum Disorder, ADHD, Autism Spectrum Disorder, intellectual disability, language disorders, acquired brain injury, and complex trauma-related neurocognitive impairment. Kate Connors (Ms Connors), former Director General of DYJVS, referred to a growing evidence base regarding the extent and impact of cognitive impairment, intellectual and developmental disability, neurodisability, and mental illness for dual order youth.[177] As the census data at section 2 above shows, 61% of dual order youth have limited to severely limited intellectual functioning or developmental delay, almost twice the rate for other children in care.

Mr Drane's evidence was stark: in many cases, the first time a dual order youth with a typical disability profile receives a comprehensive health assessment, diagnosis, treatment, and support services is upon entering youth detention, at an average age of approximately 16. He described this as “a sad indictment” and accepted that assessment at that age was, in many cases, too late to materially alter the trajectory for future offending.[178] He identified the critical intervention point as being earlier, when underlying issues first become apparent to primary service systems such as education or emergency departments.

Ms Connors submitted evidence that dual order youth with neurodevelopmental issues present a complex cohort for engagement with Youth Justice; that young people found unfit to plead continue to appear before courts for new offences without suitable forensic and therapeutic supervision options;[179] and that in Far North Queensland, a very high-risk youth had presented challenges that neither Youth Justice nor Child Safety had the framework or facilities to manage. She expressed the view that a secure care model for youth with cognitive disability involved in both systems “would be helpful”.[180]

The absence of secure care and of a sufficiently diverse placement mix to respond to the most complex and high-risk children in care, leaves the State without the tools necessary to discharge its obligations as a corporate parent. A natural parent confronted with a child in crisis retains the ability to intervene directly and immediately. The corporate parent, constrained by what the

[177] The study cited by Ms Connors was conducted in Victoria from 2016 to 2018.
[178] Transcript, Evidence of Michael Drane (23 February 2026) 4448-4450.
[179] Proactive Statement of Kate Connors (1 September 2025) [43].
[180] Proactive Statement of Kate Connors (1 September 2025) [43].

system makes available, may find itself able only to observe the escalation of harm, to the child and to others, without the means to interrupt it. That is what appears to have occurred in YP's case. The issue of secure care is examined in the companion report.[181]

3.4.4 Self-placing: from missing child to survival crime

When a child disengages from their placement and begins self-placing, the corporate parent's practical capacity to discharge its obligations is severely diminished. Financial supports that flow through an authorised placement are interrupted. The child may be bailed by police to addresses they do not attend. Outreach is limited and sporadic. Unlike a natural parent, the corporate parent has no instinctive mechanism for locating or reconnecting with a child who has withdrawn.

3.4.4.1 Scale

In July 2025, media reported that 780 children were missing from their care placements. The Government ordered a census of children in OOHC for 28 July 2025. The results, obtained by the Commission,[182] revealed the following:

Self-placing audit criteria	Measurement
Children who do not have a current placement open	594 children
Children who have never had a placement open	42 children
Youngest child with no current placement open	8 years old
Children whose location or address is unknown	93 children
Youngest child with no placement	8 years old

[181] The issue of secure care is examined in Companion Report 3.
[182] These results were provided pursuant to Notice to Produce 28. There is a slight discrepancy in the number of missing children provided via this notice and the number reported via media statement. The reason for such is not known to the Commission.

Of those 780 children, 81 were subject to a youth justice order, 51 were on bail, and 144 had some other form of youth justice involvement.[183] The youngest child with no current placement open was eight years old.

3.4.4.2 Why children self-place

Children self-place for a range of reasons: they do not feel connection or belonging in their placement and seek this from friends and family;[184] they have been told no placement is available;[185] a previous placement has closed during an extended absence;[186] they have not been involved in transition or case planning;[187] they are subject to pressure or coercion from family members or friends; they have been groomed into self-placement by those seeking to exploit them;[188] or they are escaping unsafe conditions in their existing placement.[189] Some children self-place in environments "where they have access to substance[s] and very concerning situations,"[190] and may "engage in crime as a way to connect with others."[191] Mr Drane accepted that self-placement is sometimes driven by a young person seeking safety, despite it frequently leading to worse outcomes.[192]

3.4.4.3 Links to offending and exploitation

The QFCC has reported that young people who are absent from care "are at significant risk of exploitation" and that young people who leave their placements "can become involved in property crime or selling sex or drugs to get cash or a place to stay."[193] Ms Connors accepted that when children self-place and begin couch-surfing or sleeping rough, "the risks of harm and of offending escalate exponentially."[194]

The connection between self-placing and youth offending is, on the evidence, a foreseeable consequence of a system that, having failed to provide nurturing care, then failed to locate,

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[183] Minister for Families, Seniors and Disability Services and Minister for Child Safety and the Prevention of Domestic and Family Violence, 'Crisafulli Government acts following Census on missing kids in care' (media statement), 8 September 2025.
[184] Submission No 48 to Child Safety Commission of Inquiry (via phone interview 18 August 2025).
[185] Ibid.
[186] Ibid.
[187] Submission No 804 to Child Safety Commission of Inquiry (29 March 2026 and 4 June 2026) 219.
[188] Submission No 855 to Child Safety Commission of Inquiry (30 March 2026) p 35; Witness D, 'Outline of Evidence' (Document prepared for Inquiry into Child Safety Queensland, 22 August 2025) [24].
[189] Submission 819 to Child Safety Commission of Inquiry (29 March 2026) 4.
[190] Transcript, Evidence of Corinne Porta (20 November 2025) 2419:12-4.
[191] Transcript, Evidence of Witness K (10 September 2025) 376:5-7.
[192] Transcript, Evidence of Michael Drane (23 February 2026) 4466:43.
[193] Queensland Family and Child Commission, *Absent from Care* (Insights Paper, May 2024) 8.
[194] Statement of Kate Connors (1 September 2025) [48].

support, or financially sustain the child left to fend for themselves. Witness S's evidence illustrates the point directly: "I was criminalised for the State's failure to intervene and provide me with a safe placement with access to food and basic amenities."[195] Both Witness S and YP committed survival crimes; for example, stealing food and essential items and both went on to engage in offending of escalating seriousness.

Children in OOHC are particularly vulnerable to exploitation during periods of self-placing. As Project Paradigm submitted, the relational aspect of child exploitation is a major driver of the overrepresentation of children in OOHC experiencing this form of abuse, yet their actions are:

> ...inappropriately attributed to the motivation of the young people themselves, as though they are simply making 'poor choices', often labelled as 'risk-taking behaviours', when in actual fact there are sophisticated power and control dynamics of coercive control created by the adults who are exploiting them.[196]

The Commission heard that the Department does not conduct any system-wide analysis of how to reduce the risk of children in care becoming victims of criminal offences;[197] each region takes its own approach;[198] and there is no ongoing monitoring of outcomes or assessment of the effectiveness of action taken.[199]

[195] Transcript, Evidence of Witness S (16 February 2026) 4124:2-4124:4.
[196] See Project Paradigm submission addendum, 4 March 2026, page 3.
[197] Statement of Deborah Hall (11 November 2025) [22].
[198] Ibid.
[199] Ibid [29]-[30].

3.4.4.4 Locating missing children

Remembering Tiahleigh Palmer – absence from care as a system responsibility

The disappearance and death of Tiahleigh Palmer in 2015 remains a stark reminder of the consequences when children who are missing are not responded to with urgency, coordination and shared responsibility. Tiahleigh was a 12-year-old child living under a child protection order who did not arrive at school and was later found deceased after several days missing.

Following Tiahleigh's death, the QFCC undertook a whole-of-government systems review, *When a child is missing – Remembering Tiahleigh*. The review concluded that while no single individual failure explained what occurred, systemic issues, including fragmented responsibility, inconsistent information sharing and the framing of absence as a behavioural issue rather than a safety concern, impeded an effective response.

A central finding of the review was the need to change how the system understands and responds to children absent from care. The QFCC emphasised that children who are missing or absent from their placement have not absconded or self-placed in a way that diminishes State responsibility. They are children whose safety requires urgent, coordinated action across agencies.

The Commission includes this case not to revisit tragedy, but to underscore a critical lesson, a child who is not at their placement and their location is not known is a child safety issue, not a compliance issue. Where responses are delayed, responsibility is diffused or absence is normalised, the risks to children escalate rapidly. Remembering Tiahleigh requires sustained attention to the systems, cultures and decision-making frameworks that determine how children absent from care are seen, prioritised and protected.

The absence from placement is a child safety issue, not a compliance issue. The Commission's examination of YP's circumstances confirms this. The Acting Chief Practitioner acknowledged that attempts to locate him were sporadic;[200] that enduring attempts to locate him were not made;[201] that the Department's involvement was frequently reactive, triggered by arrests, school

[200] See Statement of Victorian Van Houdt (13 March 2026) [67].
[201] Ibid [67].

suspensions, or court appearances rather than proactive;[202] and that only one missing person report was recorded across the entire relevant period, contrary to procedural requirements.[203]

Mr Drane recommended a more intensive model of contact and outreach supervision for self-placing children, including assertive efforts to re-engage young people in suitable placements.[204] He identified a gap in Child Safety's after-hours operational response capacity and proposed the Youth Justice/QPS youth co-responder model involving proactive, joint practitioner responses to problematic behaviour outside business hours, as a useful analogy for a similar capability to be developed in the child protection context.[205]

3.4.4.5 Financial support

Financial support from the Department during periods of self-placing is, in practice, minimal. Foster care and residential care allowances flow through an authorised placement and cease when a child self-places.[206] The only alternative mechanisms are discretionary departmental assistance and Centrelink youth allowance,[207] however, the latter has an age threshold (in addition to the practical difficulties and requirements of the application itself, for example identification) that many self-placing children do not meet. The Commission's examination of YP's case showed that during periods of self-placing, a prescribed home visit resulted in a $50 Woolworths voucher and a sports equipment voucher; his request for clothes was deferred for approval because he had received clothes the previous month. The predictable consequence was that a child below Centrelink age, in State care, with no financial means while self-placing, faces a survival-driven imperative to offend.

3.4.5 Motel and emergency placements

In the absence of appropriate regulated placements, the Department has developed a practice of using commercial hotels, motels, and caravan parks to house children in care. It relies on s 82(f) of the CP Act to authorise this practice. The legislative intent behind that provision is narrow: introduced in 2005, it was designed to enable placement in a facility regulated by another government agency where a child's particular needs related, for example, to disability or medical

[202] Ibid [66].
[203] Ibid [68].
204Transcript, Evidence of Michael Drane (23 February 2026) 4461 and 4466-4467.
[205] Ibid 4478-4479.
[206] Statement of Bernadette Harvey 27 March 2026 paragraph 52-53.
[207] Child Safety Procedure 'Child Related Costs – Child and Young Person Support 645.4-2 (COI.0001.0001.0256).

condition, could not be met by the range of care options approved by the Chief Executive.[208] The explanatory notes expressly provided that the provision was "not intended to be used as a means of circumventing the regulatory framework for approval of carers."

Despite that clear legislative intent, the Department treats commercial motel-style accommodation as a default emergency option. The Department's own policy position is that emergent accommodation is to be used only "where there is the unforeseen need for a care arrangement for a child or young person, or where an existing care arrangement has ended unexpectedly, and no other care arrangement option is immediately available."[209]

Data obtained by the Commission from the South West region for the period 1 July 2024 to 6 February 2026[210] revealed 48 children entering care initially placed in emergency placements; 7 placed in emergency placements following discharge from hospital; and 17 placed in emergency placements upon release from watch houses or youth detention centres. These placements included caravan parks, hotels, motels, Airbnbs, and community-based emergency accommodation services.

Motel placements are manifestly ill-equipped to manage high-risk children. They are characterised by isolation, lack of supervision, limited access to support services, and the absence of the relational care that children require. The risks this creates are not theoretical. In one instance, a 15-year-old female child placed in emergency accommodation threatened a youth worker with a knife, jumped on her CSO's vehicle to prevent the CSO leaving, and attempted to jump from a second-storey balcony before police and ambulance were called.[211]

YP's case illustrates the direct link between motel placement and re-offending. After his first detention centre stay of 53 days at age 15, he was released to a commercial motel placement. QPS records show that during this stay he was committing burglaries and stealing.

The Commission considers that the use of motels as emergency accommodation reflects a failure of system capacity and planning, not a safe or appropriate care response. Their use must be an exception, not the rule, and must be eliminated entirely for youth exiting detention in any circumstances.[212]

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[208] Explanatory Notes, *Child Safety Legislation Amendment Bill* 2005 s 20.
[209] Statement of Victoria Van Houdt (20 February 2025) [5].
[210] Notice to Produce 296 issued to the Department on 6 February 2026.
[211] Department of Families, Seniors, Disability Services and Child Safety, Email Correspondence from Residential Provider (12 December 2025) (DFS.0296.0001.2002).
[212] Transcript, Evidence of Michael Drane (23 February 2026) 4457:21-26.

3.4.6 Transition from detention to community

The transition from detention back to the community is a critical risk point for dual order youth.[213] Youth detention mitigates many extrinsic risk factors including drug use, alcohol, negative peer associations which re-emerge upon release into an environment that may involve dysfunction, absence of established relationships, and other destabilising factors.

Approximately 90% of young people in youth detention on any given day are held on remand rather than serving a sentence. Bail applications can arise without notice, creating pressure for urgent placement arrangements. Amendments to the *Youth Justice Act 1992* (QLD) prevent a court from refusing bail solely on the basis of a lack of accommodation.[214] However, the lack of a stable placement remains a material factor in courts' assessment of re-offending risk, meaning that the absence of appropriate placements can in practice lead to further periods of remand in custody.[215] Conversely, once a young person is in custody, they are not prioritised for a placement until after the court makes a decision to release them, which creates a significant risk of re-offending upon release.

Ms Connors and Mr Drane both confirmed that this dynamic produces a circular and dysfunctional result: the absence of a suitable placement may keep a young person on remand; when they are released, the urgency of the court's decision leaves no time for considered placement planning; and the placements that are available, if any, may include commercial motel accommodation that exposes the young person to conditions directly associated with further offending.[216] Mr Drane recommended that a transition plan be in place for each dual order young person in detention before their release, with defined accommodation, support, and service pathways, and that dedicated capacity and capability be developed to respond quickly to court decisions in youth justice matters.[217]

The current position, in which it is a known and recurring fact that youth will exit detention at short notice, yet the system remains unable to respond to this predictably, is a structural failure of basic corporate parenting responsibility. Planning must occur before release, not after.

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[213] Statement of Kate Connors (1 September 2025) [30].
[214] *Youth Justice Act 1992* (QLD) s 48AB(6).
[215] Transcript, Evidence of Michael Drane (23 February 2026) 4457- 4460 and 4463-4464.
[216] Statement of Michael Drane (12 February 2026) [31(b)]; Statement of Kate Connors (1 September 2025) [53].
[217] Statement of Michael Drane (12 February 2026) [30].

3.5 Girls in care: sexual exploitation and the need for a targeted response

Girls who are part of the cross-over cohort are particularly vulnerable to sexual exploitation across the State.[218] It is patent that this vulnerability is compounded by the circumstances of self-placing, residential care instability, inadequate financial support, and the absence of targeted gender-responsive services. Girls in the cross-over cohort characteristically live with complex, acute, and chronic trauma, making engagement in change-oriented programs highly challenging.[219]

Ms Connors acknowledged that in Far North Queensland girls face heightened vulnerability to sexual exploitation, which has been the subject of criminal justice responses through QPS's Operation Uniform Kalahari, but which also requires significant and highly skilled youth justice and child protection case management. She confirmed that Youth Justice was working to increase its capacity in this area and that ongoing consideration of practice approaches was required.[220]

Witness S's case illustrates the multi-layered nature of this exploitation and the system's failure to respond to it. She was sexually abused by a youth worker at a licensed residential care placement who required sexual acts in exchange for driving her to appointments. No information-sharing mechanism existed between residential care providers, Blue Card Services, and the National Redress Scheme, allowing him to remain employed in the sector despite disciplinary findings against him. Outside residential care, older men introduced her to methamphetamine and used her sexually, ultimately sending her to a motel to be sexually exploited by strangers. When she called her residential care service to be collected, the request was refused on the basis that doing so would amount to enabling “child prostitution”. On the available evidence, no meaningful intervention was attempted.

The Commission analysed critical incident reports in relation to sexual abuse of children. Approximately 67% of the reported sexual abuse of children occur for children placed in residential care. Approximately 40% of all reported instances of sexual abuse of children in care occurred whilst the child was absent from placement, many of these include the recording of

[218] Transcript, Evidence of Michael Drane (23 February 2026) 4445-4446, 4464-4465.
[219] Statement of Kate Connors (1 September 2025) [45].
[220] Ibid [46].

"self-placement" as a placement type. Notably, one incident report records the rape of a child by a youth worker whilst placed in emergent accommodation (hotel).[221]

The absence of a targeted, gender-responsive strategy for girls in OOHC at risk of sexual exploitation means that the system continues to respond to this cohort with generic placement and casework models that are plainly inadequate. The Commission considers that such a strategy, incorporating specialised placements and assertive outreach, and clear contractual and practice requirements for funded services, is both necessary and overdue.

3.5.1 Community safety and the accountability gap

Where a child under the guardianship of the State causes serious injury or death to a member of the public, the question of what the State, as corporate parent, knew, did, and failed to do is directly and urgently relevant. As a matter of logic and commonsense, an event of such magnitude should prompt a thorough review of the Department's processes, conduct, and practice in relation to the care of that child, regardless of whether it is required by policy. That is not what occurred in YP's case.

At the time of YP's significant offending event, the Deputy Director General of the combined Youth Justice and Child Safety Department was informed of his involvement and its tragic results. No review of the Department's processes or procedures followed. Regional Executive Director Leanne Black's (Ms Black) witness statement explained the reason: "as the incident was not a child death or a serious injury to a child or a young person, there was no review of processes or procedures triggered by the offending behaviour, nor any subsequent changes to legislation, policy or procedures that resulted."[222] In her evidence at the Toowoomba public hearings, Ms Black confirmed that this was because the qualifying trigger for a review, the death of or serious injury to a child, had not been met; and that this was so notwithstanding that, at the time, Child Safety and Youth Justice were a single department.[223]

The Commission regards the current trigger as inadequate. The criminal proceedings that may follow where a child in care causes serious injury or death to a member of the public are concerned with different matters, whether the relevant conduct was the child's, and whether the child is guilty of a serious offence. An internal review of the Department's conduct in caring for

[221] Notice to Produce 9 issued to Department on 24 July 2025.
[222] Statement of Leanne Black (13 January 2026) [20].
[223] Transcript, Evidence of Leanne Black (19 February 2026) 4386.

that child does not impinge upon those proceedings and cannot prejudice them. Ms Black ultimately accepted that there would be "value in having any review of any significant outcome involving a child in care." The Commission agrees and considers that such a review should be mandatory.

A policy requiring the Department to conduct a thorough review of its processes and conduct whenever a child in care causes serious injury or death to a member of the public is both a matter of basic accountability and a necessary precondition for systemic improvement.

3.6 Recommendations

Recommendation 41: Reviews incidents harming community members	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 3)**
RECOMMENDATION: That the Queensland Government within three months to the Government's response to this report, expand the terms of reference for the Department's system and practice reviews to include reviewing incidents causing serious injury or death to members of the community where such incidents materially involved a child in care.	
CONTEXT: The Commission considers that the State as a corporate parent should review all incidents of children in the State's care who are materially involved in the serious injury or death of community members. The Commission is not of the view that conducting reviews would prejudice criminal proceedings as those proceedings are concerned with different matters, that is, whether the relevant conduct is the conduct of the child, any issues of criminal responsibility and whether the child is guilty of serious offence.	
IMPLEMENTATION NOTES: Reviews should support: (a) examination of the connection between 'self-placement' and youth justice involvement prior to an incident occurring (b) embedding a proactive continuous improvement and learning culture that supports improved child and community safety outcomes	

<table>
<tr><th colspan="2">Recommendation 42: Using hotels and motels as emergency accommodation</th></tr>
<tr><th>Executive Report (Chapter 8)</th><th>Companion Report 5 (Chapter 3)</th></tr>
<tr><td colspan="2">RECOMMENDATION:

That the Queensland Government immediately suspend the practice of placing children in out-of-home care in care arrangements that require the use of hotels or motels, or other emergency accommodation, except in tightly defined emergency circumstances. These permissible emergency circumstances should not include youths exiting detention.

Where emergency accommodation is used, this use must be subject to prior approval from a senior Department officer (such as the ‘Child Guardian’ as described in Recommendation 44C), and there should be strict time limits on use accompanied by the immediate commencement of transition planning.</td></tr>
<tr><td colspan="2">CONTEXT:

The Commission heard evidence that the Department has a practice of allowing service providers to use commercial hotels, motels and caravan parks to accommodate children who cannot be placed a regulated placement (utilising sections 82(1)(a)-(e) of the Child Protection Act 1999). Such placements are understood to contribute to the opportunities or drivers for offending behaviour.

The Commission considers that the use of emergency accommodation of this nature reflects a failure of system capacity and planning, rather than a safe or appropriate care response, and its use must therefore be justifiably limited. Removing this as a regular system option will strengthen safeguards and decision making oversight at the point where placement options narrow.</td></tr>
<tr><td colspan="2">IMPLEMENTATION NOTES:

The Department should immediately commence monitoring and reviewing, at a senior level, the use of emergency accommodation across the different regions to ensure this use diminishes over time.</td></tr>
</table>

Recommendation 43: Strategy to prevent exploitation of girls in residential care	
Executive Report (Chapter 8)	**Companion Report 5 (Chapter 3)**

RECOMMENDATION:

That the Queensland Government, within 6 months of the Government's response to this report, establish a working group to coordinate across relevant agencies, and to develop and implement a targeted, gender-responsive strategy to address the risks of sexual exploitation of girls in out-of-home care.

CONTEXT:

The Commission heard evidence and received submissions indicating that girls in out-of-home care, and particularly in residential care, are at increased risk of sexual exploitation. This vulnerability is compounded by circumstances of self-placing, residential care instability, inadequate financial support, and the absence of targeted gender-responsive services. Girls in the cross-over cohort characteristically live with complex, acute, and chronic trauma, making engagement in change-oriented programs highly challenging.

As the corporate parent for these children, the Department both knows of these risks and has a clear obligation to manage and reduce this risk.

The absence of a targeted, gender-responsive strategy for girls in out-of-home care at risk of sexual exploitation means that the system continues to respond to this cohort with generic placement and casework models that are plainly inadequate. The Commission considers that such a strategy, incorporating specialised placements and assertive outreach, and clear contractual and practice requirements for funded services to minimise this risk to children, is both necessary and overdue.

IMPLEMENTATION NOTES:

This recommendation requires the Department to work closely with Queensland Police Service, Queensland Health, Department of Youth Justice and Victim Support, and any other relevant agencies. The agencies should identify the appropriate lead agency for the working group.



Child Safety

Commission of Inquiry



Companion Report 6

Complaint Systems

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Chapter 1

Introduction

Companion Report 6

Complaint Systems

Chapter 1: Introduction

This Companion Report discusses the role and significance of an effective complaints system within a well-functioning child safety system. A robust complaints system enables individual concerns to be heard and addressed. It also provides the system with a structured means of identifying recurring problems, correcting practice and improving the way services are delivered for children, families and carers.

The importance of complaints was recognised from the commencement of the Commission. The Commission's Terms of Reference called for recommendations relating to a new independent complaints escalation review process.[1] The Commission's first call for submissions, issued on 1 July 2025, also focused specifically on complaints within the child safety system[2] and yielded 20 'complaint-specific' submissions from organisations alone.

Of the 1193 total submissions received by the Commission, most were from people with direct experience of the child safety system, including current and former children in care, parents, foster and kinship carers, employees of non-government organisations, and employees of Queensland government departments. While not all were made in response to the specific call for submissions about complaints, dissatisfaction with how the Department receives, assesses and responds to complaints emerged as a recurring theme. This clearly illustrates the central importance of the Department's complaints system to those most closely connected to, and affected by, the child safety system.

This Companion Report examines the significance of the child safety system's complaint management system. It outlines the recent historical and legislative context for the current system before describing its major components. It then considers information received by the Commission from a wide range of stakeholders and identifies recurring themes. The Companion Report concludes by setting out the Commission's views on the way forward, including the mechanisms required for the Department to hear concerns raised by those within the system and take adequate action in response.

[1] 'Commissions of Inquiry Order (No. 1) 2025' in Queensland, *Queensland Government Gazette - Extraordinary*, Vol. 399 No. 16, 23 May 2025, 138.
[2] 'Commission of inquiry prioritises complaints system for frontline carers in the child safety system', *Child Safety Commission of Inquiry*, (Web Page, 1 July 2025) <https://www.childsafetyinquiry.qld.gov.au/__data/assets/pdf_file/0008/831077/media-release-2-1-july-2025.pdf>

Chapter 2

Why Complaints Matter in Child Protection Systems

Companion Report 6

Complaint Systems

Chapter 2: Why Complaints Matter in Child Protection Systems

The handling of complaints is a standard and foundational part of public administration. Any government agency delivering services to, or interacting with, the public requires systems that allow individual complaints to be received, assessed and resolved. This includes a legal obligation under *the Public Sector Act 2022* (QLD) for state government departments to have a complaint management system that complies with the current Australian standard for handling customer complaints.[3] Additionally, the Queensland Ombudsman has identified several benefits of an effective complaint management system, including reducing recurring complaints and improving standards of service to the community.[4]

The child safety system is distinctive among public sector entities because of the breadth of authority it can exercise over the lives of children and families. Parents can lose decision-making authority over their own children. The State may remove children from their families, place them in the care of others, regulate contact between children and family members, authorise medical treatment, and determine children's day-to-day routines, including where they go to school. Decisions made within the system commonly shape a child's life trajectory in profound and lasting ways.

In many areas of public administration, complaints provide a mechanism for service users to express dissatisfaction with the quality or delivery of a service. In child protection, complaints serve that purpose while also carrying a broader safeguarding function. A complaint may reveal that a decision has had unintended consequences, that a service is failing to meet a child's needs over time, that a response to known risk has been inadequate, or that concerns raised by those close to a child have not been properly heard or acted upon. This includes concerns, requests for assistance and requests for support.

Importantly, complaints are conceptually and procedurally distinct from statutory notifications of harm, or risk of harm to a child in a family setting. Complaints should not be treated as a substitute for those pathways, however, they are an important part of the information environment within which child protection agencies operate. In practice, a complaint may

[3] *Public Sector Act 2022* (Qld), Section 264.
[4] 'Complaints management', *Queensland Ombudsman* (Web Page, 25 August 2025) <https://www.ombudsman.qld.gov.au/improve-public-administration/public-administration-resources/complaints-management>

indicate that risk has not been recognised, that a response has been delayed or misunderstood, or that the system's own decisions are contributing to a child's instability or vulnerability.

The structural features of child protection make complaints particularly important. Statutory agencies make complex decisions under conditions of uncertainty, often on the basis of incomplete information and under significant time pressures. Decisions about placements, contact, health care, education, interventions and case planning may all require revision as a child's circumstances change. The system therefore requires mechanisms that allow decisions to be revisited as new information emerges, or the consequences of an earlier decision become clearer. Complaints provide one such mechanism. They operate as a feedback loop within the system, creating an opportunity to revisit assumptions, correct action, identify emerging problems and respond before those problems harden into crisis.

2.1 Functions of a complaint management system

A complaint management system serves two related functions within child safety governance. Firstly, it provides a means of individual review and resolution. Children, families and carers may use complaints processes to challenge decisions, seek clarification, or request action where they believe a child's needs are not being met. Secondly, it also supports systemic learning. Complaints data can reveal patterns that may not be visible through other monitoring mechanisms. Repeated concerns about delays in accessing supports, recurring placement instability, failures of communication, or difficulties obtaining practical assistance may indicate broader structural weaknesses. When complaints are systematically recorded, analysed and reported on, they can inform policy reform, practice change, workforce development and resource allocation.

These functions depend on trust and accessibility. The people most directly affected by the child safety system include vulnerable children, young people and families. Some experience additional vulnerabilities, including children with disability, Aboriginal and Torres Strait Islander peoples, and people living in regional or remote communities. Submissions to the Commission also identified concerns relevant to accessibility, participation and confidence in the complaints system.[5]

[5] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 2.
Queensland Family and Child Commission, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (July 2025), page 9.

Where those affected by child safety decisions believe that raising concerns will have no effect, or may result in negative consequences, they may choose not to engage with the complaints system. Important concerns may then go unheard. Fear of reprisal, perceptions of bias and previous experiences of being ignored can all discourage participation. These dynamics are particularly acute in child safety, where the imbalance of power between the State and families is substantial. Parents whose children are subject to statutory intervention may fear that challenging departmental decisions will affect future assessments of their parenting capacity. Foster and kinship carers may worry that raising concerns could jeopardise their standing as carers. Residential care workers may fear professional consequences if they report problems within services.

Many children in care have already experienced trauma, instability and disrupted trust in adults and institutions. For them, complaints processes must be clear, accessible, developmentally appropriate, trusted and safe to use. The Queensland Family and Child Commission noted a significant under-representation of child-initiated complaints presently received by the Department, characterising this under-representation as a "significant system failure".[6]

2.2 Complaints as a safeguard and a signal

The Department's role as a corporate parent reinforces the importance of a robust complaint management system. When a child enters out-of-home care, the Department assumes responsibilities analogous to those of a natural parent, including responsibility for the child's safety, development, health, identity and relationships. Those responsibilities are not discharged simply by providing a placement. They include ensuring that children, and those advocating for them, can raise concerns when care is not meeting their needs, and that those concerns are taken seriously.

In a well-functioning corporate parenting environment, complaints should be understood as legitimate and necessary parts of safeguarding and accountability. A natural parent is expected to listen to their child and respond to their needs. A State acting as corporate parent should be held to a comparable expectation. International guidance reflects this position. The United Nations Guidelines for the Alternative Care of Children emphasise the importance of

[6]Queensland Family and Child Commission, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (July 2025), page 9.

mechanisms through which children in care can raise concerns about their treatment and living arrangements.[7]

The Royal Commission into Institutional Responses to Child Sexual Abuse, which delivered its final report in 2017, had a profound effect on expectations concerning complaint handling across Australia. Although the Royal Commission focused primarily on child sexual abuse in institutional contexts, its findings and recommendations regarding complaint handling and child safety are highly relevant. It documented widespread failures in the way institutions received, managed and responded to complaints and disclosures of abuse. Survivors frequently described experiences in which their concerns were ignored, minimised or handled in ways that prioritised institutional reputation over their safety and wellbeing.

In response, the Royal Commission articulated principles that have reshaped expectations across child-related sectors. These included the importance of child-centred complaints processes, trauma-informed responses, independent oversight, clear reporting and proper record-keeping.[8] Those developments have contributed to a broader shift in safeguarding practice and have raised the standard against which complaint systems affecting children are now judged.

Children, families and carers must be able to make a complaint and know their concerns will be heard, understood and addressed. Effective complaints processes allow risks to be identified early, support meaningful participation, and provide a pathway for decisions to be questioned and improved before harm becomes entrenched. In many cases, complaints come from those closest to a child's daily circumstances. They may provide the earliest indication that a situation is deteriorating or that a decision is having unintended consequences.

Where serious concerns remain unresolved, confidence in the complaint management system and the child safety system erodes. Over time, this discourages future complaints and reduces the flow of information through which the Department might otherwise detect failure, respond to deterioration and prevent harm. The effectiveness of a complaint management system is therefore part of how the child safety system hears, learns, corrects and protects.

For that reason, the complaint management system should be understood as part of the safety and accountability infrastructure of the child safety system. It is a mechanism to resolve

[7] United Nations, *United Nations Guidelines for the Alternative Care of Children*, GA Res64/142, UN Doc A/RES/64/142* (24 February 2010) <https://resourcecentre.savethechildren.net/pdf/5416.pdf>

[8] 'Final Report', *Royal Commission into Institutional Responses to Child Sexual Abuse* (Web Page, 15 December 2017) <Final report | Royal Commission into Institutional Responses to Child Sexual Abuse>

individual concerns, prevent harm, and a core health check on whether the system is meeting the needs of children, young people and families. Complaints are therefore both a safeguard and a signal. That dual function has particular significance where the State acts as corporate parent. The value of complaints can only be realised where effective processes allow concerns to be heard, lessons to be learned, and those lessons to be translated into meaningful improvement in service delivery, system performance and public trust.

Chapter 3

Historical and Legislative Context

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Complaint Systems

Chapter 3: Historical and Legislative Context

Queensland's child safety complaint management system has been referenced in, or been the central subject of, a series of inquiries, reviews and legislative reforms spanning more than two decades.[9] Across those reviews, similar concerns have repeatedly emerged about the way complaints and concerns are raised, recorded, assessed and escalated. Each review has contributed to incremental change, yet the persistence of these themes suggests that the underlying problems are not merely procedural. They concern the deeper culture and design of the system itself.

Understanding the development of Queensland's complaint management architecture within the child safety system is important for two related reasons. It provides necessary context for the evidence presented to the Commission. It also demonstrates that repeated attempts at improvement by oversight bodies have not fully resolved the structural weaknesses that continue to affect the way concerns are handled within the child safety system.

3.1 Forde Inquiry

The former Children's Commission was originally established by the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996*. Following the Forde Inquiry, legislative changes through the *Commission for Children and Young People Act 2000* created an independent statutory body, the Commission for Children and Young People.[10] Relevant functions of the Commissioner for Children and Young People included:

- to receive, seek to resolve, monitor and investigate complaints about services provided to certain children by service providers;
- to monitor and review the way in which service providers respond to complaints about services provided by them to certain children;
- to advocate for children and, in advocating for children, to seek help from advocacy entities, service providers and other entities; and

[9] For example, Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry) 1999, Protecting children: an inquiry into abuse of children in foster care (Crime and Misconduct Commission) 2004, Queensland Child Protection Commission of Inquiry (Carmody Inquiry) 2013, Management of Child Safety Complaints Report (Queensland Ombudsman) 2016, Management of Child Safety Complaints – Second Report (Queensland Ombudsman) 2020.
[10] *Commission for Child and Young People Act 2000* (Qld) section 12.

- to promote the establishment by service providers of appropriate and accessible mechanisms for the participation of children in matters that may affect them.

3.2 CMC Report

In 2004, the then Crime and Misconduct Commission issued its report, *Protecting children: an inquiry into abuse of children in foster care*.[11] The report made a range of recommendations, including the creation of a new stand-alone Department of Child Safety. It also identified the importance of a "sophisticated mechanism for receiving, addressing and tracking all complaints" and recommended the establishment of a specific unit for that purpose. The CMC further reported that complaints about service delivery or other administrative issues should receive a quick response from the new department.

The CMC Report led to the establishment of the Child Guardian role within the Children's Commission. The role was intended to be "responsible for monitoring and investigating complaints against the Department of Child Safety or other service providers; conducting proactive audits, monitoring and reviewing those agencies; and coordinating an extended Community Visitor Program"[12]

The CMC concluded that the new Child Guardian would need a range of functions, including to:

- respond to complaints by or in relation to a child or class of children within the jurisdiction of the Department of Child Safety;
- investigate matters relating to a child or class of children within the jurisdiction of the Department of Child Safety, either in response to a complaint or on the Child Guardian's own initiative, including matters arising from research or monitoring functions;
- monitor, audit or review the handling by the Department of Child Safety, non-government organisations or other agencies of cases concerning a child or class of children within the jurisdiction of the Department of Child Safety;
- monitor, audit or review systems, policies and practices of the Department of Child Safety, non-government organisations or other agencies that affect children within the jurisdiction of the Department of Child Safety; and

[11] Crime and Misconduct, 'Protecting Children: An Inquiry into Abuse of Children in Foster Care', (Final Report, January 2004).
[12] Crime and Misconduct, 'Protecting Children: An Inquiry into Abuse of Children in Foster Care', (Final Report, January 2004), 159.

- monitor adherence to the child placement principle for Indigenous children, as set out in section 83 of the *Child Protection Act*.[13]

These recommendations shaped a significantly expanded complaints, monitoring and oversight role within the child protection system.

3.3 The Carmody Inquiry

In 2013, the Queensland Child Protection Commission of Inquiry (Carmody Inquiry), delivered its final report following a period of intense public concern about the performance of the child protection system. Although the Carmody Inquiry did not focus exclusively on complaints handling, it recognised the importance of transparent and accessible mechanisms through which families and communities could raise concerns about the operation of the child protection system.[14] The Carmody Inquiry also underscored the need for clear lines of decision-making authority and accountability.[15]

The Carmody Inquiry recommended a new Family and Child Council to fulfil a systemic advocacy role for children and young people across Queensland, with a revitalised Child Guardian to provide individual advocacy for children and young people in the child protection system.[16] This recommendation led to the establishment of the Queensland Family and Child Commission on 1 July 2014 and the Commission for Children and Young People and Child Guardian ceasing operations. Many of its functions were transferred to other agencies, including the Office of the Public Guardian, the new Queensland Family and Child Commission (QFCC), and the Queensland Ombudsman. Importantly, Carmody's recommendation envisioned the new QFCC would be focused solely on the child safety system.[17]

The Carmody Inquiry reported that the Children's Commission had performed a monitoring, complaints and investigations function which had "revealed past systemic weaknesses and [had] built capacity and awareness of deficiencies."[18] However, the Inquiry found that responsibility for that function should sit with the Department, with external review as necessary. Oversight of both

[13] Crime and Misconduct, 'Protecting Children: An Inquiry into Abuse of Children in Foster Care', (Final Report, January 2004), 160.
[14] Queensland Child Protection Commission of Inquiry, Taking Responsibility: A Roadmap for Queensland Child Protection (2013), 418-422.
[15] Ibid, 422.
[16] Queensland Child Protection Commission of Inquiry, Taking Responsibility: A Roadmap for Queensland Child Protection (2013), 413.
[17] The QFCC's focus has been broadened beyond the original Carmody recommendation.
[18] Queensland Child Protection Commission of Inquiry, Taking Responsibility: A Roadmap for Queensland Child Protection (2013), 410.

individual child safety complaint matters and systemic concerns relating to complaints management transitioned solely to the Queensland Ombudsman.

3.4 Queensland Ombudsman Investigations

In 2016, the Queensland Ombudsman published the Management of Child Safety Complaints Report, which documented a detailed investigation into how child safety complaints were received, recorded and managed within the Department.[19] It identified significant weaknesses, including inconsistent classification of complaints, inadequate guidance for staff, delays in responding to complainants, and deficiencies in record-keeping systems.

Of particular significance was the Ombudsman's finding that many concerns raised by clients were recorded as minor "issues" rather than formal complaints. The practical consequence was that those matters were not captured within the Department's complaints reporting framework and were therefore not subject to the same visibility, monitoring and oversight. The investigation concluded that these practices reduced the visibility of complaints and limited the Department's capacity to identify systemic issues arising from recurring patterns of concern.[20]

The Queensland Ombudsman conducted a follow-up investigation and published its findings and recommendations in the Management of Child Safety Complaints: Second Report in 2020. The Ombudsman acknowledged that some improvements had occurred, including the introduction of updated complaints policies and improved information systems. The second report nevertheless continued to identify weaknesses in complaint recording, procedural guidance, and consistency across regions.[21]

Following on from the Royal Commission into Institutional Responses to Child Sexual Abuse, Queensland has introduced the *Child Safe Organisation Act 2024*. The Act imposes requirements on organisations that provide services to children to create environments that promote safety and wellbeing, and to implement child safe standards and comply with a reportable conduct scheme.[22] The Queensland Family and Child Commission oversee the operation of the scheme.

One of the core child safe standards requires organisations, including child protection services, to establish responsive, child-focused complaint processes.[23] Organisations must

[19] Queensland Ombudsman, Management of Child Safety Complaints: Investigation Report (2016).
[20] Queensland Ombudsman, Management of Child Safety Complaints: Investigation Report (2016).
[21] Queensland Ombudsman, Management of Child Safety Complaints: Second Report (2020).
[22] *Child Safe Organisations Act 2024* (Qld), Section 3.
[23] *Child Safe Organisations Act 2024* (Qld), Section 9.

ensure that children and their families know how to raise concerns, and that those concerns are taken seriously and responded to appropriately. Organisations are also required to monitor and review complaint trends to identify systemic issues and drive continuous improvement. Under the reportable conduct scheme, organisations must report, investigate and manage allegations of child abuse or misconduct by their workers or volunteers.[24] These requirements reinforce the broader shift toward child-centred safeguarding frameworks across Australia and underscore the need for complaint systems within the child safety system to operate consistently with those principles.

Despite the evolution of child-centred safeguarding frameworks and complaints practices, children, families, carers, professionals and others continue to raise concerns about the way complaints are recognised, recorded, escalated and resolved within the child safety system.

The significance of this history lies in the persistence of the issues identified. It suggests that, notwithstanding repeated reviews and reform efforts, underlying challenges with the complaint's framework remain. It is against this backdrop that the Commission called for submissions about the effectiveness of the current framework for managing complaints within Queensland's child safety system.

[24] *Child Safe Organisations Act 2024* (Qld), Chapter 3.

Chapter 4

Understanding the Department's Current Complaints System

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Chapter 4: Understanding the Department's Current Complaints System

The child safety system is multi-faceted, increasing the challenges for complainants in navigating the system. There are multiple types of complaints, and a diverse range of individuals and organisations who may make them. Different types of complaints also have different complaint pathways.[25] As the QFCC notes, understanding who can complain and the nature of their concerns is critical to evaluating the effectiveness of the current complaints management system and opportunities for reform.[26]

The Department has an internal complaints unit that forms part of the Office of the Chief Practitioner. The Chief Practitioner is therefore responsible for ensuring complaints management processes are accountable, transparent, timely and fair.[27]

At first glance, the Department's complaints system appears consistent with standard public administration models. Complaints are first addressed internally by the responsible agency, with external oversight available through independent integrity bodies if the complainant remains dissatisfied.[28]

However, the weight of evidence presented to the Commission, which will be detailed later in this report, suggests that the practical operation of this framework is considerably more complex. Concerns raised through submissions, hearings and stakeholder engagement indicate that the current system is fragmented, difficult to navigate and insufficiently responsive to the types of concerns that arise in child safety matters. The evidence indicates that the Department does not handle complaints effectively, with numerous submissions highlighting stark examples of the consequences of poor responses.[29] Some submissions went so far as to highlight a significant disconnect between the Department's complaint management policy and the actual procedures being followed, including failures in properly categorising

[25] For example complaints alleging a breach of privacy may be first made to the Department however if a response is not provided within time, a complaint can be made to the Office of the Information Commissioner. Another complaint about the conduct of a funded service provider may be first made to the provider, and then escalated to the Department.
[26] Queensland Family and Child Commission, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (July 2025), page 7.
[27] Child Safety Practice Manual, Queensland Government (Web Page, 27 October 2025) <Roles, responsibilities and delegations | Child Safety Practice Manual>
[28] Department of Families, Seniors, Disability Services and Child Safety, Complaints Management (Policy, 10 October 2023) 6.
[29] Case Study of Helen and Patrick. This case study provides an example of the importance of responding appropriately and with careful judgement to complaints for the benefit of both the complainant and the subjects of the complaint.

complaints, identifying and recording all complaints, and communicating the management of complaints and outcomes.[30]

4.1 Current Complaint Management System

Understanding these challenges requires examining the structure of the current complaint management system and the pathways available to individuals who seek to raise concerns about decisions made or actions taken within the child safety system.

The Department's complaint management system is designed to address dissatisfactions and manage complaints from individuals directly affected by the services delivered or funded by the Department.[31] Complaints managed under the Department's complaint management system are distinct from other matters, such as allegations of harm or risk of harm to a child, allegations of employee misconduct, concerns about possible breaches of standards of care[32], or general feedback.[33]

What is a complaint?

Best practice complaints management in Australia is guided by the Australian Standard for complaints management systems (AS/NZ 10002:2022). The Standard defines a complaint as an expression of dissatisfaction made to or about an organisation, related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected.[34] This definition is intentionally broad. It is designed to ensure that organisations capture concerns early, avoid narrow categorisation and maintain visibility over issues that may indicate service failure, risk or emerging systemic problems.

[30] Legal Aid Queensland, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (1 August 2025), page 8.
[31] Statement of Victoria Van Houdt (2 September 2025) [27].
32 The Department has a legislative responsibility to ensure children in care are cared for in a way that meets the statement of standards as set out in section 122 of the Child Protection Act 1999 and the Charter of Rights for a Child in Care, contained at schedule 1 of that Act.
[33] Statement of Victoria Van Houdt (2 September 2025) [30].
[34] Standards Australia, AS/NZS 10002:2022 - Guidelines for complaint management in organizations (ISO 10002:2018, NEQ), Standards Australia, published March 2022.

Chapter 5

Complaint Pathways and Reporting

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Chapter 5: Complaint Pathways and Reporting

Under the Department's complaint management system policy, complaints are addressed through two distinct pathways depending on whether they fall within the Department's scope, or outside it. For the purposes of this report, these pathways are discussed separately; however, in practice they may operate concurrently. The Department follows a three level complaints management process to minimise the escalation of disputes[35].

5.1 First Attempt at Resolution (FAAR)

Concerns assessed as suitable for local resolution are referred to the relevant operational area as a First Attempt at Resolution (FAAR) matter. The FAAR process is intended to facilitate early resolution at a local level, typically through referral to the Child Safety Service Centre responsible for the case. Matters managed through FAAR are not recorded as complaints, as the Department treats FAAR as a step prior to the formal registration of a complaint. However, many submissions to the Commission suggested people often experience challenges escalating their concerns above the FAAR process.

The Department reports that approximately 81% of matters raised are 'successfully resolved' through the FAAR process.[36] During the Commission's hearings in Brisbane, Acting Chief Practitioner, Ms Van Houdt, confirmed that in this context 'successfully resolved' meant that the matter 'did not progress to the formal complaints process'.[37] Ms Van Houdt acknowledged a complainant's own assessment of resolution may differ and conceded that a matter may be classified as resolved even where it has not been satisfactorily addressed from the complainant's perspective but has simply not been taken further.[38]

Given the scale of matters managed through FAAR, and the fact that they are neither recorded nor reported as complaints, there is the risk that serious concerns are diverted into informal resolution pathways without independent oversight. This also limits the Department's ability to identify recurring issues and make systemic improvements based on patterns emerging from the FAAR process.

[35] Department of Families, Seniors, Disability Services and Child Safety, Complaints Management (Policy, 10 October 2023) 4.
[36] Statement of Victoria Van Houdt (2 September 2025) [60].
[37] Evidence of Victoria Van Houdt, Transcript, 28 November 2025, Brisbane, 3094.
[38] Evidence of Victoria Van Houdt, Transcript, 28 November 2025, Brisbane, 3094.

Early and local resolution mechanisms can provide benefits, including timely responses, maintenance of working relationships and avoidance of unnecessary escalation. However, assessing a FAAR as successfully resolved solely on the basis that it has not progressed further may be premature. Evidence before the Commission suggests that the FAAR processes can replicate the concerns identified in earlier Ombudsman investigations, particularly where matters are referred back to the same operational staff whose decisions are the subject of the concern. This can create perceptions of a conflict of interest and discourage future engagement with the complaints system.[39]

Legal Aid Queensland advised the Commission that its lawyers frequently observe that clients do not feel able to raise dissatisfaction directly with departmental staff who have direct responsibility for case management affecting their family.[40] An organisation working extensively with current and former children in care described the reclassification of formal complaints into minor "issues" as "one of the most pervasive and damaging practices within the current framework".[41] One submitter expressed their experience in the following terms:

> 'I'm extremely unhappy about the complaints system … it rolls back right where it started into the team leaders' hand who lays down all the decisions which I believe is totally wrong'[42] – Submitter to the Commission

5.1.1 Formal complaint and internal review process

Where concerns cannot be resolved through FAAR, or are assessed as unsuitable for local resolution, they may progress to the Department's formal complaints framework. This framework comprises three stages – complaint, internal review and external review.[43]

Formal complaint assessments or investigations are conducted either by regionally based complaints teams or by the Department's central complaints unit. Investigations typically consider whether departmental policies and procedures were followed and whether the actions of staff were reasonable in the circumstances. Departmental policy generally sets investigation timeframes of around thirty business days, following which complainants receive a written response outlining the outcome.

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[39] Submission No. 0045 to Child Safety Commission of Inquiry (25 March 2026). Submission No. 0281 to Child Safety Commission of Inquiry (25 March 2026).
[40] Legal Aid Queensland, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (1 August 2025), page 5.
[41] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 3.
[42] Submission No. 0167 to Child Safety Commission of Inquiry (1 August 2025).
[43] Department of Families, Seniors, Disability Services and Child Safety, Complaints Management (Policy, 10 October 2023) 6, [4.5].

While these processes provide a more structured approach to complaint handling than FAAR, they remain internal to the Department. Most complaints continue to be handled within the region in which the issue arose, meaning that the Department retains responsibility for reviewing its own decisions and actions.

Where a complainant remains dissatisfied following a complaint investigation, they may request an internal review. Two forms of internal review are generally available: a practice review, which considers the merits of the original decision or action, and a process review, which examines how the complaint was handled. These reviews are typically conducted by the central complaint's unit, which is structurally separate from regional operational teams. However, the reviews remain within the Department's organisational structure. Although this is a fairly typical approach across public sector agencies, the Commission heard that complainants often perceive this arrangement as limiting the independence, credibility and fairness of the review process.[44]

5.1.2 External review pathways

Once internal complaints processes have been exhausted,[45] complainants may seek external review through several oversight bodies or may be referred to another body for action. Formal complaints may also be lodged through multiple avenues concurrently.

There is no specialist child safety body with authority to independently review individual child protection decisions outside existing complaints and legal frameworks. External oversight bodies include, for example, the Queensland Ombudsman, Queensland Human Rights Commission, Office of the Information Commissioner, Office of the Public Guardian and the Crime and Corruption Commission.

5.1.3 Administrative oversight: Queensland Ombudsman

As previously outlined, the Queensland Ombudsman plays the most significant role in reviewing complaints relating to the Department's administrative decisions. The Ombudsman has authority to investigate whether a government agency's actions were unreasonable, unlawful, improperly discriminatory or otherwise wrong, and may make recommendations to the agency. However, the Ombudsman does not have the power to compel agencies to adopt those recommendations.

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[44] Submission No. 0107 to Child Safety Commission of Inquiry (9 March 2026). Submission No. 0063 to Child Safety Commission of Inquiry (21 July 2025).
[45] The Queensland Ombudsman has a policy of requiring internal review rights to be exhausted before a matter will be accepted for review by that office.

One submitter described their experience in the following terms:

> 'The ombudsman said there really isn't anything she can do she can't change the outcome she can only say what she thinks and then nothing usually happens anyway.' [46]

In practice, the Ombudsman exercises discretion about which complaints it will investigate. Matters may be declined where internal processes have not been exhausted or where the Ombudsman considers the agency should be given a further opportunity to resolve the issue. As a result, complainants may be required to progress through multiple internal stages before accessing external review, contributing to delay and complainant fatigue.

This approach is consistent with the Ombudsman's role as an oversight body of last resort within administrative law frameworks. However, evidence before the Commission indicates that many complainants perceive the Ombudsman as distant from the day-to-day realities of child safety casework. Ombudsman investigations typically focus on administrative fairness rather than reviewing the merits of professional judgments relating to child safety. As a consequence, some families and carers may feel the Ombudsman cannot meaningfully address concerns about complex case management decisions.

In its submission, the Queensland Ombudsman advised that 439 complaints about Child Safety were received during 2024-25.[47] Common issues raised included statutory intervention/decisions, ongoing case management, foster carer and kinship carer assessments and payments, child placement decisions; and staff behaviour, communication or alleged misconduct.[48]

5.1.4 Advocacy and child voice: Office of the Public Guardian

The Office of the Public Guardian (OPG) provides individual advocacy for children in the child protection system, particularly those under guardianship orders. Community visitors[49] from the OPG conduct regular visits to children in care and are often the first to hear concerns directly from children.

However, the OPG's advocacy function is constrained by resourcing.[50] There is also variation in how concerns raised through this channel are escalated or resolved. While the OPG provides a

[46] Submission No. 0031 to Child Safety Commission of Inquiry (14 July 2025).
[47] Queensland Ombudsman, Submission to Child Safety Commission of Inquiry (24 March 2026), page 3.
[48] Queensland Ombudsman, Submission to Child Safety Commission of Inquiry (24 March 2026), page 3.
[49] Community Visitors are independent people engaged by the OPG to visit children in OOHC, youth detention or another visitable site to check on those children and advocate for their best interests.
[50] Office of the Public Guardian, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model (February 2026) 7.

critical safeguard, it cannot substitute for an independent mechanism capable of reviewing complex child protection decisions on a case-by-case basis.

5.1.5 Complaints relating to outsourced services

A further complexity arises from the extensive outsourcing of services within Queensland's child safety system. In the 2024-25 financial year the Department spent over $1.8 billion on external service providers to deliver Child Safety services including family support programs, foster and kinship carer, residential care and outreach services to children who are self-placing.[51]

Complainants raising concerns about the actions of these service providers are often directed by the Department or the Queensland Ombudsman to the provider's own complaints process in the first instance. The number and diversity of service providers can make it difficult for children, young people and families to know where to make a complaint, and to understand whether responsibility for addressing their concern rests with the provider or the Department. The variability in pathway and quality of processes between providers is also an issue. Complaints about service providers frequently fail to progress beyond internal provider processes. Complainants may be uncertain about escalation pathways or experience confusion and delay in seeking independent review.

From a safeguarding perspective, this fragmentation of complaints pathways is problematic. Children in out-of-home care remain under the custody or guardianship of the State even where services are delivered by contracted organisations. Effective oversight therefore requires clear and transparent accountability mechanisms across both government and non-government providers.

5.1.6 Navigating the complaints system

Taken together, the various complaint pathways available in Queensland create a system that can be difficult to navigate, and for some complainants, effectively inaccessible. Children, families and carers must often determine whether their concern qualifies as a complaint under departmental decision-making or the action of a service provider, and whether internal processes must be exhausted before external oversight can be sought.

[51] Department of Families, Seniors, Disability Services and Child Safety, *2024-25 Financial Statements for the year ended 30 June 2025* (27 August 2025) 19.

For individuals already experiencing stress, vulnerability and power imbalance within the child safety system, these complexities can create significant barriers. Some disengage entirely where they believe the process will require sustained effort without a meaningful outcome.[52]

The cumulative effect of these structural features is that Queensland's complaints framework struggles to fulfil its safeguarding role. While internal complaint processes and external oversight mechanisms exist, there is no dedicated pathway through which complex child protection decisions can be independently assessed in a timely and accessible manner, nor a central mechanism for analysing issues and themes across complaints to ensure the system understands and responds.

[52] Commonwealth Ombudsman, Better Practice Complaint Handling Guide (2021).

Chapter 6

Flaws in the Current Approach

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Complaint Systems

Chapter 6: Flaws in the Current Approach

The Commission is satisfied Queensland's existing review and oversight arrangements do not provide a coherent or accessible pathway for the independent consideration of complex child protection decisions. While multiple bodies play important roles within the accountability framework, each is limited in scope, function or jurisdiction. As a result, responsibility for reviewing many administrative case management decisions with profound consequences for children's lives falls disproportionately on the Department's internal complaints system.

6.1 Legal review of decisions: courts and tribunals

Legal and review tribunal mechanisms play an important role in supervising the legality of the State's intervention in family life. The Queensland Civil and Administrative Tribunal (QCAT) provides a review of a limited range of child protection-related decisions, including decisions relating to the approval, refusal, suspension or cancellation of carer status, certain licensing and care service matters, and a limited number of other determinations made. The Children's Court remains the appropriate forum for major legal decisions affecting a child's status, guardianship, custody and longer-term care options.

However, decisions subject to court or tribunal review represent only a relatively narrow subset of the decisions routinely made during child safety casework. Many administrative decisions, including placement changes, placement type and location, access to therapeutic or medical services, educational arrangements, practical supports and aspects of contact and case planning, are not reviewable through courts or tribunals. Despite having significant and lasting consequences for children's lives, the primary avenue for raising concerns about these decisions is the Department's case management system.

This uneven distribution of accountability creates structural challenges. Complaints mechanisms are required to bear a disproportionate share of responsibility for reviewing administrative case management decisions, despite not being designed as an independent merits-review pathway.

The delineation between review channels is blurred in practice. For example, the outcome of a Standards of Care Review (SOCR) is not reviewable by QCAT and therefore impliedly reviewable under the Department's complaints management system. However, where a child is subsequently removed from a foster carer as a result of the SOCR outcome, the removal decision is reviewable by QCAT. In such cases, the tribunal will inevitably have regard to the findings of the SOCR as the basis for the removal. By contrast, when no child is removed following a SOCR, for example because the carer does not have a current placement, the carer's only avenue to dispute the SOCR outcome is through the Department's complaints management system.

A similar distinction arises where a parent receives a substantiated harm finding against them following an investigation and assessment process. If the child is removed under a child protection order, the avenue to dispute the harm finding is through the court process. However, if the child is not removed, the only avenue to dispute the harm finding is through the Department's complaints system. These examples illustrate how decisions arising from similar circumstances can give rise to different avenues of review depending subsequent departmental action.

6.2 Systemic oversight without case review: Queensland Family and Child Commission

The QFCC performs an important system-level oversight. Its functions include monitoring systemic performance, conducting research and leading the Child Death Review Board. This role enables the QFCC to maintain whole-of-system perspective and to identify broader trends and risks.

However, the QFCC does not provide a pathway for individual complaints relating to specific child protection cases. Its mandate is explicitly and purposefully designed to focus on systemic oversight rather than case-level review.[53]

6.3 Limits of whistleblower protections

Queensland law provides additional protections for some complainants through the *Public Interest Disclosure Act 2010*. A person who makes a public interest disclosure to a proper

[53] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 409.

authority may be afforded protections including immunity from liability confidentiality protections and safeguards against reprisal.

In practice, the utility of these protections in the child protection context is limited. The statutory definition of a public interest disclosure is relatively narrow. For persons who are not public officers, disclosures are generally confined to substantial and specific danger to the health or safety of a person with a disability and reprisals. Broader categories of public interest disclosures such as corrupt conduct, maladministration adversely affecting a person's interests, and substantial misuse of public resources are available only to public officers. As a result, this means that many concerns raised by parents or carers about case handling, decision-making or service quality will usually not fall within the public interest disclosure regime and therefore the protections under the *Public Interest Disclosure Act 2010* will not be available.

Even where reprisal is alleged, the Act requires detriment to be caused because, or in the belief that, a public interest disclosure has been or will be made. In a system characterised by ongoing relationships, significant power imbalances and cumulative decision-making, establishing that connection may be difficult in practice.[54]

One submitter described the impact in these terms:

> Complaints are weaponised against carers and there us a clear lack of independent oversight. A fear-based culture exists that discourages reporting and there is no feedback loop or resolution for carers. Kinship Care support agencies appeared to side with Child Safety in many cases, leaving carers feeling unsupported, alone and not advocated for.[55]

6.4 Overall accountability gap

The practical effect of the current framework is that accountability operates unevenly across different categories of decision. Legal and integrity bodies address only a limited subset of child protection decisions. Advocacy and systemic oversight bodies lack determinative authority in individual cases. As a result, the Department's internal complaints system bears a disproportionate share of responsibility for reviewing administrative case management decisions with significant consequences for children, families and carers.

[54] To the Commission's knowledge, this has never been established in Queensland.
[55] Submission No. 0110 to Child Safety Commission of Inquiry (29 July 2025).

This accountability gap provides important context for the Commission's consideration of whether the current complaints framework is capable of supporting effective safeguarding, learning and public confidence in Queensland's child safety system.

Reporting

The Department is required by the Public Service Act 2022 to publish information about the number and types of complaints it receives each year. The Department's complaint report for the period 1 July 2024 to 30 June 2025[56] separates matters relating to Child and Family Services.

The report records a total of 3239 Child and Family Services matters received during the reporting period. Of these, 2656 (82%) were classified as FAAR. Each FAAR matter is described as requiring further response or action to address specific concerns or improve departmental practice.

While this reporting provides a high-level indication of the volume of concerns raised with the Department, its utility is limited. Because FAAR matters are not recorded as complaints, the data does not provide visibility over the nature, seriousness or recurrence of concerns managed through informal resolution pathways. Nor does it allow for meaningful analysis of outcomes from the perspective of complainants, including whether concerns were substantively resolved or simply not pursued further.

The Department separately reports on human rights allegations in its annual report and provides data about conduct and performance matters to the Public Service Commission (PSC) for publication on the PSC's website. While these reporting streams serve distinct accountability purposes, they further fragment information about complaints and concerns across multiple datasets and reporting mechanisms.

Taken together, the current reporting framework does not provide a consolidated or comprehensive picture of how concerns about child safety decision-making are raised, managed and resolved across the system. In particular, it limits the capacity to identify patterns, monitor escalation points, assess the effectiveness of early resolution processes, or draw reliable system-wide lessons from complaints data. This lack of integrated reporting reinforces the broader accountability gaps identified in this Companion Report and constrains the complaints system's role as a tool for safeguarding, learning and continuous improvement.

[56] Department of Families, Seniors, Disability Services and Child Safety, 'Complaint Report 1 July 2024 to 30 June 2025', *Complaints Data 2024* (Webpage, undated) <https://www.families.qld.gov.au/_media/documents/contact-us/complaints/s219a-publishing/complaints-data-2024.pdf>

Chapter 7

What the Commission has Heard

Companion Report 6

Complaint Systems

Chapter 7: What the Commission has Heard

Throughout the course of the Inquiry, the Commission received information about the operation of Queensland's child safety complaints framework through multiple channels. These include written submissions from parents, carers, service providers and community organisations, evidence presented during public hearings, evidence produced in response to compulsive requests, and discussions with stakeholders across the child safety, legal, and community sectors.

While the length and detail of submissions vary, the themes emerging from this evidence are strikingly consistent. Individuals in the child safety system describe a complaints framework that is difficult to navigate, lacks real or perceived independence, and does not provide a meaningful pathway for resolving serious concerns about case management decisions.

> 'Current processes are often inaccessible, poorly understood, or unresponsive, particularly for children in out-of-home care and marginalised communities.'[57]

These concerns arise across a range of stakeholder groups, including families whose children have been subject to statutory intervention, foster and kinship carers responsible for the day-to-day care of children, young people in the out of home care system, and professionals working within or alongside the child protection system.

Of over 1,190 submissions received through the Inquiry in the period 1 June 2025 to 29 March 2026,[58] at least 900 of these were from individuals who had direct personal experience with the child safety system including young people in care, former children in care, carers, parents, and advocates. Most submitters raised significant concerns with the Department's complaints handling processes. While the Commission was not in a position to substantiate all these concerns, there were instances where submitters provided supporting documentation to support their allegations.

Current or former departmental staff also provided submissions about workplace grievances and inappropriate behaviour by colleagues including mistreatment of parents and carers. The evidence before the Commission demonstrated that the current child safety complaint management system is struggling to fulfilling its safeguarding function effectively. Families and

[57] Bravehearts, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (1 August 2025), page 4.
[58] The Inquiry accepted submissions via multiple mediums in the period 1 June 2025 to 29 March 2026.

carers have described difficulties navigating internal complaints processes, uncertainty about how complaints will be handled, and frustration about a lack of action or response once concerns are raised. The Commission heard that complaints may be reframed as service dissatisfaction rather than recognised as indicators of potential risk. It also heard of complainants' inability to escalate matters, or prolonged cycles of internal review that fail to resolve the underlying issue, as well as perceptions that people were disadvantaged by the Department for raising concerns. Although individual experiences differ, the Commission identified several recurring themes.

7.1 Lack of independence

One of the most common concerns raised with the Commission relates to the perceived lack of independence within the complaints process.

Families and carers have described many situations in which concerns about decisions made by caseworkers or regional offices were referred back to the same operational staff responsible for those decisions. Even where this occurs through formal processes such as the FAAR mechanism, complainants often perceived the process as lacking neutrality.[59] This perception can significantly affect confidence in the complaints system. Where individuals believe that their complaint will ultimately be assessed by the same staff involved in the original decision, they may conclude that the process is unlikely to lead to meaningful reconsideration of the issue.

> 'Without independent scrutiny, complaints are too easily dismissed, delayed, or buried within departmental bureaucracy.'[60]
>
> I was personally present as a support person for an individual who was not given due process and went on to attempt to make formal complaints to Child Safety Service Centres, only to have them ignored or dismissed outright. I have seen Centre management disregard serious allegations regarding the professional conduct of their staff. Across multiple attempts to raise serious and legitimate complaints, Child Safety staff would redirect away from the concern at hand and instead focus on discrediting the parent who raised the issue.[61]

Concerns have also been raised with the Commission that complaints made to local child safety service centres may never reach the central complaints unit, as the initial staff member may

[59] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025).
[60] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 4.
[61] Submission No. 0179 to Child Safety Commission of Inquiry (2 August 2025).

determine that the matter is dealt with through local resolution or recorded as feedback only.[62] Stakeholders have suggested that this dynamic can discourage families and carers from raising concerns in the first place, particularly where they remain dependent on the Department for ongoing case management decisions affecting their children.

A lack of independence in responses to complaints was also raised in the context of complaints about service providers funded by the Department, particularly residential care providers. Stakeholders expressed concern that complaints about the actions or quality of care provided by funded services may be managed in ways that do not provide sufficient separation between the Department's commissioning role, the service provider's interests and the assessment of the complaint itself.[63] These concerns are heightened in residential care settings, where children are placed in services operated by contracted organisations and complainants may already feel distanced from decision-making processes. Where complaints about service providers are addressed through internal or locally managed processes, without clear and independent escalation pathways, confidence in the fairness and credibility of the complaints system may be undermined.[64]

7.2 Burden placed on families, children and carers

The Commission has also heard that the structure of the complaint's framework can place a significant burden on families and carers. Individuals seeking to raise concerns must often navigate a series of procedural steps before reaching any form of independent oversight. These steps may include raising concerns with frontline staff, escalating the matter to a supervisor, participating in a local resolution process and then requesting formal complaint investigation.

> Navigating the complaints process requires a level of literacy, confidence, and procedural knowledge that many children, especially those who have experienced trauma, do not possess.[65]

[62] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025).
[63] Create Foundation, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), pages 7-8.
[64] Data provided to the Commission[64] indicates that as at March 2026, 2,800 children and young people were placed in residential care setting staffed by employed workers rather than family-based carers. Given the scale of residential care provision, ensuring independent, transparent and trusted complaints processes for concerns about service delivery is critical to safeguarding and accountability.
[65] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 3.

For families already experiencing stress related to their involvement with the child protection system, these procedural requirements can feel overwhelming. Some submissions describe situations in which individuals spent months attempting to raise concerns through internal channels without receiving clear guidance about how the process would progress.

This burden may be particularly significant for foster and kinship carers. Carers often rely on departmental support to meet the needs of the children in their care and may be reluctant to escalate disputes for fear that doing so could affect their relationship with the Department. Children in out of home care who may already feel every aspect of their lives is controlled by the Department may also fear the impacts arising from raising complaints. The current complaints system places an additional burden on children in care to not only make their complaint but to also follow up on their complaints.

In the Toowoomba hearings Witness S, a former child in care, described repeatedly raising concerns about unmet dental care with her Child Safety Officer and team leader "with no response" before lodging a formal email complaint. She gave evidence that she "never received a response" to that complaint. When she raised the issue again after leaving care, she was informed that the matter had been treated as a "first attempt at resolution" and considered resolved because it had been assessed as unsubstantiated and she had not pursued it further.[66] Her evidence shows that even where concerns are raised formally, the onus may remain on the complainant to persist, re-engage and repeatedly escalate the matter for it to receive any sustained attention.

7.3 Accessibility

Accessibility issues have also been raised, particularly by Aboriginal and Torres Strait Islander stakeholders.

Several organisations representing Aboriginal and Torres Strait Islander families have told the Commission that complaints processes must be culturally safe and accessible if they are to be effective.[67] Historical experiences of state intervention in family life have contributed to mistrust of government systems within some communities.

> The inadequacies … have a disproportionate and deeply harmful impact on the most vulnerable children in care, particularly Aboriginal and Torres Strait Islander children and

[66] Evidence of Witness S, Transcript, 16 February 2026, 4131.
[67] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025).

> children with disabilities. These groups face compounded barriers to safety, justice, and voice, and the current complaints framework fails to account for their specific needs and lived experiences.[68]

Where complaints systems are perceived as bureaucratic, inaccessible or culturally insensitive, families may be less likely to raise concerns through formal channels. Instead, concerns may be expressed informally or through community networks where they are less likely to trigger formal review mechanisms.[69]

Submissions have emphasised that culturally safe complaint pathways must involve clear communication, community engagement and the participation of Aboriginal and Torres Strait Islander organisations in oversight processes.[70]

7.4 Fear of retribution

Another recurring theme in evidence provided to the Commission is fear of negative consequences associated with raising complaints and the culture of the department.

> Factors influencing hesitance to make a complaint include the power imbalance felt by parents, a preference to build or maintain a good relationship with the Department, and fear of repercussions, reprisal or punishment for the child or the parent in light of the complaint.[71]

> I also wish to highlight that for over 16 months, I have raised cultural concerns and other complaints to the department which have been dismissed or ignored. Instead of being addressed, I am now being punished by a sudden 2-week suspension of all contact with my children, without proper explanation or justification. This is not only distressing but also violates the best interests of the children involved.[72]

Departmental staff have substantial power over the lives of children, parents and carers. Parents involved in child safety proceedings may worry that challenging departmental decisions could influence future assessments of their parenting capacity.[73] Foster and kinship carers reported

[68] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 2.
[69] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025).
[70] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025).
[71] QCOSS, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (4 August 2025), page 2.
[72] Submission No. 0194 to Child Safety Commission of Inquiry (24 October 2025).
[73] Submission No. 0847 to Child Safety Commission of Inquiry (29 March 2026).
QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025) 14.

concerns that raising complaints might affect their approval status or their relationship with caseworkers or alleged this had occurred.[74]

The evidence of Mr Trent Adams in Toowoomba provides a concrete example of this dynamic from the perspective of a worker employed by a funded service provider. His evidence that the complaint process felt as though he was being encouraged "not to progress" the matter[75] which illustrates how complainants and those supporting them may perceive risk in pursuing concerns, particularly where the complaint is directed at the Department itself.

The Commission received a concerning number of examples where carers alleged retribution action had been threatened or had occurred.[76] Most commonly the threatened or actual retribution action was the removal of children from a carer's home. These examples were not limited to one or two child safety service centres.

Similar concerns have been expressed by residential care staff who may observe safety issues within facilities but feel reluctant to escalate those concerns through formal channels. The fear of retribution against a direct care worker within a non-family based residential care setting is exacerbated when workers are employed on a casual basis or via a labour hire company.

These dynamics create the risk that significant concerns about children's safety or wellbeing may go unreported. Where individuals fear that raising concerns will lead to adverse consequences, they may choose not to engage with the complaints system at all.

7.5 Fragmented learning and lack of transparency

> One of the most pervasive and damaging practices within the current framework is the misclassification of formal complaints as mere 'issues.'[77]

Evidence before the Commission indicates that the current complaints framework is not functioning effectively as a mechanism for operational learning. While concerns may be addressed or closed at a local level, stakeholders consistently reported that complaints do not reliably inform broader reflection, quality improvement or system reform.[78]

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[74] For example, Submission No. 0102 to Child Safety Commission of Inquiry (20 October 2025).
[75] Evidence of Mr Trent Adams, Transcript, 25 February 2026, Toowoomba, 4662-4663.
[76] For example, Submission No. 0035 to Child Safety Commission of Inquiry (10 August 2025).
Submission No. 0102 to Child Safety Commission of Inquiry (20 October 2025).
Submission No. 0837 to Child Safety Commission of Inquiry (29 March 2026).
Submission No. 0148 to Child Safety Commission of Inquiry (26 July 2025).
[77] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 3.
[78] For example, see Queensland Catholic Education Commission, Submission to Child Safety Commission of Inquiry (November 2025) 12.

Where complaints are resolved informally, inconsistently recorded or classified in ways that remove them from formal reporting, opportunities to identify patterns across regions, programs or cohorts are lost. This weakens the system's capacity to detect emerging risks, address entrenched practice issues or respond proactively to repeated concerns.

Several submissions described the complaints framework as discouraging engagement rather than supporting learning or improvement:

> In our experience [the complaints framework] is a complete and utter waste of time and designed to discourage complaints rather than seeing them as an opportunities to review processes, procedures or interactions, provide context, explanation or clarification, or to build or form positive relationships with those involved as carers.[79]

The Commission also heard that complainants rarely receive meaningful feedback about how their concerns contributed to changes in policy or practice.[80] This lack of transparency reinforces perceptions that complaints are absorbed into internal processes without producing tangible outcomes, particularly where similar issues are raised repeatedly over time.

Witness S's evidence provides a practical illustration of this learning failure. She described raising the same concerns "countless times" about her care, including through a formal complaint, only to discover that the matter had been administratively treated as resolved.[81] Despite repeated attempts to escalate the issue, there was no evidence that her concerns generated sustained attention, meaningful escalation or system-level visibility.

An effective complaints system should do more than resolve individual disputes. It should operate as a critical feedback mechanism, enabling organisations to identify systemic weaknesses, monitor recurring risks and improve practice over time. Where complaints data is fragmented, misclassified or underutilised, this learning function is significantly diminished.

7.6 Weak escalation pathways

Perhaps the most significant concern raised with the Commission relates to the absence of a clear and credible escalation pathway for complex cases.

QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025) 12.
[79] Submission No. 0544 to Child Safety Commission of Inquiry (3 December 2025).
[80] QATSICPP, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (August 2025) 12.
[81] Evidence of Witness S, Transcript, 16 February 2026, 4131.

> 'Children who courageously raise concerns often find themselves trapped in a cycle of repeated disclosures, unanswered questions, and unresolved trauma.'[82]
>
> 'I would describe the child safety complaints system as a labyrinth or an illusion. Once you think you have found the entrance it takes you to some bizarre, lucky dip choice point, where blind folded, you are asked to make an informed decision.'[83]

Many complainants described reaching the end of internal complaints processes without feeling that their concerns had been adequately addressed.[84] At that point, the available options often appear limited. Where the issues are perceived by the complainant as a significant safety risk, this causes significant stress to the complainant.

The Commission heard from a former child in care who described multiple instances in which she raised concerns about her care, including safety and placement issues, which, in her words, "did not go anywhere".[85]

External oversight bodies such as the Queensland Ombudsman may be perceived as distant from the operational realities of child protection casework with families and carers potentially feeling uncertain about whether these bodies can meaningfully review professional judgments relating to a child's best interests. Further, the Ombudsman officers themselves indicate to complainants that they cannot change the outcome for them but can only review whether a 'fair' process was provided.

As a result, some complainants feel that once internal review processes have concluded, there is effectively nowhere further to go. This perception of a "dead end" within the complaints system is particularly problematic where concerns relate to ongoing case management decisions that continue to affect a child's daily life.

7.7 Concerns relating to best interests

The Commission has also heard that the current complaints framework may not adequately accommodate concerns about whether the child safety system is meeting its broader responsibilities as corporate parent.

Existing complaints processes tend to focus on specific administrative decisions or actions. However, many concerns raised by families and carers relate to broader questions about

[82] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 3.
[83] Submission No. 0092 to Child Safety Commission of Inquiry (14 July 2025).
[84] For example, Submission No. 0102 to Child Safety Commission of Inquiry (20 October 2025).
[85] Evidence of Witness S, Transcript, 16 February 2026, 4131.

whether a child's placement, care arrangements or case planning decisions are meeting their long-term needs.

For example, carers may raise concerns about placement instability, access to therapeutic services or the suitability of educational arrangements. These issues may not necessarily involve clear breaches of policy or procedure but may nonetheless raise significant questions about a child's wellbeing over time.

Where complaints frameworks focus primarily on procedural compliance, such concerns may struggle to find an appropriate pathway for independent review.

7.8 Overall findings on the adequacy of the complaint's framework

In summary, the Commission is satisfied that the available evidence demonstrates that the Department's current complaints framework is inadequate. The breadth, consistency and seriousness of concerns raised through the Inquiry, including topics of maladministration, corrupt conduct and reprisal indicate system weaknesses in the Department's capacity to reliably identify, respond to and learn from concerns raised by those within the child safety system.

The evidence suggests that a complaints model which relies predominantly on matters being referred back to the Department and then to the original decision-maker for management does not inspire confidence among families, carers, young people or professionals. In practice, the current framework does not consistently provide a clear, trusted or accessible pathway for raising concerns about services and decisions that have significant consequences for children's lives. Where confidence in the complaints system is low, individuals are less likely to raise concerns, including those that may be critical to a child's safety or wellbeing.

Reforming the complaints systems therefore requires more than procedural adjustment. It requires careful consideration of the values and principles that should underpin accountability mechanisms within the child safety system, including independence, transparency, accessibility and a genuine commitment to learning and improvement.

Given the complaints system is not peripheral to accountability and improving outcomes for children and young people, without structural reform and a redesign of the complaints pathway, the child safety system will fail those it is intended to protect.

> 'Reforming this system is not optional, it is essential to restoring trust, preventing harm and ensuring that every child in care has a voice that is heard, respected and acted upon.'[86]

[86] YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025), page 3.

Chapter 8

Conclusions about the Current System

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Complaint Systems

Chapter 8: Conclusion about the Current System

After considering the historical background to the current complaints management system and the extensive evidence provided to the Commission, it is clear the current framework is not functioning effectively to address the concerns of children, families, carers and other stakeholders. The consistency and seriousness of issues raised across submissions, hearing and stakeholder engagement indicate that the shortcomings identified as systemic rather than isolated or procedural in nature.

The experiences described to the Commission raise fundamental questions about the design and operation of the existing complaints system. If the central purpose of the child safety system is to nurture and care for children in need of State protection in a manner comparable to that of a reasonable natural parent, then the mechanisms through which concerns about risk, wellbeing and decision-making are raised, assessed and escalated must be capable of operating quickly, transparently and independently.

A culture of transparency and accountability cannot be achieved through administrative policy alone. It requires organisational structures and practices that enable concerns to be raised safely, assessed independently and acted upon when necessary. The effectiveness of any complaints management system depends not only on procedural design but on the broader accountability architecture within which it operates, and the culture and attitudes of those responsible for its implementation.

Given that concerns about the existing complaints framework have been raised repeatedly over many years, the Commission approached its review on the basis that reform must be structural rather than incremental. The task was not to refine the current system, but to consider how the broader accountability framework could be strengthened so that concerns about child safety, wellbeing and best interests can be raised easily and safely, escalated independently, and addressed in a way that improves both individual outcomes and system-level accountability.

Three central propositions emerge from the evidence before the Commission.

Firstly, the child safety complaints system must be understood as a core component of the system's safeguarding and accountability infrastructure, rather than as a standard administrative process. Complaints frequently operate as early warning signals of risk, system failure or

deteriorating circumstances in a child's life. It is essential that these signals can be identified, assessed and acted upon promptly and independently.

Secondly, the current complaints framework is overly reliant on internal departmental processes. While multiple oversight bodies exist within Queensland's integrity system, pathways for escalating concerns are complex and not always clear or accessible to those most affected by child safety decisions. Where multiple agencies may be involved, complainants can experience difficulty obtaining a coherent response to the concerns they raise, undermining confidence in the system's capacity to provide meaningful review.

Thirdly, the existing complaints framework is fragmented and lacks a credible, clearly defined pathway for independent escalation of serious concerns relating to complex child protection cases. It does not adequately distinguish between matters requiring judicial oversight, statutory review and administrative escalation. Although legal review processes exist for certain decisions under the *Child Protection Act 1999* (Qld), many administrative decisions with significant consequences for children's lives fall outside those processes. As a result, the complaints system bears a disproportionate share of the accountability burden, without being structured to fulfil that role effectively.

It is also clear evident that previous recommendations and reform efforts have not been sufficient to address these longstanding concerns. On the basis of evidence before it, the Commission considers that a redesigned complaints and escalation framework is required to restore confidence, strengthen safeguarding and ensure that concerns raised within the child safety system are heard, assessed and acted upon appropriately.

Chapter 9

The Future for Complaints Management

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Complaint Systems

Chapter 9: The Future for Complaints Management

The preceding sections demonstrate that Queensland's current child safety complaints framework is not functioning as an effective safeguard or accountability mechanism. Against this background, the Commission has turned to the design of a reformed complaints framework, guided by a recognition that trust in the complaints system has been significantly eroded and that restoring confidence will require visible, credible change.

For these reasons, the Commission has examined the design of an independent complaint's escalation and review framework, capable of operating outside the Department's existing decision-making structures. The purpose of such an approach is not to permanently displace the Department's responsibility for service delivery or local resolution of concerns, but to ensure that:

(a) serious, complex or unresolved matters can be examined independently, transparently and in a timely way; and

(b) the Department's capacity to manage complaints adequately can be rebuilt.

At the same time, the Commission recognises that complaints systems do not operate in isolation from organisational capability and culture. An effective complaints framework should support learning, strengthen practice and build confidence within the Department over time. Accordingly, the Commission's approach is not premised on permanent separation, but on the establishment of an independent model that can stabilise accountability, rebuild trust and support capability development, with the longer-term objective of enabling a more mature, trusted and internally-robust complaints function within the Department, subject to appropriate external oversight.

The sections that follow set out the principles, core functions and structural features that should guide the design of a reformed child safety complaints system. Together, these elements are intended to create a complaints architecture that is child-centred, accessible, independent where required, and capable of responding proportionately across the full range of concerns, from early resolution to urgent safeguarding intervention.

9.1 Designing a new complaints escalation review process

Drawing on the evidence before the Commission, as well as established administrative law principles and safeguarding frameworks, the Commission considers that any redesigned child safety complaints system should be guided by the following principles.

9.1.1 Independence and impartiality

The complaints system must be trusted by those who rely on it. Trust depends significantly on the perceived independence of those responsible for assessing and reviewing the complaint. Where concerns are assessed within the same operational structures responsible for the original decisions, confidence in fairness of the process is undermined. While not all complaints require external investigation, credible and clearly accessible pathways for independent review must exist for serious concerns or where internal processes have failed. Importantly, original decision-makers must not act as gatekeepers to escalation.

9.1.2 Timeliness and responsiveness

Complaints involving child safety matters often relate to circumstances in which a child's wellbeing may be affected by ongoing decisions or conditions. Delayed responses can therefore have real and immediate consequences. A redesigned system must be capable of identifying urgent matters quickly and responding proportionately, while also ensuring clear communication with complainants about how concerns are being handled and what outcomes may reasonably be expected.

9.1.3 Child-centred design

Complaints processes must be deliberately designed as safeguarding mechanisms, not treated as peripheral administrative functions. Children in care must have accessible, developmentally appropriate ways to raise concerns about their care and treatment, consistent with the Charter of Rights for a Child in Care. This includes access to advocates or trusted adults and the availability of multiple communication channels. Children who raise concerns must be protected from retaliation and supported to feel safe, heard and respected.

9.1.4 Accessibility

The complaints system must be accessible to all individuals who interact with the child safety system. Accessibility requires clarity, simplicity and safety, particularly for

individuals experiencing stress, trauma or power imbalance. For Aboriginal and Torres Strait Islander children and families, culturally safe pathways are essential and may require partnership with Aboriginal and Torres Strait Islander organisations and decision-makers who understand community context and history.

9.1.5 Procedural fairness

Complaints processes should operate in a manner that is fair, transparent and non-adversarial. Given the significant power imbalance inherent in child protection, an inquisitorial approach focused on understand concerns and resolving issues is more appropriate that an adversarial model. Complaints pathways must be accessible without legal representation and capable of addressing concerns quickly and proportionately.

9.1.6 Learning, transparency and accountability

A complaints system should function as both mechanism for resolving individual concerns and a source of insight into system performance. Complaints data must be consistently recorded, analysed and used to inform policy, practice and workforce development. Transparency about outcomes and system responses is essential to maintaining public confidence and demonstrating that concerns lead to meaningful involvement.

9.1.7 Balancing independence and practicality

A reformed complaints system must balance the need for independence with the practical realities of child safety practice.

Not every concern raised within the child safety system requires external investigation or formal escalation. Many matters can and should be resolved through timely, respectful dialogue between families, carers and frontline practitioners. Where this is safe and appropriate, early resolution may be the simplest, most humane and most effective response.

At the same time, the system must clearly recognise that some concerns require independent scrutiny. These include circumstances involving serious allegations, loss of confidence in internal processes, repeated or unresolved concerns, or broader questions about whether the system is acting in the child's best interests. A credible complaints framework must therefore accommodate both early resolution and independent review, without allowing one to obstruct or delay the other.

Designing a system that balances these conditions is essential to ensuring that complaints processes are trusted, proportionate and capable of responding appropriately across the full range of concerns that arise in child protection practice.

These principles reflect the Commission's assessment that Queensland's existing child safety complaints framework contains significant structural weaknesses. Internal complaints processes support local resolution, but lack the independence, consistency and visibility required for serious or recurring concerns. External oversight bodies provide important forms of scrutiny but are not designed to intervene rapidly in urgent safety matters or to review complex child safety case management in a specialised and child-centred way. Between these mechanisms lies a significant gap in the accountability architecture, through which both minor and serious concerns may struggle to receive timely, credible and effective review.

9.2. Core functions of a redesigned child safety complaints system

To give practical effect to the principles set out above, a redesigned child safety complaints system must perform a small number of core functions consistently and well. These functions describe what the system must be able to do, regardless of where responsibilities are located or how the system is ultimately implemented.

The evidence before the Commission demonstrates that the current complaints framework does not reliably perform these functions, particularly in relation to visibility, escalation, urgency and independence. The Commission therefore considers that a reformed system must be designed around the following core capabilities.

9.2.1 A single front door for complaints and concerns

The complaints system must provide a single, clearly identifiable entry point through which all complaints and complaint-like concerns relating to the child safety system can be raised, triaged, and managed or referred.

A single front door is essential to reduce confusion, remove barriers to access and to ensure that concerns are not lost, downgraded or misdirected at the point of entry. Children, families, carers, staff and community members should not be required to determine whether their concern constitutes a "complaint", an "issue", feedback or a safeguarding concern, nor to identify the appropriate agency, unit or escalation pathway. That responsibility must rest with the system, not the complainant.

All expressions of concern about decisions, actions or omissions affecting a child's safety, wellbeing or care should be received, recorded and assessed through this single-entry point, regardless of who raises them or how they are communicated.

9.2.2 No wrong door and consistent capture

While the system should operate through a single front door, it must also embody a no wrong door approach in practice.

Individuals may continue to raise concerns directly with the Department, a service provider, and advocate or another agency. Where this occurs, those concerns must still be captured within the central complaints architecture, rather than being resolved or closed off locally without visibility or follow-through. Local resolution and central oversight should operate as complementary functions, not as alternatives.

Consistent capturing of complaints and complaint-like concerns is foundational to transparency, escalation and learning. Without reliable system-wide visibility, neither safeguarding nor accountability functions can operate effectively.

9.2.3 Rapid triage and risk-based prioritisation

The system must be capable of rapid, independent triage of all complaints and concerns at the point of receipt.

Triage in not a procedural step, it is a safeguarding function. It requires timely assessment of the nature, seriousness and urgency of the concern, including whether it indicates:

- immediate or escalating risk to a child's safety or wellbeing;
- serious or complex case management issues;
- matters suitable for facilitated local resolution; or
- issues more appropriately dealt with by another oversight or regulatory body.

A redesigned system must be able to distinguish quickly between these categories and prioritise responses accordingly. Delayed or inappropriate triage risks allowing harm to escalate, prolong distress for children and families, and undermining confidence in the system.

9.2.4 Proportionate response pathways

Following triage, the system must be able to direct complaints into proportionate response pathways that align with the nature of the concern. This includes:

- supporting early and facilitated local resolution where safe and appropriate;
- providing independent review or investigation of serious or complex matters;
- enabling urgent safeguarding reassessment where a child's current circumstances appear to be deteriorating; and
- assisting with the referral to other bodies where statutory, regulatory or criminal thresholds are engaged.

Crucially, the availability of early resolution pathways must not operate as a barrier to escalation. Where concerns are serious, repeated, unresolved or involve loss of confidence in internal processes, independent review must be accessible without unnecessary delay or gatekeeping.

9.2.5 Independent escalation and review capability

The system must include a credible pathway for independent escalation and review, capable of examining serious and complex child protection matters outside the original decision-making chain. This function is essential to addressing the accountability gap identified throughout this Companion Report. It must be able to examine whether decisions, actions or omissions were appropriate in light of a child's best interests, and to make findings and recommendations that carry authority and weight. Independence in this context is not symbolic, it is central to trust, fairness and legitimacy.

9.2.6 Immediate safeguarding response capability

In addition to complaint resolution and review, the system must be capable of triggering an immediate safeguarding response where credible concerns indicate that a child's present safety, wellbeing or care needs may be deteriorating. This function is distinct from complaint investigation. Its purpose is not to resolve disputes or assess past conduct, but to ensure that warning signs of harm or escalation are identified and acted upon quickly, through independent reassessment where necessary. Without this capability, urgent concerns risk becoming trapped within routine processes while harm intensifies.

9.2.7 System-wide learning and accountability

Finally, the complaints system must operate as a system intelligence and learning mechanism, not solely as a case-by-case dispute resolution process. This requires:

- consistent recording and classification of complaints and concerns;

- routine analysis of trends, patterns and recurring issues;
- visibility of response timeliness and outcomes; and
- mechanisms to ensure lessons learned translate into practice improvement, policy reform and workforce development.

A complaints system that resolves individual matters but fails to learn from them cannot fulfil its safeguarding role. The Commission considers that these core functions cannot be reliably delivered through the existing complaints framework. To operationalise them in a coherent and child-centred way, a redesigned complaints architecture is required.

Chapter 10

An Integrated Complaints Response Framework

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Complaint Systems

Chapter 10: An Integrated Complaints Response Framework

A successful complaint management system within child safety sector requires three core functions to be delivered well. These functions are not discrete processes. In practice, they operate as an integrated and graduated response framework, capable of responding proportionately across the full range of concerns raised within the child safety system.

Rather than relying on a single pathway or escalating all matters through the same process, the framework recognises that different concerns require different responses. These response functions are intended to operate as connected elements of a single system, not as separate or competing processes.

10.1 Strengthening local resolution mechanisms

The first component of the framework is a strengthen approach to local resolution, supported by clear standards, oversight and central visibility.

Many concerns raised by children, families and carers arise from misunderstandings, communication failures, delays, or uncertainty about decisions. Where it is safe and appropriate, such matters may be resolved more quickly and constructively at a local level than through formal escalation. The Commission therefore does not propose removing the role of departmental or service-level complaint handling processes entirely in addressing these concerns.

However, the evidence before the Commission demonstrates that the current system often treats local resolution and central oversight as alternatives, rather than complementary functions. As a result, concerns may be resolved informally without being consistently recorded, monitored or analysed, limiting system learning and obscuring patterns of risk. Further, evidence shows current risks of reprisal or disadvantage when concerns are raised.

Under a redesigned framework, local resolution would continue to play an important role, but all complaints and complaint-like concerns would be captured within a central complaint body's architecture. This would ensure that:

- concerns addressed locally remain visible at a system level;
- unresolved or recurring issues can be identified and escalated where necessary; and
- learning from complaints informs practice improvement across the system.

10.2 Independent escalation, assessment and investigation of serious and complex matters

The second component of the framework is a dedicated pathway for independent escalation and review of serious and complex child safety concerns. These matters commonly involve concerns about the adequacy, appropriateness or timeliness of case management decisions, alleged failures to respond to known risk, disputes about placements or contact, or broader questions about whether the system is acting in a child's best interests. In such cases, complainants often seek more than an explanation, they seek independent consideration of whether decisions or actions were appropriate and whether further intervention is required.[87]

At present, individuals raising concerns must rely on internal departmental processes or general oversight bodies that are not designed to provide specialised, child-focused review of complex case management. This leaves a significant accountability gap.

The Commission therefore considers that the complaints framework must include a credible independent review function, capable of examining serious and complex matters outside the original decision-making chain. This function should be inquisitorial rather than adversarial, focused on understanding what has occurred, assessing the adequacy of responses and identifying what action is required to safeguard the child's wellbeing and rights.

This pathway would not replace court or statutory review mechanisms but would provide an accessible alternative for matters that do not readily fit within those processes and that currently risk remaining unresolved.

10.3 Immediate safeguarding reassessment for urgent concerns.

The third component of the framework addresses a critical gap identified throughout the Inquiry: the absence of a clear mechanism for responding to urgent concerns about a child's current safety or wellbeing.

Some concerns raised through complaints are not primarily about past decision or process failures, but about a belief that a child's circumstances are deteriorating in real time and that existing responses are inadequate. These may involve escalating self-harm, absconding,

87 However it should be noted that related recommendations concerning an expanded role for the Children's Court, together with the proposed court orders will address these related matters in a broadly comparable manner to the way the Family Court resolves or determines parenting disputes.

exploitation, placement breakdown, unmet health or disability needs, or repeated requests for support that have not resulted in effective action.

In such circumstances, waiting for the completion of ordinary complaints processes or local resolution may place children at further risk. The Commission therefore considers that the complaints framework should include an immediate safeguarding reassessment pathway, enabling urgent concerns to trigger rapid, independent review of a child's current circumstances. An instructive analogue exists within the Queensland Health system through Ryan's Rule, which allows patients, families and carers to seek urgent independent review where they believe deterioration is occurring and the existing response is inadequate.[88] Multiple submissions made this recommendation.[89] The Commission considers that a child protection adaptation of this concept has merit, provided its purpose and scope are clearly defined.

This mechanism would function as a safeguard rather than a complaint investigation. Its purpose would be to determine whether immediate reassessment, escalation or intervention is required to protect the child, rather than to apportion blame or resolve disputes. Importantly, access to this pathway should not depend on a person exhausting other channels or navigating complex thresholds. It should also not be a distinct pathway, but a system response through the single front door.

Queensland Health Ombudsman and the "action response" model

The Office of the Health Ombudsman (OHO) provides a useful Queensland-based example of how complaints handling can be integrated with early and proportionate safeguarding action in high-risk service systems.

Under the *Health Ombudsman Act 2013* (Qld), the Health Ombudsman is empowered to take immediate "action responses" where information received through a complaint or notification suggests a serious risk to public safety or patient wellbeing.[90] The enables the Ombudsman to respond rapidly to emerging risk, rather than waiting for the completion of a full investigation or disciplinary process.

[88] Queensland Health, 'Ryan's Rule' (Webpage, 7 November 2025) <https://www.qld.gov.au/health/support/shared-decision-making/ryans-rule>
[89]YFS Ltd, Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Complaints System (31 July 2025)
Submission No. 0094 to Child Safety Commission of Inquiry (date) page 94.
Submission No. 0110 to Child Safety Commission of Inquiry (29 July 2025), page 3.
[90] Health Ombudsman Act 2013 (Qld), Section 38.

The action response mechanism allows the Health Ombudsman to separate urgent risk management from longer-term accountability processes, ensuring that safety concerns are addressed promptly without-pre-judging outcomes or substituting for formal investigation.

The Commission considers this approach instructive for child protection. As with health services, complaints and concerns in child protection often surface early warning signs of deteriorating circumstances that require swift, independent response. The absence of a comparable mechanism within the child safety complaints system means that urgent concerns may remain trapped within routine processes while risk escalates.

The immediate safeguarding response proposed in this Report draws on the logic of the Health Ombudsman's action response model, adapting it to the child protection context. Its purpose is not to determine fault or liability, but to ensure that credible indications of escalating risk to a child's safety or wellbeing trigger timely, independent reassessment and intervention.

10.4 An integrated and navigable system

These components are intended to operate as an integrated response framework, supported by a single front door, rapid triage and clear escalation pathways.

A responsive system should be able to move between pathways as new information emerges or circumstances change. Matters initially addressed through local resolution may require escalation if they are not resolved or if risk increases. Similarly, issues identified through urgent safeguarding reassessment may give rise to longer-term review or systemic learning.

By structuring the complaints system in this way, the framework supports:

- early resolution where appropriate;
- credible independent scrutiny where required; and
- timely intervention when a child’s safety or wellbeing is at risk.

10.5 Recommendations

Recommendation 44: Independent child safety complaints and escalation framework	
Executive Report (Chapter 9)	**Companion Report 6 (Chapter 10)**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this report, progress legislation to establish an independent, child-centred complaints and escalation framework for the child safety system.

This framework should:

a. provide a clear, accessible and trusted pathway for children, families, carers and professionals to raise concerns about decisions and services affecting children, and to have those concerns independently assessed and resolved;

b. be supported by appropriate governance arrangements and structural safeguards to ensure independence, clarity of role and public confidence; and

c. if located within an existing statutory body, include clear separation from other functions, and dedicated leadership and accountability.

CONTEXT:

Complaints are a critical component of safeguarding within child protection systems. The evidence before the Commission demonstrates that complaints are not merely expressions of dissatisfaction, but often represent early indicators of risk, system failure or deteriorating circumstances in a child's life.

The Commission considers that an effective child safety system requires a coherent and independent complaints architecture that complements existing oversight, regulatory and review mechanisms. Its purpose is to ensure that concerns about children's safety and wellbeing are heard, assessed and acted upon in a timely and credible way, while also contributing to broader system learning and improvement.

The Commission's analysis indicates that multiple institutional models are capable of supporting this function. The question of where the function sits is therefore not

determinative in itself but instead reflects a broader policy judgement about the structure and integration of Queensland's accountability framework.

The reform is intended to complement, not duplicate existing judicial review, regulatory, and system-level oversight mechanisms. It is additional to complimentary recommendations concerning the expanded role of the children's court in crucial decisions such as reunification and long-term placement, which if also implemented are expected to avoid complaints from persons directly involved in the system about such crucial matters.

IMPLEMENTATION NOTES:

In determining the appropriate institutional model for this function, the Queensland Government should consider the options outlined in this Report and select the model that best reflects its preferred balance for independence, integration, implementation timeframe and reform ambition. Implementing this recommendation will require careful legislative and operational design, regardless of the institutional model adopted.

At a minimum, the framework should be established with clear statutory authority to receive complaints directly, obtain relevant information, make findings and recommendations, and refer matters where appropriate. It should operate independently from service delivery and departmental decision-making, and be accessible to children, families and carers.

The success of the reform will depend on the establishment of appropriate capability, including a skilled workforce, effective case management systems and the ability to respond in a timely way. It will also require strong mechanisms for analysing complaint information and translating this into system-level insight and improvement.

Where the function is established within an existing statutory body, particular attention should be given to managing potential conflicts of interest and maintaining public confidence. This will require clear legislative delineation of roles, structural separation between functions and dedicated leadership arrangements to preserve the independence and integrity of the complaints function.

Implementation will also require a structured transition, including detailed design of the complaints pathway, engagement with children, families, carers and the sector, and arrangements to ensure continuity of access during the transition period.

In conjunction with the Commission's recommendations for reform to the Childrens Court processes and role, in establishing the complaints framework, the

Government should consider the impacts on appeal rights to QCAT within Schedule 2 of the Child Protection Act.

Chapter 11

What this Could Look Like in Practice

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Complaint Systems

Chapter 11: What this Could Look Like in Practice

The Commission does not propose a single, rigid model for how a redesigned child safety complaints system must be implemented. Rather, it identifies a set of key components and design features that would be necessary to give effect to the principles, core functions and integrated response framework. The objective is not to replicate existing complaints structures in a new form, but to establish a function that is fit for the distinctive risks, power dynamics and safeguarding obligations present in child safety matters.

Queensland Child Safe Standards and complaints management

Queensland's Child Safe Standards, established under the *Child Safe Organisations Act* 2024 (Qld), require organisations that work with children to create environments where children's safety and wellbeing are actively promoted, protected and embedded in everyday practice. The Standards reflect the National Principles for Child Safe Organisations and are overseen by the QFCC as system regulator.

Standard 6 - Complaints management is of particular relevance to the child safety system. It requires that:

- complaints and concerns are child-focussed, accessible and developmentally appropriate;
- complaints processes are trauma-informed and culturally safe, including for Aboriginal and Torres Strait Islander children;
- complaints are taken seriously, responded to promptly and do not result in re-traumatisation; and
- complaint information is used to identify patterns, strengthen practice and support continuous improvement.

While the Child Safe Standards apply broadly across organisations that work with children, the evidence before the Commission indicated that existing complaints arrangements within the statutory child safety system do not consistently meet the intent of Standard 6. In particular, children, families and carers experience barriers to access, uncertainty about escalation, and a lack of timely, independent response when concerns relate to serious risk or complex case management.

The complaints architecture outlined in this Report is intended to give practical effect to Standard 6 within the child safety context.

11.1 Central, independent complaints function

In practice, the redesigned complaints system would be anchored by central complaints function responsible for receiving, recording and triaging all complaints and complaint-like concerns relating to the child safety system.

This function would operate as the system's single front door, ensuring that all concerns, regardless of how or where they are raised, are captured, assessed and directed appropriately. It would relieve children, families, carers and professionals from the burden of navigating complex pathways or determining whether their concern constitutes a complaint, a safeguarding issue or a request for a review.

To restore confidence and address concerns about reprisal and institutional bias, the Commission considers that this function should operate, at least initially, independently of the Department, with clear statutory authority, functional autonomy and appropriate resourcing. There is, however, scope for the complaints function to be returned to the Department in the future if capacity is built and cultural change occurs.

11.2 Centralised triage and navigation

On receipt, each complaint or concern would be subject to centralised triage, undertaken by appropriately skilled staff with expertise in child protection, safeguarding and trauma-informed practice. The purpose of triage would be to:

- identify the nature, seriousness and urgency of the concern;
- assess potential risks to a child's safety, wellbeing or rights;
- determine whether the matter is suitable for facilitated local resolution, independent review or urgent safeguarding reassessment; and
- identify whether referral to another oversight, regulatory or law enforcement body is required.

Importantly, triage would be an active safeguarding function, not a passive administration step. It would be capable of escalating matters quickly where risk is identified and of revisiting earlier

decisions if circumstances change. It would also identify the best method of responding to the issue.

No complainant would be turned away on jurisdictional grounds alone. Where referral is appropriate, the central function would assist with navigation and remain responsible for ensuring that concerns are appropriately directed and tracked.

11.3 Facilitated local resolution with oversight

For matters assessed as suitable for early resolution, the central complaint's function would support facilitated local resolution within the Department or with funded service providers. However, unlike current arrangements, facilitated local resolution would occur with central oversight, clear timeframes and defined accountability. The central function would remain engaged, receiving updates on progress and outcomes, and retaining the ability to escalate matters if resolution is not achieved or if new risks emerge. The Health Ombudsman's local resolution practices provide an example of how local resolution can be conducted with independent central oversight. This approach preserves the benefits of early resolution while addressing the current lack of visibility, consistency and trust.

11.3.1 Independent assessment and investigation of serious and complex matters

Where concerns are serious, complex, unresolved or involve loss of confidence in internal processes, the central function would be able to undertake detailed assessment and investigation to fully review the concerns. In practice this review function would:

- examine relevant records and information held by the Department and service providers;
- assess whether decisions, actions or omissions were appropriate having regard to the child's best interests;
- identify whether further action, reassessment or intervention is required; and
- make findings and recommendations at both an individual and systemic level.

This function would be inquisitorial not adversarial, focused on understanding what has occurred and what needs to change.

11.4 Immediate safeguarding reassessment

Where triage identifies credible concerns that a child's current safety or wellbeing may be deteriorating, the system would be able to activate an immediate safeguarding reassessment pathway. In practice, this would enable urgent concerns to trigger rapid, independent consideration of whether:

- a child's circumstances require immediate reassessment;
- existing responses are adequate; and
- further escalation or intervention is required to prevent harm.

This pathway would be deliberately narrow in scope, focused on present risk rather than historical grievance. Its value lies in ensuring that warning signs are not lost within routine processes or internal hierarchies when a child's circumstances require a faster and more independent response.

11.5 Clear interfaces with oversight bodies

The redesigned system would operate within Queensland's broader integrity and oversight framework, with clear protocols governing referral, information-sharing and coordination with bodies such as:

- courts and tribunals;
- the Queensland Ombudsman;
- the Department's Professional Standards unit;
- the Crime and Corruption Commission;
- the Office of the Public Guardian;
- the Queensland Family and Child Commission;
- professional regulators; and
- law enforcement agencies.

11.6 System learning, transparency and reporting

Beyond managing individual matters, the central complaint's function would serve as a system intelligence capability.

In practice, this would involve:

- consistent recording and classification of complaints and concerns;
- routine analysis of trends, patterns and recurring issues;
- reporting on response timeliness and outcomes; and
- publication of de-identified data and thematic insights to support transparency and learning.

This learning function is critical to shifting the system from reactive complaint handling to proactive improvement.

Chapter 12

Options for Institutional Location and Governance

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Complaint Systems

Chapter 12: Options for Institutional Location and Governance

In considering how a redesigned child safety complaints function could be established in practice, the Commission has examined several institutional location options. Each option is capable, in different ways, of giving effect to the principles, core functions and integrated response framework outlined in this Report. None is without trade-offs.

The discussion below focuses on the relative benefits and risks of each option, recognising that the appropriate choice ultimately turns on government's assessment of urgency, risk, reform ambition and resource constraints.

12.1 Option 1: A stand-alone Child Protection Complaints Commission

One option would be to establish a stand-alone Child Protection Complaints Commission, comparable in form to the Office of the Health Ombudsman, but without prosecutorial or disciplinary powers.

12.1.1 Potential benefits

A stand-alone body would provide a single, clearly identifiable and specialist entry point for child safety complaints in Queensland. It would allow the function to be designed from inception.

This model offers the strongest signal of independence from service delivery, commissioning and internal departmental accountability, which is of significance given the evidence of fear of reprisal and loss of trust in existing complaints pathways.

By excluding prosecutorial or disciplinary functions, the model would avoid many of the costs and complexities associated with other specialist ombudsmen bodies, while still providing robust review, escalation and safeguarding capability.

12.1.2 Risks and limitations

A stand-alone commission would involve higher establishment and operating costs than embedding the function within an existing agency. It would require new legislation, governance arrangements and corporate infrastructure.

There is also a risk that creating a new body could add to the actual, and perceived, system complexity however carefully integrated with existing oversight entities.

12.2 Option 2: A dedicated Child Protection Complaints Division within the Queensland Ombudsman

A second option would be to establish a specialist Child Safety Complaints Division within the Office of the Queensland Ombudsman, led by a Deputy Ombudsman for Child Safety.

12.2.1 Potential benefits

This option would avoid the creation of a new statutory authority while leveraging the Ombudsman's existing legislative framework, governance arrangements, intake capability, case management systems, and reporting infrastructure. It would preserve parliamentary accountability and coherence with Queensland's broader integrity system and may be more readily implementable in the short term.

Embedding this function within an established oversight body may also reduce establishment costs and administrative duplication, while providing immediate independence from the Department. Benefits would include the existing expertise within the Queensland Ombudsman to undertake administrative investigations, as well as the significant savings arising from utilising the Queensland Ombudsman's already established complaints workflows and database. It would also preserve integrity of the complaints function.

12.2.2 Risks and limitations

Child safety complaints raise distinct considerations that differ significantly from most areas of public administration. Further, notwithstanding resourcing constraints, the current procedural approach of the Queensland Ombudsman shows potential limitations in its institutional willingness (though not its theoretical capability) to deliver the requisite accessible, child-friendly and focused child safety work. A Child Safety Complaints Division within a generalist ombudsman structure would therefore benefit from explicit legislative requirements, dedicated resourcing and strong functional separation to be effective.

Without these safeguards, there is a risk that the function could be constrained by:

- standardised "first resort / last resort" thresholds not suited to safeguarding contexts;

- procedural compliance-focused review, rather than merits-based consideration of impact on children;
- limited capacity for rapid escalation in circumstances of critical risk; and/or
- insufficient child-specific, trauma-informed and culturally appropriate engagement capability.

Clear differentiation in approach from departmental complaints processes would be essential, particularly where confidence in internal resolution has broken down. These requirements would need to be embedded in legislation to ensure durability and prevent erosion over time.

12.3 Option 3: Embedding the function within the Queensland Family and Child Commission

The Commission has examined whether the complaints' function could be embedded within the Queensland Family and Child Commission (QFCC).

The QFCC was established following recommendation 12.3 of the Carmody Inquiry with a clear mandate to perform system-level monitoring, review and leadership functions across Queensland's child protection system.[91] Its statutory purposes include monitoring and reporting on system performance, providing strategic advice and building sector and workforce capability.

Since its establishment, the QFCC's remit has expanded significantly, reinforcing its role as a safeguarding and system oversight body for all child-related matters across Queensland. In particular:

- the QFCC performs the Child Death Review function, requiring it to undertake independent, multi-agency analysis of child deaths and serious injuries for the purpose of identifying systemic learning and reform opportunities;
- the QFCC has responsibility for maintaining the Child Safe Standards; and
- from 1 July 2026, the QFCC has been designated as the regulator for the Reportable Conduct Scheme (RCS) under the *Child Safe Organisations Act* 2024 (Qld).

[91] Recommendation 12.3 of the Carmody Report called on the Premier to establish an entity to:
- monitor, review and report on the performance of the child protection system in line with the National Framework for Protecting Australia's Children 2009–2020
- provide cross-sectoral leadership and advice for the protection and care of children and young people to drive achievement of the child protection system
- provide an authoritative view and advice on current research and child protection practice to support the delivery of services and the performance of Queensland's child protection system
- build the capacity of the non-government sector and the child protection workforce.

These developments suggest that the QFCC is increasingly positioned as Queensland's central oversight and safeguarding authority, with responsibility spanning monitoring, regulatory assurance, system learning and sector capability.

12.3.1 Potential benefits

Embedding a child safety complaints function within the QFCC presents a number of opportunities for system reform.

Firstly, it would align complaints handling within the child safety system with Queensland's broader safeguarding architecture. Locating the complaints function within the State's central child-focused oversight body could create a more integrated accountability system, bringing together:

- complaints and concerns;
- system oversight and monitoring;
- regulatory functions (including reportable conduct); and
- system-wide learning and reform.

Secondly, the QFCC's existing system visibility places it in a strong position to translate individual complaints into broader insight. One of the most persistent weaknesses in the current framework is the fragmentation of complaint data and the limited capacity to identify patterns across agencies, regions and service types. Embedding the complaints function within the QFCC would strengthen the link between individual experiences, trend identification and policy and practice reform.

Thirdly, this model supports the development of a single, trusted entry point for complaints and concerns across the child safety system. The QFCC's existing profile as an independent and child-focused entity may assist in rebuilding confidence among children, families and carers who currently perceive complaints processes as inaccessible or lacking independence.

Finally, this option avoids the need to establish a new statutory authority while still providing independence from the Department. This may support a more timely implementation and reduce duplication across the existing integrity system.

12.3.2 Risks and limitations

The Commission recognises that embedding a complaints function within the QFCC also raises important governance and design considerations.

The QFCC's current legislative framework draws a clear distinction between system-level oversight and individual case involvement.[92] Section 9(2) of the *Queensland Family and Child Commission Act* 2014 (Qld) limits the QFCC's role in relation to individual matters, reflecting an intentional separation between system stewardship and monitoring, and case-level decision-making or advocacy.

In addition, QFCC's expanding role across oversight, regulation and system review creates a risk of functional overlap, particularly where complaints intersect with areas subject to reportable conduct oversight, child death reviews or system monitoring or reform advice. This would be made significantly more complex should the QFCC be assigned further, regulatory-type roles in the future.

Without careful design, there is a risk that the same entity could be perceived as reviewing complaints about system performance, while also being responsible for monitoring, analysing or advising on that same system. This may create perceived or actual tensions relating to independence, role clarity and public confidence. There are also practical considerations. The QFCC does not currently operate a complaints intake or investigation function. Establishing this capability would require investment in complaints handling infrastructure, specialist workforce capability and supporting systems and processes. The Commission considers that these risks, while significant, would not be insurmountable and could be mitigated through deliberate structural and legislative design.

Key essential safeguards would include:

- clear statutory separation of functions: there would need to be a distinct complaints function within the QFCC, with legislated independence from its system oversight, regulatory and advisory roles as well as distinction from the Child Death Review Board;
- dedicated leadership and governance arrangements: A separate statutory Child Safety Complaints Commissioner would be required, with defined powers and responsibilities. This role could nominally report to the Principal Commissioner, but would require statutory independence to undertake the complaints function effectively;
- information and operational separation: Creating internal divisions with controlled information-sharing protocols to prevent conflicts of interest or perceived self-review, as

[92] This was as a result of recommendations arising out of the Carmody Report, where the former Commission for Children, Young People and the Child Guardian was abolished and the new Queensland Family and Child Commission was created.

well as to meet information privacy requirements such that complaints information was not used in other QFCC functions without clear consent from those complaining;

- explicit role delineation: Clearly distinguishing between those roles engaged in complaints handling and individual review, from those roles engaged in system monitoring and reporting and regulatory oversight; and
- transparency and accountability mechanisms: Including public reporting, independent scrutiny and clear escalation pathways external to the QFCC where required, to ensure the delivery of a transparent complaints system that functions separately to the QFCC's other roles.

These types of structural protections are not unique to this model and are routinely used across complex regulatory and oversight environments to manage functional separation.

12.3.4 Overall position

On balance, the Commission considers that embedding the complaints function within the QFCC offers a strategically aligned and system-strengthening approach to reform, provided that robust safeguards are implemented to preserve independence, clarity of role and public confidence.

This model supports a more integrated safeguarding architecture, strengthens the connection between individual complaints and system learning, and leverages an existing child-focused institution that is already evolving toward a central oversight and regulatory role.

For these reasons, the Commission considers that, subject to appropriate legislative design and structural separation, the QFCC is a suitable institutional location for the establishment of an independent child safety complaints function.

12.4 Comparative Assessment of Options

The Commission has examined three broad institutional models for the establishment of an independent child safety complaints and escalation functions. Each model is capable of supporting an independent complaint's function. The choice between them turns not only on institutional design, but on government's assessment of risk, reform ambition, implementation timeframe and the degree of structural change considered appropriate for Queensland's child safety system.

12.4.1 Option 1: New standalone statutory authority

A new statutory authority provides the clearest pathway to establishing a purpose-built, independent complaints body. It allows for full structural and operational independence from existing agencies, a clear and singular mandate focussed on complaints, review and escalation and the design of governance, powers and processes tailored specifically to child safety complaints.

This option offers the highest degree of clarity in role and function, reducing the risk of overlap or perceived conflict with existing oversight bodies. However, this model also involves the greatest implementation complexity. Establishing a new entity would require:

- new legislation and governance arrangements;
- establishment of workforce, systems and infrastructure; and
- additional public investment and administrative overhead.

Implementation timeframes may therefore be longer, and there is a risk that reform momentum is delayed while institutional capability is built.

12.4.2 Option 2: Expansion of an existing integrity body

Expanding the remit of an existing integrity body, such as the Queensland Ombudsman, provides a more administratively efficient approach, leveraging existing complaints handling infrastructure, investigative capability and statutory powers and processes.

This model may support more rapid implementation and reduce duplication across the integrity system. However, generalist integrity bodies are not specifically designed for the unique features of child safety complaints, which often involve:

- complex, ongoing case management decisions;
- high levels of vulnerability and trauma; and/or
- the need for child-centred, relational and accessible processes.

Additional legislative, operational and practice redesign would therefore be required to ensure that a generalist model can respond effectively to the specific needs of children, families and carers in the child safety context.

12.4.3 Option 3 – Embedding within the QFCC

Embedding the complaints function within the QFCC presents a structurally integrated model, aligning complaints handling with broader system oversight, safeguarding and reform functions.

As outlined in section 12.3, this option offers potential to strengthen connections between individual complaints and system-level learning, consolidate elements of Queensland's accountability architecture within a child-focused institution and support the development of a more coherent and accessible complaints pathway.

However, this model also represents the greatest departure from the QFCC's current statutory role, which is intentionally focused on system-level oversight rather than individual case resolution.

Introducing a complaints function would require:

- legislative amendments to expand QFCC's functions;
- engagement of officers experienced in complaints and investigative work;
- careful structural separation between complaints handling and existing oversight; regulatory and advisory roles; and
- governance arrangements to manage real or perceived conflicts of interest.

Without these safeguards, there is a risk of blurring the boundary between system stewardship and adjudication, with implications for independence, role clarity and public confidence.

12.4.4 Weighing the options

All three options are capable of supporting the establishment of an independent complaints function. Each involves different trade-offs between:

- independence and clarity of mandate (strongest in Option 1);
- speed and administrative efficiency (strongest in Option 2); and
- system integration and alignment with safeguarding functions (strongest in Option 3).

The evidence before the Commission indicates that the current complaints framework is difficult to navigate and lacks a clear, trusted pathway for escalation. Addressing these issues requires reform that strengthens independence from service delivery, accessibility for children, families and carers, capacity to respond to individual concerns in a timely and credible way and mechanisms for translating complaints into system-level learning and improvement.

The Commission considers that there is no single model that is determinative in all respects. Each option can support the intended reform objectives, provided that it is implemented with appropriate legislative authority, governance safeguards and resourcing.

The choice between these models ultimately requires a policy determination by government regarding:

- the preferred balance between independence and integration;
- the level of structural change it is prepared to undertake;
- the urgency of implementation; and
- the long-term vision for Queensland's child safety accountability architecture.

In this context:

- a new statutory authority (Option 1) provides maximum clarity and independence, but requires greater time and investment;
- an expanded integrity body (Option 2) supports more immediate implementation, but requires adaptation to a child-specific context; and
- an embedded model within the QFCC (Option 3) offers strong alignment with broader safeguarding reform but depends on careful legislative and structural design to manage risks.

For these reasons, the Commission considers that Options 1 and 3 represent the most substantively capable models for achieving the intended reform outcomes, with Option 3 offering advantages where government seeks to purse a more integrated safeguarding framework.

Chapter 13

Implications for Reform

Companion Report 6
Complaint Systems

Chapter 13: Implications for Reform

The establishment of an independent child safety complaints and escalation function represents a significant step in strengthening Queensland's child safety accountability framework. The Commission's analysis indicates that current arrangements are fragmented and difficult to navigate, and do not consistently provide a clear or trusted pathway for raising and resolving concerns about children's safety and wellbeing. Reform is therefore necessary to address these structural limitations and to ensure that concerns can be raised, assessed and responded to in a way that is timely, independent and credible.

The implications of this reform are both structural and practical. At a minimum, the function will require a clear legislative foundation, including authority to receive complaints directly, obtain relevant information, make findings and recommendations, and refer matters where appropriate. Just as importantly, it must operate in a way that is demonstrably independent from service delivery and departmental decision-making. This is central not only to the integrity of the function, but to its capacity to restore confidence among children, families and carers who may be reluctant to engage with existing processes.

Reform will also require deliberate attention to accessibility. The effectiveness of any model will depend on whether it is experienced as real, visible and usable by those it is intended to serve. This includes providing a clear point of entry, child-centred and trauma-informed processes and support for participation where needed. Without these features, structural change alone is unlikely to address the barriers identified in evidence to the Commission.

Beyond its role in resolving individual concerns, the function will need to contribute to broader system improvement. Complaints provide important insight into how the system is experienced in practice, particularly where issues recur or escalate. Ensuring this information is systematically analysed and fed back into policy and practice will be critical to strengthening safeguarding over time. Each of the institutional options considered in this Report is capable of supporting these objectives, but they do so through different structural pathways.

In this respect, the implications of reform are not limited to the creation of a new function but extend to the broader configuration of Queensland's accountability architecture. Careful attention will need to be given to the interface between the complaints function and existing bodies, including the Department, the Queensland Ombudsman and other oversight and regulatory agencies, to ensure clarity of role and avoid duplication or confusion.

Implementation will require a structured approach, including detailed design of the complaints pathway, development of capability and systems and engagement with children, families, carers and the sector. Transitional arrangements will need to ensure continuity of access and support the progressive establishment of trust in the new model.

Ultimately, the success of the reform will not depend solely on where the function sits, but on whether it is able to operate as an accessible, independent and trusted mechanism for responding to concerns, and as a source of insight that contributes to sustained, system-wide improvement in safeguarding and accountability



Child Safety

Commission of Inquiry



Companion Report 7

System Enablers

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands across the State of Queensland, and pays our respects to the Elders past, present, and emerging. We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have contributed to our communities, and recognise our collective responsibility as government, communities, and individuals to ensure equality, recognition, and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Content Warning: All Reports and Appendices may be distressing. They may include reference to violence, abuse, neglect and exploitation and may refer to suicide or self-harming behaviours. They may contain graphic descriptions and strong language. Some narratives may be about First Nations people who have passed away.

Need Help?

If you need urgent help, or are worried about your safety or the safety of a child, please call Triple Zero (000) any time. You can also free call 1800 177 135 for the Department responsible for Child Safety.

For more support services head to:

13YARN – Crisis support for Aboriginal and Torres Strait Islanders
Phone: 13 92 76
https://www.13yarn.org.au/

Lifeline – Crisis support
Phone: 13 11 14
https://www.lifeline.org.au/131114

Headspace Australia – Mental health support for young people
Phone: 1800 650 890
https://headspace.org.au/

1800RESPECT - 24/7 Domestic Violence counselling
Phone: 1800 737 732
https://1800respect.org.au/

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Introduction

> 'Queensland cannot reform its way out of this crisis by doing more of the same—even if trying to do it better...'[1]

This Report examines the conditions that sit beneath the visible and practical operation of the child safety system. They are not concerned with what the various parts of system do at particular points in time, but with what makes it possible for the system to function as intended.

In complex human service systems, outcomes are rarely determined by policy settings alone.[2] They are shaped by the interaction between structure, capability, incentives and information.[3] The public administration and systems theory literature consistently points to one key insight: systems produce the results they are organised to produce,[4] or as Beer (2002) acutely observed: 'the purpose of a system is what it does.'[5] Where the underlying conditions — and especially structure, capability, incentives and information — are aligned, policy intent can be translated into consistent practice. Where they are not, even well-designed policies may yield variable results or unintended consequences.

These underlying conditions will be described for the purposes of this Report as 'enablers.' This term captures the factors that influence, within the child safety system, how authority is exercised, decisions are made and sustained, resources are directed, information is used, and responsibility is understood and maintained. Enablers shape the operation of the child safety system and, consequently, the manner in which frontline practitioners operate and the ways in which children experience the system.

The weight of evidence presented to the Commission indicates that many of the enablers within the child safety system are not consistently aligned, and at times are functioning as inhibitors or obstacles to optimal system performance and outcomes for children. Across many parts of the system, the Commission has identified patterns that suggest the underlying architecture of the system is not configured to support the outcomes that the system seeks to achieve. Some decisions are made without clear lines of responsibility. Services may be available, but not consistently accessible or coordinated. Information is generated, but not translated into sustained learning. Resources may be committed, but not always directed in a way that

[1] Cape York Institute for Policy and Leadership, Submission to Child Safety Commission of Inquiry (April 2026), 26.
[2] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* (Report, November 2016).
[3] Donella Meadows, *Thinking in Systems: A Primer* (Chelsea Green Publishing, 2008); Brian Head and John Alford, 'Wicked Problems: Implications for Public Policy and Management' (2013) 47(6) *Administration and Society* 711-739.
[4] Donella Meadows, *Thinking in Systems: A Primer* (Chelsea Green Publishing, 2008) 89.
[5] Stafford Beer, 'What is cybernetics' (2002) 31(2) *Kybernetes*, 209-219, 218, quoted in Joel Cullin, 'If We Look at Child Protection Reform through the lens of Systems Science, What do we See?' (2022) 52(7) *British Journal of Social Work* 3964-3981, 3965.

reinforces stability over time. Staff work hard, but their efforts are not always supported by structures that enable them to be effective.

These are not discrete issues or a reflection on individual practitioners. Rather, they are manifestations of how the system is organised and supported by its core enabling features.

Queensland's experience of successive reform efforts demonstrates that durable reform in child protection depends not only on identifying the right interventions, but also on ensuring the conditions and supports which enable those interventions to be implemented, sustained and adapted over time. Multiple inquiries, reviews and reform programs have identified the same issues and, in some cases, have partially addressed them.[6] However, the evidence before the Commission indicated that these efforts have not consistently been translated into sustained and widespread change. Indeed, despite these efforts, Queensland has been subjected to yet another Inquiry and public scrutiny has again focused on the system, breaking, failing and existing in the shadow of opportunities lost.

What has become apparent from the legacy of past inquiries and reviews is that reform efforts appear to falter when attention is concentrated largely on frontline or operational functions without sufficient attention to governance, organisational alignment, workforce capability, funding discipline and whether the system is learning from information gathered about its operation and from past mistakes. In such circumstances, reform efforts are unlikely to be sustained.

This Report provides the foundation for the Commission's consideration of reform implementation. It details and examines the enabling conditions that underpin and animate the visible operation of the system. The analysis is organised across five interrelated domains:

1. How the system is structured;
2. How accountability is defined and exercised;
3. How the workforce is supported to perform its role;
4. How services are commissioned and delivered; and
5. How information is generated, interpreted and translated into action.

[6] For instance, Crime and Misconduct Commission, *Protecting children: an inquiry into abuse of children in foster care, Crime and Misconduct Commission* (2004), Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) and Queensland Ombudsman, *Management of Child Safety Complaints: Investigation Report* (2016).

For the sake of clarity, these domains are presented separately. In practice, they are interdependent and, at times, overlapping. For example, decisions about organisational structure affect accountability. Commissioning arrangements shape workforce conditions and service quality. Information systems influence accountability, resource allocation and whether the system can learn from past mistakes. Accordingly, the effectiveness of any one domain depends on its alignment with the others. For this reason, and to avoid fragmentation or duplication, recommendations for this Report are drawn together at the completion of this Report as opposed to the end of each chapter. This supports the presentation of an integrated and coherent set of recommendations that reflect the interdependency of these enablers and their combined influence on the performance of the child safety system.

Chapter 1

System Design, Structure and the Operating Model

Companion Report 7

System Enablers

Chapter 1: System Design, Structure and the Operating Model

Abstract

This chapter examines how Queensland's child safety system is organised and how its functions operate across the service continuum. It explores the way responsibilities are distributed across intake, assessment, litigation, family-based care, non-family-based care, permanency, youth justice interfaces and transition from care. The chapter concludes that many of the system's weaknesses are not isolated practice failures, but arise from structural fragmentation, unclear pathways and an operating model that too often responds to crisis rather than guiding children and families through a coherent, purposeful system.

1. Introduction

The organisational design of Queensland's child safety system establishes the structural conditions within which all decisions relating to the safety and care of children are made. This organisational design shapes how work is distributed, information travels and authority is exercised. It also determines how the system behaves in practice, including the consistency of decisions and how responsibility is maintained over time, as well as how quickly and how effectively the system can respond to risk and need.

The Commission heard of many issues that are not adequately explained by practitioner judgement, policy intent or resourcing levels alone. Rather, these issues are better understood as consequences of how the system is structured and operates across its constituent elements. These structural features include the distribution of functions across different parts of the Department, the regionalised model of service delivery, the relationship between departmental decision-making and services delivered by non-government providers, and the way in which responsibility for children is transferred or shared over time both within the child safety system and across adjacent human service systems. Each of these features entail critical points of interface where information is transferred, decisions are translated into action, and responsibility must be maintained.

The significance of organisational design has been recognised in earlier Queensland Inquiries[7] and in the work of institutions with a role in monitoring or supporting the system,[8] although often expressed in other terms. Previous reviews have drawn attention to the challenges of coordinating responses across the Department, the difficulty of maintaining consistent practice across a geographically dispersed system, and the need for clearer alignment between system objectives and organisational arrangements.[9] Contemporary research similarly emphasises that the effectiveness of child safety systems is strongly influenced by how they are structured, including the clarity of roles, how functions are integrated, and the degree to which responsibility for outcomes is sustained rather than episodic.[10]

The evidence presented to the Commission suggests that, in Queensland, the current operating model combines elements that on their own are coherent and usually necessary, but collectively difficult to align in practice, particularly at the points where responsibility must be transferred, shared or coordinated.[11] In order to operate coherently and effectively, the system requires significant coordination.[12] However, in Queensland, child safety services are delivered through regional offices, the system is structured both around different roles, functions and geographical locations, and the system relies heavily on outsourcing (for example, the Queensland Family and Child Commission (QFCC) notes that approximately 75% of the Department's out-of-home care expenditure is directed to external providers).[13] The operations of the Department require constant interaction with other human services systems, including the health, disability, education, housing, policing and youth justice systems. Each of these features introduces points at which coordination is required, decisions must be made and implemented, and responsibility must be shared.

[7] For instance, Leneen Forde, *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (Report, May 1999); Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013).
[8] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 23; PeakCare, *Submission to Child Safety Commission of Inquiry regarding Youth Justice and Corporate Parenting* (23 January 2026).
[9] Leneen Forde, *Report of the Commission of Inquiry into Child Abuse in Queensland Institutions* (Report, May 1999); Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013).
[10] Nanne Isokuortti, 'Organizational and Systems Factors Impacting the Adaptation of a Child Welfare Practice Model from the UK to Finland' (2024) 48(4) *Human Services Organizations: Management, Leadership & Governance*.
[11] For example, evidence presented during the Far North Queensland hearings showed that when a child is placed in care, the detailed discussion and agreement about how the child's needs will be met occurs with the provider after placement, and that in emergency placements there is insufficient time to work through those specific actions beforehand. In the same hearing, the witness also accepted that, at a regional level, the Department did not 'undertake or hold' information about efficacy, value for money and outcomes, and that those matters sat with those involved in investment and commissioning. That is a very concrete example of an operating model that fragments frontline regional decision-making, provider engagement and central commissioning oversight. Each element is individually understandable; but taken together, they are difficult to align around a single child's needs and a single line of accountability.
[12] For a discussion of the importance of coordination in complex systems, see Brian W. Head and John Alford, 'Wicked Problems: Implications for Public Policy and Management' (2013) 47(6) *Administration and Society* 711, 724-728.
[13] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026).

Where these points of connection are well designed and actively managed, they can support responsive and locally informed practice. Where they are not, they can produce fragmentation, variability and discontinuity in the experience of children and families.

A central issue emerging from the evidence is the challenge of coordinating and maintaining responsibility for individual children as they move through the system over time. Children are rarely affected by a single part of the child safety system: instead, their experience is shaped across functions, teams, regions, providers as well as, often, multiple human service systems. At each transition, information must be transferred, relationships re-established, and decisions reinterpreted in a new context. The extent to which the system can maintain continuity for children across these transitions is not solely a matter of individual practice by frontline practitioners: It is fundamentally shaped by how the system is designed to operate. The evidence provided to the Commission by children in care and by carers illustrates the consequences of this discontinuity — including repeated transitions, loss of relational continuity and decisions made without a sufficient understanding of the child's circumstances.[14]

This chapter examines the structural conditions related to organisational design that underpin the performance of the child safety system. It considers whether the current design of the system supports continuity of responsibility, coherence of decision-making and consistency of the experience of care for children, or whether it contributes to the fragmentation and variability of service provision identified throughout the course of the Commission. In doing so, the chapter proceeds on the basis that enduring improvements in outcomes for children will depend not only on what the system does, but on how it is organised to do it.

2. Current State

The Department administers a number of functions internally as well as funding and overseeing a range of external services, including foster and kinship care, and some supports for children in out-of-home care.[15] The current operating model has developed incrementally over time in response to changing demand, policy reform and administrative restructuring.

[14] 1) Witness X described an absence of Department support for their multiple movements between care placements and reunification, identifying that an environment of chronic instability made them 'grow up really fast.' 2) Foster carer Witness H described their experience of a Child Safety Officer urgently removing a child from their care, saying 'we've found a placement' as justification for removal.
[15] Statement of Belinda Drew (3 September 2025) [21].

The Commission recognises the social, cultural and geographical diversity across Queensland, and that service delivery must balance competing demands, including specialist expertise, local responsiveness, scalability and coordination across a complex human services environment.[16]

At a functional level, responsibility for the protection and care of children is distributed across a series of interdependent functions, including intake and assessment, litigation processes, ongoing case management, placement coordination, engagement with carers, and the commissioning and oversight of services delivered by non-government organisations.[17] In principle, this differentiation supports specialisation and enables the system to manage high volumes of work. However, it also means that responsibility for a child is not held within a single, continuous locus. As children move through the system, the primary point of responsibility commonly shifts between teams performing different functions. This results in changes in the decision-making context, the need for information to be transferred, and for new relationships between Departmental staff, families, carers, professionals and children to be established. Such an approach also greatly increases the likelihood of inconsistent decision-making.

A second defining feature of the operating model is its reliance on regionally based service delivery.[18] This model allows staff in regional offices to draw on local knowledge, respond to community conditions and build relationships with local service providers and Aboriginal and Torres Strait Islander communities.[19] It also reflects the practical necessity of delivering services across all corners of a State comparable in size to Western Europe and extending from dense urban centres to some of the most remote communities in Australia.

At the same time, regionalisation introduces additional layers of complexity. It requires the system to maintain consistency of practice and decision-making across multiple operational environments, each with different challenges, resource profiles and service landscapes. It also creates a degree of separation between central policy direction and local implementation, requiring mechanisms to ensure that system-wide objectives are translated into consistent practice at the regional level.

A further defining feature of the operating model is the extent to which service delivery is shared with, and outsourced to, the non-government sector. A significant proportion of placement and support services, including family support, foster and kinship care support, and residential care, are delivered by external providers under commissioning arrangements.[20] This creates a hybrid

[16] Statement of Meegan Crawford (29 August 2025) [10]-[13].
[17] Statement No. 3 of Meegan Crawford, pp. 3-5.
[18] Statement of Meegan Crawford (29 August 2025) [9]-[13].
[19] Statement of Meegan Crawford (29 August 2025) [12].
[20] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026).

system in which the Department (except in cases of Delegated Authority[21]) retains statutory responsibility for decision-making, while much of the direct service response is delivered by organisations operating under contractual arrangements.

This model expands the range of services available, potentially brings in new expertise, and allows for flexibility in service delivery. It also introduces additional interfaces as well as commercial relationships that must be managed effectively. Decisions made within the statutory system must be translated into service responses delivered by providers external to the Department, and information generated in the process of non-government service delivery must ideally be fed back into departmental decision-making. The quality of these interactions depends on the clarity of roles, clear and precise specification of contractual obligations, the alignment of objectives, and the effectiveness of communication and oversight mechanisms. Gaps or failures of the commissioning process or lack of clarity in expectations or accountability create weak points in the system which directly impact the experience of children or families.

The system also continually interacts with other human service systems.[22] These interactions are not peripheral. Children involved in the child safety system frequently require services across multiple domains. The effectiveness of the system therefore depends not only on internal coordination, but on how it relies upon, and interacts with, these adjacent systems.

When considered together, these features describe how the child safety system's design, structure and operating model is widely distributed in a networked fashion, rather than a tighter, more linear structure. Its effectiveness therefore depends not only on the performance of its individual components, but on the integrity of the relationships and interactions between them.

3. Functional distribution and functional tensions

A defining feature of the Department's current operating model is the distribution of core child safety functions across multiple roles, teams and organisational layers. This distribution reflects deliberate policy choices, including separating investigation from support, distinguishing decision-making about guardianship from service delivery, introducing independent legal scrutiny, and drawing upon specialist expertise at different stages of a child's involvement with the system. Each of these elements has a clear rationale, and taken individually, they are coherent and, in many respects, necessary in a system that must balance risk, rights, care and

[21] Under the *Child Protection Act 1999* (Qld), a prescribed delegate has the statutory responsibility to perform or exercise specific function(s) or power(s) delegated by the chief executive, in relation to an Aboriginal or Torres Strait Islander child who is a child in need of protection; or likely to become a child in need of protection.
[22] Including health, mental health, disability, education, housing, police and youth justice.

accountability. However, the evidence available to the Commission indicates that when these functions are brought together in practice, they generate structural tensions that are not easily reconciled.

The most direct manifestation of this tension is at the level of frontline practice. Child Safety Officers (CSOs) are required to perform a range of functions simultaneously: assessing risk, supporting families, making decisions that may lead to removal of a child from their family or carer, engaging in court processes and coordinating services. Each of these functions carries different expectations, and requires different modes of engagement, some of which may directly conflict with others, or come at the expense of other priorities. The same practitioner may be required to build trust with a family while also gathering evidence that may support removal, and to respond to immediate safety concerns while supporting longer-term change and reunification.[23] Evidence before the Commission reflects the practical consequences of the breadth of the CSO role,[24] including circumstances in which practitioners must make decisions about removal in the absence of suitable placement options, or intervene in cases where underlying need could not be addressed through available supports.[25] This is not a matter of individual capability. It is a consequence of how the role is structured within the broader system.

Similar tensions arise at the interface between practice, legal processes and decision-making authority. The current litigation model (analysed in detail in Companion Report 2: Child Protection Litigation) introduces both professional separation and independent scrutiny. In principle, this creates checks and balances; in practice, the evidence indicates that it fragments responsibility across multiple parties and shapes practice in ways that prioritise procedural requirements alongside, and at times over, relational engagement. Decisions about children's lives are therefore influenced not only by their needs, but by how responsibility is distributed across the legal and administrative architecture. The Commission has heard about tensions and disagreements between the judgment of frontline staff and the ultimate legal decision-makers engaged in court processes that directly impact children and families within the system and lead to delays and confusion.

[23] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3244:39-3244:47.
[24] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025.
[25] 1) This tension in the role of CSOs is illustrated by their evidence that 'there are children who continue to be at risk because we simply don't have anywhere to put them if removed' and other 'cases which do not need to be involved in child safety but because there is not enough support or services for the children to remain safely at home… they are removed.' Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 31. 2) Deputy Chief Executive Officer of Goolburri, Trent Adams described the impact of broken trust between the family and the CSO when a child is removed, explaining that 'if the CSO's been deemed to be the… reason of removal, whether it's an upstairs decision or downstairs, the community member will blame the CSO in the short.' Transcript, Evidence of Trent Adams (25 February 2026) 4709:7-4709-10.

A further dimension of functional tension arises between frontline responsibility and control over system levers. Regional and frontline staff are responsible for decisions about children, including their placement with carers and case management. However, key elements that affect what can be delivered, including commissioning, funding and some aspects of service availability, sit elsewhere in the system. This reflects a sometimes-logical separation between policy and purchasing and delivery. However, it can result in situations where those accountable for outcomes do not control the mechanisms required to achieve them.[26]

This pattern extends to the relationship between specialist functions and broader service delivery. Specialist teams (often located centrally) provide expertise, guidance and targeted support, including in areas such as domestic and family violence, alcohol and other drugs, and supporting children with disability. Their role is critical in addressing specific needs. However, their involvement is often episodic or advisory, while responsibility for ongoing case management remains with generalist frontline teams. This creates a further interface that must be navigated to maintain coherence in decision-making and continuity in a variety of forms for children.

These examples point to a broader characteristic of structure: the system is comprised of functions that may be individually rational but are collectively difficult to align. These tensions do not arise from a single design decision. They are the result of the cumulative layering of activities over time, often introduced to address identified risks or gaps. Each addition may have a clear purpose. The unintended consequence, however, is an operating model that must accommodate multiple, and at times competing, imperatives within the same operational sphere. The challenge for the system is not whether these functions should exist, but how they are to be configured and connected so that they operate as a coherent whole and achieve their intended purpose – which must be to support the best interests of the children within the system.

Structural example: legal independence, portfolio alignment and system design

Companion Report 2: Child Protection Litigation details the current child protection litigation model and makes a series of recommendations to reshape the court process into a streamlined, unified litigation system focussed on achieving the

[26] Witness Corinne Porta agreed that as Regional Director, she had strategic leadership, management and service delivery oversight of Child Safety Service Centres in her region. However, when asked whether that extended to oversight of residential care placements, she distinguished between her role in a 'practice sense and decision-making sense' and the oversight of contracts, licensing agreements and service agreements, which sat with a different director who oversaw investment and partnership teams, and who reported to the Regional Executive Director. That vividly illustrates the disconnect between local practice responsibility and the settings that govern what is purchased, contracted or licensed. The same evidence demonstrated that regional decision-makers may carry operational responsibility for children but no power to shape implementation. Transcript, Evidence of Corinne Porta (24 November 2025) 2598:4-2598:10.

purposes of statutory intervention. For example, the Commission recommends the Government move to a model where all child protection applications are litigated by a single, independent, statutory legal entity. The positioning of this statutory entity is a useful example of the broader system-design issues examined in this chapter. In child protection, structural constraints impact upon practice. Where functions are separated across entities, portfolios and information and case management systems, any system design must be clear about who is responsible for what, how decisions are made, how information is shared, and how the child's best interests will be achieved.

The Commission recommends that the statutory entity responsible for child protection litigation remains separate from Departmental operations and retains independent legal decision-making authority. One question then arises as to where that entity should sit within government to best achieve the purposes of the child protection litigation system. For example, locating the independent statutory entity within the Justice portfolio may strengthen institutional independence, arm's-length legal judgement and confidence that applications are scrutinised before being brought before the court. However, location within the child protection portfolio more naturally supports closer alignment with the system's purpose, reform priorities, ministerial accountability and outcomes for children.

Child Protection Orders form the basis for the Department's intervention beyond voluntary engagement, including Decisions about case planning, permanency, family participation, cultural planning and service access. Similarly, greater complexity in the litigation model often increases the time children spend in uncertainty. If the legal entity is structurally distant from the Child Safety portfolio, the government must take steps to enhance collaboration and reduce the fragmentation currently observed in the system. A well-designed litigation function should be formally independent, yet sufficiently connected to the work of the Department and accountable for its contribution to fair, timely, evidence-based decisions in the best interests of children.

This issue illustrates a recurring theme in the system's operating model. Independence, oversight, specialisation and regional differentiation are valuable, but they must be designed in a way that strengthens coherence rather than creating disconnected parts of the Department, the system or the Government.

4. Regionally based delivery model

A second defining feature of the current operating model is its reliance on regionally based service delivery. Queensland's geographic scale and diversity require services to be organised in a way that is responsive to local context. A centrally administered, uniform model would be unlikely to meet the needs of children and families across metropolitan, regional, rural and remote settings.

The regional model is grounded in the principle that decision-making and service delivery should sit as close as possible to the communities they serve. It also allows for contextualised practice. Regions can draw on local knowledge, respond to community conditions and build relationships with local service providers and Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCOs). This is particularly important given that in regional and remote areas local knowledge and relationships are critical to effective engagement of children and families.[27]

At the same time, the Commission heard consistent evidence that the regional model can result in variation in practice, unequal access to services, and inconsistencies in decision-making approaches across the State.[28] This variation arises from several interacting factors.

Firstly, there is variation in service availability. The range of family support services, therapeutic supports, placement options and specialist providers differ significantly across regions. In metropolitan areas, a broader range of services provides the 'requisite variety' that enables more tailored responses. In regional and remote areas, described by Far North Queensland Regional Director Corinne Porta, as impacted by 'the tyranny of… distance', [29] options are often more limited. This shapes both service delivery and decision-making, including whether children can remain safely at home, the types of placements available, and the supports that can be provided and sustained over time.

[27] 1) During the Far North Queensland hearings, witnesses described delegated authority as a means of increasing Aboriginal and Torres Strait Islander family participation in interventions or legal proceedings through ATSICCOs and identified local initiatives. 2) Separate evidence in the litigation hearing also supported the proposition that family support is best delivered through ATSICCOs under delegated authority.
[28] 1) Witness Y remarked that 'the poverty, the housing, the limited services, [and] the isolation' are key points of variance between remote communities and urban communities. These differences contributed to differential application of the Child Safety Practice Manual in remote settings, as evidenced by their experience of a Child Safety Manager visiting a remote community and viewing the treatment of children in the community through a seemingly urban lens, saying 'I just felt like going there and removing every child.' 2) Clair Martin, Principal Lawyer of the Office of the Child and Family Official Solicitor described differences in practice between regional and urban settings, particularly regarding engagement with community-controlled organisations and external services. She observed that the 'higher populations of First Nations families' in Far North Queensland tended to result in CSOs who were 'more aware of the obligations with respect to active efforts and the placement principle and independent persons,' compared with their counterparts in South-East Queensland.
[29] Transcript, Evidence of Corinne Porta (20 November 2025) 2475:4-2475:14.

Secondly, there is variation in workforce capacity and capability across child safety regions. Recruitment, retention and experience levels of staff differ across regions. In some areas, high turnover of staff affects continuity of relationships between departmental staff and carers, parents and children, as well as consistency of practice. In others, more stable teams support stronger relationships and engagement with carers, parents and children, and result in more effective use of local knowledge. These differences influence how policy is interpreted and applied in practice.[30]

Thirdly, variations between staff in the translation of policy into practice is amplified by regional differences. While policies and practice frameworks are intended to provide consistency, their implementation depends on local leadership, the capabilities of staff and context. For example, the Commission was told 'Policies and legislation are made by people who don't live in our reality. Don't take into account remote, rural areas and the lack of everything that goes with it.'[31] Children, carers and parents across the regions may have different residential care experiences of the implementation of the same policy.

Evidence presented to the Commission emphasised the importance of collaboration across Queensland's child safety system. Consultation with local communities is important to create policy that generates good practice tailored to the needs and requirements of each region, rather than a one-size-fits-all approach across Queensland. This demonstrates that variation in practice across Queensland's regions is not inherently problematic. Given the scale of the system, some degree of variation is both inevitable and appropriate. However, different applications of policy become problematic where those differences affect access to services, the quality of decision-making, or the stability of outcomes for children.

The regional model also has implications for the 'line of sight' of accountability mechanisms. Responsibility for service delivery and some commissioning sits within regions, while policy, overarching funding and oversight functions are located centrally or across different parts of the system.

This creates a distributed model in which accountability must be exercised across intra-organisational boundaries, rather than there being a clean line of sight between decisions that sit

[30] 1) Witness Ken Pyne, the Regional Manager of Kanda Care in Cairns described how 'the nature of Cairns as a region' created ongoing issues with recruiting and retaining staff, resulting in some CSOs not being around for long enough to 'form a relationship with the child.' 2) Similarly, Acting Director General of Youth Justice and Victim Support, Michael Drane identified 'workforce shortages in some… regional and remote locations' as one of the most significant challenges to Queensland's 'human services sectors' that other states don't experience to the same degree.
[31] Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 30.

in one part of the system and the consequences or flow-on effects of the decision throughout the entire chain of the system.

The effectiveness of the regional model depends on the strength of its coordination mechanisms, including governance structures, reporting frameworks and communication between central and regional teams. Under the current model, the Department relies on coordination mechanisms to maintain coherence. These include governance structures, reporting frameworks, performance monitoring and communication channels between central and regional teams. The weight of evidence presented to the Commission suggests that where these mechanisms are strong, they support alignment while preserving local flexibility. However, where they are weaker or inconsistently applied, the system operates as a distribution of more loosely connected regional systems rather than as a single, integrated whole. After using an analogy of a jigsaw puzzle, Witness AB concluded that 'if communication and people aren't working together it just totally breaks down.'[32]

Inherent in the regional model is a fundamental tension between responsiveness and consistency. This tension enables locally informed service delivery but operates within a child safety system that seeks to provide equitable outcomes for children across the State. The effectiveness of the model depends on the system's ability to manage this tension and maintain coherence across regions.

5. Shared service delivery with the non-government sector

A defining feature of the operating model is the extent to which service delivery is shared with, and in some instances, outsourced to, the non-government sector. Non-government organisations play a central, and in some parts of the system, a dominant role in delivering services to children and families. In practice, the State commonly retains statutory authority and decision-making responsibility, while a substantial proportion of service delivery, including family support, foster and kinship care support, and residential care, is undertaken by non-government organisations and individual carers.

A shared delivery model has two main advantages. Firstly, it enables the system to draw on a wide range of non-government organisations and partners with diversity in their approaches, flexibility and community connection of the non-government sector, including ATSICCOs and specialist providers. These organisations can provide culturally grounded, specialist residential care,

[32] Transcript, Evidence of Witness AB (12 September 2025) 581:18-581:19.

community-based and therapeutic services, and can offer forms of continuity with community, culture and relationships. They can also provide responsiveness that is not always available within the parameters of departmental capacity or expertise. Secondly, the involvement of non-government providers also allows the system to increase the level of service delivery beyond what could be provided directly by government, particularly in a system experiencing sustained demand for care services. However, the evidence indicates that the shared service model introduces complexity in relation to how responsibility, control and accountability are exercised.

The State retains ultimate responsibility for the safety and wellbeing of children, including those placed with or supported by non-government providers. At the same time, the day-to-day care of children and the delivery of services are undertaken by organisations operating under contractual arrangements. This creates a model in which responsibility is retained, but delivery is distributed.

The effectiveness of this model depends on the system's ability to ensure consistent and adequate service delivery through commissioning, contracting and oversight arrangements.

Key terminology

- Commissioning entails determining what services are available and where, and which of these are best suited to the Department's requirements.
- Contracting arrangements specify the Department's expectations, the funding structures and the performance requirements.
- Oversight mechanisms monitor the way in which services are carried out, identify emerging risks, and if needs be, take measures to ensure full and substantive compliance with contractual requirements.

The evidence suggests that in practice these elements are not consistently implemented in Queensland. As a result, there is variation in service models, workforce arrangements and the quality of care experienced by children and families. These problems are particularly evident in parts of the system where service delivery is heavily dependent on provider capability, most notably residential care, are particularly vulnerable to variation in staffing, practice quality and organisational approach, resulting in inconsistent, and at times poor, experiences for children.[33]

There are differences in the care and support provided to carers. There are also differences in recruitment, training and other support provided by different service providers. These differences

[33] For example: Funding and commissioning settings can influence these models, including the extent to which services are able to provide stable, relational care as opposed to shift-based supervision. The presence of both not-for-profit and for-profit providers further adds to the diversity of the service landscape. See Companion Report 4: Understanding and Reforming the Residential Care System.

contribute to variation of experience of outcomes, though supply side constraints, particularly in remote areas contribute significantly to these variations.

An important aspect of the shared services model is the interface between statutory decision-making and the delivery of the specified services. Decisions about placement, case planning and intervention are made within the statutory system, however their implementation depends on the capacity, capability and approach of non-government providers. Successful implementation depends on the quality and availability of services and upon the effectiveness of the relationships between the Department, providers and carers. Where these relationships are collaborative, they are likely to support communication and trust and responsiveness. Where they are transactional or focused on literal or paper compliance, they can limit the ability of the system to respond flexibly to children's needs.

The shared delivery model reflects a fundamental tension between scale and control, diversity and consistency, and responsibility and delivery. It enables the system to draw on a broader service base but requires strong alignment between statutory authority and service provision. The evidence suggests that this alignment is not consistently achieved, and that the system does not always operate as a single, coherent model of responsibility for children. Diversity in how services are provided is not inherently problematic. It becomes problematic where the parties do not share clear expectations, or if oversight is lax or inconsistent, and especially if the result is that children experience sub-standard care.

The Commission is satisfied that the current model of shared service delivery does not contain appropriate and consistent commissioning, contracting, and oversight arrangements to deliver adequate care and support to children, parents, and carers.

6. The involvement of multiple human service systems

A fourth defining feature of the operating model is that the child safety system does not operate in isolation. It is embedded within, and dependent upon, a broader child protection network of human service systems, including health, mental health, disability, education, housing, police and youth justice systems. This reflects a fundamental reality: the children and families involved with the child safety system commonly have multiple, complex and overlapping needs. Effective responses therefore require coordinated involvement across multiple systems, recognising that each of these systems has its own mandate, legislative framework and service architecture.

At its strongest, this multi-system model enables a more comprehensive response to children's needs than any single system could provide, recognising that the child safety system alone cannot address the drivers of harm or deliver long-term stability.

The evidence suggests, however, that when multiple systems are engaged to support children and families in the broader child protection system, they do not consistently operate in a coherent and successfully integrated system. Instead, they are fragmented, and function as adjacent systems with intersecting responsibilities, rather than a unified system with shared accountability. Fragmentation across systems is a significant problem, because it can result in delays, gaps in service provision, and carers and practitioners wasting time and effort while they navigate multiple systems to secure support for children.[34]

Firstly, there is misalignment in access and eligibility across systems. Different systems apply different thresholds, criteria and timeframes for service provision. A child or a family may be identified as requiring support but may not meet the criteria for timely access to mental health, disability or housing services. This can result in delays, gaps in service provision, or the need for practitioners to navigate multiple systems on behalf of children and families.

Secondly, there is fragmentation in planning and delivery. While mechanisms such as case planning processes and interagency forums exist, services are not always delivered in a coordinated or concurrent manner. Interventions may occur sequentially rather than in parallel, and responsibility for coordination often rests with individuals rather than being structurally embedded within the system.

Thirdly, accountability is diffused across systems. Each system is accountable for its own functions, but no single system holds clear or full accountability for the overall outcome for the child. This creates a structure in which responsibility is shared but not owned, particularly for children with complex needs, requiring ongoing support from service providers within different systems. Thomas Allsop, former CEO of PeakCare, described the difficulty of assigning 'accountability for prevention and early intervention when multiple systems are involved,' recognising that 'the toughest work of the child safety system is how to be responsible for things that they can't control… because other parts of the system need to be driving that work.'[35]

[34] 1) Kinship carer Witness F explained how they independently facilitated access to supports because ongoing Departmental delays meant that these supports 'kept being put off or diverted; Community Living Association, *Submission to Child Safety Commission of Inquiry* (9 March 2026); CREATE Foundation, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Corporate Parenting* (12 March 2026); Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026); Public Advocate, *Submission to Child Safety Commission of Inquiry* (26 February 2026).
[35] Transcript, Evidence of Thomas Allsop (15 September 2025) 715:8-715:12, 715:24-715:25.

Fourthly, there is variation in the degree of engagement between systems. In some contexts, relationships between agencies are strong and collaborative, supporting integrated responses.[36] In others, engagement is more limited or transactional.[37] These differences in engagement are attributable to the nature of local relationships, leadership and system capacity, as well as structural factors such as funding and governance arrangements.

The evidence relating to children in care who have had contact with the youth justice system provides a particularly clear illustration of these dynamics.[38] The Commission has heard that, in these circumstances, the various systems address different aspects of need without a single, coordinated approach.[39] The result can be a pattern of movement between systems that does not resolve underlying issues, 'where people fall through the cracks because everything's fragmented.'[40]

Similar patterns arise for children with disability or mental health needs. Where these needs are not met within the relevant systems, the impact within the child protection system includes placement instability and escalation into more intensive forms of care. Witness H provided an example where she did not have the necessary supports to look after a child in her care.[41] This lack of support resulted in a placement breakdown and the child entering residential care, with Witness H explaining to the child that 'she didn't leave because she was bad, she left because she needed more than we could give and things were too difficult in terms of the systems around her.'[42]

The multiple human service model also has implications for system boundaries. The point at which responsibility shifts between systems is not always clear or consistently managed. This can result in children moving between systems without continuity of support, or having issues addressed within one system, even though they would more appropriately be addressed within another.[43] Acting Director-General of Youth Justice and Victim Support, Michael Drane, told the Commission that when children move across primary service system boundaries without receiving early support, they may have less opportunity to alter their trajectory away from future offending upon entering the Youth Justice system.[44]

[36] Transcript, Evidence of Renee Garske (23 February 2026) 4536:10-4536-15.
[37] Transcript, Evidence of Renee Garske (23 February 2026) 4518:32-4518:39.
[38] Statement of Luke Twyford (28 November 2025) [3.11]; Statement of Kate Connors (1 September 2025) [3]-[18].
[39] Statement of Luke Twyford (28 November 2025) [3.11f]; Evidence of Elizabeth Colahan (19 September 2025)1341:33-1341:39; Statement of Kate Connors (1 September 2025) [10].
[40] Transcript, Evidence of Elizabeth Colahan (19 September 2025) 1355:45-1355:47.
[41] Transcript, Evidence of Witness H (8 September 2025) 132:28-132:33.
[42] Transcript, Evidence of Witness H (8 September 2025) 132:30-132:33.
[43] Statement of Kate Connors (1 September 2025) [16]; Transcript, Evidence of Michael Drane (23 February 2026) 4449:1-4449:18.
[44] Transcript, Evidence of Michael Drane (23 February 2026) 4449:7-4449:36.

Overall, the evidence indicates that the involvement of multiple human service systems expands the system's capacity to respond to complex need but also fragments responsibility for outcomes. It introduces specialisation and capability, while requiring a level of coordination, alignment and shared accountability that is not consistently achieved in practice.

7. Concluding observations

The analysis in this chapter indicates that the performance of Queensland's child safety system is shaped not by a single design flaw, but by the interaction of multiple structural features, each individually rational, but collectively difficult to align.

Functions are distributed across roles, teams and organisational layers in a way that introduces inherent tensions at the point of practice. Service delivery is organised regionally, enabling responsiveness to local context while producing inconsistencies in access, service capability and decision-making. A substantial proportion of services are delivered through non-government providers. While deliberate, to expand system capacity and allow the Department to focus on determining risk and harm, court support and case management, it does require effective alignment between the statutory responsibility of the Department and service delivery by providers. At the same time, the system operates in continual interaction with other human service systems, broadening its reach while diffusing responsibility for outcomes across multiple domains.

The evidence before the Commission suggests that this coordination is not consistently achieved. Where alignment is strong, the system is capable of delivering responsive and effective outcomes. Where it is not, the effects are fragmentation and inconsistency in service provision, and discontinuity in children's experiences of support and care. Responsibility for children can become distributed across multiple parts of the system without a clear, continuous line of sight.

A significant implication of this analysis is that the nature of the accountability within the system is shaped by the structure of the system. Where responsibility is distributed and processes intersect at many points, accountability can become diffuse, particularly where no single part of the system holds both responsibility for outcomes and control over the mechanisms required to achieve them. This has consequences not only for system performance, but for the system's capacity to identify, respond to and learn from failure. The next chapter will address the Commission's observations in relation to leadership, governance and accountability within the system.

Chapter 2

Leadership, Governance and Accountability

Companion Report 7

System Enablers

Chapter 2: Leadership, Governance and Accountability

Abstract

This chapter analyses how decisions are made, how responsibility is allocated, and how accountability operates across Queensland's child safety system. It considers the complexity created by shared responsibility across departments, regions, courts, statutory bodies, providers and other human services systems. The chapter concludes that accountability is too often dispersed across the system, making it difficult to identify who is responsible for outcomes, who must act when risks emerge, and how sustained reform is to be governed over time.

1. Introduction

Queensland's child safety system is entrusted with extraordinary authority: It is empowered to intervene in family life and determine where children live, with whom they have relationships, and how they are supported into adulthood. These processes, actions and decisions have profound and enduring consequences for children and families alike. Consequently, the Commission has deeply considered how the system is directed, governed and held to account over time.

The preceding chapter (Chapter 1) considered *how* the system is structured and *how* services are delivered. This chapter focuses on leadership, governance and accountability as the enablers that determine whether the system can carry out its functions coherently, consistently and in line with its purpose to nurture and care for children in need of State protection, as would a reasonable natural parent.[45] Both systems theory and literature relating to public administration make it clear that the performance of a system depends not only on organisational design but also on the extent to which authority is structured alongside appropriate forms of accountability within the system.[46] Furthermore, these sources stress that governance and accountability mechanisms are interdependent, and together shape how systems set priorities, structure decision-making processes, oversee performance and exercise control.[47]

[45] See Chapter 1.6.1 of the Executive Report, the full definition of purpose is in paragraph [1].
[46] OECD/SIGMA, *Organisation of public administration: agency governance, autonomy and accountability* (SIGMA Paper No. 63, October 2021); Raphaël Zumofen, Vincent Mabillard and Gregory Porumbescu, 'Accountability and Responsibility of Public Managers' in Kuno Schedler (ed), *Elgar Encyclopedia of Public Management* (Edward Elgar Publishing Limited, 2022) 131-135.
[47] OECD, *G20/OECD Corporate Governance Principles Overview* (Report, September 2023).

The evidence presented to the Commission indicates that Queensland's child safety system operates within a widely distributed model of leadership, governance and accountability. Authority is exercised across ministerial, departmental, regional and frontline levels.

Governance is enacted through a combination of internal structures, statutory oversight bodies, courts and interagency arrangements. As demonstrated in Chapter 1 of this Companion Report, responsibility for children is shared across the Department, non-government providers and other human service systems. The Commission recognises that the formulation of each of these elements, in all likelihood, reflects deliberate design choices, many of which were intended to strengthen scrutiny, improve decision-making and safeguard children.[48] It is not so much that Queensland's child safety system has an absence of oversight or accountability; rather, the system is presently characterised by multiple forms of partial accountability operating simultaneously. In and of itself, a distributed model of leadership, governance and accountability is not problematic. However, the evidence presented to the Commission overwhelmingly indicates that in the current state, these mechanisms do not operate in a consistent, coherent or integrated manner. As a result, they are not yet effective system enablers.

In submissions and in evidence presented during hearings, there were many instances where authority, responsibility and accountability are separated in practice, requiring coordination rather than alignment.[49] Indeed, Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) described Queensland's child safety system as marked by 'late, fragmented responses.'[50] Responsibility for outcomes for families and children may sit with one part (or even two parts) of the system, while key decisions, service delivery or enabling conditions sit with others. Oversight mechanisms identify important issues, but do not always follow through with timely responses or sustained improvements. Those accountable for the system (at ministerial, executive or senior departmental levels) appear to have little visibility of, responsibility for, or ability to impact how it operates in practice for children, parents, and carers within the system.

[48] For example, the Carmody Report recommended introduction of the bifurcated child protection litigation model, involving the establishment of an internal Office of the Official Solicitor within the Department and an independent statutory agency, the Director of Child Protection within the Justice portfolio. The bifurcated model intended to provide oversight of the conduct of proceedings by the Department and to ensure that the material relied upon in proceedings was supported by relevant evidence.
[49] 1) FNQ Regional Director Corinne Porta accepted that she had oversight of residential placements 'in a practice sense and decision-making sense,' but not of the licensing agreements or service agreements for those placements, which sat with investment and partnership functions reporting elsewhere. 2) Principal Legal Officer Clair Martin said her team sat within statewide operations, whose purpose was to support frontline service delivery, but that her team's core purpose 'has to be independent legal advice,' and she expressed concern that the imperative to support regions could compromise that legal independence. 3) Official Solicitor Angela Schifilliti described the bifurcated litigation model as difficult for families to navigate, with confusion about who the relevant decision-makers were and with court work dominating case management.
[50] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (30 March 2026) 3.

Well-functioning accountability and governance systems enable organisations to identify emerging risks, interrogate assumptions, connect operational experience with system-level oversight, and adapt their approach using information from performance data.[51] For Queensland, this means that in practice, the child safety system *should* proactively be able to detect early signs of risk or placement instability, test whether current interventions are effective, and connect frontline knowledge of a child's circumstances with both operational-level and system-level decision-making.

What appears to occur in Queensland currently, however, is that accountability is often most visible 'after the event' at points of crisis, when serious harm has occurred or when external scrutiny is triggered.[52] While these processes are important, they are not sufficient to ensure continuous performance monitoring and system improvement over time. Persistent recurrent findings in Inquiries and oversight reports, and in submissions to the Commission, further indicate that while the child protection system is subject to ongoing scrutiny, proposed solutions to identified problems have not resulted in sustainable reforms.[53] It seems that existing accountability mechanisms may produce descriptions of system weaknesses without reliably altering the conditions that produce them. This dynamic is particularly concerning in the context of child protection where serious failures are rarely the product of a single decision or event, but arise through an accumulation of missed opportunities, delayed responses and unresolved concerns.[54] Evidence before the Commission suggests that such patterns are recurrent, reinforcing the need for accountability mechanisms that operate prospectively and continuously, rather than episodically.

This chapter considers how leadership, governance and accountability operate within the current child safety system, and how their interaction shapes the system's capacity to deliver consistent outcomes for children.

[51] Australian National Audit Office, 'Strategic governance of risk: Lessons learnt from public sector audit', (Speeches and papers, 8 August 2018) <https://www.anao.gov.au/work/speeches-and-papers/strategic-governance-risk-lessons-learnt-public-sector-audit>; Karen Gardner et al., *How can systems thinking enhance stewardship of public services?* (Issues Paper No 4, October 2019); OECD, *Systemic Thinking for Policy Making*: *The Potential of Systems Analysis for Addressing Global Policy Challenges in the 21st Century* (Report, May 2020).
[52] The Child Death Review Board conducts systemic reviews following the death of a child connected to the child protection system. The Board receives reports from each agency and the Director of Child Protection Litigation that conducted a review following the death of a child, using this information to identify opportunities to improve systems, legislation, policies and practices across the child protection system and preventative mechanisms to help protect children and prevent deaths that may be avoidable.
[53] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 62.
[54] Child Death Review Board, *Systemic findings, insights and recommendations of the Queensland Child Death Review Board* (Annual Report 2024-25, October 2025).

2. Current state

The current leadership, governance and accountability framework within Queensland's child safety system is best understood as a complex network of interdependent structures and parties, each exercising degrees of authority and responsibility within defined but overlapping domains.

At a formal level, the system establishes clear lines of authority. Ministerial accountability is exercised through Parliament. The Department holds statutory responsibility for the protection of children and the administration of the legislative framework. Executive leadership is structured through departmental hierarchies, with central functions responsible for policy, strategy and oversight, and regional structures responsible for service delivery. Courts, independent statutory bodies and legal parties (for example the Director of Child Protection Litigation) provide additional layers of review and scrutiny, and in the case of the courts, legal oversight and decision making. Interagency mechanisms also exist at a number of levels to support coordination across related human services systems including health, education, disability, housing, police and youth justice systems. These arrangements reflect the gravity of child protection issues, with leadership, governance and accountability mechanisms operating at many levels across the system.

Leadership is exercised simultaneously across multiple levels. Strategic direction is set centrally, while operational authority is exercised within regions and at the frontline.[55] Meanwhile, regional leaders are responsible for translating policy and legislative mandates into practice across diverse contexts throughout Queensland, often characterised by differences in service availability, workforce capacity and community needs. Frontline leaders are responsible for maintaining the continuity and consistency of operations in an environment defined by escalating demand, high pressure, complexity and risk. This distribution of leadership both reflects and evidences the scale and complexity of the system, with different levels of leadership exercising authority across strategy, policy, operational and practice domains.

Governance is similarly multi-layered and overlapping. Internal departmental governance operates alongside external and independent oversight mechanisms. Interagency governance arrangements commonly sit across these structures. Governance is exercised through parallel and complex intersecting frameworks. Again, this is a reflection of the breadth and scale of both the child safety and broader human services systems with the coherence of governance

[55] Queensland is divided into seven regions: Far North Queensland, Central Queensland, Darling Downs & South West Queensland, Greater Whitsunday, North Queensland, South East Queensland and Wide Bay Burnett.

arrangements dependant on the extent to which the various frameworks align and function in practice.

Finally, accountability is dispersed across the various governance structures. Responsibility for children is shared across ministerial portfolios, departmental functions, non-government service providers, the Director of Child Protection Litigation and other human service systems. As a key example, while the Department retains ultimate statutory responsibility for the care of children within the child safety system, the delivery of services, the conduct of legal proceedings and the provision of supports are generally undertaken by other parties (including nongovernment providers or the Director of Child Protection Litigation). This creates a model in which responsibility is retained, but delivery and influence are distributed across the system.

The system also contains a visible set of oversight and review mechanisms. Complaints processes, incident reviews, statutory oversight bodies[56] and Inquiries[57] generate substantial information about the system's performance and outcomes. Submissions to the Commission emphasised the importance of oversight mechanisms in promoting transparency, identifying system weaknesses and providing avenues for challenge and review. However, the presence of multiple oversight functions does not, in itself, ensure that insights are aggregated, escalated or translated into system-wide change.

Performance within the system is primarily monitored through administrative and process-based indicators.[58] These include, for example, compliance with statutory timeframes, completion of required processes and other activity-based measures. These indicators have the potential to provide important assurance that the system is operating in accordance with prescribed requirements. At the same time, however, they provide less information about outcomes for children, the stability and quality of placements, the continuity of relationships and long-term life trajectories. This distinction has been noted in the literature, which differentiates between measures of service activity and measures of outcomes for children and young people.[59] Evidence to the Commission indicates that this emphasis on process can obscure how children are actually faring within the system, limiting the extent to which accountability is grounded in lived experience and developmental outcomes.[60]

[56] See for example the Office of the Public Guardian and the Queensland Ombudsman.
[57] For instance, Crime and Misconduct Commission, *Protecting children: an inquiry into abuse of children in foster care, Crime and* Misconduct Commission (2004), Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) and Queensland Ombudsman, Management of Child Safety Complaints: Investigation Report (2016).
[58] See Appendix G, Commission of Inquiry into Child Safety System, *Guide: A self-regulating child protection system,* 45-47.
[59] Eileen Munro, *The Munro Review of Child Protection: Part One: A Systems Analysis* (Report, 2010).
[60] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 38.

These features describe the child safety system as a system in which enablers of leadership, governance and accountability are widely distributed across multiple structures and parties in a complex web. The implications of this configuration for system coherence and performance are considered in the sections that follow.

3. Leadership in a distributed system

As a result of the model described above, the evidence indicates that leadership within the current system is frequently required to operate in a reactive and remedial way, urgently addressing gaps and misalignments rather than progressively directing performance within a consistently aligned framework.

Regional and frontline leaders are frequently required to navigate constraints that sit outside their direct control, including the availability of services and service providers, workforce capacity and the ways in which the child safety system interfaces with other the broader child protection system. Leadership therefore often focuses on managing these misalignments, rather than solely working toward improving performance or outcomes. As noted in Chapter 1, those responsible for casework and placement decisions do not necessarily control the commissioning and service settings that determine what options are available, requiring leaders to work within the limits of existing supply rather than design responses around assessed need.

This dynamic is particularly evident in the context of residential care. Evidence before the Commission indicates that placement decisions are often made in circumstances where the 'best' placement is not available, requiring Departmental practitioners and their supervisors to select from limited or suboptimal options to meet the needs of an individual child. In the Far North Queensland hearings, there was evidence that decisions about placements were made at a practice level, while the availability and configuration of residential services were determined through separate investment and contracting functions within the Department.[61] Submissions similarly describe decisions placing children with care providers as frequently constrained by availability rather than suitability, particularly for children with complex needs.[62] In these

[61] Transcript, Evidence of Corinne Porta (20 November 2025) 2598:4-2598:11.
[62] 1) Far North Queensland Regional Director Corinne Porta accepted that the responsibilities of her role included strategic oversight of residential care placements in a 'practice sense and a decision-making sense,' but did not extend to 'the oversight of contracts for those placements under their licencing agreement and service agreement.' 2) Far North Queensland Regional Director Corinne Porta outlined that foster carer vacancies resulted in 'a hundred or more children, who actually are suitable for family-based care,' being placed in residential care. 3) In a Far North Queensland submission to the Commission, Queensland Aboriginal and Torres Strait Islander Child Protection Peak expressed concern that the current system 'prioritises institutional responses over culturally grounded, family-led solutions,' placing children in settings that were misaligned with their needs.

circumstances, leadership becomes an exercise in prioritisation and risk management, rather than an exercise in deliberate, outcome-focused stewardship and leadership.

Thomas Allsop, former CEO of PeakCare, described the system as under sustained tension with 'significant demand pressures placed on services, given the unrelenting demand for placements of the system and the finite resources available to support that demand.'[63] Out of necessity, frontline leaders appear focused on immediate operational issues, including allocation of cases, management of risk and compliance with statutory requirements. In the public hearings focused on residential care in April 2026 (residential care hearings), evidence from former departmental leaders acknowledged the scale and growth of demand within the system and the pressures this places on decision-making at all levels, including the need to respond to urgent placement and safety concerns as they arise.[64] These conditions can limit the opportunity and capacity for reflective practice, strategic oversight and longer-term planning.

Research in public administration highlights that in systems characterised by high demand and complexity, frontline and mid-level leaders often informally coordinate across organisational boundaries, compensating for gaps in formal structures.[65] This appears to be the case in Queensland, and places significant reliance on individual personality, capability and judgement. In such circumstances, system performance can become uneven, depending on the strength and experience of leadership at different levels and in different locations. Where leadership is strong and stable, it can mitigate the effects of structural misalignment and support more consistent practice. Where leadership capacity is constrained, the effects of those misalignments may be more pronounced. Submissions to the Commission point to variation in practice and outcomes across child safety regions, reflecting differences in workforce and leadership stability, service availability and local capability.[66] These variations are not solely attributable to leadership, but they illustrate how system performance is being influenced by the conditions within which leadership is exercised.

The way leadership is exercised is also shaped by organisational culture. Submissions from both organisations and individuals within the system almost unanimously proffer the view that the Department frequently exhibits a degree of defensiveness and risk aversion, particularly in

[63] Transcript, Evidence of Thomas Allsop (16 September 2025) 961:33-961:36.
[64] Transcript, Evidence of Natalie Wilson (8 April 2026) 5000:30-5001:11; Transcript, Evidence of Deidre Mulkerin (14 April 2026) 5326:1-5326:20.
[65] Michael Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (Russell Sage Foundation, 1980).
[66] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026).

response to external scrutiny.[67] In this context, leadership can appear to be oriented toward managing exposure and ensuring compliance, rather than toward openness, learning and improvement. This has implications for how issues are identified, escalated and addressed within the system.

The Commission's analysis does not suggest that leadership within the system is absent or ineffective.[68] Rather, it suggests that leadership is operating within a set of conditions that require it to compensate for structural complexity, limit its capacity to direct system performance consistently and place significant reliance on individual capability and judgement in the face of immense risk and scrutiny.

4. Governance coherence and system integration

As described in section 2 of this chapter, governance within Queensland's child safety system is extensive, layered and institutionally dispersed, operating across departmental, legal, statutory and interagency domains. These arrangements have largely emerged in response to identified problems and risks, the need to reorganise, restructure and build scrutiny into the system and various reform processes. Each governance mechanism likely has a rational purpose. The difficulty lies not in the existence of each of these mechanisms, but in the extent to which they operate together as a coherent system of direction, oversight and control.

At a departmental level, governance is exercised through executive leadership, policy frameworks, practice directions and internal oversight processes. External to these structures sit courts, review bodies and independent statutory authorities, each applying different timelines, standards and forms of scrutiny. In addition, interagency governance arrangements purport to support coordination across health, education, disability, housing, police and youth justice systems. In formal terms, this produces a system with many points of governance. In practical terms, the result is a system in which governance is frequently exercised through parallel and intersecting frameworks, rather than through a single integrated architecture.

The implications of this are visible in the litigation model evidence described in detail in Companion Report 2: Child Protection Litigation. The bifurcated structure – with the Office of the

[67] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 66; Child Protection Practitioners Association of Queensland, *Submission to Child Safety Commission of Inquiry* (29 March 2026) 14; Submission No. 0170 to Child Safety Commission of Inquiry (1 August 2025); Submission No. 0084 to Child Safety Commission of Inquiry (26 September 2025).
Submission No. 0524 to Child Safety Commission of Inquiry (26 November 2025).

[68] While only one former minister was called as a witness, the Honourable Leanne Linard MP (former Minister for Children, Youth Justice and Multicultural Affairs) was twice described as 'astute and diligent' by the Counsel Assisting the Commission in recognition of her approach to the role.

Child and Family Official Solicitor inside the Department and the Director of Child Protection Litigation established as an independent statutory body – was itself a valid governance reform in response to earlier concerns about insufficient oversight and independence.[69] Yet the Commission heard evidence that this structure has itself created practical complexity in operation. The Official Solicitor of the Office of the Child and Family Official Solicitor (OCFOS), Ms Schifilliti described the model as 'very difficult to navigate for families,' and pointed to uncertainty about exactly who were 'the players in the model' among other issues.[70] Ms Schifilliti also suggested that fragmentation of the model contributed to the fact that the length of matters 'more than doubled under this current' system.[71] Principal OCFOS Lawyer, Ms Martin gave evidence that her legal team sat within statewide operations, 'which is service delivery' but said that their 'core purpose' has to be to provide 'independent legal advice,' thereby identifying a tension between supporting frontline delivery and maintaining legal independence.[72] Together, these examples illustrate a governance model in which scrutiny and independence have been strengthened, but not always in a way that produces clarity, simplicity or coherent direction.

A similar pattern emerges outside the litigation context. Evidence in the public hearings held in Far North Queensland in September 2025 revealed that Regional Directors are responsible for approving placement decisions, such as the placement of a child in residential care, but not for licensing and service agreements.[73] Far North Queensland Regional Director Corinne Porta accepted that she had oversight of residential placements 'in a practice sense and decision-making sense,' but that oversight of the relevant contracts, licensing agreements and service agreements sat with officers responsible for investment and partnership functions elsewhere in the regional structure.[74] This is not simply an operating-model issue or a leadership issue. It is also a governance issue, because it demonstrates that authority over decisions and over the conditions needed to implement them are not always held together. Effective governance therefore depends on coordination across different internal centres of control.

The same theme is evident in the broader child protection system. Submissions to the Commission suggest that governance across the child protection system often relies heavily on informal coordination, local relationships and goodwill. QATSICPP submitted that when children's needs 'fall across multiple systems, coordination relies on goodwill, informal arrangements and variable practice rather than enforceable obligations,' describing the current

[69] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 481.
[70] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3298:10-3298:14.
[71] Transcript, Evidence of Angela Schifilliti (9 December 2025) 3298:22-3298:27.
[72] Transcript, Evidence of Clair Martin (12 December 2025) 3737:17-3737:28.
[73] Transcript, Evidence of Corinne Porta (20 November 2025) 2380:43-2381:25, 2382:19-2382:23.
[74] Evidence of Corinne Porta on 24 November 2025) 2598:4-2598:10.

approach as a 'patchwork of arrangements'.[75] Similarly, the Queensland Council of Social Services pointed to the need for mechanisms for early resolution of issues between government departments, services and teams, by developing 'more integrated and holistic ways of working with one another and with the community service sector to enable nimble responses.'[76] These are not simply calls for better collaboration. They point to a governance environment in which the structures for shared decision-making and shared accountability are not sufficiently embedded to produce consistent integration in practice.

This problem is particularly significant because Queensland's child safety system depends on multiple parties engaging in relation to different aspects of a child's life. Governance is strongest when it is clear who decides, who implements, who monitors and who must respond when outcomes are deteriorating. In Queensland, these functions are spread across different entities, each operating with its own mandate, incentives, internal culture, and reporting lines. The result is a governance infrastructure that is densely populated yet not well integrated. This can make it more difficult to align decisions across the system, to maintain clear responsibility for outcomes, and to ensure a consistent approach to translating policy settings into practice.

The Commission's analysis does not suggest that the answer lies in creating more governance mechanisms. The evidence points instead to a need for better alignment and integration of existing mechanisms, so that they collectively support clear direction, coordinated action and more consistent accountability for outcomes. Where governance remains dependent on coordination across multiple frameworks, rather than operating through a more coherent and integrated system, the risks are well known: inconsistent decision-making, delays in response, and reduced capacity to act on emerging issues before harm escalates.

5. Performance, accountability and line of sight

The effectiveness of leadership, governance and accountability as system enablers within the child safety system is closely tied to the system's capacity to see, understand and respond to its own performance. Simply collecting information is not sufficient. The system needs to ensure that performance is defined in terms that reflect outcomes for children, that information is visible across the system, and that it is used to inform decision-making and corrective action.

The evidence before the Commission indicates that, within the current system, performance is more consistently understood by looking at activities and compliance than by examining

[75] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of* Inquiry (February 2026) 6.
[76] Queensland Council of Social Services, *Submission to Child Safety Commission of Inquiry* (4 August 2025) 2.

outcomes, and that understandings of how the system is performing is fragmented across functions, regions and providers.

At a formal level, the system includes a range of performance indicators. These measures provide assurance that the system is operating in accordance with legislative and procedural requirements. They support consistency and enable monitoring at scale.[77] However, the evidence suggests that they do not, on their own, provide a clear or comprehensive picture of how children at either an individual or aggregate level are faring within the system.

Submissions to the Commission consistently emphasised that reporting frameworks are heavily weighted toward administrative outputs, rather than developmental, relational and life-course outcomes. The QFCC, for example, observed that system reporting does not consistently capture children's experiences within the system or longer-term wellbeing, while PeakCare noted that existing measures often fail to reflect whether interventions are improving children's circumstances over time.[78] As a result, the system has a better understanding of what it does than what it achieves, that is, whether children are in fact benefitting from the system intended to act in their best interests.

This distinction is significant because activity does not necessarily equate to effectiveness. Without a clear connection between the activities of the child safety system and the outcomes it generates, it is difficult to assess whether interventions are improving the lives of children or simply maintaining system throughput.

The issue also extends to both the visibility and integration of information across the child safety system. Information about children, services and outcomes is generated across many parts of the system, including departmental functions, non-government providers, courts and other service systems. There is, however, little evidence to suggest that this information is aggregated or otherwise linked in a way that provides a system-wide view of performance.

This fragmentation is reinforced by the distributed nature of service delivery and its governance. The variations in practices across regions, the diverse provider models and the way in which activities reach across systems mean that information is often held in different formats, across different systems, by different agencies/organisations, and with different levels of detail.

[77] The 2026 Report on Government Services provides performance data for governments providing child protection services across Australia. Examples of data include: the number of children aged 0-17 in care, children placed in relative/kinship carer households, children placed in foster carer households, Government real recurrent expenditure on all child protection services, and ratios showing how Aboriginal and Torres Strait Islander children aged 0-17 years are disproportionately represented in the child protection system.[78] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026).

[78] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026); PeakCare, *Submission to Child Safety Commission of Inquiry* (29 March 2026).

Evidence presented to the Commission indicates that this can limit the system's ability to identify patterns of concern, detect emerging risks and understand how different parts of the system are interacting.

This issue is apparently not unknown to the Department, or to the system at large. In the residential care hearings, departmental witnesses acknowledged the need to maintain consistent, system-wide scrutiny of placement capacity and of the experiences of children across different parts of the system.[79] Submissions from the non-government sector similarly highlighted that information about children is often held across multiple agencies and providers, with limited integration, making it difficult to form a complete picture of a child's circumstances, trajectory or wellbeing.[80]

However, the consequences of this fragmentation are evident at all levels of the system. At the frontline, practitioners may have detailed knowledge of individual children and families, but limited visibility of broader system patterns. Alternatively, they may have partial knowledge of individual children and families due to the information being held by service providers, but full responsibility for making decisions about that child or family. At a regional level, leaders may know about operational performance within their region but may not be easily able to compare performance across regions or identify system-wide trends. At a central level, aggregated reporting may provide a high-level view but may not always capture the nuances of practice or how children are experiencing the system or whether there are outliers in experience across the State.

The result is that there is no part of Queensland's child safety system consistently that holds a complete and integrated view of system performance or the impact of the system on children.

The implications for accountability are significant. Accountability depends on the system's ability to define expected outcomes, measure performance against those outcomes and respond where performance is not meeting expectations. Given performance of and within the child safety system appears to be presently measured primarily through process output indicators, accountability has become oriented toward compliance with process requirements; and because there is fragmented, rather than holistic, scrutiny of the system, it is extremely difficult to identify where responsibility lies for system performance and where corrective action is required.

[79] Transcript, Evidence of Michelle McNamara (9 April 2026) 5124:19-5124:28; Transcript, Evidence of Arthur O'Brien (13 April 2026) 5298:3-5298:13.
[80] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry* (30 March 2026); Queensland Council of Social Services, *Submission to Child Safety Commission of Inquiry* (4 August 2025).

The Commission also heard evidence that inadequate measures of outcomes affects public accountability. Submissions emphasised that current reporting does not always provide a clear or accessible picture of how children in care are faring, and that this limits the ability of the community to assess system performance.[81] The QFCC submitted that transparent reporting on outcomes is essential to maintaining public confidence and ensuring that the system remains focused on improving children's lives over time.[82]

The evidence also highlights the role of ministerial and Cabinet decision-making processes in ensuring a clear line of accountability. In the residential care hearings, former Minister Leanne Linard described the need to balance investment and policy decisions across the whole of government, including through Cabinet Budget Review Committee processes. In that context, the information available to decision-makers, and the way in which system performance is presented for analysis, directly influences how child protection priorities are weighed against competing demands. Where performance is framed primarily through activity, compliance or cost pressures, rather than outcomes for children, there is a risk that system-level decisions may not be consistently guided by a clear view of children's experience of the system, and longer-term trajectories, in line with the State's responsibility as corporate parent.

Ministerial accountability in this context does not arise from responsibility for individual case decisions. Rather, it arises from responsibility for the performance, architecture and reform discipline of the system within which those decisions are made. Where recurring risks, shortcomings and patterns of harm are repeatedly identified through reviews, oversight reports, complaints and evidence about children's experience of the system, ministerial accountability is affected and gauged by the adequacy and urgency of the system's response to this information. In that sense, ministerial accountability is closely connected to what the system measures, what it reports publicly, how it defines improvement and whether known weaknesses are acted upon and translated into sustained reform over time.

The Commission considers performance information is not always used to drive proactive system management. Where visibility is partial or delayed, leadership may only be able to respond to issues after they have escalated, rather than intervening early. This reinforces a pattern identified elsewhere in the evidence before the Commission, which shows that the responses of the system are more often reactive than proactive.

[81] Transcript, Evidence of Witness S (16 February 2026) 4136:15-4136:22; Transcript, Evidence of Luke Twyford (25 February 2026) 4782:8-4782:13.
[82] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026).

Of note, since at least 2015, the Minister responsible for the Child Safety portfolio has also held multiple other portfolios within a relatively junior ministry. While there are undoubtedly benefits from the approach of considering portfolios together, the Commission considers that in the current reform climate this may not provide sufficient focus to achieve the desired reform outcomes, particularly where levers for reform sit across other portfolios, such as health, education, youth justice, and policing.

Considering the concept of shared portfolios, line of sight and accountability at a departmental leadership level, the Director-General of the Department leads an agency with a broad remit across multiple complex human services portfolios. Again, this has been the case since at least 2015, despite successive governments being aware of the recommendation from the Crime and Misconduct Commission (CMC) Inquiry in 2004 that expressly recommended that child safety be a stand-alone portfolio.[83] The complexity of these intersecting portfolios necessarily limits the attention that can be directed towards the existing structure and function of the child safety system, let alone substantial reform. Furthermore, what is tellingly observable about the current structure is that executive roles are not aligned with clear accountability for outcomes. The model the Department has adopted delivers services through regional structures, reporting on the performance of disparate functions through Regional Executive Directors to a single Deputy Director-General. This approach in effect enables regional variances and disconnection from the Department's senior executives, with no executive truly accountable for the Department's key functions.

Scotland's approach to a dedicated children's minister

In Scotland, child protection policy is assigned to the Minister for Children, Young People and The Promise. This approach shows the value of placing child protection, care and children's wellbeing within a clearly identifiable and dedicated ministerial portfolio.

The Commission infers that a specific allocation of ministerial leadership is central to creating a visible point of accountability for reform, particularly when it is supported by national structures that connect policy, practice, data, inspection, workforce development and local leadership.

Scotland's approach to dedicated ministerial leadership and accountability is proposed to make reform in Scotland harder to diffuse or defer by establishing a named ministerial

[83] Crime and Misconduct Commission, *Protecting Children: An Inquiry into Abuse of Children in Foster Care* (Report, January 2004) 133.

owner, a national forum for escalation and challenge, and clearer expectations that local leaders must account for the effectiveness of child protection in their area.

The Commission's analysis proceeds on the basis that performance, accountability and line of sight are inseparable. Effective accountability requires clarity about which outcomes are to be defined and measured, processes which ensure consistent measurement of those outcomes, and visibility of performance across the system. The evidence suggests that these conditions have not been met, and so the Department's capacity to understand its own performance, hold itself to account and improve over time is constrained.

6. System responsiveness and corrective action

A defining test of leadership, governance and accountability is not whether a system can identify weaknesses within itself, but whether it can respond to them in a timely, coordinated, effective and sustained way. The Commission's analysis therefore distinguishes between the generation of information about system performance and the system's capacity to translate that information into corrective action.

The evidence before the Commission indicated that Queensland's child safety system generates a great deal of information about its own operation. Even though they may be imperfect, complaints mechanisms, incident and case reviews, statutory oversight bodies, internal audits and external inquiries all contribute to a detailed and evolving understanding of system performance. Submissions from oversight bodies emphasise that these mechanisms play an important role in identifying and managing emerging risks, driving reform efforts and providing avenues for children, families and carers to raise concerns.[84]

The central issue identified in the evidence is not the absence of insight, but the inconsistent translation of that insight into system-level response. Evidence from submissions and Commission hearings revealed a consistent pattern in which concerns are identified, documented and, in many cases, acknowledged, but are not always aggregated, analysed, escalated or acted upon in a way that clarifies the dynamics of the problem or produces sustained change. This is evident across multiple sources of system intelligence.

[84] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints Systems* (30 July 2025); Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints Systems* (1 August 2025).

Complaints, for example, are frequently managed at a local level through the 'First Attempt at Resolution' process (Refer to Companion Report 6: Complaints). In principle, this supports timely resolution of individual issues; however, submissions indicate that, among other issues, it can limit the extent to which patterns of concern are recognised and addressed at a broader system level.[85] Similarly, incident reviews and case reviews often identify practice issues or systemic gaps, but the evidence suggests that these findings are not always followed up by the Department.[86]

Oversight bodies play a critical role in identifying system weaknesses and making recommendations for reform. While recommendations are often received or noted by the Department, there is limited evidence of a disciplined, system-wide mechanism that compels implementation, tracks progress over time and verifies whether change has been achieved. This creates a disjunction between the identification of issues and the assurance that those issues have been addressed and resolved.

This dynamic contributes to a broader pattern identified throughout the evidence: that accountability within the system is often activated at points of crisis, rather than operating as a continuous mechanism of performance monitoring and improvement. Serious incidents, including those leading to child deaths or significant harm, trigger intensive scrutiny. The scrutiny includes reviews, which make findings and recommendations. These processes are essential and form a critical component of system accountability. However, they are episodic in nature, focused on discrete events rather than on the ongoing performance of the system. The evidence suggests that they are more effective at describing failure after the fact than at preventing its recurrence.

This problem is compounded by the fact that inquiries, reviews and submissions regularly make similar findings, however these recurrent findings are rarely linked or acted upon effectively.[87] Thus accountability appears to have become largely descriptive: the system documents and describes system weaknesses but does not reliably act to alter the structures, incentives or conditions that produce those weaknesses.

[85] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints System* (July 2025) 11.
[86] Evidence of youth worker Witness D, who described writing incident reports in response to violent incidents that occurred whilst they were working in a residential care facility. They were never contacted by anyone from Child Safety regarding the events of these incident reports and 'what might be done about them.'
[87] For example – the CMC report raised that many children experience multiple placements during their time in foster care, adversely impacting their 'confidence, resilience and sense of worth.' Similarly, the Carmody Inquiry raised that multiple placements for children in foster or other alternative care can be seen as a sign of 'systems abuse,' meaning 'the abuse or neglect that children suffer at the hands of systems involved in their care, education, health and welfare.' More recently, the Child Death Review Board Annual Report 2023-24 provided a case example of a boy who experienced multiple placements in the year prior to his death, despite a health worker 'reiterat[ing] the importance of a safe and secure placement.'

The implications of this are significant in a system where failures are rarely the result of a single decision. As the Commission has seen, most poignantly described through witnesses and submitters with direct experience of the system, serious failings commonly arise through an accumulation of missed opportunities, delayed responses, fragmented decision-making and unresolved concerns. Addressing these patterns requires a system that can detect early signs of weakness or deterioration, respond at an appropriate level of intensity and with carefully considered interventions, and monitor whether these reforms are improving outcomes over time.

A further dimension of system responsiveness is transparency and openness to scrutiny. Submissions to the Commission contend that the Department's organisational culture is often characterised by defensiveness and limited transparency, particularly in response to external scrutiny. QATSICPP described how 'serious concerns persist regarding the lack of cultural safety, transparency and accountability in how complaints are recorded, investigated, and resolved.'[88] This can affect the extent to which the system engages constructively with critical feedback in order to learn and grow. Developing this transparency, a cultural dimension, is not only a matter of public accountability: it is also a critical mechanism through which the system can learn from its own performance. Complaints and appeals processes, for example, provide valuable insight into the experience of children, families and carers. Where this information is systematically analysed and acted upon, it can support earlier identification of risks and emerging issues and enhance the system both for those presently in care, and those to come. Where it is not, opportunities for improvement will continue to be lost.

The Commission's analysis demonstrates that the current system does not operate in a way that responds to performance information in a coordinated, sustained and outcome-focused way. Strengthening this responsiveness is central to improving the effectiveness of Queensland's child safety system. Without it, the system will continue to identify the same issues over time, without addressing or changing the conditions that produce them.

7. Concluding Observations

The Commission's analysis in this chapter indicates that the governance, and, to a lesser extent, leadership and accountability, in Queensland's child safety system is extensive in form but uneven in effect. The evidence indicates that these system enablers do not support the system

[88] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding Complaints Systems* (1 August 2025) 14.

to respond proactively to early signs of instability, and instead induce reactive responses that are often at crisis point.

A central theme from the analysis is the leadership conditions required to deliver continuous system improvement are flawed. Leadership is distributed at multiple levels simultaneously across the child protection system, from central leadership to regional directors and frontline workers. However, these layers can create misalignment between policy direction and practice, resulting in conditions where there is a focus on responding to urgent placement and safety concerns and compensating for structural complexity. As a result, these conditions can limit the capacity for longer-term planning, reflectivity and consistent practice.

The Commission also considered that ministerial and departmental structures obscure clear lines of accountability for critical child safety system functions, including early intervention, intake and assessment, litigation, placements and casework. This reflects broader weaknesses in the Department's accountability arrangements, which operate across multiple layers of responsibility without consistently aligning authority, oversight and accountability for outcomes as well as the sheer breadth of portfolios commonly connected with the child protection portfolio. The Commission therefore concludes that government must ensure Cabinet gives sufficient weight to the State's corporate parent role, and that the Department's executive structures make accountability for core child safety functions clear, visible and capable of supporting sustained reform.

The ability of a system to continuously improve is dependent on coherent approaches to governance and the coordination of the system. The evidence does not suggest an absence of governance structures within the child protection system, but rather an extensive, fragmented network that lacks integration, coordination and alignment. Governance is spread across departmental, legal, statutory and interagency domains, each operating with its own mandates, incentives and reporting lines. Unless governance is coordinated across the different frameworks, there is a risk of significant inconsistency in directions, decision-making and accountability for outcomes.

The Commission also concludes that the scrutiny of the system's performance is undermined by fragmented oversight mechanisms and administrative performance measures. Oversight that is disseminated across functions, regions and providers purports to give an assurance that the system is meeting specific legislative and procedural requirements. However, a fragmented and administrative focus on accountability neglects the individual and collective experiences of children within the system. While academic literature demonstrates that performance measures

that consider developmental, relational and life-course outcomes may be better equipped to determine whether interventions are improving children's lives, the system reporting processes continue to favour the collection of administrative performance data focused on processes and their outputs.

A central implication of this analysis is that the system contains many of the elements typically associated with strong oversight and control, including multiple layers of review, independent scrutiny and defined lines of authority. However, these elements do not consistently operate together in a way that produces coherent direction, clear responsibility or that enables sustained improvement in outcomes for children.

Taken together, the Commission's observations suggest that a major challenge facing the child safety system is the extent to which these elements operate as a connected and mutually reinforcing set of system enablers. The Commission considers that addressing these issues requires a shift in focus from the component parts of the system and their individual points of accountability, to a broader understanding of, and co-ordination between these parts that interconnect and collectively contribute to continuous system improvement.

A concluding case in point: the bifurcation of litigation

The State's dual-entity approach to child protection litigation (analysed in detail in Companion Report 2: Child Protection Litigation) provides a useful example of the broader system design issues identified in this Part. It demonstrates how a reform directed at enhancing independence, scrutiny and the quality of evidence can, if not carefully integrated into the operating model, create additional complexity, diffuse accountability and increase pressure on the workforce required to support children and families.

The Carmody Inquiry recommended the bifurcated approach to child protection litigation following widespread mistrust and concerns about the Department's ability to conduct child protection litigation proceedings and put material before the Court founded upon a proper basis[89] The model sought to separate legal decision-making from child protection casework through the establishment the Office of the Child and Family Official Solicitor (OCFOS) (intra-Department) and the Director of Child Protection Litigation (DCPL) (an independent statutory office situated within the Justice portfolio).

[89] Tim Carmody, *Taking Responsibility: A Roadmap for Queensland Child Protection* (Report, June 2013) 481.

Since this model has been introduced, it has strengthened formal independence and legal scrutiny. The Court process remains critical to fairness, public confidence and oversight of the Department's exercise of statutory power. The concern is not with the existence of independent legal oversight, but with how that oversight has been structurally embedded and operationalised.

The evidence before the Commission suggests that the bifurcated model has created practical complexity. It also illustrates the difficulty of aligning a legal framework with a human services framework. The DCPL's statutory independence properly orients it toward ensuring sufficient evidence, legal defensibility and the conduct of proceedings. OCFOS, by contrast, is embedded closer to departmental operations and therefore closer to the practical realities of casework, family engagement and service delivery. Those perspectives are both relevant; however, when they are not governed through a clear, shared operating model, they can pull against one another. A legal process designed to test evidence can become experienced by families, practitioners and service centres as duplicative, adversarial and remote from the relational work required to support change.

That tension has implications for the workforce. The preparation of court applications, affidavits and referral material can impose a substantial burden on CSOs, diverting time from direct work with children, families and carers. Large volumes of material may improve forensic coverage, but can also overwhelm parents, extend proceedings, increase costs and shift practice toward legal defensibility rather than timely, child-centred decision-making.

The model also demonstrates how accountability can become diffused. The Department retains statutory responsibility for children. OCFOS advises and prepares material within the Department. The DCPL makes decisions about child protection order applications and conducts proceedings independently. The Court determines matters. Each entity performs a legitimate function, yet each influences the child's safety, stability and permanency. Where legal responsibility, operational responsibility and outcome responsibility are separated without strong end-to-end governance, families can experience confusion, practitioners can experience duplication, and no single part of the model may clearly own the overall timeliness and coherence of the child's pathway.

The lesson is not that independence was the wrong objective. The lesson is that independence must be designed so that it strengthens, rather than fragments, the system. Oversight should improve evidentiary quality, procedural fairness and accountability, while also supporting timely resolution, coherent stewardship, reduced administrative burden and a shared focus on the child. The bifurcated Child Protection Litigation model shows the broader point made in this Part: Structural reform cannot be assessed only by whether it creates new roles, offices or safeguards. It must be assessed by whether those arrangements work together in practice to improve the experience and outcomes of children and families. For the reasons discussed in Companion Report 2: Child Protection Litigation, the Commission has recommended that Government move to a model with a single, independent, statutory legal entity with authority to litigate *all* child protection matters.

Chapter 3

Workforce, Culture and Practice Capability

Companion Report 7

System Enablers

Chapter 3: Workforce, Culture and Practice Capability

Abstract

This chapter examines the workforce conditions, organisational culture and practice capability required to deliver safe, relational and effective child protection work. It explores workload pressure, turnover, supervision, professional judgement, training, practice consistency, relational work and the effect of crisis-driven operating conditions on frontline decision-making. The chapter concludes that reform cannot be achieved through additional policy or procedure alone: the system must create the conditions in which skilled practitioners can build relationships, exercise judgement, work collaboratively and sustain high-quality practice.

1. Introduction

The integration between workforce configuration, organisational culture and practice capability shape how Queensland's statutory child safety responsibilities are carried out and how the system responds to the individual needs and circumstances of children over time. These elements are interdependent and mutually reinforcing and are brought into effect in an environment characterised by complexity, pressure and real-life consequence.

This analysis of workforce, culture and practice capability as system enablers considers how the conditions in which frontline practitioners work enables or inhibits system performance and the delivery of positive outcomes for children.

The Commission has been resolute in its recognition that frontline practitioners hold a key but fraught position within the system. These staff are required to assess risk and to engage with children and families across varied and challenging contexts and to make decisions that are likely to have long-term implications for children, families and their communities. The literature consistently emphasises that such work depends on the exercise of informed professional judgement, supported by experience, supervision and opportunities for reflection, rather than the mechanical application of prescriptive rules.[90] This form of judgement requires the capacity to

[90] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 133; Eileen Munro, 'Decision-Making under uncertainty in child protection: Creating a just and learning culture' (2019) 24 *Child & Family Social Work* 123.

integrate multiple sources of information, to test assumptions, to weigh competing risks and to remain open to revision as new information becomes available.[91] Where systems are able to sustain conditions that enable this degree of professional judgement, on the ground decision-making is more likely to be proportionate and responsive to the particular circumstances of the child. Where they are not, practice tends to narrow, with increased reliance on standardisation, procedural compliance and risk containment. [92]

In this context, the workforce capability at the frontline of Queensland's child safety system is not reducible to qualifications, staffing numbers or individual competence. It is produced through the interaction of a range of system conditions, including workloads, role design, supervision structures, training and access to support.[93] These conditions shape what practitioners can attend to, how they prioritise competing demands and the extent to which they can sustain engagement with children, families and carers over their child protection journey. They also influence how information is interpreted and acted upon, how uncertainty is managed and whether emerging concerns are identified and responded to before they escalate.[94] Capability, in this sense, is both individual and systemic. It reflects not just what practitioners know, but also what the system enables them to do with that knowledge.

The configuration of work on the front line is central to this analysis. The literature tells that 'effective child protection systems are built from the front line.' The literature also tells us that in complex human service systems, there is often a divergence between the formal description of a role and the work that is actually performed.[95] Over time, functions accumulate, new requirements are introduced, and existing tasks expand in scope and/or intensity. Unless there is a corresponding adjustment in role design, workload allocation and support structures, this process results in a redistribution of practitioner time and attention. Activities that are measurable, time-bound or externally scrutinised tend to take precedence, while those that are relational or focused on prevention are more readily deprioritised.[96]

Organisational culture operates through these same dynamics. As outlined in Chapter 2 of the Commission's Executive Report[97], culture is expressed in patterns of behaviour, decision-making and information flow that develop over time within an organisation.[98] In practice environments,

[91] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[92] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 45.
[93] KPMG, *The Current State of Child Safety Service Centres: Report for the Department of Children, Youth Justice and Multicultural Affairs* (Report, January 2023).
[94] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[95] Henry Mintzberg, *The Structuring of Organizations* (Prentice-Hall, 1979).
[96] Henry Mintzberg, *The Structuring of Organizations* (Prentice-Hall, 1979).
[97] See Chapter 2.6.1 of the Commission's Executive Report, the full definition of organisational culture is in paragraph [1].
[98] Ron Westrum, 'A typology of organisational cultures' (2004) 13 *BMJ Quality & Safety* ii22.

such as for child safety, which are characterised by high demand, scrutiny and the potential for serious consequences, cultural tendencies are reinforced through the conditions under which work is carried out.[99] The literature is clear that where these systems emphasise procedural compliance, documentation and risk defensiveness, these priorities shape how practitioners understand their role and how decisions are made. Where they support reflection, learning and shared responsibility, different patterns of behaviour emerge.[10]

A further consideration is the relationship between the stability of staff and children's circumstances, and the quality of decisions about children made by staff. Effective statutory decision-making depends on an informed understanding of the child's circumstances over time, including their relationships, history and changing needs.[100] This requires continuity and stability in engagement and the capacity to maintain a coherent understanding of the child's situation. Where workforce instability, workload pressure or role fragmentation disrupt this continuity, decision-making is more likely to rely on partial information, recent events or simplified representations of risk.[101]

The evidence before the Commission indicated that the conditions shaping practice of workers in the frontline of Queensland child protection system are not consistently aligned with the expectations placed on the system. Across multiple sources, including practitioner evidence, submissions from children, families and carers, and prior system reviews, there is a consistent picture of work being undertaken within constraints that limit the capacity to sustain relational engagement, exercise considered judgement and respond early to emerging concerns.[102] These constraints interact with one another, reinforcing patterns of practice that are shaped by urgency, procedural demand and the management of risk, and that in turn, become ingrained as part of the organisational culture.

2. Current state

The evidence presented to the Commission indicated that the conditions in which statutory child safety work is undertaken have shifted over time in ways that materially affect how frontline practice is carried out. The roles of CSOs and other frontline staff at the centre of statutory decision-making have expanded in both scope and complexity. While this is reflective of the

[99] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011); Ron Westrum, 'A typology of organisational cultures' (2004) 13 *BMJ Quality & Safety* ii22.
[100] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[101] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[102] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 3 [18], [21-23]; KPMG, *The Current State of Child Safety Service Centres: Report for the Department of Children, Youth Justice and Multicultural Affairs* (Report, January 2023) 62.

changing profile of children and families entering the system,[103] it also reflects the accumulation of additional procedural, administrative and legal requirements that have, over time, built up within the functions of frontline roles. Practitioners are now required to operate across a broader range of domains, including responding to domestic and family violence, intergenerational trauma, substance misuse and mental health issues, while also navigating increasingly structured statutory and court processes.[104]

> The child protection system has become the default absorber of unmet need across multiple government agencies. Health, disability, housing, and mental health services routinely decline, defer, or redirect families into the child protection system without providing the supports they are responsible for. Without dedicated resourcing to manage that interface, it falls to frontline workers who are already at capacity.[105]

This expansion has not occurred in isolation. It has been accompanied by an increase in the volume and intensity of work associated with each case, with evidence indicating that individual matters require greater coordination, documentation and oversight than in earlier periods.[106]

A consistent feature of the current operating environment is the extent to which administrative and compliance-related activity occupy practitioner time. The Commission received evidence that documentation requirements, procedural steps and court-related work form a substantial component of day-to-day activity, often displacing direct engagement with children, families and carers.[107]

Workload pressure is a defining characteristic of the current system. The evidence demonstrates that caseloads remain persistently above levels previously identified as appropriate for effective practice, and that this pressure is compounded by vacancy rates and workforce turnover.[108] These factors interact to create a system in which available capacity is frequently insufficient to meet demand. Practitioners are required to manage multiple matters simultaneously, each with competing priorities and varying levels of urgency.

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[103] Ines Zuchowski, 'Five Years after Carmody: Practitioners' Views of Changes, Challenges and Research in Child Protection' (2019) 44(3) *Children Australia* 165.
[104] KPMG, *The Current State of Child Safety Service Centres: Report for the Department of Children, Youth Justice and Multicultural Affairs* (Report, January 2023) 95.
[105] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 40.
[106] KPMG, *Review of Demand and Resourcing for Child Protection in Queensland* (Report, February 2017) 22-23.
[107] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 4 [30]; 1) Together Union noted that 'The preparation of this [rule 13 affidavit] material consumes, at minimum, one full working day during which the child safety offer is offline from every other child on their caseload'; 2) Witness AF said that '… I am completing huge amounts of affidavit material, and every hour that I spend on that material is hours I can't spend with children and families.'
[108] Team leaders consistently reported 225 or more staff above the caseload trigger (being 16 cases, which is the trigger for review of a workload) across consecutive reporting periods in 2024-24, Together, Submission to Child Safety Commission of Inquiry (6 March 2026) 64.

Workforce instability is a further feature of the current state. The Commission heard consistent evidence of high turnover within frontline roles, resulting in frequent reassignment of cases and disruption to relationships between practitioners, children and carers.

> Turnover means children experience constant changes of child safety officer. Each change breaks a relationship and forces the child to start again with a stranger. Institutional memory is lost. The new officer works from files, not from the knowledge that only sustained engagement can build.[109]

Children described experiencing multiple changes in assigned workers over relatively short periods, requiring them to repeatedly recount their circumstances and re-establish relationships.

> They change too much, every week I was given a new card or told whom I was looking for wasn't my CSO anymore.[110]

Carers similarly reported difficulties in maintaining consistent communication and coordination with the Department.

> The child in our care has been in our care six years, and in that time... it is above 25 CSOs who have been assigned to the child in our care and ourselves as foster carers! We have had five changes of CSOs just since January 2025! More than 25 changes in people turning up at home introducing themselves to the child in our care and ourselves, and all of them asking to be told the child's story and ours.[111]

The configuration of roles within the system also reflects an accumulation of functions that are not always clearly differentiated. CSOs operate within a broader team structure that includes supervisory, administrative and specialist positions. However, the evidence indicated that, in practice, tasks are not consistently distributed in a way that aligns with role design. Practitioners frequently undertake work that extends beyond core statutory functions, including administrative coordination and legal preparation, while support roles are variably available or utilised.[112]

Training and supervision arrangements form part of this broader picture as well. The Commission received evidence that initial training provides a foundation in knowledge about legislative and procedural requirements but does not consistently equip practitioners for the practical demands of the role.[113] In particular, there is limited structured in-field learning, and exposure to complex

[109] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 73.
[110] Youth survey response No 114 from former child in care (24 October 2025).
[111] Submission No 225 to Child Safety Commission of Inquiry (15 August 2025).
[112] Bendelta, *PO2 CSO Review and Workforce Model Options* (Final Report, December 2021) 17.
[113] Bright People, *CSO Recruitment & Retention Findings & Recommendations, Rockhampton Service Centre* (June 2019) 13-17; Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 1-3. The current mandatory training consists of corporate training modules and role-specific practice modules. There is no mandatory training prior to commencement of duties, nor is there a policy in place to require the completion of mandatory training.

casework often occurs early in employment. Supervision arrangements are variable and, in practice, are shaped by workload pressures and team capacity.[114] While supervision frameworks exist, their consistent application is constrained by the same conditions affecting frontline practice.

These features describe a system in which the conditions for practice are uneven and often in tension with the expectations placed on practitioners. The result is an operating context in which time, attention and continuity are constrained, and in which the balance between relational work, professional judgement and procedural compliance is shaped by the practical demands of the system.

3. Competing demands and the allocation of professional attention

The competing and, at times, conflicting demands on frontline Departmental staff time and attention shape what work is prioritised, how decisions are made and the extent to which practitioners are able to engage in relational work with children, parents and carers, and evaluative tasks. In essence, these demands are not confined to the margins of practice and have a very real impact on the ability for practitioners to work within a human or social services framework to connect with children and families and to contribute to improved outcomes.

This dynamic is clearly illustrated in the interaction between administrative and legal compliance requirements on the one hand, and the relational and analytical work required for effective child protection practice on the other. Frontline practitioners told the Commission that they are *required* to complete detailed documentation, meet statutory timeframes, prepare material for legal proceedings and adhere to structured procedural guidance. At the same time, they are *expected* to form and maintain relationships with children, families and carers, to assess risk in conditions of uncertainty, and to make decisions that are responsive to the particular circumstances of each child.[115] Not only do these demands draw on different forms of professional skill and require different allocations of time and attention but also the evidence indicates that functions that are time-bound, externally scrutinised or linked to formal accountability mechanisms tend to assume priority.[116] This is consistent with Munro's observations that work that is visible, auditable and often subject to external review often takes

[114] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 1 [3].
[115] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025.
[116] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 68-69; Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).

precedent over relational engagement, reflective assessment and follow-up work that is less visible and more difficult to measure.[117]

The Commission's observation is that this dynamic is reinforced by the cumulative effect of workload pressure. Prioritisation is necessary when managing high caseloads and multiple concurrent demands.[118] However, the consequences are significant at a workforce level where many staff sought out employment in child protection to do good work for children and families,[119] and for children and families who are supported most effectively when they have sustained, engaged and committed workers around them.[120]

This analysis does not suggest that administrative and legal requirements are unnecessary: they are integral to ensuring accountability, procedural fairness and the protection of rights (See Companion Report 2: Child Protection Litigation). The issue identified in the evidence is the way in which these requirements interact with workforce capacity and organisational expectations to shape the allocation of practitioner time and attention. Where this interaction is not calibrated to support the full range of tasks required for effective practice, the system's capacity to deliver relational, child-centred and contextually informed decision-making is constrained.

4. Capability, experience and the formation of professional judgement

The evidence presented to Commission indicates that members of the Departmental workforce have not developed their skills and capabilities only through acquiring qualifications alone. Instead, staff have acquired knowledge, skills, experience and judgement in many ways, including through activities developed, supported and applied in practice over time.

A central issue identified in the evidence before the Commission is the gap between formal preparation for the role of a CSO and the demands of practice. Entry pathways emphasise tertiary qualifications in disciplines such as social work, psychology and human services, reflecting the importance of foundational knowledge in areas including child development, family dynamics and risk assessment.[121] However, the evidence indicates that such qualifications do not, in

[117] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[118] KPMG, *The Current State of Child Safety Service Centres: Report for the Department of Children, Youth Justice and Multicultural Affairs* (Report, January 2023) 25.
[119] '…Departmental employees work exceedingly hard, [are] doing a very difficult job… They do this because they care deeply about the welfare of children in our community…,' Together, Submission to Child Safety Commission of Inquiry (6 March 2026) 34.
[120] 'Turnover undermines not only service delivery but also trust, permanency outcomes, emotional well-being, and the perceived legitimacy of child protection systems,' MacLochlainn et al, 'The effects of child protection social worker turnover on children and families: A scoping review addressing a critical gap in social work turnover research' (2026) *The British Journal of Social Work* 20.
[121] Queensland Government, 'Mandatory qualifications', *Child Safety Officer careers* (Web Page, 20 March 2026) <https://www.families.qld.gov.au/campaign/cso-careers/become-cso/qualifications>.

themselves, equip practitioners for the realities of statutory practice.[122] The role of a CSO requires the integration of multiple forms of knowledge, including legal frameworks, organisational processes, relational skills and situational judgement, often under conditions of time pressure and incomplete information, and CSOs themselves stressed the importance of in-field learning, mentoring and supervision in enabling practitioners to translate formal knowledge into effective decision-making.[123] However, CSOs describe this type of support as inconsistent. Training is described as uneven in depth and orientation, with a strong focus on legislative and procedural requirements and more limited emphasis on applied practice.

> [Speaking about GRO training] So that seemed very heavily focused on the assessment space. I've been working in the ongoing intervention space. It seemed really inadequate as to what [to do] in the ongoing intervention space... I don't think [the training is] enough... It's not enough to for the amount of stuff you have to deal with and you have to learn. There's so much that you're learning on the job day to day. And like, I find that I'm still learning now 18 months [in].[124]

Structured opportunities for in-field learning and observation are not uniformly embedded, and the availability of supervision is affected by workload pressures at team and organisational levels.[125]

> [After being asked whether in-field training is a benefit to new CSOs] Absolutely. Yeah. That's sort of up to your senior team leader at the time if they think that's important, they'll push forward and try and make opportunities for you. But if, like I said, if the circumstances are that there's a lot going on and you know workloads are too heavy, and those CSOs need to go out there as soon as possible, sometimes they don't get the opportunity, and that infield training stops quite quickly as well, because obviously once you get allocated your own case, you do not have time to go out with other, more experienced CSOs to see what they do. [126]

In this context, new practitioners may assume significant levels of responsibility before they have developed the experience or confidence required to exercise judgement effectively.

This dynamic can have significant implications at an individual case level and at a systemic level. Research shows that where experience is limited and support is constrained, practitioners are

[122] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 1 [2].
[123] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025.
[124] Transcript, Child Safety Officer Interview (31 October 2025) (COI.0001.0003.8330) 6-7.
[125] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 1 [3].
[126] Transcript, Child Safety Officer Interview (23 October 2025) (COI.0001.0003.8318) 6-7.

more likely to rely on prescribed frameworks, standardised tools and established practices.[127] While these resources are intended to support consistency and accountability, where they are used in the absence of strong underlying judgement, they may reduce responsiveness to the specific circumstances of the child.

The evidence also highlights the influence of the composition of the workforce and the structure of career pathways in shaping capability. High levels of turnover and resulting vacancies disrupt the accumulation of experience within teams and reduce continuity in case management.[128] At the same time, limited pathways for progression from support roles, and restrictive entry requirements for statutory positions, may constrain the system's ability to draw on a broader base of practical and life experience.[129] This includes the experience of those who have developed skills within the system over time but are not able to transition into decision-making roles.

The Commission considers that these factors interact in ways that affect both the depth and distribution of capability across the system. Capability is influenced by the availability of experienced practitioners, the structure of teams, the quality of supervision and the pathways through which individuals enter and progress within the workforce. As has been observed in relation to all system enablers explored in this Companion Report so far, where these elements are not aligned, capability becomes variable, and the quality of decision-making correspondingly uneven.

The issue identified in the evidence is not that the workforce lacks commitment or foundational knowledge. It is that the system does not consistently provide the conditions required to develop, sustain and apply professional capability at the level required by the statutory task. Strengthening those conditions is therefore central to improving the quality and consistency of decision-making across the child protection system.

5. The conditions for relational and reflective work

The evidence before the Commission indicated that workforce capability cannot be understood independently of the cultural conditions within which practice occurs. Capability is enabled, constrained or otherwise shaped by the expectations, incentives and norms that define how work is undertaken. In this respect, organisational culture operates as the environment within which

[127] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[128] Data provided by the Department of CSO vacancy rates for each region, for the beginning of each quarter from 2025 to 2026 (DFS.0357.0001.0011).
[129] Bendelta, *PO2 CSO Review and Workforce Model Options* (Final Report, December 2021) 22; Schottler Consulting, *Child Safety Officer recruitment campaign 2021 – market research*, (Report, May 2021) 4-5.

professional judgement is either supported as a central discipline of practice or displaced by other imperatives.

A consistent tension identified in evidence before the Commission is the interaction between a compliance-oriented environment and the capacity for relational and reflective work.[130] As set out in earlier analysis, child protection practice requires sustained engagement with children, families and carers, alongside careful evaluation of risk, need and context.[131] These activities depend on time, continuity and the ability to exercise judgement under conditions of uncertainty. However, the evidence indicates that prevailing organisational settings tend to privilege adherence to procedures, documentation and risk aversion.[132]

In this context, the Commission has observed that engagement in relationships with children, families and carers, while recognised as important, is less visible within formal accountability structures and therefore more vulnerable to being deprioritised. The result is not the absence of relational engagement, but a narrowing of the space within which it can be realised.

These cultural conditions affect the system's capacity for reflection and learning. Reflective practice requires time, supervision and a degree of psychological safety in which practitioners can examine decisions, consider alternative perspectives and learn from outcomes.[133] Where workload pressures are high and accountability is framed primarily in terms of adherence to processes, opportunities for such reflection are constrained. Supervision may become focused on case progression and compliance with requirements, rather than on the development of judgement and critical thinking.

In turn, this has further downstream implications for how knowledge is generated and used within the child safety system. Where reflective processes on the frontline are limited, practice is more likely to rely on established assumptions and less likely to incorporate new information or alternative perspectives.[134] This can affect engagement with children, families and carers, whose insights are a critical source of information about the child's circumstances. Where those perspectives are not consistently sought or integrated, decision-making is less informed and less responsive to context.

[130] Angela Schifilliti (Official Solicitor) said that '[referral to DCPL] moves from a human services framework to a litigation framework as soon as that happens… there's a disconnect… So, on one hand, you've got CSOs who are trying really hard to build relationships with families and to support families and, on the other hand, they're constantly being asked for more and more evidence to support the application before the court, and then you have this issue then with how do you build trust between the CSO and between families'.
[131] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[132] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026).
[133] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[134] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).

> I do not enjoy having to work around my schedule to have a meeting with my CSO. When they have been told what my views and wishes are, there is no action put toward anything, restricting major opportunities in my life, including my communication with my siblings in a different residence. Instead of taking initiative and getting things done, they continue to say they forgot or that they did attempt what was asked. But when followed up, the story changes.[135]

The Commission does not suggest that these cultural patterns are uniform across the system or all of the child safety regions. As noted in earlier chapters, large organisations may exhibit variation across regions, teams and functions.[136] However, the recurrence of these themes, supported by multiple sources of evidence, indicates that they are sufficiently widespread to influence system-level behaviour.

The issue identified is not simply one of workforce numbers or individual capability. It is the alignment, or lack of alignment, between the expectations placed on the workforce and the conditions provided to meet those expectations. Given that the dominant culture emphasises compliance and defensiveness, and that structural pressures limit time for engagement and reflection, the system inadvertently constrains the very forms of practice on which effective child protection depends.

Strengthening workforce capability therefore requires attention not only to training, supervision and workforce supply, but to the cultural and organisational settings that shape how that capability is expressed. Without such alignment, efforts to improve capability are likely to have limited effect, as the conditions necessary for relational, reflective and child-centred practice remain underdeveloped.

6. Alignment with statutory purpose

Workforce design determines how work is distributed, which functions are prioritised and the extent to which practitioners can focus on the core tasks required by the statutory framework. A central issue identified in the evidence presented to the Commission is the expansion and diffusion of the CSO role over time. This role has come to encompass a wide range of functions, including statutory decision-making, case management, administrative processes, coordination across service systems and preparation for legal proceedings.[137] While each of these functions is

[135] Youth survey response No 112 from child in care (23 October 2025).
[136] Ron Westrum, 'A typology of organisational cultures' (2002) 13 *BMJ Quality & Safety* ii22.
[137] Department of Child Safety, Seniors and Disability Services, *CSO Functional Analysis Project Phase 1 Summary Report* (Report, March 2024) 9-10.

necessary, their aggregation within a single role has significant implications for how time is allocated and how effectively responsibilities can be discharged.

The evidence indicated that there is a misalignment between the intended purpose of the CSO role and the work that the CSO is required to perform in practice. The statutory task requires sustained engagement with children, families and carers, alongside careful assessment and decision-making.[138] However, the accumulation of behind-the-scenes tasks and procedural responsibilities has reduced the proportion of time available for these core activities.[139] This is not simply a matter of workload volume; it reflects the way in which tasks are structured and distributed across the workforce.

The Commission considers that this dynamic is reinforced by the limited availability and utilisation of supporting roles. Evidence from trials and reviews indicates that the introduction of roles such as case support workers and paralegals can reduce administrative burden, improve timeliness of processes and enable CSOs to focus more directly on assessment and engagement.[140] However, these roles are not consistently embedded or scaled across the system, and their deployment has, at times, been ad hoc or temporary.[141] In the absence of a stable and clearly defined support structure, administrative and coordination tasks remain concentrated within the primary statutory role.

This concentration of functions has implications for efficiency and the quality of decision-making, as well as workforce recruitment and retention. Where highly trained practitioners are required to undertake tasks that do not require their level of expertise, the overall capacity of the system is reduced.[142] At the same time, fragmentation of attention across multiple competing demands limits the depth of engagement and analysis that a CSO can apply to each case. The result is a workforce that is both overextended and underutilised in relation to its core professional function.

The Commission considers that these issues reflect a broader absence of systematic workforce planning aligned to the evolving demands of the child protection system. While individual reviews and projects have identified the need to redesign roles and redistribute tasks, there is limited evidence of sustained implementation at a system-wide level.[143] In this context, workforce design

[138] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[139] Appendix F, CA-40, *Issues arising from interviews with Departmental staff in Far North Queensland,* tendered 17 November 2025, 3 [21].
[140] Department of Child Safety, Seniors and Disability Services, *FNQ regional trial of paralegal officer positions* (Final Review, February 2024) 10.
[141] The paralegal and case support worker trial was permanently funded in December 2024, however at ratios well below the trial model, Together, Submission to Child Safety Commission of Inquiry (6 March 2026) 56.
[142] KPMG, *The Current State of Child Safety Service Centres: Report for the Department of Children, Youth Justice and Multicultural Affairs* (Report, January 2023), 18.
[143] Statement of Meegan Crawford (22 December 2025) [11]-[19].

has been dominated by historical configurations and incremental adjustments, rather than by a clear articulation of the functions required to deliver effective statutory practice.

While the Together Union emphasises a need for additional workforce resourcing,[144] the Commission's analysis does not suggest that the challenges identified can be resolved simply by expanding the workforce. Increasing the number of practitioners without addressing how work is structured and supported is unlikely to produce sustained improvement. The more fundamental issue is one of alignment: ensuring that roles, responsibilities and support functions are configured in a way that enables practitioners to perform the tasks that are central to the system's purpose and are appropriately aligned with their skills, experiences and interests.

Case in point – The Child Safety Officer as a system lens

The role of the CSO is at the heart of the of the structural issues described not only in this chapter but throughout this Companion Report.

A CSO's work does not occur in a single setting or within a single function in the system. At any given time, a CSO is required to have responsibility for multiple children whose circumstances span different stages of intervention, different placement types and, often, and different service systems. Over the course of a day, a CSO may move between speaking with a child in care, responding to a carer seeking approval for a decision, liaising with a service provider about support arrangements, preparing material for court, and managing new information about risk within a family. Each of these tasks sits within a different part of the system, but in practice they are experienced as part of a single, continuous role.

The CSO must maintain a working understanding of each child's circumstances across these interactions. This includes not only the child's safety and wellbeing, but also the availability of placements, the status of legal processes, the involvement of external services, and the dynamics within the child's family and care network. Information relevant to those matters is generated across multiple sources and is not always held in a single place. The CSO is therefore required to bring that information together and make decisions in real time, often in circumstances that are evolving and often through or with more senior staff who may be the delegate for some decisions.

[144] Together, *Submission to Child Safety Commission of Inquiry in response to Call for Submissions regarding the Child Protection Litigation Model* (1 December 2025); Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026).

Many of the actions a CSO must take depend on factors that sit beyond their direct control. The availability of a suitable care placement for a child may depend on the capacity of the non-government sector. A child's access to therapeutic or health supports may depend on other service systems with their own thresholds and timeframes. Legal processes introduce additional steps, requirements and timelines that shape how and when decisions can be implemented. In this environment, the CSO is required not only to make decisions, but to coordinate their execution across a system that is distributed and, at times, constrained.

At the same time, the role requires direct engagement with children, families and carers. The CSO is often the person through whom the system is experienced. They are required to build relationships, listen to concerns, explain decisions and, in some cases, implement decisions that are contested or distressing. This relational work occurs alongside, and is shaped by, the structural conditions within which the role operates.

These responsibilities are exercised within an operating environment characterised by distributed functions, regional variation in service availability, shared delivery with non-government providers, and ongoing interaction with other service systems. As a result, the CSO is required to work across multiple interfaces, each of which requires coordination, judgement and the management of competing demands.

Seen in this way, the CSO's experience reflects the way the system functions as a whole. The role sits at the intersection of multiple functions, regions, organisations and service systems, bringing into a single point the effects of how functions are distributed, how services are organised, how responsibilities are shared, and how information and decision-making flow across the system.

7. Concluding observations

The Commission's analysis throughout this chapter hinges around the idea that workforce design is a critical enabler of the performance of the child safety system. The chapter outlined the many elements that operate in combination to shape how the statutory responsibilities of the Department are carried out in practice The evidence indicated that the current configuration of these elements does not consistently support the form of practice required by the legislative framework or by the needs of children and families.

A central observation from the analysis is the misalignment between what the system requires of practitioners and the conditions within which they are expected to operate. The statutory task depends on sustained engagement, careful evaluation and the exercise of judgement under conditions of uncertainty. However, the prevailing practice environment is characterised by competing demands, high workload and an emphasis on procedural compliance and defensiveness. In these conditions, practitioner attention is directed toward activities that are time-bound and auditable, while relational and reflective work is more difficult to sustain.

This misalignment has implications for the operation of professional capability. The evidence does not suggest a lack of commitment or foundational knowledge within the workforce. Rather, it indicates that the child safety system does not consistently provide the structures, supports and cultural settings necessary to develop and apply knowledge, skills and professional judgement effectively. Experience is unevenly distributed, supervision and in-field learning are constrained and opportunities for reflection are limited. As a result, professional judgement is more likely to be shaped by available frameworks and immediate pressures than by a comprehensive understanding of the child's circumstances.

The Commission also considered that the configuration of roles within the workforce are problematic. The aggregation of administrative, procedural and statutory functions within the CSO's primary decision-making role limits their capacity to focus on core responsibilities. While there is evidence that alternative configurations, including the use of supporting roles, can improve efficiency and enable more effective practice, these approaches are not consistently embedded. Workforce design therefore continues to reflect historical arrangements rather than a considered alignment with the demands of contemporary practice.

These dynamics are reinforced by the organisational culture within the Department. As examined in earlier chapters in this Companion Report and reflected in the evidence considered in this chapter, the system exhibits features of a compliance-oriented environment in which performance is demonstrated through adherence to process requirements. This orientation influences how work is prioritised, how judgement is exercised and how learning occurs. Where deviation from prescribed approaches carries perceived risk, practitioners are more likely to rely on established processes and less likely to engage in the deliberative and adaptive reasoning required in complex cases.

The Commission considers that addressing these issues requires a shift in focus from individual roles or isolated workforce measures to the overall configuration of enabling conditions. This includes the alignment of workforce design with statutory purpose, the provision of structured

opportunities to enable staff to develop the knowledge, skills and other capabilities they need for the job, the calibration of workload and support functions, and the reinforcement of cultural settings that support judgement, reflection and engagement with children, families and carers.

Chapter 4

Funding, Commissioning and Market Design

Companion Report 7

System Enablers

Chapter 4: Funding, Commissioning and Market Design

Abstract

This chapter considers how funding, commissioning and market settings shape the services available to children and families. It examines the growth of residential care, the State's role as market steward, the limits of reactive procurement, the incentives created by pricing and contracting arrangements, and the difficulty of assessing value without reliable quality and outcome information. The chapter concludes that commissioning must become a deliberate system-design function, capable of shaping supply, quality, price and provider behaviour toward the care models Queensland needs.

1. Introduction

Funding, commissioning and market design form the economic architecture of Queensland's child safety system and, as a result, are powerful system enablers. They determine where investment is directed, what services are available, which providers enter and remain in the market, and how the system balances cost, quality, safety and accountability over time.

In a sense, how funds are distributed through the commissioning process are expressions of the priorities of the system because they translate policy intent into service delivery. Procurement and market design then shape and reinforce provider behaviour, price, quality, supply and accountability. These enablers are not peripheral administrative functions. They are central mechanisms through which the State either supports, or undermines, its own objectives.

The evidence before the Commission indicated that Queensland's child safety system is not merely experiencing cost growth: Its funding and commissioning arrangements are reinforcing a late, high-cost and increasingly residential-care-dependent model of response.[145] Residential care provides the clearest illustration of this dynamic, but the implications extend more broadly across the breadth of the child protection system. The Department's stated objective — to enable families to safely care for their children and young people, and provide services to support the safety, belonging and wellbeing and best interests of children and young people not able to be

[145] In January 2026, the Commission engaged KPMG to provide a detailed analysis on the current market for residential out-of-home care in Queensland, the financial position of a sample of providers and the models that have been constructed or published to assess future demand and cost for these services. This analysis has underpinned the Commission's evidence gathering and analysis as it related to funding, commissioning and market design for residential care.

cared for by their families[146] — will not be achieved if investment settings, commissioning practices and market structures continue to pull the system toward late, high-cost and crisis-based responses.[147]

The residential care hearings examined these issues, focusing on the costs of residential care, different funding models, investment and commissioning in regional and remote areas, procurement, resourcing, licensing, contract management and government responses to known challenges in the out-of-home-care system. A thorough examination of the Commission's work related to these issues can be found at Companion Report 4: Understanding and Reforming the Residential Care System. In essence, the evidence analysed by the Commission confirmed the following key issues: a rapid growth in residential care; the increasing cost of the provision of residential care; growing reliance on Individualised Placement and Support (IPS) arrangements; supply side market concentration; the greater use of for-profit providers; a marked increase in the number of unlicensed providers; relatively limited participation by Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCOs); and limited quality and performance data.

The QFCC *Buyer Beware* report,[148] released while the Inquiry was being conducted, similarly described Queensland's residential care market as being shaped by economic forces and market failures, with the system on an unsustainable trajectory without urgent reform.

This chapter examines the potential for Queensland's funding, commissioning and market settings to operate as enablers of the child safety system. It also explains how the current approaches to funding, commissioning and market settings reinforce the patterns of late intervention, crisis response and reliance on residential care. The challenge is to understand the dynamics underpinning the current issues in the system in order to produce sustainable reforms.

2. Current state

Queensland's child protection system operates through a funding and commissioning architecture in which a substantial proportion of services are delivered externally through non-

[146] Department of Families, Seniors, Disability Services and Child Safety, *Strategic Plan 2025-2029* (Strategic Plan, June 2025) 3.
[147] Note: This chapter should not be read as a criticism of all providers or of frontline, carers and organisations working in good faith within the Queensland's child protection system. The Commission recognises that overwhelmingly providers and frontline workers are committed to children, operate under difficult conditions, and often attempt to meet complex needs in circumstances shaped by workforce shortages, placement pressure, funding constraints and limited service alternatives. This chapter is not intended to attribute system failure to providers as a class. Rather, it is intended to examine how government-created market settings, pricing arrangements, contracting models and accountability mechanisms shape provider behaviour and determine whether good practice is enabled, rewarded and sustained.
[148] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025).

government organisations, including ATSICCOs. Apart from instances of delegated authority,[149] the Department retains statutory responsibility for decision-making, but relies on commissioning, procurement and contract management to translate that responsibility into the delivery of services through external providers across the State. As a result, commissioning and procurement are central to how the system functions in practice.

The Department's 2025/26 Service Delivery Statements identify a total controlled budget of $3.617 billion, with expenditure largely directed toward out-of-home care services and other outsourced supports for vulnerable children and families.[150] This reflects an operating model in which funding is predominantly directed to care and support at the tertiary end, once children have entered the statutory system, rather than to earlier preventive forms of support and intervention. Similarly, QFCC's analysis in the *Buyer Beware* Report indicates that out-of-home care expenditure increased as a proportion of the child protection budget from 58% in 2020 to 73% in 2024, while the proportion of funding directed toward early family support declined over the same period.[151] Within that profile, residential care represents a particularly significant and growing component of the overall child protection system. The QFCC *Buyer Beware* report states that more than $1.1 billion, or approximately 51% of total child protection expenditure, is currently spent on residential care services for around 2,000 of the approximately 12,000 children in out-of-home care.[152] The evidence before the Commission is that most of the children in residential care are placed there because suitable family-based care is unavailable.

This current funding profile sits alongside an operating model in which the Department funds a broad range of non-government providers to deliver placement and support services, consistent with its stated strategic priorities of enabling families to care safely for their children, and of providing services to support the safety, belonging, wellbeing and best interests of children in care.[153] In practice, the extent to which investment patterns align with these stated departmental priorities is shaped by demand, service availability, assessment of risk, and commissioning decisions across the system and at a government level through Cabinet Budget Review Committee deliberations and decisions.

[149] See Chapter 1.2.
[150] Queensland Government, *Service Delivery Statements - Department of Families, Seniors, Disability Services and Child Safety* (State Budget Paper, 2025) 11. Note: This reflects controlled income for the entirety of the Department of Families, Seniors, Disability Services and Child Safety. Controlled items, which includes controlled income, are items which relate directly to the departmental operational objectives and arise at the discretion and direction of that department.
[151] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 32.
[152] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 1.
[153] Department of Families, Seniors, Disability Services and Child Safety, *Strategic Plan 2025-2029* (Strategic Plan, June 2025) 3.

Within the Department's broader economic architecture, residential care provides a clear illustration of the present pattern of funding and service delivery. Over the past decade, residential care has expanded rapidly, shifting from a relatively limited placement option, intended for children not suitable for family-based care, to a core component of the tertiary system. A majority of the significantly increasing number of children placed in residential care would otherwise be suitable for family-based care.[154]

This growth has delivered an exponential increase in expenditure. Residential care costs have risen substantially over time, both in aggregate and on a per-placement basis. The system has also increasingly relied on IPS arrangements, which are intended to be used to secure placements on a short-term or emergency basis when planned capacity is unavailable, or for ongoing placements for children with very complex needs, requiring specialised support. These arrangements have become a significant and increasing component of placement arrangements and expenditure. Put simply, these IPS arrangements have been overwhelmingly used to cover the gap between funded placements and demand.

The Department has indicated a current, renewed focus on addressing some of the above issues. The ballooning scale, cost and reliance on residential care generally, and the IPS arrangements within residential care, were primary catalysts for initiating this Commission of Inquiry.

The structure of the residential care market reflects the above-described growth. The analysis prepared for the Commission by KPMG in the lead up to the residential care hearings — entitled "Financial Review of Non-Family Based Residential Care" (KPMG analysis) dated 2 April 2026 — found that funding is concentrated among a relatively small number of providers, with a limited group receiving a large share of the total expenditure on residential care.[155] At the same time, the composition of the market has shifted, with increasing participation by for-profit providers.[156] While the number of licensed providers has remained relatively stable, the number of unlicensed providers has increased, particularly in response to demand for flexible or immediate placement options.[157]

Supply conditions vary across regions in Queensland, with differences in provider availability, cost and service mix. ATSICCOs represent a relatively small proportion of residential care providers (as well as other forms of out-of-home care provision), and the number of ATSICCO

[154] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 34.
[155] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 19.
[156] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 22.
[157] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 22.

providers has consistently been at a level below the demand for culturally focused placements for Aboriginal and Torres Strait Islander children.[158]

As described in Chapter 2 and Chapter 5 of this Report, across the system, information about service quality and performance is limited. Available data tends to focus on throughput, activity and funding, and far less so on outcomes for children, the quality of provider performance, or the quality of care being delivered.[159] This limits the system's ability to compare providers, monitor performance and assess whether investment is achieving intended outcomes.

3. Resource allocation across the system

The pattern of resource allocation within Queensland's child safety system provides a critical lens through which to assess whether the system is positioned to achieve its stated objectives of reducing harm, supporting families earlier and limiting reliance on out-of-home care,[160] or indeed the briefly expressed purpose of the system as described by the Commission: to nurture and care for children in need of State protection as would a reasonable natural parent.[161] The evidence presented to the Commission indicates that, while overall expenditure has increased, the distribution of that expenditure remains weighted toward the point at which harm has already escalated and statutory intervention is required.

The KPMG analysis found that demand pressures are increasing rapidly and at a high level within the tertiary system. Firstly, since 2016, there has been sustained growth in demand for out-of-home care overall, which may be associated with broader social drivers including domestic and family violence, housing instability, mental health challenges and economic disadvantage. Secondly, within out-of-home care, there has been a marked increase in the use of residential care placements, largely reflecting inadequate supply of family-based care alternatives. Thirdly, within residential care itself, there has been growing reliance on high-cost, short-term IPS arrangements, where planned capacity is unavailable or where children's needs cannot be met within existing service models. These three factors are interrelated and cumulatively contribute to the system's increasing cost profile.[162]

While external demand is a factor contributing to this pattern, another contributing factor is the availability, or absence, of earlier responses within the primary, secondary and tertiary parts of the system. The KPMG analysis indicates that limited investment in early intervention and

[158] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 2.
[159] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27.
[160] Department of Families, Seniors, Disability Services and Child Safety, *Strategic Plan 2025-2029* (Strategic Plan, June 2025).
[161] See Chapter 1.6.1 of the Executive Report, the full definition of purpose is in paragraph [1].
[162] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 33.

constraints in the supply of foster and kinship care contribute to increased reliance on residential care.[163] Where children cannot be safely supported within their families, and where family-based placements are not available at the required scale, the Department is required to procure residential care as the last resort.

Submissions to the Commission, including from QATSICPP, argued that a substantial majority of child protection funding is directed toward statutory intervention and out-of-home care, with comparatively limited investment in early intervention and prevention.[164] QFCC's *Buyer Beware* Report similarly noted that expenditure on out-of-home care has increased as a proportion of the total child protection budget, while the relative share directed to early family support has declined.[165] In this sense, the growth of residential care is not only a response to need, but also a consequence of limited capacity in other parts of the system, and decisions about resource allocation.

This pattern is confirmed by data comparing Queensland with other jurisdictions. Queensland has a higher proportion of children in residential care than other Australian jurisdictions. Most notable is that residential care comprises a significantly larger share of out-of-home care placements in Queensland than in the other larger states such as New South Wales and Victoria.[166] At the same time, residential care is substantially more expensive than family-based alternatives, with indicative annual costs per child significantly exceeding those associated with foster or kinship care by an order of magnitude of approximately 10-15 times.[167]

When considered as a whole, this evidence suggests that the system is financially weighted toward tertiary intervention. The allocation of resources is concentrated at the point at which children have already entered care, rather than at earlier points where families might be supported. While underinvestment into the system broadly is explored as a fundamental issue in Companion Report 4: Understanding and Reforming the Residential Care System, the distribution of that investment across the system is also a critical issue. In light of this, it is important to distinguish between these two related but separate dynamics. The first is overall expenditure growth driven by demand. As more children enter the system, unavoidably expenditure will need to increase. The second is the investment strategy directed toward reducing that demand or meeting it most cost-effectively. This involves allocating resources to interventions that reduce the likelihood of children entering care, shorten the duration of care, or

[163] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 34.
[164] Queensland Aboriginal and Torres Strait Islander Child Protection Peak, Submission to Child Safety Commission of Inquiry in *response to call for submissions regarding Far North Queensland (Child Safety Commission of Inquiry* (August 2025).
[165] Queensland Family and Child Commission, *Buyer Beware* (Report, June 2025) 32.
[166] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 35.
[167] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 35.

enable placement in less intensive (and less costly) settings. The evidence before the Commission indicates that the system in Queensland has certainly experienced the first dynamic, but that there has been insufficient investment in the second at a scale to alter overall demand patterns, or to ensure adequate supply of suitable lower cost placements to ensure that cost growth does not exceed demand.

In this context, the growth in residential care expenditure is not only a budgetary pressure, it is an indicator of how the system is functioning. It reflects a pattern in which earlier supports are either insufficient, unavailable or unable to operate at the scale required to meet need, resulting in increased reliance on sub-optimal and more expensive forms of care.

This gives rise to a central question of system design and whether investment has been directed to the points in the system with the greatest potential to change trajectories for children and families. An ongoing risk for Queensland's child safety system is that it continues to underinvest in the conditions required to reduce future demand, noting that the single most material determinant of variable cost is gross demand. Should this continue to occur, additional funding injections will unavoidably be required to sustain system operation without materially altering outcomes.

4. Commissioning

Commissioning is the mechanism by which policy intent is translated into funded services. It is a multifactorial process involving design and stewardship. It entails determining care placement options; choosing service models; specifying criteria for the quality of services, accountability for performance; and seeking out, choosing and entering into contracts with providers.

Properly understood, commissioning is not the same as procurement. Procurement is one component of commissioning in that it is the mechanism through which specific services are purchased. Commissioning is the broader strategic function that identifies need, designs the service response, shapes the provider market, prices services properly, specifies outcomes, monitors performance and adjusts investment over time.[168]

When considering commissioning as a system enabler, the Commission has examined whether the Department's approach to commissioning operates as a deliberate system-design function capable of shaping supply toward the needs of children. The evidence suggests that this is not consistently the case. Too often, commissioning appears to have operated as a 'just in time' procurement mechanism for securing immediate capacity in response to placement pressure,

[168] J. Gordon Murray, 'Towards a common understanding of the differences between purchasing, procurement and commissioning in the public sector' (2009) 15(3) *Journal of Purchasing and Supply Management* 198.

rather than as a strategic function for designing and stewarding the system.[169] This belated approach has exposed the Department to opportunistic market participants, particularly unlicensed providers. It has also inverted market power, insofar as the Department has become a price taker rather than a price maker. In a market in which the Department is the single buyer, this is a distortion of market forces which reflects a failure to make timely commissioning plans.

The residential care hearings were directed to precisely these matters. Collectively, the evidence from these hearings points to a commissioning cycle that has not been sufficiently disciplined by long-term planning, future supply forecasting, robust performance information or clear specification of expected outcomes. Since at least 2018, the Department's commissioning cycle has started from a point of unmet demand by purchasing the capacity available at the point of crisis rather than commissioning supply suitable for the number and profile of children likely to require care, the regions in which demand will arise, the service models required, the capability providers must have, and the outcomes to be achieved. This is the commissioning failure.

The KPMG analysis helps explain the consequence of this failure and provides a model of best-practice commissioning for the Department to consider adopting.[170] Residential care costs reflect a dependence on short-term, high-cost, IPS arrangements[171] that have been used to address a continuing shortfall in contracted long-term placements, alongside the decline of family-based care. The evidence does not suggest that the Department should never use short-term or individualised arrangements. The Commission accepts that there will always be children whose needs require emergency or tailored responses. However, the evidence demonstrates an overreliance on such arrangements, which were initially designed for exceptional circumstances.

The KPMG analysis also identifies the importance of modelling and data as the first step in a commissioning model.[172] Demand for residential care does not arise evenly across Queensland. Regional and remote areas face different labour markets, housing markets, provider capacity and service gaps. Data needs to be collected and analysed to support planning not only at the state level, but also at regional and subregional levels. This data is critical to enable any analysis and understanding of drivers of demand and market dynamics at all levels. If this is not done, the Department will not be able to identify those variations, and trends, early enough to shape supply proactively. This will result in continued reliance on surge purchasing when placements are needed, as with any 'spot-market.'

[169] Transcript, Evidence of Michelle McNamara (9 April 2026) 5090:28-5090:43.
[170] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 44.
[171] In contrast with longer-term Outsourced Service Delivery contracts, which usually span multiple years and provide greater price certainty for government and greater funding stability for providers.
[172] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 44.

The QFCC *Buyer Beware* report frames the same problem from a market perspective. It describes government-funded mandatory services, such as child protection, as involving inelastic demand, with government acting as the principal purchaser, funder and regulator. In this environment, weak design and weak regulation can distort market incentives, reduce accountability and leave taxpayers as passive price takers in an inefficient procurement ecosystem.[173]

To more plainly illustrate the above points, Queensland's tertiary care market has been directly shaped by government commissioning behaviour, in that:

- Government has repeatedly purchased high-cost emergency capacity. Accordingly, the market has adapted to provide high-cost emergency capacity.
- Government has paid for presence rather than outcomes and has tolerated weak assessment of quality. Accordingly, the market has adapted to those tolerances.
- Government has not provided sufficient long-term certainty for high-quality providers to recruit, train, lease, build capability and specialise. Accordingly, the supply base has not comprehensively developed in the way children require, and providers have instead resorted to relying on labour hire arrangements and casualised workforces.

The KPMG analysis also suggests commissioning should not end when a contract is signed.[174] It should continue through performance monitoring, quality assurance, assessment of placement outcomes, financial transparency, developing workforce capability, and building intelligence about the performance of care providers from complaints information, incident data, child voice and independent oversight. Without those feedback loops, the Department cannot know whether the services it has purchased are achieving their intended purpose. Nor can it reliably decide whether to expand, redesign, terminate or replace particular service models or providers.

5. Market stewardship and provider behaviour

Queensland's child safety OOHC market has been created by the State, funded by the State, governed and regulated by the State, and sustained by the State's need to provide care for children for whom it has assumed statutory responsibility. Within that framework, government is not simply one purchaser among many; rather, it is the purchaser, the funder, the regulator and, ultimately, the corporate parent. This gives the State a strong market stewardship obligation over the market, an obligation that requires more than monitoring providers after contracts are signed. The above market characteristics should empower the State to shape the market to commission

[173] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 7.
[174] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 44.

and procure the services which will deliver improved care for children. However, this requires the State to improve the market it has created, the incentives it has embedded, and the behaviours that those incentives make rational, with the ultimate view to understanding the outcomes for children individually, and for the system generally.

The QFCC *Buyer Beware* analysis is important because it frames residential care as a market problem, not a service-delivery problem.[175] In residential care, children are not directly market participants. A child in residential care cannot exercise the ordinary consumer power that disciplines other markets; children cannot choose a provider, compare quality, exit a poor service (beyond absconding or self-placing), or withhold payment for unsatisfactory services. As in all respects generally, children are vulnerable to arrangements made on their behalf. The Department, not the child, purchases the service; and the child experiences the consequences. If the State's commissioning strategy and procurement settings reward the availability of care as a last resort at a crisis point, the market will produce care as a last resort at a crisis point. If the State rewards stable, capable and relational care and positive outcomes, the market has a reason to invest in that kind of care. The evidence suggests Queensland's settings too often reward the former rather than the latter.

There may always be cases where the provision of care is below standard and requires a response from the government (an investigation, termination of the contract or another sanction). However, this does not detract from the core proposition that market behaviour follows market design, driven by the service delivery requirements of the single buyer. The KPMG analysis noted that the Department has become dependent on IPS arrangements as described above. As noted above, this is an inversion of market forces and the self-executing consequence of the Department's failure over time to plan strategically to procure stable long-term services. IPS arrangements are materially weaker than Outsourced Service Delivery (OSD) arrangements, impose fewer requirements and lack contractual protections that would ordinarily be expected where public funds are being spent.[176] This distinction is central to market stewardship. The market has adapted to the State's overreliance on arrangements designed for immediacy and exception. Providers have a rational basis for favouring the more flexible and more commercially attractive model. The State then becomes increasingly dependent on the very form of supply it should be seeking to reduce.

[175] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 8.
[176] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 49.

The KPMG analysis also points to the growth of for-profit participation in that market. In 2024-25, around 70% of providers were for-profit, up from 62% in 2021-22.[177] Further, in a sample of providers analysed by KPMG, for-profit providers received average daily rates around $500 higher than not-for-profit providers, equating to approximately $182,000 more per child per year.[178] That does not mean for-profit provision is inherently inappropriate. Rather, the question is whether the State's market settings ensure that public money procures safe, stable and effective care, instead of simply purchasing available labour and accommodation at escalating prices. The market can include different types of providers, but the State needs to ensure that the provider's commercial incentives are aligned with the State's assessment of the child's interests. The State has the capacity, as the buyer and regulator, to do so by instituting the right pricing, quality assurance and accountability mechanisms, and by clearly specifying the required outcomes. This includes the ability to specify, and reward, features most likely to matter to children: stability, continuity, relational care, a capable workforce and a suitable and reliable model of care.

The State's market power and influence is not without its limitations and constraints. Market constraints are more acute in regional and remote Queensland. Thin markets mean there may be few providers, supply shortage of suitable care workers, constrained accommodation and too few care options. The KPMG analysis pointed to variability in costs across providers and regions, and observed that premiums are often paid for regional, rural and remote placements because of the lack of availability of qualified workers. For instance, North Queensland was a region where rates per day accelerated dramatically.[179] In those circumstances, while higher costs are likely inevitable and appropriate, the State is still able to reduce its vulnerability to becoming a price taker. Accepting that a child must be placed, the State cannot simply decline to purchase a placement; in this market, demand is inelastic. That reality makes prior planning, regional commissioning and strategic supply development all the more critical.

The QFCC *Buyer Beware* report reaches a similar conclusion, albeit in broader terms. It states that Queensland has not demonstrated effective market stewardship in its management of out-of-home care services, and notes that all tertiary care services have been outsourced to non-government providers over several decades with minimal strategic oversight, no clear commissioning framework and little planning for suitable capacity. It describes a system that

[177] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 22.
[178] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 51.
[179] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 24.

evolved reactively rather than intentionally, with escalating costs, increasing complexity and insufficient regard for long-term sustainability or child outcomes.[180]

The reform task ahead is not simply to criticise providers after the event. Rather, it is to influence the redesign of the market so that the response of the rational provider is child-centred and focused on the best outcomes for children. That means stronger entry controls, transparent pricing, more rigorous licensing, tighter financial disclosure, accurate measurement of outcomes for children and discussions about improvement where the data identifies problems, deliberate regional service planning, and a clear transition away from crisis-driven purchasing to pre-planned acquisition. This approach will enhance the State's practical ability to insist upon models of care which align with the needs of the children, rather than being hostage to its own inelastic demand.

These issues and potential solutions are explored at a level of granularity in Companion Report 4: Understanding and Reforming the Residential Care System.

6. Quality, outcomes and value for money

Simply examining Queensland's OOHC system by cost, contract type or commissioning arrangements is insufficient. Those elements relate to how services are purchased and how much the State paid for them. However, they are not directed at the more important question of the quality of the services measured against the needs of children in residential care. The focus of any analysis must encompass the quality, safety, stability and outcomes for children. Evidence to the Commission from many witnesses with direct experience of the child safety system made clear that an available placement is not necessarily appropriate, nor that all placements are safe.[181] Merely providing a 'roof over the child's head,' while meeting an immediate need does not mean that it attains a desirable standard.[182]

The KPMG analysis suggests that the Department is unable to assess quality of care with sufficient confidence.[183] The State is able track expenditure, placement nights, contractual activity and some target measures; however, those measures alone do not reliably show whether children are safe, whether placements are stable, whether care is therapeutic or culturally responsive, or whether children's health, education and wellbeing needs are being met. While

[180] Queensland Family and Child Commission, *Buyer Beware: How economic forces are shaping Queensland's residential care market* (Report, June 2025) 13.
[181] Transcript, Evidence of Thomas Allsop (15 September 2025) 730:47-731:5; Evidence of Witness C (8 September 2025) 62:20-63:7; Evidence of Witness D (19 September 2025) 1300:35-1300:44.
[182] Transcript, Evidence of Witness S (16 February 2026) 4126:47-4127:3.
[183] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27.

these domains are captured by the Queensland Care Services Outcomes Framework, the KPMG analysis indicates the available performance information does not allow a robust assessment of performance against those outcomes.[184]

The same caution applies to certification and audit data. The KPMG analysis reveals that licensed providers are required to attain and maintain Human Services Quality Framework (HSQF) certification against the Human Services Quality Standards. HSQF certification applies to licensed providers only. Assessments under the HSQF can cover a number of types of service and are not restricted to residential care. Indeed, many providers deliver services across the human and social services. An audit outcome may therefore provide assurance about organisational systems, but it does not necessarily provide a residential-care-specific assessment of the quality of care experienced by children in a particular home.[185]

The value-for-money problem is sharpened by the KPMG analysis about IPS arrangements. While sections 4 and 5 of this chapter address commissioning and market stewardship of IPS arrangements, its significance here is more specific. As described above, IPS contracts formed a growing proportion of total placement nights and total funding between 2021-22 and 2024-25, and became increasingly more expensive per day compared with OSD arrangements. However, as mentioned, higher cost is not inherently unjustified. Some children need extremely high levels of supports. Some placements require higher staffing levels, carers with specialist skills, regional loadings, or additional therapeutic input.

The critical issue is that the State should be able to clearly ascertain why a higher price is being paid and what additional quality, safety or outcome is being purchased. The KPMG analysis indicates that the State's ability to do that was weak. It found limited scrutiny of IPS Pricing Schedules. So much was also confirmed by the Chief Procurement Officer, Hanelie Lategan, who identified that there was high variability in provider pricing and negotiation was mostly explanatory, not assertive.[186] This in turn undermines confidence that prices reflect reasonable or value-for-money service delivery. KPMG also found in its analysis that growth for some for-profit IPS-only providers appeared driven by pricing schedules and their ability to access

[184] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27. For example, KPMG's analysis found that between 2021/22 and 2024/25 Outsourced Service Delivery providers combined to deliver 1,023,280 residential care nights, representing 88.6% of the total target of 1,154,714 nights. Performance against target nights was relatively consistent across regions and years, although North Queensland showed greater variability, with overall achievement of 84.7% and a range from 78.9% in 2024/25 to 91.1% in 2021/22. That information is useful for understanding throughput, but it is not a measure of quality.
[185] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 27.
[186] Department of Families, Seniors, Disability Services and Child Safety, *IPS Business Rules Review Current State Analysis* (Memo) (DFS.0377.0001.0001) 3.

placements, rather than demonstrated needs, efficiency, service maturity or measurable quality-of-care outcomes for children.[187]

The Commission emphasises that it is not suggesting that cost control should be pursued at the expense of providing quality care to children. Residential care is inherently expensive, especially when it is done properly. Safe and effective care requires suitable housing, stable staffing, training, supervision, therapeutic capability, cultural knowledge, transport, education support, family contact, after-hours responsiveness and strong organisational systems. The KPMG analysis also speaks to the contemporary and emerging pressures such as labour constraints, casualisation, SCHADS award rate increases, competition with the disability sector for resources, housing shortages, rising electricity costs and exposure to insurance coverage, all of which affect the sustainability or care providers.[188]

In essence, Queensland spends a very large and increasing sum of money on residential care. However, the Commission has found that the State does not seek or utilise information about performance and outcomes in the residential care sector to determine, with confidence, whether that increased expenditure procures better care, safer care, more stable care or improved outcomes for children. In those circumstances, value for money has not been demonstrated under the present commissioning and procurement arrangements. The Commission considers there is an urgent need for the Department to address the commissioning and procurement deficiencies discussed above, without which the present cost trajectory will only get worse.

7. Concluding observations

This Chapter has demonstrated how increased demand for out-of-home care, insufficient availability of family-based care, limited early intervention and the availability of short-term mechanisms to purchase residential care services have combined to make that a default response to broader pressure for care places in the child safety system. The more the system relies on residential care, the more it must purchase expensive residential care services. The more it purchases expensive services, the more the market adapts to provide it. In that sense, the system is not only expensive, it is financially and structurally pushed and pulled toward the wrong end of the continuum in a way that is self-perpetuating. The push factors are limited investment in early intervention and family-based care. The pull factors are inadequate, or absent, commissioning and procurement strategies.

[187] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 51.
[188] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026) 39.

This trajectory is not inevitable. It is shaped by policy choices, investment decisions, commissioning settings and market design. If there is to be positive change, commissioning must become a central reform lever, not merely a purchasing process. It should be used to identify need, plan supply, design care models, properly price services, set quality expectations, and monitor whether expenditure is producing safety, stability and improved outcomes for children.

In the future, market stewardship must also be more active. The State created and funds the residential care market. It must take responsibility for removing the undesirable incentives embedded in its own contracting, pricing and procurement settings, and redesign them to ensure a wider range of care offerings for children, including much better quality residential care.

Chapter 5

Information, Technology, Feedback and Learning Systems

Companion Report 7

System Enablers

Chapter 5: Information, Technology, Feedback and Learning Systems

Abstract

This chapter examines the information systems, records, data, complaints, reviews, audits, outcome measures and feedback loops through which the child protection system sees children and learns from its own operation. It explores the limits of activity-based reporting, the importance of case records as system memory, the role of information sharing, and the need to translate child voice, complaints and review findings into action. The chapter concludes that information and technology are safeguarding infrastructure, and that Queensland needs a learning system capable of detecting risk, understanding outcomes and correcting course before failure becomes entrenched.

Of note, the Commission has not investigated or analysed the Unify to any extent, however, it does recognise the broader lesson that when the record system does not function properly, the State's ability to protect children is compromised.

1. Introduction

Queensland's child safety system is unlikely to improve only by developing new policies, creating new programs or increasing expenditure. The system must also enable Department staff and other service providers to see what is happening to children and families, understand whether its interventions are helping, and change course when they are not.[189] That obligation is heightened by the nature of the child safety system's statutory role. When the State intervenes and assumes responsibility as corporate parent, it must be able to know whether children are safe, whether families are receiving effective ongoing support, whether placements are stable, whether relationships and cultural connections are being maintained, and whether the system's involvement is improving or worsening a child's life.[190] Information, technology, complaints,

[189] Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis (Report, 2010) 10.
[190] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014–2020)* (Report, 2021); Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024); Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 38, 59, 60, 80-81, 85; Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022)195–202; Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis (Report, 2010).

reviews, audits, performance reporting and outcome measurement are therefore not separate administrative functions. Together, these elements are key system enablers: the learning infrastructure through which Queensland can see the child, understand the system, and take action to correct course.[191]

Information is therefore a critical component of the safeguarding infrastructure. To use it requires a shift in how the system understands its own records, data and technology. Data quality must not be treated simply as a reporting issue.[192] The system must enable risks to be understood, decisions to be properly informed, and a child's history to follow them when workers, placements or services change. Information sharing must not merely be an interagency process. Information determines whether those responsible for a child within and across agencies, have access to what they need to act safely and in timely way.[193] Technology must not be treated merely as a platform. It shapes what practitioners can record, retrieve, analyse and share, and how much time they have for direct work with children and families.[194]

The same is true of complaints, reviews and audits. These are not peripheral accountability mechanisms. They are sources of intelligence about how the system is experienced and where it is failing. However, these mechanisms only improve the system if the findings they produce are analysed, connected to other information, and translated into changed practice, policy, resourcing or oversight. A system that repeatedly receives findings but does not act on them is failing to learn from the information that it generates.[195]

The Commission's concern is therefore not simply whether Queensland collects enough data. The evidence suggests that the system collects substantial information about its activities, demand, statutory process, service use, and expenditure. The more important question is whether that information is accurate, accessible, shared appropriately, analysed thoughtfully, and used to improve decisions that benefit children and families. A system that collects data but does not learn from it remains reactive. It may count the number of notifications, investigations, case closures, visits and placements, and measure expenditure, while still failing to know whether children are, and feel, safe, whether families are being helped and supported, whether relationships are being built, or whether the system's involvement has improved a child's life.[196]

[191] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022)195–202; Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis (Report, 2010).
[192] Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis, (Report, 2010).
[193] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022).
[194] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022).
[195] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022); Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis, (Report, 2010).
[196] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026).

The core premise of this chapter is that Queensland should move toward a more self-correcting child safety system. That does not mean a system that regulates itself without external accountability. It means a system that embeds feedback loops strong enough to detect risk, identify practice drift, test whether interventions are working, enable discussion about lessons learnt, and correct course before failure becomes entrenched.[197] Such a system does not wait for a tragedy, complaint, media investigation, coronial finding or a Commission of Inquiry before it understands where it is failing. It routinely uses information from children, families, carers, frontline workers, service providers, complaints, reviews, audits, performance reports and outcome measures to understand and digest what is happening and what needs to change.

Queensland's child safety system should be capable of seeing, hearing, remembering, analysing and acting. Without those capabilities, the child safety system will continue to react to crisis and external scrutiny to discover what its own systems should already have revealed.

2. Current state

As noted above, the child safety system collects and publishes substantial data about demand, statutory activity, service usage, expenditure and how children move through the system. Existing sources include Departmental performance reporting, AIHW data, RoGS data, QFCC reporting, child death data, departmental dashboards, HSQF material, investment specifications, the Children in Care Census and the My Life in Care survey.[198] These sources provide important foundations upon which a feedback and learning system can be built. They allow the State to see, at least in broad terms, the volume of children and families entering the system, the rate at which matters progress through statutory pathways, the number of children in care, the use of placement types, and some aspects of system performance.

One issue is that much of this information describes activity rather than impact. It tells the system what happened, but not always what changed or how what happened has affected children and families. A statutory system must have information about demand, workload, cost and compliance. However, these measures do not, by themselves, reveal whether families were helped, whether children were, and felt, safe, placements were suitable, cultural connection was real, relationships were stable, health, disability, education and mental health needs were addressed, or whether children leaving care were better prepared for adult life.

[197] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022); Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis (Report, 2010).
[198] See the brief discussion of these in Appendix G, Commission of Inquiry into Child Safety System, *Guide: A self-regulating child protection system*.

This gap has already been identified by key institutions in the child safety system including the QFCC,[199] the Together Union,[200] and KPMG.[201]

There are, however, important foundations on which to build. The Department's Children in Care Census provides a foundation for understanding outcomes within the system because it gathers information about children's pre-care experiences, placement stability, health, education, relationships, family connection, cultural support planning and transition to adulthood.[202] The My Life in Care survey also provides an important source of child-centred information. At the public hearings held in November 2025 regarding Far North Queensland, the 2024 survey results were tendered, and counsel noted that the survey asked children about feeling 'safe, secure and stable' and about how they felt in their current placement.

The current position may be characterised as *information-rich* in relation to activities and workload but not yet *intelligence-rich*. Queensland has many of the required data sources, but information remains fragmented. Data quality is uneven. Access and retrieval can be difficult. Reporting is often output-heavy, rather than focused on whether the circumstances of children and families have improved (outcomes). Complaints, audits and reviews do not consistently translate into system learning. Most significantly the current system does not sufficiently target, or analyse information on outcomes for children, young adults and families.

3. Record management and technology

The Commission considers that the case management system that supports the frontline of the child safety system is not to be thought of as merely an administrative, back-office platform. It is the system where risk is recorded, accounts are preserved, decisions are explained, and where workers who have had contact with a child can access information necessary to understand the child's circumstances. It is the primary source of material about the child's life and experiences. The quality of the record affects the quality of service delivery in many ways. If information is incomplete, poorly structured, difficult to retrieve or unreliable, the system's ability to recognise risk, understand chronology, identify escalation and make the best possible decisions is

[199] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014–2020)* (Report, 2021); Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024); Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026).
[200] Together, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 37.
[201] KPMG, *Financial Review of Non-Family Based Residential Care* (Report, 2 April 2026).
[202] Department of Families, Seniors, Disability Services and Child Safety, *Children in Care Census 2024* (Report, 2024).

diminished.[203] Record and information management must therefore be treated as part of Queensland's safeguarding infrastructure.

This is particularly important given that children and families move between intake, investigation, ongoing intervention, court processes, placements, service centres, funded providers and oversight bodies. Workers change. Supervisors change. Placements change. Providers change. The case management system records the institutional memory that the system itself may otherwise lose. It needs to record accurately the child's pathway, family context, cultural identity and risk history, as well as strengths and supports that help keep the child safe. It also records prior professional judgements, reasons for decisions, unresolved concerns and actions required. A record that captures only episodic activity is not sufficient for workers within the system to understand the child's circumstances, including cumulative harm, and progress.

The case management system needs to be designed to minimise administrative burden. It must reduce unnecessary recording, improve practice and make access to data more automatic.[204] If it requires duplicate entry, excessive manual work or informal workarounds, it removes time from direct work with children and families. That is not merely an efficiency problem, it is a practice problem. Child protection depends on relationships, observation, professional judgement and timely engagement. Technology should enable those functions, not impede them.

The challenges with the Unify system demonstrate why case management technology must be treated as a safeguarding tool. While this Commission has not interrogated Unify to any extent, it does recognise the broader lesson that when the record system does not function properly, the State's ability to protect children is compromised.

Data quality and information accessibility similarly affect frontline practice, supervision, legal decision-making, service oversight, complaints handling, audit, review and system learning. Poor data can make patterns look like isolated events. Weak chronology can obscure escalation. Inconsistent data entry can compromise reporting and analysis. Information that exists but cannot be found, understood or trusted may as well not exist at the point of decision.

For practitioners, accessibility means the ability to retrieve the right information quickly, lawfully and in a form that supports judgement. For children and care leavers, accessibility has a different but equally important meaning. The submission to the Commission from the Office of the Information Commissioner noted that information about time in care assists individual children and care leavers to understand their early life, develop identity, establish family and cultural

[203] Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis, (Report, 2010)16–18; Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022) 221.
[204] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022) 221.

connections, and in some cases obtain redress. It also identified challenges faced by individuals seeking meaningful access to care records, including family history, reasons for entry to care and reunification considerations.[205]

Privacy remains an important safeguard, particularly in a system that holds highly sensitive information. However, privacy should not become a reason for preventable blindness within the system, or for withholding from children and care leavers the information necessary to understand their own lives. The challenge is to design information governance that protects confidentiality while enabling lawful information sharing, timely decision-making, meaningful access to personal history and system learning.

4. Performance, quality and outcomes

As described above, Queensland collects substantial information about the operation of the child safety system. However, its focus is largely on measures that do not, by themselves, help the system or the Department to understand whether interventions have improved the life of a child or strengthened the safety and functioning of a family.

The distinction between outputs and outcomes is central. Outputs describe what the system does or has done. Outcomes describe what changed for children and families.[206]

The QFCC has previously observed that Queensland's child protection data does not adequately show how each part of the system affected children and young adults, including whether they were kept safe, had their needs met, experienced improved health, wellbeing or education outcomes, were reunited with family, or transitioned successfully to adulthood.[207] The Together Union made a similar point from the workforce perspective, submitting that the system measures quantity more readily than quality, with the risk that it rewards surface-level work rather than meaningful practice.[208]

The KPMG analysis of residential care demonstrates the same problem within residential care. It found that available contract, quality and performance information did not enable a robust

[205] Office of the Information Commissioner, *Submission to Child Safety Commission of Inquiry* (19 December 2025).
[206] Mark Friedman, 'A Guide to Developing and Using Performance Measures in Results-based Budgeting', *The Finance Project* (Guide, May 1997) <https://files.eric.ed.gov/fulltext/ED432371.pdf>; Mark Friedman, 'The Results and Performance Accountability Implementation Guide', (Guide, 2001) <https://raguide.org/wp-content/uploads/2014/04/RapaComplete.pdf>; Jonathan Dickens et al, 'Courts, care proceedings and outcomes uncertainty: The challenges of achieving and assessing "good outcomes" for children after child protection proceedings' (2019) 24 *Child & Family Social Work* 574–581; Clare Tilbury, 'The Influence of Performance Measurement on Child Welfare Policy and Practice' (2004) 34(2) *The British Journal of Social Work* 225, 232. See also Appendix G, Commission of Inquiry into Child Safety System, *Guide: A self-regulating child protection system*.
[207] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014–2020)* (Report, 2021).
[208] Together Queensland, *Submission to Child Safety Commission of Inquiry* (6 March 2026) 37–38, 77.

assessment of the performance of care providers, and that outsourced service delivery measures largely related to throughput, volume and cost rather than the quality of care.[209] The significance of these observations is broader than just for residential care. If the State can count service activity more readily than it can assess quality, safety, stability or outcomes, then performance reporting may create false confidence while leaving the most important questions unanswered.

There are important foundations on which to build. Sources such as the Children in Care Census are important because they report on the child's experiences and circumstances. But such information should be collected regularly and should not remain episodic. The system needs a stable outcomes architecture that can track children's safety, stability, belonging, cultural connection, health, disability support, education, family relationships, reunification, permanency and leaving-care outcomes over time. Longitudinal information is particularly important because the effect of child safety involvement may not be immediately visible at the point a file is closed.[210]

The Commission therefore considers that performance reporting must be rebalanced. The system should not stop counting activity, but it must stop treating activity as a proxy for effectiveness. A mature reporting framework would distinguish between access, output, quality and outcome indicators, and would use a range of indicators. Some indicators may be performance-based, such as measuring placement stability health checks or education participation. Some may be evidence-based, drawing on research about effective program elements or validated outcome measures. Others should be drawn from the experience of children, young adults, families and carers.

To get the most out of indicators, the system must understand how they were developed, what they assume and when they can and cannot show. A range of indicators, rather than just one should be used. Indicators should be treated as a first question, not the answer.[211] In short, the data and performance information should 'be treated as information that needs to be carefully and intelligently interrogated in order understand the particular circumstances and pattern of provision'.[212]

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[209] KPMG, *Residential Care Analysis*, ES.14, A.24, A.25 and A.28.

[210] Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024) 29–36; Verso Consulting Pty Ltd, *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report* (Report, November 2011); Leslie Morrison Gutman et al, 'A longitudinal study of children's outcomes in a residential special school' (2018) 32(4) *Journal of Social Work Practice* 409–421; Áine Kelly et al, *Success: whose definition counts? A co-designed framework by and for young people leaving care* (Report, November 2025).

[211] Ivana La Valle et al, *How we know if children's social care services make a difference? Development of an outcomes framework* (Report, July 2019) 11-14.

[212] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 48; For an in-depth discussion of these categories, see Appendix G, Commission of Inquiry into Child Safety System, *Guide: A self-regulating child protection system*.

5. Complaints, child voice and system intelligence

Complaints, reviews and audits (discussed in detail in Companion Report 6: Complaints) are often treated as accountability mechanisms. They are that, but they should also be also sources of intelligence about the operation of the system and its effects on children and their families. Their value depends not only on whether an individual matter is resolved, but on whether the information they reveal is connected with other relevant information, analysed and used to identify weaknesses in the system and bring about change.

Complaints are essential feedback from users of the system. They provide a pathway for children, families, carers, workers and others to raise concerns about decisions, conduct, delay, communication, safety, placement quality or access to services. However, complaints are an incomplete measure of system performance. They depend on a person recognising a problem, knowing where to raise it, feeling safe to raise it, and believing that raising it will make a difference. These assumptions are often weak in child protection.

Children may be too young to complain, may not know their rights, may not have a trusted adult to support them, or may be fearful of the consequences of speaking up. Some children may be dependent on the very person, placement or service about which they would need to complain. Families may fear that raising concerns will affect their relationship with the Department or influence decisions about contact, reunification or placement. Carers may worry that complaints will not be heard, or that raising concerns will create tension with the Department or the provider supporting them. Workers may also feel vulnerable to the consequences of speaking up, or prefer to raise concerns informally without those concerns being recorded, escalated or analysed as part of a broader pattern.

For those reasons, absence of a complaint cannot be assumed to constitute evidence that a child is safe, a placement is stable, or a service is operating well. Complaints data should be read alongside other intelligence sources, including the child's voice, community visiting, advocacy, incident reports, placement movement, missing-from-care episodes, workforce feedback, carer feedback, case audits, review findings, provider reporting and performance data.

Children's voice is particularly important. Children and young people are not merely recipients of services. They are primary sources of evidence about whether the system is safe, relational, responsive and intelligible. A child may be able to describe whether they feel safe in a placement, have trusted adults, understand what is happening to them, have contact with siblings or family, culture is respected, and feel listened to in decisions affecting their life. Those accounts should

not be treated as anecdotal material sitting outside system intelligence. They are central evidence about the quality and effect of the system.

The same point applies to the experiences of parents, kin, carers and frontline workers. Parents and kin may identify barriers to reunification or family support that are not visible in compliance data. Carers may identify placement stress, lack of support or emerging instability before breakdown occurs. Frontline workers may identify workload, supervision, technology, policy or service access issues that prevent good practice. If these signals are not captured and analysed, the system misses the opportunity to intervene early.

Reviews and audits provide another source of intelligence. Internal reviews, child death reviews, coronial findings, provider audits, HSQF material, external oversight reviews and Commission findings can each identify failures, gaps or risks. But the system must do more than receive and respond to individual findings. It must ask whether similar issues are appearing elsewhere, whether earlier recommendations have been implemented in substance, whether the response changed practice, and whether the risk has reduced.

This requires disciplined 'close-the-loop' processes. When a complaint, concern, review or audit identifies an issue, the system should be able to answer: what was raised; what was found; what action was taken; who was accountable; what changed; and whether the change worked. These loops must operate at multiple levels: the child, the family, the service centre, the provider, the region and the system as a whole.

The Commission considers that the child safety system requires a more disciplined method for analysing complaints, concerns, reviews and audits, and converting the information into learning. This is not only a matter of better complaints handling. It is a matter of system intelligence. The system should be able to discern patterns across concerns, not only resolve individual matters one by one.

6. Learning, correction and assurance

6.1 Self-regulation through feedback loops and learning cycles

The preceding sections identify the system's informational building blocks: the record, information access, information sharing, performance reporting, outcome measurement, complaints, child voice, reviews and audits. Those elements are necessary, but they are not sufficient. The central task is to convert information into a learning system in which feedback

loops help the system understand both its operation and its effectiveness.[213] Information that does not alter practice, policy, resourcing, commissioning, workforce planning or oversight is not yet system intelligence. It is stored knowledge.

Feedback loops and learning cycles are central to systems thinking. Child safety is a socio-technical system in which people, technology, organisational structure, tools, processes and culture interact.[214] In such systems, failure is rarely produced by a single decision. It more often emerges from the interaction of broad range of circumstances and decisions. Feedback loops enable the system to detect malfunctioning parts, unintended consequences and practice drift, and then take corrective action.[215]

This is also the bridge between compliance and learning. Compliance remains necessary in a statutory system. Visits must occur, records must be maintained, decisions must be lawful, and explained, and timeframes must be monitored. But a compliance culture asks only whether the required step occurred. A learning culture asks whether the step achieved its purpose.[216] It asks whether the visit helped the child to be seen, whether the record supported the next decision, whether the referral led to support, whether the placement was safe, and whether the reform changed practice.

This requires feedback and learning loops at multiple levels. At the child and family level, the system must ask whether intervention is improving safety, stability and support. At the service centre level, it must ask whether workload, supervision, decision-making environments and practice conditions are safe. At the provider level, it must ask whether services are delivering their intended model and achieving good outcomes for children in care. At the system level, it must ask whether policy, funding, legislation and commissioning are changing the conditions that produce demand.

Responsibility for system learning must also be clear. The Department remains responsible for service delivery, internal quality assurance and improving its operations. But a self-correcting system requires more than internal assurance. It requires a clear institutional arrangement capable of coordinating system-wide learning across agencies and providers. See Companion Report 6: Complaints for a related discussion.

[213] see Appendix G, Commission of Inquiry into Child Safety System, *Guide: A self-regulating child protection system*.
[214] Eileen Munro, The Munro Review of Child Protection: Part One: A Systems Analysis, (Report, 2010)16-18.
[215] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011).
[216] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 129; Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 69.

6.2 Proactive Inspection of the System

Complaints, dashboards, audits and reviews tend to be reactive, document-based or retrospective. In the present system, the current accountability framework relies too heavily on children, families and carers to raise concerns when something has gone wrong.

Proactive inspection is one possible way to shift the accountability logic from reactive response to prevention and assurance.[217] It can test whether policies are operating in practice, records support safe decisions, supervision and workload conditions support good practice, children and families experience the system as intended, and concerns are being identified and acted on before harm occurs.[218]

The Commission does not consider it necessary and is not in a position to settle the design, location or powers of any child protection inspection function. That requires further work. However, there is a clear opportunity for Queensland to explore whether a proactive inspection capability should form part of the broader accountability and learning architecture.

What proactive inspection adds: the Ofsted example

The Ofsted model is useful not because Queensland should import the English inspection regime wholesale, but because it illustrates how inspection can operate as a public child focused mechanism for learning and correction. Ofsted's inspections are preventive, proactive and system-focused – local authorities and care providers are routinely and regularly visited. Inspections focus on whether the system is operating as designed, and in particular on the impact of care and support on the experiences and progress of children, rather than primarily on whether policies and procedures exist on paper.

When Ofsted conducts inspections to see how well a local authority is fulfilling its statutory functions, inspectors examine how the authority is implementing 'family help', family group decision-making and multi-agency child protection arrangements and teams. Inspectors ask senior leaders to explain how they are implementing local arrangements to help and protect vulnerable children. Inspectors' evaluation of

[217] 'Inspection' is defined by the OECD as 'any type of visit or check conducted by authorised officials on products or business premises, activities, documents. Organisation for Economic Co-Operation and Development (OECD), *OECD Best Practice Principles for Regulatory Policy: Regulatory Enforcement and Inspections* (OECD Publishing, May 2014), 11.
[218] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 69-84.

practice with children and families focuses on the experience and progress of children.[219]

Ofsted's inspections of care providers are conducted largely through case tracking and sampling: 'inspectors spend less time looking at policies and procedures and more time looking at the impact of services on children's lives'.[220] Inspectors consider the quality of care, relationships, belonging, stability, health, education, emotional wellbeing, children's views, day-to-day experience, preparation for the future and access to specialist services.[221] They engage directly with children, speak with carers, and observe daily practice.[222] They examine leadership and governance, the quality of care provided for children, safeguarding practices and outcomes for children.

Ofsted's enforcement policy states that the protection of children is paramount and that action should reduce risk, secure compliance and improve quality.[223] When it identifies breaches, Ofsted has significant enforcement powers to redress flaws in the system, and operational weaknesses.

Following an inspection visit, Ofsted may identify breaches, raise statutory requirements, make recommendations, issue compliance notices, and take other forms of enforcement action such as restricting accommodation, suspending registration or, in serious cases, cancelling registration. Where a compliance notice is issued, it can require immediate action within a specified timeframe, with a follow-up visit or inspection to assess compliance with the notice.[224]

Ofsted inspectors also publish inspection reports which are publicly available on the Ofsted website.[225] The reports focus on 'the things that matter most to children's lives'; that is, 'the progress and experiences of children' and others who use the

[219] Ofsted, 'Inspecting local authority children's services', *Guidance* (Web Page, 20 March 2026) <https://www.gov.uk/government/publications/inspecting-local-authority-childrens-services/inspecting-local-authority-childrens-services>.
[220] Ofsted, 'Social care common inspection framework (SCCIF): children's homes', *Guidance* (Web Page, April 2026) <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-childrens-homes/social-care-common-inspection-framework-sccif-childrens-homes#the-focus-of-inspections>.
[221] Ofsted, 'Social care common inspection framework (SCCIF): children's homes', *Guidance* (Web Page, 1 April 2026) <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-childrens-homes/social-care-common-inspection-framework-sccif-childrens-homes#the-focus-of-inspections>.
[222] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026).
[223] Ofsted, 'Social care enforcement policy', *Guidance* (Web Page, 30 April 2024) <https://www.gov.uk/government/publications/social-care-ofsteds-enforcement-policy/social-care-enforcement-policy>.
[224] Ofsted, 'Social care enforcement policy', *Guidance* (Web Page, 30 April 2024) <https://www.gov.uk/government/publications/social-care-ofsteds-enforcement-policy/social-care-enforcement-policy>.
[225] Ofsted, 'Find an inspection report' (Web Page, 16 May 2026) <https://reports.ofsted.gov.uk/>.

> services.[226] In making its assessment, Ofsted uses a 4-point scale (outstanding, good, requires improvement to be good, and inadequate) and takes into account 'how well children are helped and protected' and 'the effectiveness of leaders and managers'.[227] Inspection reports are publicly available on the Ofsted website.[228]

Any such exploration should be guided by established inspection principles rather than by the creation of another duplicative oversight body.[229] It should consider the purpose of inspection, its relationship with existing complaints, advocacy, regulatory, departmental and functions of other parties (such as the QFCC, Queensland Ombudsman or Community Visitors), and whether inspection should commence with Child Safety Service Centres before any staged extension to funded non-government services. It should also consider how inspection would hear from children and families, examine cultural safety, observe practice conditions, review casework quality, and report publicly without displacing the responsibilities of operational agencies.

Comparative models provide useful reference points, but not a template to be imported wholesale.[230] Ofsted in England provides one example of an inspection model that examines children's services and social care providers, with a focus on children's experiences, safeguarding culture, leadership and the impact of services on children's lives.[231] Queensland's Inspector of Detention Services provides a local example of a preventive inspection model in a high-risk statutory environment. These examples show that inspection can be used to test conditions, identify risk and promote improvement. The question for Queensland is whether a child safety-specific inspection capability would add a missing preventive safeguard, and if so, how it should be designed.

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[226] Ofsted, 'Social care common inspection framework (SCCIF): children's homes', *Guidance* (Web Page, April 2026) <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-childrens-homes/social-care-common-inspection-framework-sccif-childrens-homes#the-focus-of-inspections>.
[227] Ofsted, 'Social care common inspection framework (SCCIF): children's homes', *Guidance* (Web Page, April 2026) <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-childrens-homes/social-care-common-inspection-framework-sccif-childrens-homes#the-focus-of-inspections>.
[228] Ofsted, 'Find an inspection report' (Web Page, 16 May 2026) <https://reports.ofsted.gov.uk/>.
[229] Organisation for Economic Co-operation and Development, *OECD Best Practice Principles for Regulatory Policy: Regulatory Enforcement and Inspections* (Report, 2014).
[230] Organisation for Economic Co-operation and Development, *OECD Best Practice Principles for Regulatory Policy: Regulatory Enforcement and Inspections* (Report, 2014); Arie Freiberg, *Regulation in Australia* (Federation Press, 2017) 192, 385; Keith Hawkins, *Environment and Enforcement: Regulation and the Social Definition of Pollution*, (Oxford University Press, 1984) 38-101.
[231] *Education and Inspections Act 2006* (UK), Pt 8; *Care Standards Act 2000* (UK); Rick Hood and Allie Goldacre, 'Exploring the impact of Ofsted inspections on performance in children's social care' (2021) 129(2) *Children and Youth Services Review*; Ofsted, 'Safeguarding concerns: guidance for inspectors' *Guidance* (Web Page, 7 November 2025) <https://www.gov.uk/government/publications/ofsted-safeguarding-policy/safeguarding-concerns-guidance-for-inspectors>; Ofsted, 'Social care common inspection framework (SCCIF): children's homes', *Guidance* (Web Page, 1 April 2026) <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-childrens-homes/social-care-common-inspection-framework-sccif-childrens-homes#the-focus-of-inspections>; Ofsted, 'Inspecting local authority children's services', *Guidance* (Web Page, 20 March 2026) <https://www.gov.uk/government/publications/inspecting-local-authority-childrens-services/inspecting-local-authority-childrens-services>.

The important point is not the institutional form but the function. A child safety system should not be reliant only on complaints, internal assurance, retrospective review or crisis to know whether practice is safe and child-centred. It should have a way to test, independently and proactively, whether policy, records, practice conditions and children's experiences align in the real world.

6.3 A reform body to coordinate and manage reform initiatives

The Commission observed, repeatedly, that there was a degree of "reform fatigue" within the Department and a tendency for such initiatives to lag behind or fall entirely off the Department's radar. In this regard, the former Director-General, Deidre Mulkerin, gave evidence that:

1. Throughout her time as Director-General, the Department was often in the process of implementing and designing many hundreds of recommendations from previous QFCC reviews, Inquiries, Royal Commissions, Child Death Review Board reports, Coronial inquests, and reviews commissioned by Government relating to specific case matters.
2. The capacity of the strategic policy teams and the data analytics teams was impacted by the focus on historical reviews, due to the ongoing need to track and report to internal stakeholders, Government or oversight bodies about the progress of recommendations against previously agreed timeframes.
3. Reform fatigue manifested for the commissioning and procurement teams by way of increased expectations to develop regional procurement plans to respond to current and future demand and to review the current funding profile of private providers in terms of scale, location and model type to the projected need of children and families.[232]

In response to these types of issues, in 2025 the Department established the Reform Implementation Office (RIO) to lead and coordinate the Department's reform activities at an enterprise level. Its role is to bring together efforts from across the Department, key agencies, and stakeholders to ensure a unified and effective approach to delivering reform. RIO is designed to oversee and drive the changes needed, ensuring everyone involved is working together, maximising and mobilising effort across all divisions.[233]

The Commission recommends that, in the long-term, a team with the functional responsibilities of the RIO be embedded within the Department to support the implementation of reform initiatives. The Commission agrees with the observations of Michelle McNamara, a Director within the RIO, that having a body like this promotes strong coordination, clear accountability, and effective collaboration, which are essential for managing complex changes. Having a reform

[232] Statement of Deidre Mulkerin (8 April 2026) [35]-[39].
[233] Statement of Michelle McNamara (25 March 2026) [31]-[32].

focused division also helps build skills and share knowledge across the Department, ensuring reforms are sustainable and adaptable to future challenges.[234]

A direct line of reporting should also be established for such a body, for instance to the Director-General, Head of Internal Audit or a Director specifically appointed to lead the reform implementation body. That will encourage senior executives within the Department to prioritise reform initiatives.

7. Concluding observations

Queensland's child safety system generates large amounts of information: in reports, dashboards, case records, complaints, reviews, audits, surveys, census material, performance indicators and national datasets. The problem is more fundamental. The system has not yet converted these sources into a coherent learning architecture capable of seeing risk clearly, understanding children's experiences of care, measuring whether interventions are helping, and changing course when they are not.

That distinction matters. More data will not, by itself, make children safer. Nor will more reporting, more dashboards or more compliance checks. The system needs better information, but it also needs better ways of interpreting that information, connecting it across agencies and functions, and translating it into changed practice, policy, investment and oversight. As Munro observed, child protection systems require continual feedback so that organisations can learn what is working, identify emerging problems and adapt accordingly.[235]

The Commission considers that information and technology must be treated as safeguarding infrastructure. The case record is the memory of the system. Information sharing is the mechanism by which risk is made visible across institutional boundaries. Performance reporting should show not only what the system did, but whether it made a difference. Complaints, child voice, reviews and audits should not sit as separate accountability events. They should be treated as intelligence about how the system is experienced and where it is failing.

The same logic applies to outcome measurement. Queensland should continue to count demand, activity, timeliness and expenditure. Those measures remain necessary. But they must be balanced by measures that show whether children are safe, stable, connected, healthy, educated, heard and supported to belong. The system should know whether families were helped before statutory escalation, whether reunification was supported safely, whether cultural

[234] Statement of Michelle McNamara (25 March 2026) [33]-[34].
[235] Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 62; Eileen Munro, *The Munro Review of Child Protection: Part One: A Systems Analysis* (Report, 2010) 10.

connection was maintained, whether placements were suitable, and whether young people left care with the relationships, housing, education, health support and practical foundations they needed.[236]

A learning system also requires institutional discipline. Findings from complaints, audits, child death reviews, coronial processes, inspections, service reviews and commissions must be tracked beyond acceptance and implementation. The harder question is whether they changed behaviour, practice conditions and outcomes. A system that repeatedly receives findings but does not convert them into changed practice has a learning failure, not merely an implementation delay.

Proactive inspection should be considered in that broader architecture. It would not replace complaints, advocacy, departmental assurance, QFCC monitoring or provider regulation. Its value would be different. Inspection can test directly whether policy, records, practice conditions and children's experience align in the real world. It could identify practice drift, weak supervision, cultural safety failures, poor information flows and unsafe local conditions before harm becomes catastrophic.[237]

The central reform task is therefore to build a system capable of seeing, hearing, remembering, analysing and acting. Without that capacity, Queensland will remain dependent on crisis, complaint, media exposure, coronial findings and inquiries to discover what its own systems should already have revealed. With it, the system can begin to become self-correcting: not self-regulating in the absence of accountability, but continuously informed, externally tested, and capable of learning in the interests of children and families.[238]

[236] Queensland Family and Child Commission, *Measuring what matters: Evaluating outcomes achieved through the Queensland Child Protection Reform Environment (2014–2020)* (Report, 2021); Queensland Family and Child Commission, *A system that cares: Queensland Family and Child Commission response to Child Safety's A Roadmap for Residential Care in Queensland* (Report, April 2024) 29-36.
[237] Queensland Family and Child Commission, *Submission to Child Safety Commission of Inquiry* (27 March 2026) 38-40; Eileen Munro, *The Munro Review of Child Protection: Final Report – A Child-Centred System* (Report, May 2011) 69-84, 46.
[238] Josh MacAlister, *The Independent Review of Children's Social Care* (Final Report, May 2022) 200, 221-222; Eileen Munro, *The Munro Review of Child Protection: Part One: A Systems Analysis* (Report, 2010) 15.

Chapter 6: Recommendations

Recommendation 45: Redesign and restructure of the Department	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government should, within six months of Government's response to this Report, redesign and restructure the Department. This redesign and restructure must address, at a minimum, the following matters:

(f) a direct alignment between decision-making authority and executive-level accountability for outcomes;
(f) strengthened independence and visibility of oversight, review and practice-quality functions;
(f) a clearer separation between operational delivery of specific functions, internal assurance, and system oversight;
(f) discrete functional alignment and reporting lines across the Department's functions of intake, investigation, case management, placement, commissioning, provider oversight and reform implementation, rather than based on regions or locations;
(f) clear statewide practice standards and mechanisms to address unacceptable regional variation; and
(f) improved visibility of children's pathways through the system.

This redesign must also deliver against the specific structural changes in Recommendations 45A, 45B, 45C, and 45D.

CONTEXT:

The Commission has heard evidence of fragmented responsibility, variable practice, unclear accountability and difficulty tracking children's pathways through the system. Structural arrangements within the Department affect whether decisions are made at the right level, whether oversight functions have sufficient independence, and whether statewide practice standards are implemented consistently.

The intended outcome is to align the Department's structure with the functions it must perform, and perform well: statutory decision-making, practice quality, placement and pathway management, commissioning, provider oversight, internal assurance and reform implementation. For children, the expected impact is more consistent practice, clearer responsibility for decisions, better pathway oversight and reduced variation in service quality depending on location.

IMPLEMENTATION NOTES:

Planning related to the redesign should include:

(i) a current-state functional map of the Department
(i) identification of functions that require clearer authority, independence or separation
(i) a proposed future-state operating model
(i) a staged implementation timetable
(i) transitional arrangements to manage operational risk

(i) workforce and capability implications
(i) arrangements for strengthening statewide practice leadership
(i) mechanisms for monitoring regional variation
(i) reporting to government and the independent implementation and reform assurance function.

The redesign should not be limited to organisational charts. It should address how decisions are made, how risks are escalated, how practice is supervised, how children's pathways are tracked and how system learning is converted into operational change.

Recommendation 45A: Creation of a function focused on intervention and family support	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on targeted intervention and family support, with responsibility and stewardship for early and targeted intervention services and family support, distinct from statutory child safety functions.

This business function, under dedicated executive leadership and with corresponding accountability, should be responsible for:

(c) the commissioning, procurement, performance oversight and independent evaluation of intervention and support responses for families known to the child safety system;
(c) intervention/diversion responses at or near statutory thresholds; and
(c) supporting the provision of continuing family support during statutory involvement and reunification pathways.

At a minimum, this function will:

(viii) provide clear system leadership and accountability for early intervention and family support, including setting intent, activation points, and outcome expectations for services delivery once families are known to the system;
(viii) oversee commissioning and funding arrangements, with models that recognise relational, preventative, and whole-of-family practice as essential system functions, rather than short-term or compliance-focused activities;
(viii) enable early activation of support once concerns first emerge, so that targeted intervention can meaningfully influence decision-making before escalation occurs;
(viii) integrate targeted intervention with statutory child safety functions so that there are clear mechanisms for information-sharing, participation in planning, and consideration of support outcomes prior to escalation, removal, or permanency decisions;
(viii) protect targeted intervention capacity from being overwhelmed by crisis-driven statutory demand, including through organisational separation from statutory investigation and case management functions;
(viii) support pathways for Aboriginal and Torres Strait Islander children and families;
(viii) ensure all existing and new interventions delivered or funded by the Department (including place-based activities and programs delivered by ATSICCOs), are subject to an outcome evaluation conducted independently from those delivering, funding or overseeing the program (including independently from peak bodies).
(viii) consistently and publicly report on performance trends and performance outcomes measures over the long-term, with measures focused on family preservation and preventing escalation, reunification, and sustained family stability.

CONTEXT:

The purpose of the function is to ensure that intervention and family support can operate as core system functions capable of stabilising families, preventing unnecessary escalation, and supporting preservation and reunification where safe to do so, rather than as discretionary or ancillary activities subordinated to statutory demand.

The Commission's analysis demonstrates that targeted intervention and family support are among the most consequential, yet least clearly stewarded, functions within the current child safety system. The absence of a dedicated locus of responsibility within the Department has contributed to late activation, fragmented service delivery, and weak integration with decision-making, thereby increasing reliance on intrusive statutory responses. Further, reporting on outcomes at present is largely measured through service throughput, procedural compliance, or short-term outputs.

Establishing a dedicated and clearly stewarded function within the Department is a system design reform intended to correct structural misalignment and is not a service expansion. This function will improve outcomes for children and families and deliver on the benefits identified in previous reviews of enhancing early intervention responses.

IMPLEMENTATION NOTES:

The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources.

Recommendation 45B: Creation of a function focused on coercive statutory powers	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on the Department's use of statutory (coercive) powers, including intake, assessment and investigation functions, court processes, and reunification. This business function must be staffed by specialised suitably qualified staff.

At a minimum, this function should:

(e) Restore clarity for intake, assessment and investigation functions within the Department;
(e) Restore the integrity of intake thresholds, including the purpose and operation of statutory entry point;
(e) Ensure that assessment and investigation processes are not driven or limited by demand-management or resourcing constraints but are sufficiently funded and enabled to carry out their critical statutory and administrative decision-making functions;
(e) Ensure the inclusion of appropriate professional expertise to support investigations and robust administrative decision-making; and
(e) Establish dedicated executive-level accountability for the Child Safety System function, including oversight of intake, assessments, court-related processes and reunification outcomes.

CONTEXT:

The Department's coercive statutory powers cannot be understood, designed or governed as isolated operational processes or teams. They constitute the point at which the State's statutory authority is first exercised, and, in doing so, set the direction for all subsequent legislative decision-making within the child safety system, including court involvement, ongoing statutory intervention and reunification pathways. Decisions made at that stage have enduring consequences for children and families and significantly influence whether harm is addressed early or escalates toward more intrusive intervention.

The exercise of these powers should therefore be carefully delivered by specialised staff with clear lines of oversight.

IMPLEMENTATION NOTES:

The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources.

Recommendation 45C: Creation of a 'Child Guardian' function	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The structural redesign in Recommendation 45 must deliver against the following specific structural changes:

The creation of a discrete business function focused on delivering on the Department's corporate parenting functions to care for children in care, led by a 'Child Guardian' at a senior executive level within the Department.

The role of 'Child Guardian' should be created under the *Child Protection Act 1999* with responsibility to deliver on the Department's statutory obligations to care for children within the child safety system through dedicated, focused and relationship-based care and to prioritise the delivery of individual children's needs. At a minimum, the 'Child Guardian' should:

(d) provide system-level leadership and executive-level accountability for the Department's corporate parenting responsibilities, including oversight of care quality, stability and outcomes for children in care;
(d) work collaboratively with executive colleagues responsible for the child safety system function (including intake, assessment, and litigation) to support coherent statutory decision-making, continuity of information and clear transitions of responsibility relevant to the care of children;
(d) ensure that children in care receive dedicated, consistent and relationship-based support, protected from dilution by competing statutory, investigative or demand-management pressures;
(d) establish and oversee clear performance and outcomes measures, consistently reported over the long-term, focused on the safety, wellbeing, stability and best interests of children in care.

CONTEXT:

The purpose of establishing the Child Guardian (or equivalent) role is to ensure sustained executive-level focus and accountability for the Department's corporate parenting responsibilities to children in the child safety system. While the State assumes full responsibility for children once they enter care, the Commission understands that accountability for corporate parenting is currently diffuse, with decision-making and oversight distributed across multiple functions and levels of seniority.

The Commission heard that, in practice, responsibility for ensuring children's day-to-day care, stability and wellbeing is often delegated to junior staff operating within demanding and competing statutory environments, with limited central oversight of whether children's needs are being consistently met over time. This has resulted in insufficient executive visibility of children's lived experiences in care of the outcomes being achieved for them as corporate parent.

The Commission was also told that there are approximately 1,555 children currently living in residential care environments who are assessed as suitable for family-based care, highlighting the consequences of a system in which corporate parenting responsibilities lack clear ownership and leadership.

The Commission considers that establishing a 'Child Guardian' with statutory authority and executive accountability is necessary to ensure that children in care of the Department

receive the focused attention, stability and relational care they require, and that the Department discharges its corporate parent obligations intentionally, transparently and in the best interests of each child.

IMPLEMENTATION NOTES:

The intent of this recommendation is to better align existing roles within the Department, rather than to add substantial additional resources.

Until established under legislation, the role could be administratively created within the Department within the 6 month timeframe.

Following administrative establishment of the role, an initial priority of the 'Child Guardian' should be to undertake a systemic review of the circumstances of each child currently in the care of the Department, to assess whether the Department is meeting its corporate parenting obligations and whether each child's living arrangements, supports and planning are appropriately tailored to their needs and best interests. This should include consideration of which children currently living in residential care environments could be supported to transition to family-based care where safe and appropriate.

Recommendation 45D: Creation of an Associate Director-General or similar position	
Executive Report (Chapter 10)	**Companion Report 7**
RECOMMENDATION: The structural redesign in Recommendation 45 must deliver against the following specific structural changes: The creation of an Associate Director-General or other senior position within the Department, reporting directly to the Director-General, with responsibility for overseeing the reform of the Department's child safety functions. The executive-level roles created within recommendation 45A, 45B, and 45C would report to this Associate Director-General position, allowing for the dedicated senior focus on child safety functions.	
CONTEXT: The purpose of establishing this position is to enable the Director-General to provide consistent senior focus on the child safety reform package, without requiring the separation of child safety functions into a new Department to enable such focus.	
IMPLEMENTATION NOTES: While experience within the child safety system will be a benefit for the person filling this role, it will be critical at this stage that an external leader is appointed to support the Director-General to steward the Department through the necessary cultural changes. This role would be an ideal position for the Reform Implementation Office (see Recommendation 46) to report to, as well as the senior point of engagement with the independent implementation and reform assurance function (see Recommendation 51).	

Recommendation 46: Permanent reform implementation office	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government, within six months of the Government's response to this Report, establish and resource with appropriately qualified staff a permanent internal function reporting directly to the Board of Management to coordinate and provide oversight of the Department's actions in response to recommendations arising from internal and external audit reports, external consultant reports, inquest findings, external oversight reports, and industry stakeholder reports.

CONTEXT:

The purpose of this body is to ensure that, moving forward, the Department pays adequate attention to opportunities for system learning and improvement arising out of external review and recommendations.

It is envisaged such a body would have an ongoing role akin to the functions presently being performed by the temporarily-established Reform Implementation Office, with scope for focusing on both policy and operations.

IMPLEMENTATION NOTES:

The first role for this focused (redesigned) Reform Implementation Office should be to conduct an audit of all existing recommendations being actioned within the Department, to centralise and coordinate the current work.

While this body could have a role in coordinating the Department's responses to this Commission, the Commission notes that such a body, being internal to the Department, would not satisfy the Commission's recommendation that there be an independent implementation and reform assurance function in response to this Commission.

Recommendation 47: Ministerial-level accountability for broad child protection system	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government should, within two months of Government's response to this Report, establish a broad accountability mechanism across multiple Ministerial portfolios for the entirety of the child protection system, including for young adults who have left care or children who have otherwise transitioned from direct child protection involvement.

The mechanism could take the form of:

(c) a designated lead Minister with responsibility for coordinating cross-government action across the child protection system, and escalating barriers affecting outcomes for children in care and care leavers;
(c) the establishment of a new Cabinet Committee; or
(c) another suitable form that will deliver broad Ministerial-level attention to the child protection system as a whole.

The mechanism will not displace the obligations of existing Ministers or departments, including the Minister with responsibility for child safety, but will operate as a lead accountability and escalation function for outcomes that require whole-of-government action.

CONTEXT:

The Commission has heard that children in care and young adults leaving care often require coordinated responses across child protection, health, disability, education, housing, justice and other systems. No single department can meet those needs alone, but fragmented accountability can allow service barriers to persist without clear ministerial ownership or escalation.

The intended outcome is to create a clear mechanism for ministerial accountability where children's needs require whole-of-government action. For children and care leavers, the expected impact is improved access to services, faster resolution of interagency barriers and stronger accountability for outcomes that sit across portfolios.

IMPLEMENTATION NOTES:

The mechanism should include:

(f) Cabinet-level oversight of outcomes for children in care and care leavers
(f) Associated delegated Chief Executive-level obligations across relevant departments
(f) shared outcome measures across relevant portfolios
(f) escalation pathways where a cohort of children's needs cannot be met by one agency acting alone (for example, youth justice care leavers, or young parents who have been in care);
(f) public reporting on cross-government performance (which may be via the outcomes and accountability framework in Recommendation X)
(f) mechanisms for resolving systemic barriers to service access, funding, information sharing or operational responsibility.

It may be feasible for the independent implementation and reform assurance function (see Recommendation 51) to report to this mechanism.

In designing this mechanism, consideration should be given to the model adopted in Scotland (where responsibility for the care and wellbeing of children was placed within a clearly identified Ministerial portfolio, increasing the prominence of and ensuring the ongoing attention to delivering on the reforms).

Recommendation 48: A whole-of-system outcomes and accountability framework	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

That the Queensland Government, within 12 months of the Government's response to this Report, work across portfolios to establish a whole-of-system framework for child protection outcomes and accountability with relevant indicators and measures that link directly to these outcomes.

This framework should require Ministers and relevant departments to report at least quarterly, through a public-facing, consolidated reporting mechanism, on defined outcome measures for:

(h) children and families receiving early intervention or family support;
(h) children subject to statutory child protection intervention
(h) children in out-of-home care
(h) Aboriginal and Torres Strait Islander children and families
(h) children in residential care and other non-family-based care
(h) children reunified with family
(h) children supported in foster, kinship or specialist family-based care
(h) young adults who have left care or otherwise transitioned from direct child protection involvement.

The framework should include, at a minimum, measures relating to safety, stability, relational continuity, family connection, health, disability support, education, transition to adulthood, and children's experience of care and support.

The framework should require outcome data to be disaggregated, where appropriate, by region, age, Aboriginal and Torres Strait Islander status, disability, placement type, care experience, and other relevant characteristics.

CONTEXT:

The Commission has heard that Queensland's child protection system does not have a clear whole-of-system accountability framework capable of showing whether children and families are safer, better supported, more stable and better connected over time. Existing reporting does not consistently connect activity, expenditure, placement type, service response and child outcomes.

The intended outcome is to create a single public framework across all agencies that have involvement in the broader child protection system (that is, not just the agency that provides child safety services). The framework will hold Ministers, departments and the system to account for the outcomes that matter across the child protection continuum. For children, the expected impact is for additional transparency to improve government decision-making, investment, commissioning and reform implementation across measures that are meaningful to their lives.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51).

Implementation should include:

(g) establishing the framework and reporting obligations;
(g) a defined set of outcome domains and measures;
(g) allocation of responsibility for each measure to relevant Ministers and departments;
(g) data-sharing arrangements across relevant agencies;
(g) annual public reporting against the framework;
(g) disaggregated reporting to identify regional variation, cohort outcomes and service gaps; and
(g) mechanisms requiring government to respond where reporting shows persistent poor outcomes, unacceptable variation or lack of progress.

The framework can be drawn on to inform government budget decisions, interagency collaboration, and identify areas of high risk that may lead to poor outcomes for children within the child protection system.

Recommendation 49: Design and feasibility review for a child protection inspectorate	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The Queensland Government should, within 12 months of the Government's response to this Report, undertake and publish a design and feasibility review for the establishment of a proactive child protection inspectorate function in Queensland.

The review should consider:

(h) the purpose, scope and powers of an inspectorate within the Queensland child safety system, and any overlap with existing inspection mechanisms;
(h) whether the function should be located within an existing independent statutory body or established separately;
(h) the relationship between the functions of inspection, complaints, child advocacy, departmental assurance, external monitoring, provider regulation and the role of the Ombudsman;
(h) potential stages for the implementation of an inspectorate;
(h) how inspection would examine children's experience, practice conditions, cultural safety, casework quality, decision-making, supervision, workload and implementation of policy in practice;
(h) public reporting arrangements;
(h) escalation and improvement powers; and
(h) legislative, resourcing and implementation requirements.

CONTEXT:

The Commission has heard evidence of a gap between policy intent and frontline practice. Complaints, internal assurance and system monitoring each serve important functions, but they do not provide a regular, proactive and independent mechanism for examining how the system is operating at the level of local service delivery and children's lived experience.

The purpose of the feasibility study would be to test, proactively and independently, whether policies, records, practice conditions and children's experiences align in practice. The intended outcome is to determine whether Queensland should establish a system inspectorate function, similar to the OFSTED model, capable of examining practice conditions, service quality, cultural safety, decision-making and children's experience before serious failure occurs.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51).

The review should proceed on the basis that inspection would not replace existing or anticipated complaints, advocacy, internal assurance or system monitoring.

The review should be independently led and should include consultation with children and young people with direct experience; Aboriginal and Torres Strait Islander organisations; frontline Child Safety staff; funded service providers; carers; oversight bodies, including the QFCC, the Office of the Public Guardian, and the Ombudsman; and relevant departmental assurance, complaints and regulatory functions.

The published review should cover the following matters:

(viii)	whether an inspectorate should be established;
(viii)	the preferred statutory location and governance model;
(viii)	inspection powers and limits;
(viii)	initial inspection scope;
(viii)	reporting and escalation mechanisms;
(viii)	implementation sequencing;
(viii)	resourcing requirements; and
(viii)	legislative amendments required to establish such a body.

Recommendation 50: Structured reinvestment and reform framework	
Executive Report (Chapter 10)	**Companion Report 7**

RECOMMENDATION:

The Queensland Government should, within eight months of Government's response to this Report, establish and publish a structured reinvestment and reform framework for the implementation of significant change across the child protection system over the next three years.

The framework should be developed by the independent implementation and reform assurance function (see Recommendation 51) to guide staged investment, implementation sequencing and fiscal discipline across the reform program. The framework is to include:

(g) a costed investment plan for the reform program, that incorporates the projected savings from residential care investment and commits to the allocation of necessary funds arising from these actual or avoided future costs to the reform package;
(g) protected investment in critical areas of family-based care, early intervention, reunification, carer support and step-down pathways;
(g) explicit investment in workforce capability, supervision, retention and practice quality
(g) linkage between any expansion of non-family-based care and the development of family-based alternatives, step-down pathways and earlier supports
(g) transparent modelling of demand, cost, capacity and implementation risk
(g) monitoring of the effect of investment decisions on placement stability, workforce pressure, provider behaviour and child safety risk
(g) public reporting on whether expenditure is shifting the system towards the stated reform direction or reinforcing crisis response.

CONTEXT:

The Commission has heard that child protection reform requires sustained investment, but investment alone will not shift the system if expenditure continues to follow crisis demand rather than the intended reform direction. Without a structured reinvestment framework, new funding may reinforce existing reliance on late, expensive and less relational responses, including non-family-based care.

The intended outcome is to ensure that reform is staged, funded, sequenced and monitored in a way that builds the capacity of the system inclusive of earlier support, stronger family-based care, better reunification, sustained carers, step-down pathways and reduced unnecessary reliance on residential care. For children, the expected impact is earlier help, more stable care, better supported carers and fewer children entering or remaining in high-cost, crisis-driven placement responses because alternatives were not available.

IMPLEMENTATION NOTES:

This should be treated as a Tier 1 recommendation and led and assured through the independent implementation and reform assurance function (see Recommendation 51). The recommendation will significantly advance the reform work for the child protection system.

Implementation should include:

(i) alignment between reform pace, workforce capacity and implementation risk;
(i) a published reform investment plan;
(i) annual reporting on expenditure by reform priority and care type;
(i) modelling of demand, placement capacity, workforce capacity and cost pressures;

(i) identification of protected investment categories;
(i) staged investment triggers linked to workforce readiness and service capacity;
(i) monitoring of whether new investment is reducing or increasing reliance on non-family-based care;
(i) reporting on the effect of investment decisions on placement stability, carer retention, workforce pressure and provider behaviour; and
(i) review points to redirect funding where expenditure is not producing the intended system shift.

The framework should make clear that expansion of non-family-based care, where required to meet immediate safety needs, must be accompanied by investment in family-based alternatives, earlier support and step-down pathways.

