

Child Death Review Board

Queensland **Family & Child** Commission

Annual Report 2022–23

*A report on the operations and systemic findings
of the Queensland Child Death Review Board*

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding this document, you can contact Translating and Interpreting Service National on 13 14 50 to arrange for an interpreter to effectively explain it to you. Local call charges apply if calling within Australia; higher rates apply from mobile phones and payphones.



Contact for enquiries

For enquiries or further information about this annual report (including to receive a hard copy) please contact:

Secretariat, Queensland Child Death Review Board

Level 8, 63 George Street

PO Box 15217, Brisbane City East QLD 4002

Email: cdrb@qfcc.qld.gov.au

Website: www.cdrb.qld.gov.au/

ISSN 2653-2263 (Print)

ISSN 2653-2271 (online)

Attribution and license

© The State of Queensland (Queensland Child Death Review Board). *Child Death Review Board Annual report 2022–23*.

This annual report is licensed by the State of Queensland (Queensland Child Death Review Board) under a Creative Commons Attribution (CC BY) 4.0 International licence. You are free to copy, communicate and adapt this report as long as you attribute the work to the State of Queensland (Queensland Child Death Review Board). To view a copy of this licence visit <https://creativecommons.org/licenses/by/4.0/legalcode>.

Content from this document should be attributed as: The State of Queensland (Queensland Child Death Review Board). *Child Death Review Board Annual report 2022–23*.

Copyright inquiries should be directed to the Secretariat of the Board by email to cdrb@qfcc.qld.gov.au or in writing to PO Box 15217, Brisbane City East QLD 4002.

Acknowledgements

The Queensland Child Death Review Board (the Board) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

The Board acknowledges the difficult and important work of the government agencies that are required to review the services they provided to these children. We are all committed to working together to learn from these reviews and to make the changes needed to promote the safety and wellbeing of children and help prevent future deaths.

The Board relies on the collective knowledge and contributions of government agencies and non-government organisations to inform its systemic reviews. It thanks these agencies and organisations and acknowledges their efforts in protecting Queensland children and assisting their families to care for them.

The Board also acknowledges the work of its Secretariat in analysing child death reports, gathering research, collating data, preparing reports, and coordinating meetings.

Warning

This report may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline: Phone: 13 11 14

Beyond Blue: Phone: 1300 22 4636

Kids Helpline (for 5–25-year-olds): Phone: 1800 55 1800

13YARN [Thirteen YARN] for Aboriginal and Torres Strait Islander people: Phone: 13 92 76

Aboriginal and Torres Strait Islander peoples should be aware that this report contains data about deceased children and information about systemic issues facing Aboriginal and Torres Strait Islander peoples.

Child Death Review Board

Queensland Family & Child Commission

Reference: TF23/714 – DOC23/3525

31 October 2023

The Honourable Yvette D’Ath MP
Attorney-General and Minister for Justice
Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29J of the *Family and Child Commission Act 2014*, I am pleased to provide for presentation to the Parliament the 2022–23 Annual Report for the Queensland Child Death Review Board.

In 2022–23 the Child Death Review Board reviewed the deaths of 60 children. This Annual Report details the key system issues identified in those child death reviews and offers the Child Death Review Board’s insights and recommendations to improve the system.

The Child Death Review Board has focused on opportunities to strengthen service delivery in the areas of safeguarding children registered for home education, youth justice, improving responses to the needs of First Nations communities, creating safety for children of parents with problematic alcohol and drug use and increasing visibility of children and young people in the context of coercion and parental deception.

We also include our monitoring of the 16 recommendations made in the prior two years.

Yours sincerely



Luke Twyford
Chairperson
Child Death Review Board

Table of contents

Message from the Chair	6
Introduction	7
Chapter 1: Cases reviewed by the Board in 2022–23	8
Summary of recommendations	13
Chapter 2: Assessing the safety of children who are registered for home education	14
Chapter 3: Reappraising the response to youth crime and the purpose of youth justice	21
Chapter 4: Improving research on the needs of First Nations communities	43
Chapter 5: Strengthening child safety practice in response to parental substance and methamphetamine use	48
Chapter 6: Increasing system visibility of children and young people in the context of coercion and parental deception	61
Chapter 7: Monitoring recommendations	72
Chapter 8: Governance	95
Child Death Review Board members	95
Attendance	100
Conflicts of interest	101
Stakeholder engagement and partnerships.....	101
Promoting our work	102
Information requests	102
Risk management	102
Member farewell and recruitment	102
Appendices	103
Appendix 1–Child Death Review Process	103
Appendix 2–Glossary of terms and acronyms	104
Appendix 3–Remuneration of the Child Death Review Board	107

Message from the Chair

All Queensland children should be loved, respected and have their rights upheld. Each year, too many children known to the child protection system die or suffer serious physical injuries.

The loss of any child has long-lasting impacts on family, friends, communities and the professionals who provided support to the child and their family. The Queensland Child Death Review Board (the Board) seeks to honour the lives of children and young people by ensuring that we conduct respectful reviews aimed at preventing future loss of life.

This year, the Board has reviewed the cases of 60 deceased children. From the lives of these 60 young Queenslanders, we have considered the ways in which government services and the community interacted with the young person and their family.

Within this report we have outlined the lives of the young people whose cases we have reviewed. While the Board has seen many examples of great practice which held at its core the safety, wellbeing and voice of children, young people and their families, some opportunities for system improvement stood out. From our review and discussions, the Board has identified five areas where it believes that more action is needed. These are set out in this report and cover the issues of:

- assessing the safety of children who are registered for home education
- reappraising the response to youth crime and the purpose of youth justice
- improving research on the needs of First Nations communities
- strengthening child safety practice in response to parental substance and methamphetamine use
- increasing system visibility of children and young people in the context of coercion and parental deception.

I am hopeful that the delivery of this report, with the details of the cases across these five areas leads to internal consternation and action within and across Government.

This is the third Annual Report of the Child Death Review Board. It represents the last for several Non-government Board members who are appointed to three-year-terms. I would like to specifically thank Deputy Chair Professor Jody Currie and members Bruce Morcombe, Professor Jeanine Young, Margie Kruger and Shanna Quinn for the time they served on the Board. Reviewing the case details of child deaths is not something that can be done lightly and each of these members made profound and significant contributions during their time on the Board. I also thank the government representatives and the Board's staff for their ongoing role in reviewing child deaths to identify opportunities for continuous improvement in systems, legislation, policies and practices.

Yours sincerely



Luke Twyford
Chairperson
Child Death Review Board

Introduction

The Child Death Review Board (the Board) is responsible for conducting system reviews following the death of a child known to the child protection system. The Board undertakes reviews to identify opportunities for system improvements and to make recommendations about the changes needed to keep children safe.

The Board was established on 1 July 2020 and has the power to make and monitor recommendations and publicly report on the outcomes of child death reviews.

Queensland's child death review process is two-tiered. Government agencies that were involved with a child in the 12 months prior to their death undertake an internal agency review of their service delivery to the child. These reviews are provided to the Board for its consideration and to inform its recommendations about whole of system improvement and child death prevention.

This report has been prepared under section 29j of the *Family and Child Commission Act 2014*. It describes the work of the Board in 2022–23 in carrying out its reviews and other functions under Part 3A of the *Family and Child Commission Act 2014* and the Board's *Procedural Guidelines*.

- 1** **Chapter 1** provides an overview of key characteristics of the 60 children and young people reviewed in the reporting period. It looks at the causes of death of the children, basic demographics and cultural status.

- Chapters 2 to 6** discuss the key themes and service system issues identified by the Board in 2022–23. These chapters also share relevant case studies and research projects that were undertaken by the Board, and the recommendations the Board made for the reporting period. The key themes and service system issues explored in this report are:
 - 2** Assessing the safety of children who are registered for home education.
 - 3** Reappraising the response to youth crime and the purpose of youth justice.
 - 4** Improving research on the needs of First Nations communities.
 - 5** Strengthening child safety practice in response to parental substance and methamphetamine use.
 - 6** Increasing system visibility of children and young people in the context of coercion and parental deception.
- Chapter 7** revisits the recommendations that were made in the previous two annual reports and provides an update on the implementation of these recommendations. The chapter presents a summary of key actions, practice reform and changes that the responsible agencies have reported for the years 2020–21 and 2021–22.
- Chapter 8** considers issues relating to the governance of the Board.

Chapter 1

Cases reviewed by the Board in 2022–23

Cases reviewed by the Board in 2022–23

In 2022–23 the Board received a total of 72 notices of child deaths known to the child protection system and completed reviews of 60 cases. To complete these 60 reviews, the Board assessed 197 agency reviews.

Completing the review of 60 cases is an increase of five cases compared to the 2020–21 and 2021–22 years when 55 cases were reviewed. The increase in cases reviewed by the Board reflects an increase in the total number of child deaths known to the child protection system during the same reporting period.^{1,2}

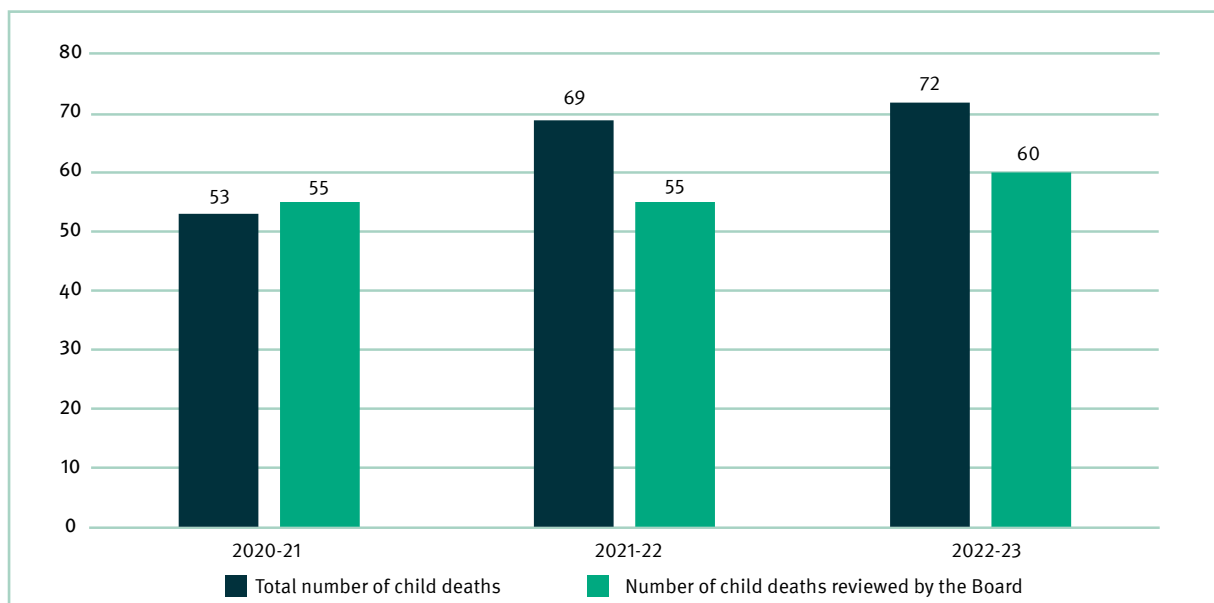
In the financial year 2022–23, 72 children died who had been known to the child protection system in the 12 months prior to their deaths. This is the second year that the Board has not reviewed as many cases as it has received. Consequently, there are 68 cases awaiting review by the Board. Ideally, it takes less than 12 months to review a case (reflecting the legislated six month period for agencies to review their own service delivery, and a further six months for the Board to review the agency findings and identify broader system issues).

After the Board receives all agency review reports and supporting information for a case, a three-tier categorisation framework is utilised to determine the terms of reference and depth of analysis required for each review.³

The categorisation framework is based on the extent to which systemic learnings and opportunities can be identified from a case, with those categorised to a Level 3 presenting the most significant opportunities for improvements and requiring in-depth review by the Board. Level 2 reviews are primarily focused on practice improvements, where agencies might have correctly identified areas of improvement in their own reviews. Level 1 cases contain minimal opportunities for learning or child death prevention mechanisms. Cases across all three levels of reviews are monitored to identify recurring issues and trends.

To improve its efficiency and impact, in 2022–23 the Board agreed that matters may be included in a themed collective review. This means that when deemed appropriate by the Chair, matters will be grouped into similar themes and considered together to highlight opportunities for system improvement and child death prevention. This can lead to further collaboration with subject matter experts and ongoing information exchange to support the making and monitoring of recommendations.

Graph 1: Number of child deaths known to the Queensland child protection system and reviewed by the Board by year, 2020–21 to 2022–23⁴



¹ The Queensland Family and Child Commission (QFCC) 2023, *Annual Report: Deaths of children and young people 2022–23*.

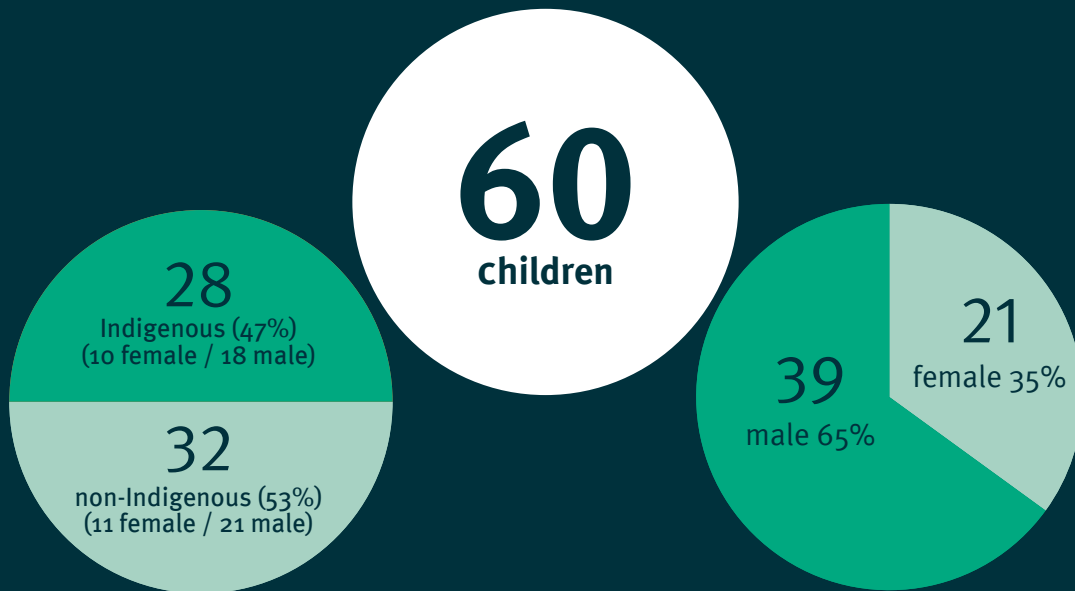
² Seventy-two child deaths were known to the child protection system in the 2022–23 reporting period.

³ For further information, see the *Child Death Review Board Procedural Guidelines*, <https://www.cdrb.qld.gov.au/wp-content/uploads/2023/09/Procedural-Guidelines-version-1.4-August-2023.pdf> for accessibility

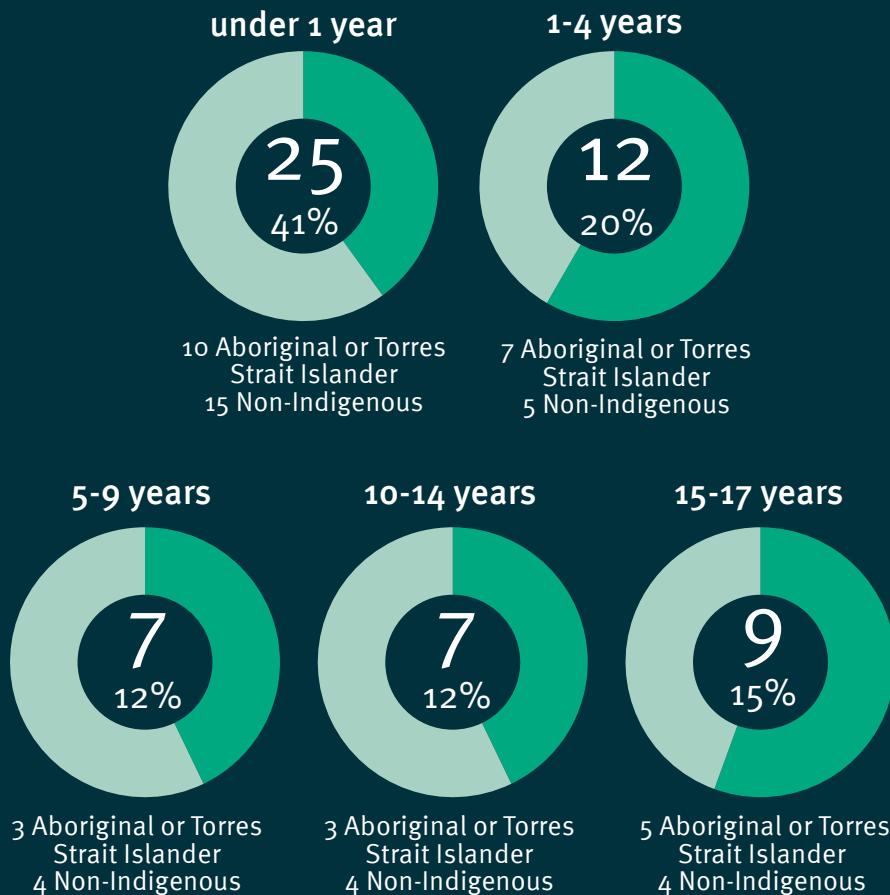
⁴ In its first year of operation, the Board reviewed two additional cases that had previously been reviewed by the former Child Death Review Panel, due to new information becoming known.

Demographics

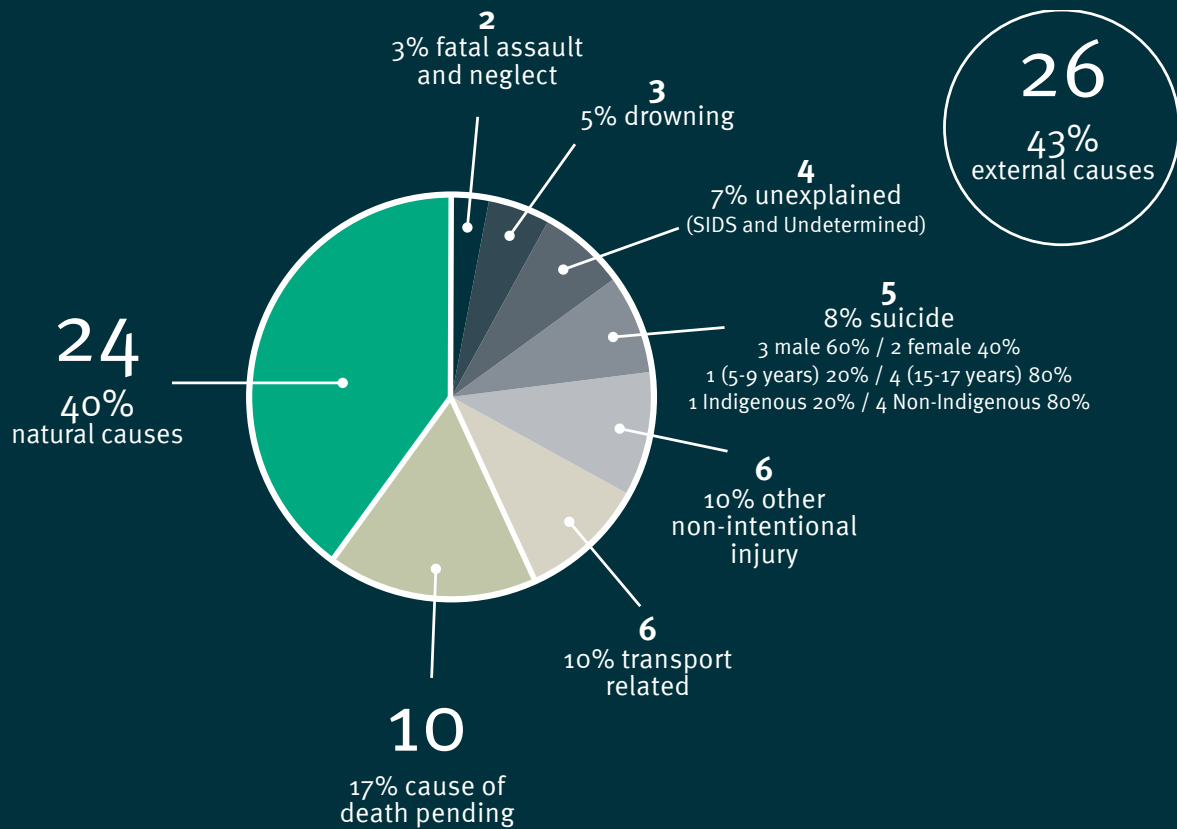
In 2022-23, the Board considered the deaths of



The number of deaths reviewed in each age group



Category of deaths reviewed by the Board



Sudden Unexpected Death in Infancy⁵

11 (18%) deaths fell within the SUDI research classification (**4** Aboriginal or Torres Strait Islander / **7** Non-Indigenous)

Care circumstances

49 (82%) were living with family or friends or independently at the time of their death
10 (16%) were in foster or kinship care or on a permanent guardianship order⁶
1 (2%) was in residential care

Agency reviews considered by the Board (197)

60 The Department of Child Safety, Seniors and Disability Services (Child Safety)
95 Queensland Health⁷
18 The Department of Education (Education)
12 The Queensland Police Service
6 The Department of Youth Justice, Employment, Small Business and Training (Youth Justice)
6 The Director of Child Protection Litigation (DCPL)

Case Review Classification

Level 1 **28** (47%)
 Level 2 **17** (28%)
 Level 3 **15** (25%)

⁵ This is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause.

⁶ One child was in hospital at the time of their death with a plan to place them with approved foster or kin carers upon discharge.

⁷ The higher number of review reports from Queensland Health (compared to the number of child deaths) is reflective of multiple Hospital and Health Services undertaking reviews for some children.

Summary of recommendations

Recommendation 1

Assessing the safety of children who are registered for home education

The Board recommends the Department of Education:

- 1.1 Initiate a regular process of data sharing with the Queensland Police Service and the Department of Child Safety, Seniors and Disability Services to identify home-schooling students who may benefit from in-school support services.
- 1.2 Pursues legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.

Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice

The Board recommends the Department of Youth Justice, Employment, Small Business and Training:

- 2.1 Takes immediate action to articulate Queensland's Detention Operating Model, and Government commits to publishing this model.
- 2.2 Produce a workforce strategy for Queensland youth detention centres for immediate effect, and for inclusion into the Detention Operating Model for Queensland's new detention centres.

Recommendation 3

Reappraising the response to youth crime and the purpose of youth justice

The Board recommends the Queensland Government:

- 3.1 Immediately fund and introduce improved reporting on youth detainees time out of cells (in alignment with the Report on Government Services reporting that already occurs for adults) and agree to champion this measure for inclusion in nationally consistent reporting with other jurisdictions.
- 3.2 Commission the Board to utilise its review process to review a sample of cases of young people on the Serious Repeat Offender Index and advise Government on the common system issues and opportunities to prevent and reduce reoffending for young people in this cohort.

Recommendation 4

Improving research on the needs of First Nations communities

The Board recommends the Queensland Government strengthens its policies and commits to ensuring that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

Recommendation 5

Strengthening child safety practice in response to parental substance and methamphetamine use

The Board recommends the Queensland Government invests in a practice guide that will support frontline practitioners in their risk assessments of children whose parents' substance use is problematic. This practice guide should cover:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety.

Recommendation 6

Assisting workers to recognise and respond to parental deception

The Board recommends the Queensland Government invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence (the frontline practitioners involved should include child protection, health services, education, law enforcement, courts staff and secondary services).

Chapter 2

Assessing the safety of children who are registered for home education

Assessing the safety of children who are registered for home education

Home education in Queensland

Under the *Education (General Provisions) Act 2006*, home education is a legally recognised alternative to school enrolment in Queensland.

In 2022–23, the Board considered the case of a child who was homeschooled. This young person was diagnosed with multiple mental health conditions and had a history of suicidal ideation and self-harm.

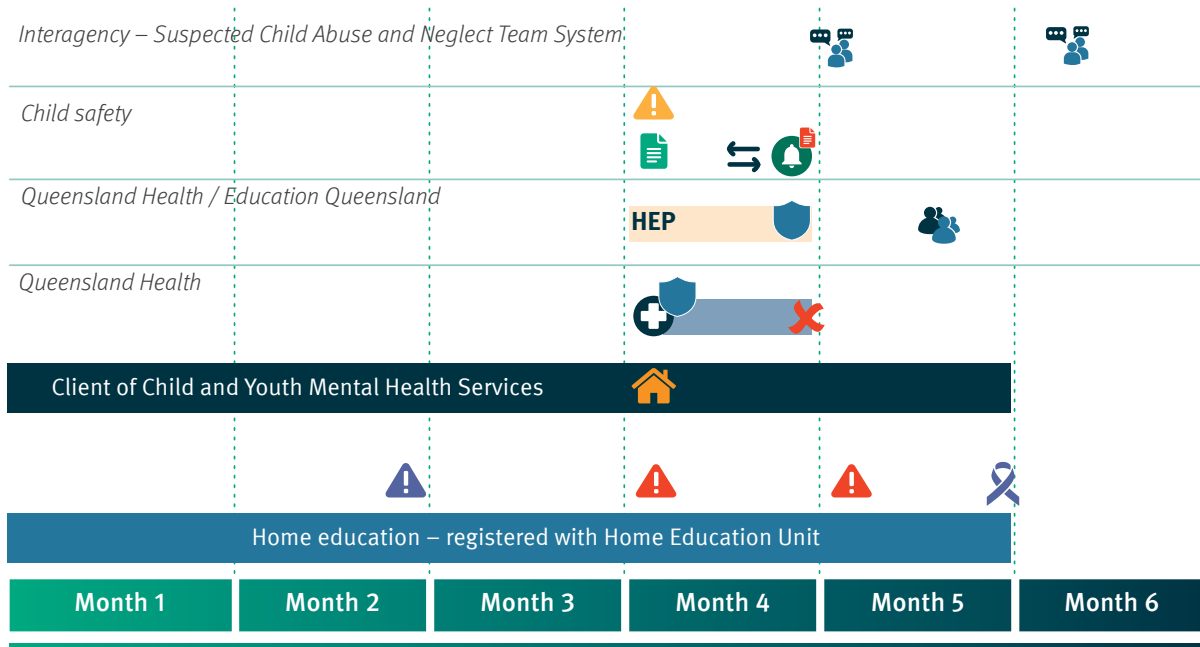
The young person was a client of Child and Youth Mental Health Services (CYMHS) and presented as highly anxious, scared and suicidal during a home visit by CYMHS. The young person's living environment was considered unhygienic and there were worries their basic care needs were not being met. The young person was subsequently admitted to an adolescent mental health unit in hospital, where they remained for three weeks, and Child Safety was notified of concerns about the young person's living situation and the impact on their health, functioning, mental health, and sense of connectedness to others. The young person's case was referred to the Suspected Child Abuse and Neglect (SCAN) team.⁹

While in hospital, the young person expressed to a school Guidance Officer that they felt worried about their missing out on education and wished to return to school. They reported feeling socially isolated and not being actively engaged in their home education program during the six months prior to their death. The young person was referred to the Department of Education's Youth Engagement Service for further support to re-engage with schooling or an alternative education program.

After the young person was discharged from hospital, there were further suicide attempts and the young person died two weeks later. Child Safety had not yet commenced an Investigation and Assessment of the child protection concerns and the Department of Education's Youth Engagement Service had not yet been initiated at the time of the young person's death.

The young person's experiences led the Board to consider the regulatory oversight of, and support for, children registered for home education in Queensland.

⁹ The purpose of the SCAN team system is to enable a coordinated response to the protection needs of children. See: <https://cspm.csyw.qld.gov.au/procedures/investigate-and-assess/consider-a-suspected-child-abuse-and-neglect-team>
















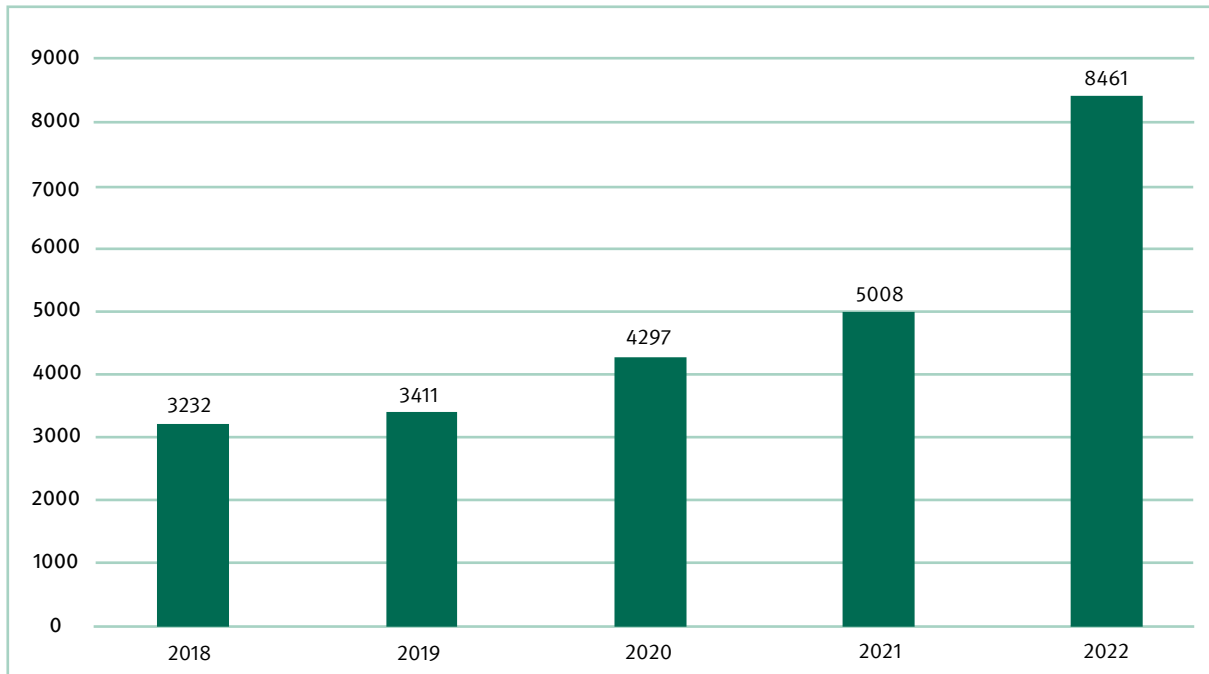
-  Notification
-  Self-harm
-  Suicide Risk Alert
-  Suicide attempt / ideation
-  CYMHS Home visit
- HEP** Hospital Education Program
-  Report to Child Safety
-  Information request/shared (under CPA)
-  Referred to support service
-  Additional Notified Concerns
-  SCAN Meeting
-  Young person died
-  Discharged
-  Hospital admission

Figure 3: Timeline of system touchpoints for the Young Person

The growth of home education

In recent years, home education has become an increasingly popular option for learning in Queensland. As of 5 August 2022, 8,461 students were registered for home education in Queensland, an increase of 69% from the 5,008 students registered in 2021 (see Graph 2). By comparison, only 722 students were registered for home education in Queensland in 2011.



Graph 2: Students registered for home education 2018–2022 in Queensland

The Department of Education will publicly release the August 2023 census data for home education registrations in late 2023. The Board has been informed that home education registrations in 2023 are likely to have continued on a growth trajectory.

Home education application process

In Queensland, a parent must apply for and be granted registration to educate their child at home.

The registration process consists of documentation submission and review. Applications for registration must provide a summary of the educational program to be used or learning philosophy to be followed. The application must satisfy the Home Education Unit that the home-educated child will receive a high-quality education.¹⁰ The guiding principles for assessment of a high-quality education are detailed as follows:

- is responsive to the changing needs of the child as indicated by the short and long term educational and personal goals
- has regard to the age, ability, aptitude and development of the child concerned
- is conducted in an environment conducive to learning
- is responsive to the child’s need for social development
- utilises suitable and relevant teaching strategies to deliver the educational program to the child
- engages the child in a range of rich and varied learning experiences
- is supported by sufficient and appropriate resources; and
- uses strategies for monitoring educational progress.

Standard conditions of registration for home education in Queensland

The education program should show evidence of a high-quality education that:

If the Chief Executive is satisfied the standard conditions of registration will be complied with, registration is granted and a certificate of registration and notice is issued to the parent.¹¹

¹⁰ Department of Education 2020, *Home education in Queensland procedure*. Accessed 14 December 2022. <https://ppr.qed.qld.gov.au/attachment/home-education-in-queensland-procedure.pdf>

¹¹ Ibid.

Once a child is registered for home education in Queensland, the parent is legally responsible for providing the child with a high-quality education. Compliance with the standard conditions of registration is monitored via an annual self-report of the child's educational progress. If the parent does not report as required or if the chief executive is not satisfied with the educational progress of the child, a show cause notice is issued to the parent to demonstrate within 30 days why the registration should not be cancelled.¹²

Home education regulation in other Australian states and territories

The Board compared the regulatory frameworks for home education across Australia (see summary at Table 2). It considered Queensland's regulatory powers to be more limited than most. Most notably, Queensland does not have the ability to undertake home visits or to request contact with a child where there may be concerns about a parent meeting the child's educational needs. Home Education Unit staff do not sight or speak to the child being registered for home education, nor do they visit the residence where education will usually take place. Moreover, there is no legislated requirement to speak to the parent or registered teacher who will be undertaking home education.

The regulatory frameworks in some other states appear to enable a more robust assessment of registrations and a child's educational progress, while also giving more explicit attention to the registered child's rights, best interests, and wellbeing. For example:

- South Australia's regulatory body may consult with the Department for Child Protection and other agencies/professionals about a home education application. The information obtained may determine that home education is not in the child's best interest and therefore a home education exemption may be refused or revoked on these grounds.¹³
- In South Australia, the Principal of the child's most recent school is notified of the intention to home educate a child and invited to provide relevant information to support the assessment of an exemption for home education.¹⁴

- In Victoria, there is explicit consideration of the child's rights: *When assessing your application, we consider all the relevant rights of the child. This is done in accordance with Victoria's Charter of Human Rights and Responsibilities.*¹⁵
- In Western Australia, Home Education Moderators may request to meet the child as it is reasonably necessary to enable them to evaluate the home education program and the child's educational progress.¹⁶
- In New South Wales, Authorised Persons conduct a home visit to review the current and/or proposed educational program for the child. Authorised Persons are mandatory reporters. Mandatory reporters have a legislated obligation to report to Family and Community Services if they have reasonable grounds to suspect that a child is at risk of significant harm.¹⁷

As a result of its review of other jurisdictions, the Board wrote to the Director-General of Education advising of concerns about the apparent lack of powers and oversight in Queensland's jurisdiction. This included the inability to undertake home visits, to sight or speak to the child registered for home education, or to engage with child protection authorities and previous schools to assess suitability for home education.

To explore this issue further, the Board requested that the Queensland Family and Child Commission (QFCC) lead a system review into the regulation of home education in high-risk home environments in Queensland. This project seeks to *work with agencies to match data to identify the number of children in home education living in high-risk home environments (including those with concerning child protection and domestic and family violence histories).*¹⁸ The QFCC is now working with the Department of Education to develop a cross-agency reference group to collect and link this data. The Department of Child Safety, Seniors and Disability Services and the Queensland Police Service are partners in this project. Information about this review has been included in the QFCC 2023–24 Oversight Forward Workplan.¹⁹

¹² Ibid.

¹³ Government of South Australia, Department for Education 2023, *Guide to Home Education in South Australia: Information for families considering applying for exemption from school attendance*, 6. <https://www.education.sa.gov.au/sites/default/files/guide-to-home-education-in-south-australia.pdf>

¹⁴ Ibid., 21.

¹⁵ Victorian Registration and Qualifications Authority 2022, *Registering for home education*. Accessed 14 December 2022. <https://www.vrqa.vic.gov.au/home/Pages/hsregister.aspx>

¹⁶ Government of Western Australia, Department of Education 2020, *Home Education Procedures*. Accessed 14 December 2022. <https://www.education.wa.edu.au/web/policies/-/home-education-procedures>

¹⁷ New South Wales Government 2019, *Registration for Home Schooling: Authorised Persons Handbook*, 10. Accessed 14 December 2022. <https://educationstandards.nsw.edu.au/wps/wcm/connect/460a8280-ff57-402f-89e1-3835adabb891/authorised-persons-handbook.pdf?MOD=AJPERES&CVID=>

¹⁸ Taken from an unpublished QFCC Terms of Reference document provided to the Board.

¹⁹ See QFCC 2023-2024 *Oversight Forward Workplan*. <https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/oversight>

State or Territory	Regulatory body	Legislation	Registration process	Child sighted	Home visits
QLD	Department of Education – Home Education Unit	<i>Education (General Provisions) Act 2006</i>	Documentation review only	No	No
NSW	NSW Education Standards Authority	<i>Education Act 1990</i>	Documentation review and home visit	Yes	Yes
VIC	Victorian Registration and Qualifications Authority	<i>Education and Training Reform Act 2006</i>	Documentation review only	No	Possible
WA	Department of Education – Home Education Moderators	<i>School Education Act 1999</i>	Documentation review and home visit	Yes	Yes
SA	Department of Education – Home Education Unit	<i>Education and Children’s Services Act 2019</i>	Documentation review and home visit	Yes	Yes
TAS	Office of the Education Registrar	<i>Education Act 2016</i>	Documentation review and registration visit	Yes	Possible
NT	Department of Education	<i>Education Act 2015</i>	Documentation review only	No	Possible
ACT	ACT Government – Home Education Team	<i>Education Act 2004</i>	Documentation review and video conference	No	No

Table 2: Comparison on home education regulatory frameworks across Australian states and territories

Actions taken by the Department of Education

The Department of Education has also advised that it has recently undertaken a review of the *Education (General Provisions) Act 2006*. This has included a re-examination of the provisions relating to home education. Key issues raised through this review related to opportunities to enhance the regulation of home education and streamline aspects of the home education registration process. The outcomes of this review are yet to be made public.

In 2022, the Department of Education commissioned research to better understand the factors that influence a family’s decision to home educate their child/ren. The research, involving 565 parents or guardians registered (or previously registered) for home education in Queensland, found the following factors were key:

- a belief that home education provides a better learning environment for their child/ren
- the ability to provide more personal, flexible and individual learning at the child’s pace
- educational philosophy, faith or personal beliefs of the parent
- the ability to better support a child’s health or disability needs
- concerns about negative influences on the child or bullying
- COVID-19 related issues, including worries about transmission or alternatively a positive experience during lockdowns/isolation.²⁰

Two thirds of the parents or guardians advised in the survey the children they were educating at home had a disability or health issue. Most commonly, these were children who were neurodivergent (e.g., Autism, Attention Deficit Hyperactivity Disorder), or had social emotional or behavioural difficulties, learning disabilities or mental health issues.

Wellbeing supports for children registered for home education

School-based learning environments afford children a level of informal monitoring, social connection, and access to wellbeing support. For children enrolled in state schools, the Department of Education’s *Supporting students’ mental health and wellbeing* procedure outlines specific responsibilities for school staff, guidance officers and principals. This includes:

- building staff capability to support the mental health and social and emotional wellbeing of all students
- building capacity for mental health promotion and intervention by linking with local agencies and health providers—including key local specialist mental health services such as the Child and Youth Mental Health Service (CYMHS) and headspace centre
- ensuring schools have clear processes for referring children to internal and external supports
- ensuring school prevention and postvention response plans are developed and available.

²⁰ Department of Education 2022, *Home Education Unit: Parent with child/ren registered for home education research insight report*. Accessed 28 September 2023. <https://education.qld.gov.au/schools-and-educators/other-education/Documents/research-insight-report.pdf>

State and non-state schools can also engage Ed-LinQ²¹ to facilitate early access to mental health advice.

The risk and benefit of school attendance was further demonstrated by research the QFCC undertook in a small sample review of commonalities in child and family trajectories of cases considered by the Board, *Lessons from the life-story timelines of 30 Queensland children who have died*. The review highlighted the protective factors that engagement in education can bring to the lives of children and young people, and conversely, that school disengagement often coincided with children and young people's display of increasingly complex behaviours.²²

The QFCC report found that *all school-aged children who died by suicide had disengaged from education and learning; children were either totally absent from school or were attending for administrative supports only and that disengagement from school can lead to a breakdown of social connections and create barriers to accessing additional supports to manage health and wellbeing. Of the eight school aged children in this sample who died by suicide, five children died within 12 months of disengagement from school.*

The high rates of suicide within the school aged, disengaged cohort reflects the need for robust mental health and wellbeing supports to be integrated when risk of school disengagement is first identified.

Children registered for home education are completely reliant on their parents or caregivers for their educative, social, health and wellbeing needs. While most children who are home educated will have these needs met, there is a risk that others become invisible to society and their needs go unmet.

In consulting with Government departments on the proposed recommendation, the Board was advised that this issue is also significant for children who are enrolled in schools of distance education, noting that enrolments in distance education are also increasing at a significant rate. Children who participate in distance education are also isolated from protective factors that attendance at a physical school can provide. While these students do have periodic access to a teacher virtually, there is a potential for these students to be exposed to similar risks as their peers in home education.

Concluding comments

The number and rate of children registered for home education in Queensland continues to rise. These children require oversight mechanisms to ensure their safety, including social development and overall wellbeing, are protected.

The Board holds concern that:

- the existing regulatory system for home education in Queensland lacks necessary rigour, powers, and accountability in relation to registration processes to ensure that a child's educative, social, health and wellbeing needs are considered, monitored, and upheld throughout the course of their home education
- there is currently an absence of the child's views and wishes captured and considered throughout a child's home education registration
- there is a lack of visibility of the children registered for home education. For example, there is no legislative requirement to conduct regular home visits or hold discussions with children or parents/educators.

Recommendation 1

Assessing the safety of children who are registered for home education

The Department of Education:

- 1.1 initiate a regular process of data sharing with the Queensland Police Service and the Department of Child Safety, Seniors and Disability Services to identify home-schooling students who may benefit from in-school support services; and
- 1.2 pursues legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.

²¹ The Ed-LinQ Program was established in 2009 to improve linkages and service integration between the education sector (Department of Education, Catholic Education, and Independent Schools), primary care, community and mental health sectors to support the early detection and collaborative care of school-aged children and young people at risk of – or experiencing – mental health problems or mental illness. See <https://www.childrens.health.qld.gov.au/service-statewide-ed-linq-program/>.

²² The QFCC 2023, *Lessons from the life-story timelines of 30 Queensland children who have died: A small sample review of commonalities in child and family trajectories considered at the Child Death Review Board*. Accessed 28 September. <https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/lessons-from-life-story-timelines-of-30-children-who-have-died>

Chapter 3

Reappraising
the response to
youth crime and
the purpose of
youth justice

Reappraising the response to youth crime and the purpose of youth justice

Over the 2022–23 period, the Board discussed the deaths of six young people who were known to both the child protection and youth justice systems. All six were boys, and four were Indigenous Australians.

Two of these cases drew the Board's attention to an in-depth exploration of the youth justice system. One boy identified as Aboriginal, and the other as Aboriginal and Torres Strait Islander. The boys had extensive contact with Youth Justice, which included periods of time spent in youth detention. The stories of these boys are set out below to bring awareness of the circumstances of some of the young people who are known to the Queensland youth justice system.

Common circumstances in life of the two boys involved in Youth Justice

The stories of these two boys feature experiences of in-utero exposure to violence, alcohol and illicit substances, chronic child abuse and neglect, periods in care, and separations and disconnection from family. Furthermore, the boys had poor educational engagement, attainment, and subsequently left school early; they experienced cognitive and language impairments (unrecognised until adolescence), mental illness, substance use, associations and friendships with antisocial (and highly visible) peer groups, ongoing contact with police from an early age, criminal offending, and periods in detention.

Both boys, though not related, shared similar challenges and trajectories in their short lives. Both were the second child born to young mothers (first child born at 16 and 17 years) and were exposed to substances in-utero. Both were raised by extended family members under family arrangements, as their mothers were unable to meet their care and protection needs. This was due to concerns which included exposure to domestic and family violence, problematic substance use, criminal offending, and mental health issues. Their fathers were absent from their lives. Consequently, Child Safety had significant involvement in the lives of both boys. However, there was no ongoing intervention because they were in the care of kin.

Their families found it hard to manage these behaviours and as a result both boys experienced instability as they moved between family members. One was returned

to the care of his mother at age 11 for the first time since being an infant, and the other was moved between his cultural mother and cultural aunts (and possibly cultural grandmother) across towns with significant distance across Queensland. Despite these challenges, the records do not show evidence of support being provided to the extended families to help with the care of either child.

Themes of parental rejection and disconnection from family and culture were significant for both boys. For one boy, his paternal family had chosen not to have any contact with him and the records state that he felt rejected because of this. As he identified as Indigenous on his paternal side, this formed a barrier for connecting with his cultural identity. He also experienced rejection by his mother, who in the weeks prior to his death had relinquished her care of him and blamed him for the problems in the family. The other boy equally had a mostly absent relationship with his mother, while his father had chosen not to be involved in his life at all. As an adolescent, the boy disclosed that his transient childhood resulted in him feeling disconnected.

Against this shared background of complex trauma, abuse and neglect, family dysfunction, disrupted attachments, parental rejection, and disconnection, both boys sought to find connection and meaning through peer groups who carried with them a negative influence, contributing to their entry into the youth justice system and detention.

In early adolescence, both boys began displaying more challenging and complex behaviours. This included criminal offending (property, stealing and motor vehicle offences), anti-social and dysregulated behaviours, disengagement from school, substance use (alcohol, illicit drugs, and chroming), self-harm and suicidal behaviours. These behaviours brought both to the attention of Police and Youth Justice, ultimately resulting in significant periods in detention.

Despite the youth justice system existing to try and help young people address the disadvantage and circumstances that contribute to offending, the system appeared ineffective at achieving improvements in safety and wellbeing for either boy. Arguably, their experiences in detention served to cause further trauma, disconnection, and hopelessness.

Boy 1

One boy became known to Police and Youth Justice at the age of 11 due to property-related, theft, and fraud offences. His offending behaviours continued until his death, leading to eight separate periods of detention and multiple youth justice orders. This boy had a history of suicidal ideation, self-harming, and suicidal behaviours. Between 2017 and 2020, there were nine Suicide Risk Alerts.

The boy's engagement with education during this period was sporadic, with some limited attendance. His enrolment ultimately ended due to his threatening behaviours and periods in custody. He was enrolled with schooling while in the detention centre, but his engagement was interrupted by the significant periods of separation.

The boy disclosed regular substance use in the community, which included alcohol, cannabis, MDMA and methamphetamines. Attempts were made to refer him to the Adolescent Forensic Mental Health Service for support around his substance use; however, he declined the referral.

In the year before he died, this boy's offending and high-risk behaviours continued. Despite curfews and the conditions of multiple statutory youth justice orders, he was frequently identified by Police engaging in anti-social and criminal behaviours, and was the subject of 25 court appearances, resulting in four separate periods in youth detention. He spent a total of nine nights in Police watchhouses and 128 nights in detention during the year of his death.

Boy 2

This boy's household consisted mainly of family members who are known to Youth Justice and Queensland Police, and records indicate he "...was unable to identify any family members or peers that may have a positive impact on him". At age 13, he disengaged from school and had his first contact with the youth justice system for minor offending behaviour. During this time the boy was sexually assaulted in a public place on more than one occasion. Both his offending and substance-use (including methamphetamine use) significantly increased at this time. From this point he demonstrated an escalation in anti-social behaviour, resulting in regular contact with Youth Justice. This included episodes of community-based supervision, and four admissions to youth detention. His charges included stealing, fraud, receiving stolen property, unlawful use of motor vehicles, possession of a knife in a public place, entering premises with intent, and dangerous driving. There are reports he made several suicide attempts around this time also.

While in detention, Boy 2 was verified as having a mild intellectual disability, a moderate to severe delay in receptive language and a mild delay in expressive language. Due to demonstrated impulsivity and attention difficulties, he was suspected to have attention deficit hyperactivity disorder (ADHD). He was not formally diagnosed, and he was unwilling to engage in an assessment for a NDIS referral.

Boy 2 disclosed he engaged in alcohol use, sniffing/chroming, cannabis, and methamphetamine use prior to entering detention. He declined ongoing support to help him manage his substance use, identifying he intended to return to substance use upon his release from detention.

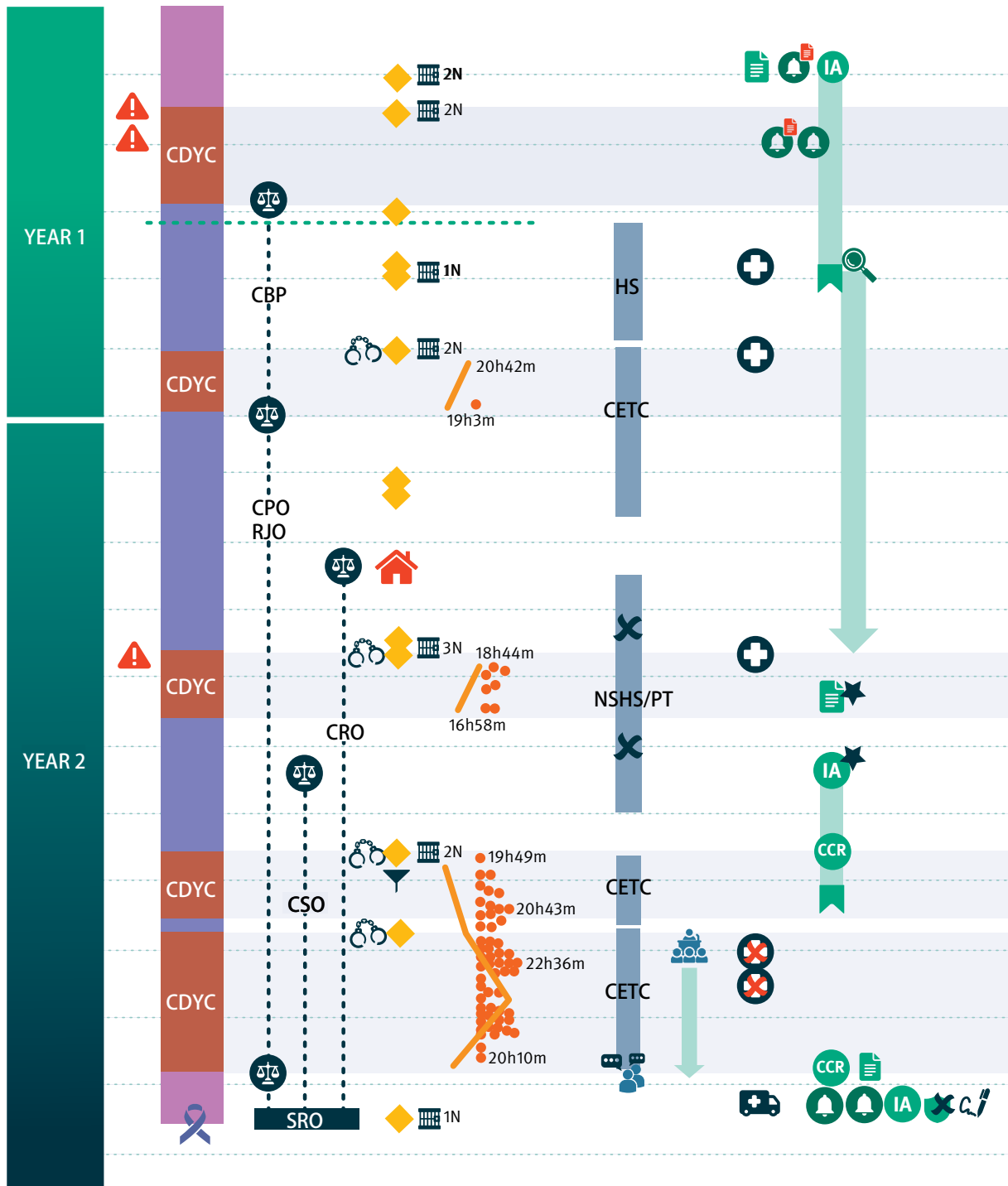






Figure 4: Timeline of system touchpoints for Boy 1




JUSTICE SYSTEM

-  YJ order
-  Mother arrested / charged
-  Remanded
-  Watchhouse
-  YJ Home visit
-  Average hours in separation per 24-hour period
-  Occurrences noted in CDYC (behavioural)
-  Suicide Risk Alert
-  YJ risk assessment (re-offending) - VERY HIGH





EDUCATION

-  Enrolment
-  Education planning post-release
-  Coordinating Care of Vulnerable Young People Forum
-  Suspension
- HS High school
- CETC Cleveland Education and Training Centre (CETC)
- NSHS/PT Non-state high school - part time









LIVING ARRANGEMENTS

-  Mother
-  Extended family
-  Cleveland Youth Detention Centre (CYDC)

QUEENSLAND HEALTH

-  QH/Mental Health services accessed / referred
-  QH/Mental Health services declined
-  QAS response
-  Young person died

CHILD SAFETY

-  Notification
-  Child Concern Report
-  Investigation and Assessment
-  Home visit
-  Safety assessment - UNSAFE
-  Additional notified concerns - Child Concern Report / Notification
-  I&A outcome substantiated - CNINOP
-  Mother signs Assessment Care Agreement

N Number of nights

h / m Hours and minutes

★ Other child

CBP Conditional Bail Program

CPO Current Probation Order

RJO Restorative Justice Order

CSO Community Service Order

CRO Conditional Release Order

SRO Supervised Release Order

JUSTICE SYSTEM



YJ order



Arrested / charged



Remanded



SMART Panel



YJ Home visit (Final)



Average hours in separation
per 24-hour period



Occurrences noted in CDYC
(behavioural)



YJ risk assessment
(re-offending) (final)



Referral QH/Mental Health
service



YD order type - Probation
Order



Youth Detention
Centre 1 or 2

CHILD SAFETY



Child Concern Report



Child Protection Order



Mother pregnant



Residing in City1 or City2

*AMHS *AMHS (Adolescent Forensic Mental
Health Service)

QUEENSLAND HEALTH



QH/Mental Health services
accessed / referred



Young person died



Prison Health Services
(West Moreton HHS)

EDUCATION



West Moreton Education
and Training Centre

In its 2021–22 Annual Report, the Board reported on a cohort of children and young people with complex needs who display challenging behaviours—such as substance use, use of violence, criminal offending and suicidal ideation or attempts. Among this cohort of children and young people (aged 12–17 years), the Board identified several common features in many of their life trajectories, including:

- disengagement from, or limited engagement with, education or school
- use of illicit substances
- regular contact with the Queensland Police regarding offending behaviours or involvement with Youth Justice services
- unstable housing, with many not living with their families or frequently leaving their family home
- significant child protection involvement from a young age, mostly due to reports about their families’ experiences of domestic and family violence, parental substance use, physical harm or neglect
- while several had suspected or confirmed intellectual disabilities and mental illnesses by the time they became involved with statutory Child Safety and Youth Justice services, there were distinct gaps in assessments and service delivery when their behaviours first emerged in early childhood.²³

These factors are also reflected in the below figure.

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8	Child 9	Child 10	Child 11	Child 12
Child protection concerns (from young age)	•	•	•	•	•	•	•	•	•		•	•
School disengagement or low attendance	•	•	•	•	•	•	•	•	•	•	•	•
Substance use	•	•	•	•		•	•	•	•	•	•	•
Poor mental health or suicidal behaviours	•	•	•	•		•	•	•		•	•	•
Diagnosed or suspected intellectual disability	•									•		
Current child protection intervention	•								•			
Current youth justice intervention	•	•		•								
Contact with youth justice services	•	•		•	•	•	•	•	•	•	•	
Contact with police	•	•	•	•	•	•	•	•	•	•	•	•
Risk-taking behaviours relevant to death incident	•	•	•	•	•	•	•	•	•		•	•

Figure 6: Common features in the life trajectories of a cohort of 12 children and young people (aged 12–17 years) identified by the Board

The Australian Institute of Health and Welfare (AIHW) notes avoidable deaths are those that can be prevented when timely and effective healthcare is provided, including by interventions that are targeted at the population-level.²⁴ The deaths of the two boys were recorded as suicide and drug overdose. Both deaths were preventable, and the Board sought to understand how contact with the youth justice system was both an indicator of broader risk, and an opportunity to address risk, in the lives of Queensland children.

²³ Child Death Review Board 2022, *Annual Report 2021–22*.

²⁴ The Australia Institute of Health and Welfare (AIHW) 2018, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, 111. Accessed 28 September 2023. <https://www.aihw.gov.au/reports/indigenous-australians/atsi-adolescent-youth-health-wellbeing-2018/contents/summary>

Children in Youth Justice in Queensland

In Queensland, youth justice services and detention centres are established under the *Youth Justice Act 1992* (the Act). The Act recognises the importance of services designed to rehabilitate and reintegrate children and young people who have offended. The youth justice system exists to reduce criminal offending by young people, to improve community safety, and to provide opportunities for young people to turn their lives around and live productively in the community.²⁵

Queensland locks up more children than any other State and leads the nation for the number of nights our young people spend in custody. Queensland children and young people comprise 21.7% of the national population of people who are aged 10–17 years but represent 66.1% of the national population of 10–17-year-olds under youth justice supervision. On an average day in 2022, 267 Queensland young people aged 10–17 years were in youth justice custody, 256 were in a youth detention centre and 227 spent time in a youth detention centre on unsentenced detention.²⁶ During 2021–22, Queensland had the second highest rate of young people in youth justice custody on an average day (4.8 per 10,000) and the second highest rate of young people under community-based supervision on an average day (16.6 per 10,000) behind the Northern Territory.²⁷

During 2021–22, Queensland children spent the most nights in custody (100,425 total), followed by 68,172 total custody nights in New South Wales and 44,129 total custody nights in Victoria. As such, more than a third of the national nights in custody were served by Queensland children.²⁸

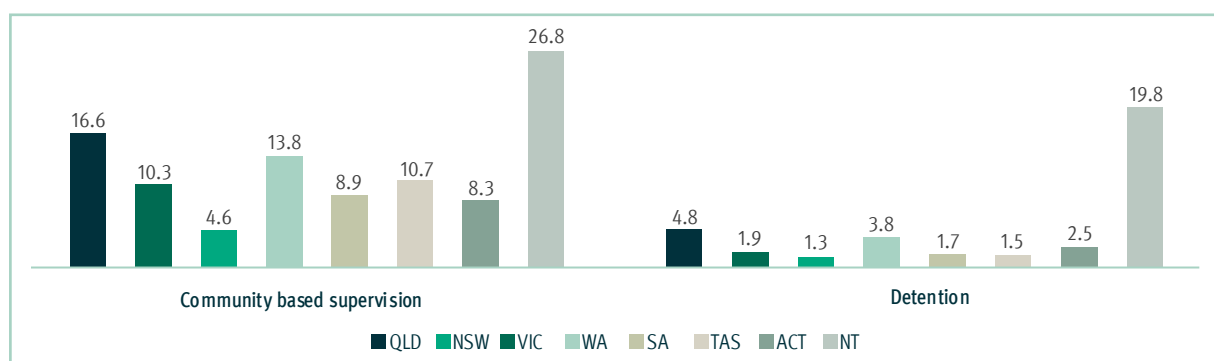
Of the young people completing a period of unsentenced custody in 2021–22, 60% completed a period of 30 nights or longer (62% for First Nations young people and 56% for non-Indigenous young people).²⁹ Across the cohort of Queensland young people in the youth justice system, First Nations children were significantly over-represented. On an average day in 2021–22, in Queensland 64% of 10–17-year-olds under youth justice supervision and 66% in detention identified as Aboriginal or Torres Strait Islander (compared to 7% of the general population).

Indigenous young people aged 10–17 are 21 times more likely than non-Indigenous young people to be under youth justice supervision (175 per 10,000 compared with 8.2 per 10,000) and 23 times more likely to be in detention than their non-Indigenous peers.

The high degree of commonalities in the cases reviewed by the Board where youth justice involvement existed caused the Board to consider key themes and outcomes that may improve the protection of our young people. In conducting this work, the Board has chosen to present its discussion and findings against four areas of note. These are:

1. improving the social and emotional wellbeing of young people to prevent crime and save lives
2. poor educational engagement amongst children in the youth justice system.
3. the impacts and effectiveness of the current youth detention model.
4. over-representation of First Nations children in the youth justice system.

Graph 3: A comparison across Australian jurisdictions of the rate of young people aged 10–17 per 10,000 in community-based supervision and youth justice detention (2021–22). Source: Productivity Commission, 2023 Table 17A.³⁰



²⁵ Queensland Government 2022, *Basics of youth detention*. Accessed on 28 May 2023 <https://www.qld.gov.au/law/sentencing-prisons-and-probation/young-offenders-and-the-justice-system/youth-detention/about-youth-detention/basics-of-youth-detention>

²⁶ Department of Youth Justice, Employment, Small Business and Training (Youth Justice) 2023, *Community supervision, unsentenced custody and all custody*, unpublished data request.

²⁷ The AIHW, 2022, *Youth justice in Australia 2021–22*. Accessed 5 October 2023. <https://www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2021-22/contents/summary>

²⁸ Youth Justice 2023, *Unsentenced custody and Indigenous status*, unpublished data request.

²⁹ Ibid.

³⁰ Australia Government, Productivity Commission 2023, *Report on government services 2023: Youth justice services*, Table 17A.1. <https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/youth-justice>

Improving the social and emotional wellbeing of young people to prevent crime and save lives

In Queensland, the *Working Together Changing the Story: Youth Justice Strategy 2019–2023* (the Youth Justice Strategy) acknowledges that prevention programs – such as those that improve parenting, strengthen community, support families at risk, address mental illness, disability and substance use and respond to childhood delay and education problems – are not only effective but are extremely cost-effective.³¹ The cases reviewed by the Board highlight the tragic outcomes when service systems do not prioritise prevention and early intervention to promote the safety, health and wellbeing of at-risk children and young people.

Intervene early is the first of the ‘four pillars’ recommended by Mr Bob Atkinson AO APM in his *Report on Youth Justice*, delivered to the Queensland Government at the conclusion of his independent review into the Queensland Youth Justice System in June 2018. The ‘four pillars’ were adopted by the Government and underpin the Youth Justice Strategy. The four pillars of the Youth Justice Strategy are:

1. Intervene early
2. Keep children out of court
3. Keep children out of custody
4. Reduce re-offending.

Very early in the lives of two young people reviewed by the Board (arguably from in-utero), it was apparent their parents and families would need additional support to help meet their needs. Both children were exposed to disadvantage and multiple adverse childhood experiences. They and their extended families were left to navigate these challenges largely on their own. It was only after the impacts of their experiences became behaviourally challenging that the service system became more involved. By this stage, the response was often punitive and in reaction to their offending or anti-social behaviours.

There were multiple missed opportunities for targeted early intervention to support the boys and their families in their infancy and childhood, to prevent their escalation into the child protection and youth justice systems. This included:

- **Screening and diagnosis of Foetal Alcohol Spectrum Disorder** – Both boys’ mothers were known to have used alcohol to excess during their respective pregnancies, with agency records identifying the possibility of Foetal Alcohol Spectrum Disorder (FASD) for both. Despite these worries, no formal exploration of these concerns manifested in the records. Appropriate screening and diagnosis of FASD provides opportunity for multi-disciplinary support and early interventions for children and their families. This is particularly important given young people with FASD are over-represented in youth justice settings and are at increased risk for mental health issues including suicidality.³²
- **Trauma-informed support for informal family care arrangements** – Both boys experienced neglect, physical and emotional abuse in their parents’ care. Following child safety interventions and periods of detention, both boys were returned to family care arrangements with very limited support or a trauma-informed response.³³ There is little evidence of Child Safety considering the carers’ ability and willingness to protect and meet the boys’ safety and wellbeing needs and it appeared that there was reliance on Youth Justice services to do this.
- **Early identification and response to speech and language disorders** – Both boys were identified as having language disorders during their admissions to youth detention. Boy 1 was diagnosed with a mild developmental language disorder and Boy 2 was diagnosed with a severe receptive language delay and mild expressive language delay. Boy 2’s verbal IQ was found to be extremely low and he was verified with a mild intellectual impairment. These language difficulties and intellectual impairment were likely evident well before their diagnosis in youth detention. Given the noted correlation between oral language competence in early life and the risk for engagement in anti-social behaviours in adolescence, early identification of speech and language delays in early childhood education or school settings, with therapy and targeted supports, must be a priority for the service system.³⁴
- **Supporting mental health and wellbeing in childhood** – At seven years old, Boy 1 was referred to mental health support by a paediatrician after exhibiting self-harming behaviours (self-strangulation), anti-social behaviours and socialisation issues. It was reported his family was provided with community-based support information to meet his needs. These behaviours were a significant red-flag and opportunity for more specific trauma-informed and culturally appropriate therapy.

³¹ Queensland Government, Department of Child Safety, Youth Justice and Multicultural Affairs (Child Safety) 2019, *Working Together: Changing the Story*, 8. <https://www.cyjma.qld.gov.au/resources/dcsyw/youth-justice/reform/strategy.pdf>

³² McLean S 2022, *Foetal Alcohol Spectrum Disorder (FASD): An update on policy and practice in Australia*, Australian Institute of Family Studies. <https://aifs.gov.au/resources/policy-and-practice-papers/fetal-alcohol-spectrum-disorder-fasd-update-policy-and>

³³ The only evidence of ‘support’ identified in ICMS records (page 257) provided to the Board was checking that maternal grandmother had sufficient food to be caring for the children (four of mother’s children in her care as of February 2021), subsequent provision of food vouchers and a phone call after Police had attended the home in response to a fight between the children.

³⁴ Snow P & Powell M 2012, ‘Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence’, *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. <https://www.aic.gov.au/publications/tandi/tandi435>

Without appropriate efforts to engage with families, early diagnosis and early intervention, the system is incapable of appropriately supporting children and providing the remedial services they need to achieve their potential. Since the early 2000s, compelling evidence has emerged about the ways in which the social determinants of health (SDH) explain disparities in health outcomes between groups within society. Research has established that those who experience social, economic, political, and environmental disadvantages are more likely to experience poorer health outcomes. Within the realm of justice, McCausland and Baldry note that the majority of prisoners in Australia come from highly disadvantaged backgrounds.³⁵ In 2020–2021, 10–17-year-olds from the lowest socioeconomic areas were five times more likely to be under youth justice supervision than those from the highest socioeconomic areas.

In 2022, a total of 1,605 young offenders were surveyed in the Youth Justice Census. Of these, it is estimated that:

- 45% had disengaged from education, training or employment
- 53% had experienced or been impacted by domestic and family violence
- 30% had been living in unstable and/or unsuitable accommodation
- 27% had at least one parent who spent time in adult custody
- 19% had an active child protection order
- 27% had a disability (diagnosed or suspected), including 17% who had a cognitive or intellectual disability
- 33% had at least one mental health and/or behavioural disorder (diagnosed or suspected).³⁶

It is clear that there is some level of predictability to the young people who will come into contact with the Queensland Youth Justice system, and that holistic family support services are likely to be a more effective crime prevention strategy than current ‘tough on crime’ approaches.

It is the responsibility... of adults, not vulnerable young people themselves, to ensure that a risky start in life does not result in social marginalisation and offending.³⁷

Transactional justice responses

To address youth crime and change youth offending, we must understand the root causes and motivations that are present in the young people’s lives and tailor our responses to be effective. When considering the cases involving youth justice contacts, the Board noted that the individualised and risk-focused models used within our systems are narrow, issue-specific, siloed, and fail to capture the complexity of the drivers of social and emotional wellbeing for children, young people, and families. Youth justice is a highly transactional system; its services primarily and predominantly attach to an episode of offending and a court matter. Youth justice services are therefore transactional, or episodic, often leading to superficial, time-limited exchanges. This is counter to the evidence of what works, which is relational or relational-based interactions that have a longer-term, more personal, and deeper engagement with the young person.

The cases of two young people highlight the system’s focus on risk and deficit (health & illness/criminogenic/child protection) and how each system can take a transactional approach to ‘delivering its statutory process’. While much was known about the problems and difficulties faced by these young people, it was not apparent that any system had accountability for understanding and addressing the root cause issues present in these boys’ lives.

In the Board’s attempts to understand and make sense of the constellation of factors contributing to the deaths of the boys, it identified that different foci, theories, and frameworks are used within each service system.

³⁵ McCausland R & Baldry E 2023, ‘Who does Australia lock up? The social determinants of justice’, *International Journal for Crime, Justice and Social Democracy*. <https://www.crimejusticejournal.com/article/view/2504>

³⁶ Child Safety 2023, *Youth justice census summary statewide*. Accessed 28 September 2023. <https://www.cjima.qld.gov.au/resources/dcsyw/youth-justice/resources/census-summary-statewide.pdf>

³⁷ Snow P & Powell M 2012, ‘Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence’, *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. <https://www.aic.gov.au/publications/tandi/tandi435>

- **Youth Justice, Youth Level of Service/Case Management Inventory (YLS/CMI) and Criminogenic Risk** – The YLS/CMI is a risk/needs tool based on the ‘big four’ criminogenic factors and more broadly the ‘central eight’ criminogenic factors in predicting offending and re-offending to assist in case planning. The ‘big four’ are antisocial attitudes and cognitions, antisocial peers, history of antisocial behaviour and an antisocial personality pattern. The ‘central eight’ adds problematic family circumstances, problems at school or work, problems with leisure activities and substance use.
- **Child Safety: Structured Decision Making, Child Strengths and Needs (SDM CSN)** – The SDM CSN is a tool to assess across 12 individual domains to assist in case planning. These are behaviour, emotional wellbeing, alcohol and drug use, family of origin relationships, peer relationships, cultural identity, physical health, child development, education or employment, preparation for independent living, relationships with carer family or with residential placement, and an option to add a unique identified strength.
- **Queensland Health, Mental Health Services: Biopsychosocial Assessment** – The biopsychosocial model grew from dissatisfaction with traditional and sometimes reductionist biomedical approaches to health and illness.³⁸ The biopsychosocial model recognises that illness and health are the result of an interaction between biological, psychological, and social factors. In the context of Queensland mental health services, anecdotally, the consideration of biological and psychological factors predominates. Social factors beyond the individual’s personal social context and participation, like the structural and systemic barriers faced by First Nations peoples, are not as well integrated into assessments and intervention plans as considerations for the individual.
- **Adverse Childhood Experiences (ACE)** – The original Adverse Childhood Experiences (ACE) study was conducted at Kaiser Permanente (California) from 1995 to 1997. Seven categories of adverse childhood experiences were examined: psychological, physical, or sexual abuse; violence against mother; or living with household members who used substances problematically, were mentally ill or suicidal, or ever imprisoned. The researchers found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.³⁹ More recently, ‘ACE scores’ are available to be used as assessment tools.⁴⁰

It is tempting to remain focused on individual risk factors and illness models, particularly because suicide and overdose deaths are often considered in the realm of health and healthcare. While valid and valuable, these frameworks guide practitioners toward individualistic and risk-based approaches to understanding and intervening. For example, it could be concluded that with timely access to quality drug detoxification and rehabilitation services, one boy would not have died from an overdose; or with earlier treatment of mental ill health the other would not have died from suicide. While possibly not untrue, these conclusions infer ‘drug abuse’ and ‘mental illness’ as the causes of the boys’ deaths, and this would not present the truth of their life and the broader social, political, and cultural contexts in which they lived.

In Table 3, Boy 1 and Boy 2’s experiences are mapped against social and emotional wellbeing domains. This demonstrates the significant risks that impacted them across their life spans.

³⁸ Wade D and Halligan P 2017, ‘The biopsychosocial model of illness: A model whose time has come’, *Clinical Rehabilitation*, 31(8).

³⁹ Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS 1998. ‘Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study’, *American Journal of Preventive Medicine*, 14(4), 245-258.

⁴⁰ National Centre for Injury Prevention and Control, Division of Violence Prevention 2021, *About the CDC-Kaiser ACE Study*. Accessed 29 September 2023. <https://www.cdc.gov/violenceprevention/aces/about.html#:~:text=The%20CDC%2D%20Kaiser%20Permanent%20adverse,two%20waves%20of%20data%20collection>.

Boy 1	Boy 2
Connection to body: Physical health – feeling strong and healthy and able to physically participate as fully as possible in life.	
<ul style="list-style-type: none"> • Substance use (methamphetamine use from age 13, alcohol, marijuana, MDMA) • Enjoyed fishing, basketball, football and computer games. 	<ul style="list-style-type: none"> • Substance use (methamphetamine, alcohol); consumption rapidly increased following experiencing sexual assault/s • Enjoyed playing football.
Connection to mind and emotions: Mental health – ability to manage thoughts and feelings.	
<ul style="list-style-type: none"> • In utero exposure to alcohol and maternal stress domestic and family violence • Mild language disorder • Possible FASD – late recognition • Low self-esteem • Poor emotional regulation and problem-solving skills • School disengagement from 14 years • Self-reported feelings of anxiety • Self-harm, suicidal behaviours and suicide attempts • Anti-social behaviours from age 11 resulting in nine periods in youth detention. Ongoing offending behaviours and contact with Police and YJ from age 11 until the days before his death. 	<ul style="list-style-type: none"> • In utero exposure to alcohol, illicit substances, and maternal stress domestic and family violence • Behavioural concerns through childhood that family found difficult to understand/manage • Overall, very poor engagement with education from Prep Year onwards; 10 school enrolments • Cognitive and language impairments (intellectual disability and speech and language disorder) – late recognition of same • Possible ADHD – late recognition • Possible FASD – late recognition • Received mental health support for self-harming and behavioural concerns • Victim of sexual assault/s when aged 14 • Suicide attempts reported • Antisocial/pro-criminal attitudes with multiple subsequent convictions • Help-rejecting • Withdrawn, isolating, possibly depressed in the months post exit from detention.
Connection to family and kinship: Connections to family and kinship systems are central to the functioning of Aboriginal and Torres Strait Islander societies.	

Table 3: Boy 1 and Boy 2’s experiences mapped against domains of social and emotional wellbeing

Criminogenic responses to young offenders show an issue-specific mindset and target single events, rather than considering a holistic response that utilises both the strengths and developmental needs of children and young people. The punishments and sanctions given to young people must have context and relevance to their circumstances if they are to be effective. Narrowly focused, risk-based and issue-specific responses to youth justice within key government agencies represents a collective failure to prevent youth crime and to rehabilitate young offenders.

Table 4 provides a summary of Boy 1 and Boy 2’s interactions with the Youth Justice system in the twelve months prior to their death.

In the twelve months prior to their death:	
Boy 1	Boy 2
<ul style="list-style-type: none"> • Held in watchhouses four times, for a combined nine nights • Arrested and/or charged 10 times • 25 court appearances including 19 adjournments, nine appearances resulting in custody and 15 finalised outcomes • Four admissions to detention (of a total eight admissions in his lifetime) • Subject to ten statutory orders, including: <ul style="list-style-type: none"> – Two Reprimands, – One Community Service Order – Three Conditional Release Orders – One Supervised Release Order paired with one Detention Order, – One Probation Order – One Restorative Justice Order • Subject to a Conditional Bail Program.⁴⁴ 	<ul style="list-style-type: none"> • Two court appearances • One admission to detention (of a total of six admissions in his lifetime) • Subject to three statutory orders, including: <ul style="list-style-type: none"> – two Probationary Orders – one Court Diversion Referral.

Table 4: Boy 1 and Boy 2’s interactions with the youth system in the twelve months prior to their death

For Queensland to make a difference to protect the community, change young people’s offending behaviour and prevent crime, it must recognise the factors contributing to offending, and preventing each individual’s behaviour change. Our collective response across government should be to prioritise a system of engagement with young people that builds and maintains relationships, trust, and understanding, and provides hope and opportunity. Transactional justice responses for young people that leave them in the same life circumstance are unlikely to lead to significant change.

⁴⁴ Conditional Bail Program targets young people who the court believes are unlikely to comply with bail, by engaging them in program activities, which become a condition of their bail undertaking.

Poor educational engagement amongst children in the youth justice system

School disengagement is a known risk factor for a young person’s entry into the youth justice system. The 2021 Youth Justice Census identified that 52% of the 1642 young offenders surveyed were disengaged from education, training, or employment.⁴⁵

The school enrolment records for the two young people highlights the challenges they experienced in terms of movements between family members and subsequently their schools, sporadic attendance, behavioural challenges, and lack of engagement with schooling, training or employment.

	Boy 1	Boy 2
Enrolments	15 school enrolments: <ul style="list-style-type: none"> • two state primary schools • four state high schools • eight Education and Training Centre (in detention centre) • one non-state school 	Ten school enrolments: <ul style="list-style-type: none"> • three state primary schools • three state high schools • one flexi-school • three Education and Training Centre (in detention centre)
Behaviour	Decline in school functioning, and disruptive and anti-social behaviour from age 11.	Self-harming and anti-social behaviours, and socialisation issues from age seven. Non-compliance and withdrawal from age 13.
Attendance	Poor engagement in learning in high school. Attended school programs in detention however significantly impacted by lockdowns and separations.	Attendance at school from Prep onwards, sporadic. No school attendance in community post age 13 years. Attended school programs in detention, though engagement limited at times.
Suspensions	Two recorded	One recorded
Verifications	Mild developmental language disorder. Not verified until after school disengagement.	Cognitive and language impairments (intellectual disability and speech and language disorder). Not verified until after school disengagement.
Enrolment status at time of death	Not engaged in education, training, or employment.	Not engaged in education, training, or employment.

Table 5: Summary of school enrolments and education issues for Boy 1 and Boy 2

Both young people went through their schooling without their challenging behaviours being explored from a developmental perspective. The result was that their language and learning difficulties remained unaddressed during their schooling, likely contributing to behavioural escalations, increasing frustration, disconnection, and ultimate disengagement from schooling.

⁴⁵ The QFCC 2023, *Policy Submission: Strengthening Community Safety Bill 2023*. <https://www.qfcc.qld.gov.au/sites/default/files/2023-02/QFCC%20Submission%20to%20Strengthening%20Community%20Safety%20Bill.pdf>

Boys with unidentified language difficulties who display disruptive and uncooperative tendencies in the classroom will, of course, be identified as ‘behaviour problems’ rather than as at-risk for unidentified language impairment and their management thereafter typically reflects this characterisation.

Keeping all children engaged academically has significance for health and wellbeing at a community level and it is vital that educators position their work within a broader public health context.⁴⁶

Another key factor observed was the use of suspensions by schools in response to difficult behaviours. School suspension is recognised as contributing to academic failure, dropout, and a range of negative behavioural outcomes, including violent and antisocial behaviour and tobacco use.⁴⁷ It also increases the risk of young people who are marginalised and excluded entering the youth justice system and eventually adult incarceration.⁴⁸ Suspended students can become alienated from school, impacting what for many disadvantaged and vulnerable students is a key protective factor in their lives. This was again shown in the QFCC research mapping the life trajectories of 30 Queensland children published this year.⁴⁹

The current model of youth detention

The Government recognises the youth justice system must ensure the young people in detention are provided with health, rehabilitation services and programs, are supported to develop education and vocational skills and are assisted to transition effectively back into their families and communities, and to adulthood.⁵⁰

Both boys’ experiences in youth detention was far from this ideal – either in terms of their life outcomes, or community safety. One boy served his periods of detention at Cleveland Youth Detention Centre (Townsville) while the other served his time at West Moreton Detention Centre (Brisbane).

Collectively, Boy 1 and Boy 2 spent a combined 600 days in detention during their lifetimes. Boy 1 had eight admissions for a total of 217 days, while Boy 2 had six admissions for a total of 383 days. Table 6 provides the number and duration of each of their admissions.

	Boy 1	Boy 2
Admission 1	11	1
Admission 2	6	4
Admission 3	28	50
Admission 4	44	25
Admission 5	20	80
Admission 6	23	159
Admission 7	27	-
Admission 8	217	-
Total	376	319

Table 6: number and duration in days of Boy 1 and Boy 2’s admission to youth detention.

During these repeated entries into detention, the boys received health, education and wellbeing services, and case management that was otherwise missing in their external world. The effectiveness of these services however was hampered by low and changing staffing numbers in the facilities, frequent periods of separation and an operating culture within detention centres that did not contribute to sustained behaviour change.

⁴⁶ Snow P & Powell M 2012, ‘Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence’, *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. <https://www.aic.gov.au/publications/tandi/tandi435>

⁴⁷ Hemphill S, Broderick D, Heerde J 2017, ‘Positive associations between school suspension and student problem behaviour: Recent Australian findings’, *Trends & issues in crime and criminal justice*, 531. Australian Institute of Criminology. <https://www.aic.gov.au/publications/tandi/tandi531>

⁴⁸ Snow P & Powell M 2012, ‘Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence’, *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. <https://www.aic.gov.au/publications/tandi/tandi435>

⁴⁹ The Queensland Family and Child Commission 2023, *Lessons from the life-story timelines of 30 Queensland children who have died: A small sample review of commonalities in child and family trajectories considered at the Child Death Review Board*. Accessed 28 September 2023. [Lessons from the life-story timelines of 30 Queensland children who have died \(qfcc.qld.gov.au\)](https://www.qfccc.qld.gov.au/lessons-from-the-life-story-timelines-of-30-queensland-children-who-have-died)

⁵⁰ Queensland Government, Child Safety 2019, *Working Together: Changing the Story*. <https://www.dcssds.qld.gov.au/resources/dcsyw/youth-justice/reform/strategy.pdf>

*Youth detention centres, in their current design and operation, have proven to be ineffective in addressing the root cause of offending, evidenced by the high rates of repeat offending. Youth detention centres are highly expensive to operate and maintain, and persistent workforce pressures can contribute to sub-optimal outcomes for children.*⁵¹

Youth Justice recognised in its review of Boy 1 that detention centres manage young people with high levels of complexity, with many young people entering detention with significant mental health, disability, psychiatric and social disorders. Their offending behaviours are symptomatic of the significant trauma and disadvantage experienced in their lives.

The records of a young person's time in custody largely show the transactional exchanges with the system. This includes records of incidents, separations, and service events – such as attendance for medical assessment or treatment. What is not apparent in the records for the boys at this time was the long-term planning for their life and re-entry into the Queensland community with prosocial intent.

One boy experienced incidents of bullying and victimisation from other young people while in detention. Records show he was spat on by other young people, punched in the head, had water thrown on him and was bullied because of his size. Records show this boy requested to move cells *because he feels he is being bullied ...[and]... that he is sick of the sexualised behaviours and inappropriate comment[s] by some of the other young people in the unit.*⁵² When he considered that this move was not actioned quickly enough, he tried to flood his cell and his access to water was turned off. He reported spending additional time in his cell by choice because he felt unsafe.

Both boys' time in detention (in the year prior to their deaths) was significantly impacted by extended periods of separation. In the Queensland context, separation is defined as placing *a young person in a locked room by themselves for a purpose defined in section 21 of the Youth Justice Regulation 2016.*⁵³ International human rights prohibit the use of solitary confinement on children and young people.⁵⁴ The United Nations defines solitary confinement as the *confinement of prisoners for 22 hours or more a day without meaningful human contact.*⁵⁵

⁵¹ The Queensland Family and Child Commission 2023, *Policy Submission: Strengthening Community Safety Bill 2023*, 9. <https://www.qfcc.qld.gov.au/sites/default/files/2023-02/QFCC%20Submission%20to%20Strengthening%20Community%20Safety%20Bill.pdf>

⁵² Youth Justice records provided to the Board, *Attachment 5 – Client records for Boy 1*, 5214.

⁵³ Youth Justice 2023, *Youth Detention centre operational policy: YD-3-8 Youth detention - Separation*. Unpublished document provided to the Board.

⁵⁴ The United Nations, Office of the High Commissioner for Human Rights 1990, *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*, Rule 67: "All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned...". See <https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-rules-protection-juveniles-deprived-their-liberty>

⁵⁵ The United Nations, Office on Drugs and Crime 2015, *United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)*, Rule 44. See page 14 of https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-book.pdf

*We cannot dismiss our obligation to provide quality education, health, disability and other universal supports and services because a young person has committed an offence.*⁵⁶

During a routine day in detention, young people are locked in their cell between 7.30pm and 7.30am – known as a 12-hour overnight lockdown. Youth detention operational procedure specifies routine overnight lockdowns are excluded from the total count of hours of continued separation.

Both boys experienced periods of separation during the day in addition to and often adjoining the 12-hour overnight lockdown. Boy 2 was confined to his cell for more than 22 hours of the day (cumulative and including the 12-hour overnight lockdown period) on 55 of the days he was in detention. On 22 days, he was in his cell for more than 23 hours. The Youth Justice report identified three occurrences of Boy 2 spending 24 consecutive hours in his cell without a break and a further consecutive period of 31 hours and nine minutes.⁵⁷

Table 7 outlines the additional hours of separation experienced by both boys. Youth Justice reports these separations were undertaken in line with current youth detention centre policy and procedures.⁵⁸

In the twelve months prior to their death:	Total hours in detention	Hours spent in separation during the 12 hour daily overnight lockdowns	Additional time spent in separation	Total time spent in separation	Percentage of their time in detention spent in separation
Boy 1	3,072 hours (128 days)	1,536 hours	875 hours and 57 minutes	2,411 hours and 57 minutes	78.51%
Boy 2	4,920 hours (205 days)	2,460 hours	208 hours and 41 minutes	2,668 and 41 minutes	54.24%

Table 7: Additional in-cell separation time experienced by Boy 1 and Boy 2 in the 12 months prior to death.

Critically, extended separations significantly impacted Boy 2’s access to education, therapeutic and cultural programs, social and leisure activities, exercise, fresh air, and sunlight. Youth Justice noted separation periods directly led to Boy 2 having *limited ability to engage in criminogenic programs during his time remanded*.⁵⁹ While the number and length of separations experienced by Boy 1 were not as significant, he too had his programs, education and activities interrupted by staff shortages and separations.

These separations were for a variety of reasons, including in response to incidents, for staff meetings, and at the young people’s own request, but predominantly there was significant separation due to staff shortages. It was noted for the separation in Cleveland Youth Detention Centre authorised on 17 July 2021 there were 23 detention youth worker positions vacant, and eight detention youth workers reported as “did not work”.⁶⁰ Staff shortages of between ten and 23 detention youth workers were a common occurrence during the boys’ admissions.

Periods of separation, isolation, or solitary confinement can impact a child’s health and wellbeing in severe, long-term and irreversible ways.⁶¹ Many of the children and young people in detention have experienced a life of significant disadvantage and marginalisation, with many being the victims of abuse and neglect. Being confined in a cell for extended periods of time, without interaction with peers, family, culture, and support networks creates an environment of re-traumatisation. Research has shown pre-existing mental health problems are likely exacerbated by experiences during incarceration, such as isolation, boredom and victimisation.⁶²

⁵⁶ The QFCC 2022, *Yarning for Change*. <https://www.qfcc.qld.gov.au/sites/default/files/2022-11/Yarning%20for%20Change.pdf>

⁵⁷ Phone records (page 15) provided by Youth Justice to the Board suggest Boy 1 made five phone calls during this period, the longest 9 minutes in duration, which suggests records of separation on this occasion were not accurate.

⁵⁸ Youth Justice records provided to the Board, *System and Practice Review for Boy 1*, 35.

⁵⁹ *Ibid.*, 14.

⁶⁰ Youth Justice records provided to the Board, *Attachment 1 – Client Records for Boy 1*, 6602.

⁶¹ Baldry E & Cunneen C 2019, ‘Locking up kids damages their mental health and sets them up for more disadvantage. Is this what we want?’, *The Conversation*. Accessed 5 October 2023. <https://theconversation.com/locking-up-kids-damages-their-mental-health-and-sets-them-up-for-more-disadvantage-is-this-what-we-want-117674>.

⁶² Dudgeon P 2022, *Locking up kids has serious mental health impacts and contributes to further reoffending*. Accessed 29 September 2023. <https://www.uwa.edu.au/news/Article/2022/November/Locking-up-kids-has-serious-mental-health-impacts-and-contributes-to-further-reoffending>

*As children are still in the crucial stages of developing socially, psychologically, and neurologically, there are serious risks of solitary confinement causing long-term psychiatric and developmental harm.*⁶³

As First Nations adolescents, separation and solitary confinement likely had additional and compounding impacts. The Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recognised the psychological effects of isolation can be amplified for First Nations children and young people due to their specific cultural needs.⁶⁴ Furthermore the 1991 Royal Commission report found solitary confinement causes “extreme anxiety” and has a particularly detrimental impact on Aboriginal and Torres Strait Islander prisoners, many of whom are already separated from family, kin, and community.⁶⁵

The practice of detention that these boys experienced were more likely to increase, rather than address, feelings of hopelessness, worthlessness and low self-esteem.

Separation is counter-productive: rather than improving behaviour, it creates problems with reintegration and fails to address the underlying causes of behaviour.⁶⁶ Both boys experienced heightened emotions and behaviours as a direct result of extended periods of separations and the associated reduction in access to activities and programs. Youth Justice identified 17 Incident Reports recorded in relation to Boy 1’s behaviours during the review period. One recorded that he “appeared extremely agitated and it was clear that [he] was frustrated being in the unit and with minimal activities”.⁶⁷ Records relating to Boy 2 identify multiple behavioural escalations where he voiced separation periods were a precipitating factor in his behaviours:

- In December 2020, Boy 2 was verbally abusive and kicking the cell door. He said he was triggered by frustration about when he would be let out.
- In March 2021, Boy 2 verbally abused staff because he was not allowed out of his cell.
- In July 2021, Boy 2 threw a cup around the room as he did not want to go back to his cell. This was in response to being asked to return to his cell after 51 minutes out for day.
- Also in July 2021, Boy 2 was assessed as part of a Suicide Risk Assessment. He identified his main emotions as boredom and frustration.
- In August 2021, Boy 2 armed himself with a broom. Post-incident, Boy 2 voiced he had not wanted to return to Continuous Cell Occupancy (the young people had only been out of their rooms for one hour and 12 minutes of the day). Some of Boy 2’s personal belongings were confiscated in response to the incident. He requested their return the following day, and was denied, resulting in another behavioural incident.

A number of behavioural incidents were noted for Boy 2 over his four admissions. Like Boy 1, there is a trend with the number of behavioural incidents increasing as his time locked in his cell per day increased. Figures 4 and 5 outlines the system touchpoints for each boy and illustrates this trend.

One of the boys was charged with criminal offences relating to incidents in youth detention and the police watchhouse, including common assault and wilful damage. Youth detention is intended to be a place of rehabilitation. Responding to behavioural incidents in custody with criminal charges further punishes young people who are being triggered by isolation and denial of pro-social services.

⁶³ Ibid.

⁶⁴ Royal Commission into the Protection and Detention of Children in the Northern Territory, ‘Isolation’, Volume 2A, 285. <https://www.royalcommission.gov.au/system/files/2020-09/Volume%202A.pdf>

⁶⁵ Human Rights Watch 2020, “He’s Never Coming Back”: People with Disabilities Dying in Western Australia’s Prisons. Accessed 29 September 2023. <https://www.hrw.org/report/2020/09/15/hes-never-coming-back/people-disabilities-dying-western-australias-prisons>

⁶⁶ British Medical Association 2021, *Solitary confinement and children and young people*. Accessed 29 September 2023. <https://www.bma.org.uk/advice-and-support/ethics/working-in-detention-settings/solitary-confinement-and-children-and-young-people>

⁶⁷ Youth Justice records provided to the Board, Attachment 1 – Client Records for Boy 1, 278.

The Youth Justice Department acknowledged the flow on effects of extended separation in its report to the Board, including:

- escalated behaviours
- fractured relationships and breakdown of therapeutic alliances
- reduced compliance and commitment to programs
- additional workload placed on staff in a therapeutic position required to support young people
- lack of privacy due to speaking with young people through their doors.⁶⁸

Children and young people need a youth justice system that can provide trauma-informed responses to address their underlying beliefs and behaviours. Instead, we have a system that can too easily fall into providing a negative cycle of more punitive practices and escalating behaviours that trap young people into anti-social and risk-taking behaviours that led to a cycle of incarceration.

In 2018, the British Medical Association (BMA), the Royal College of Paediatrics and Child Health (RCPCH), and the Royal College of Psychiatrists (RCPsych)⁶⁹ published a joint position statement on solitary confinement of children and young people. In agreement with international organisations such as the United Nations Committee on the Rights of the Child, the European Committee for the Prevention of Torture, and the United Nations Special Rapporteur on Torture, the statement condemned the practice for its serious risks of *causing long-term psychiatric and developmental harm* and exposed the practice as counter-productive, as it *fails to address underlying causes [of youth crime] and creates problems with reintegration*.

Across Australia each jurisdiction's youth justice system uses terms such as 'separation', 'lockdown', 'confinement' and 'segregation' to explain times when young people are confined to their cells. No jurisdiction acknowledges it uses 'solitary confinement'. The Board recognises that there are times when safety drives operation – this may include times when young people are 'isolated' due to the threat they pose to others; or alternatively when young people are 'isolated' for their protection from others. These two instances are distinct from the use of 'isolation' to manage the overall safety of a centre because there is insufficient staffing – including using 'lockdowns' when staff are having lunch, or when insufficient recruitment has occurred. Labelling each of these situations with the same word, and then failing to properly record and

report on the instances and solutions should not be acceptable. Youth Justice centres across Australia, including Queensland, claim that there are system limitations impacting the accurate and more nuanced reporting of lockdown periods. This limitation does not apply to adult corrections – which transparently report into a national data base on detained adults "time out of cell". The Board joins calls made by Australia's Childrens Commissioners and Guardians to: "ensure that the Report on Government Services (17 Youth Justice services) at least includes jurisdictional data about "time out-of-cells (average hours per day)" as currently is done for Adult Corrections (8 Corrective services)".

Exits from detention as a measure of success of detention

Boy 1 and Boy 2 left detention on eight occasions and six occasions respectively. The time between Boy 2's last exit from detention was less than five months. Boy 1 died 20 days after his last exit from detention.

Data released in 2022 indicates that for the 12-month period ending 30 June 2021, over 90% of young people that completed a detention period in Queensland committed another offence in the 12 months following their release.⁷⁰ The cases of these two boys, and the data confirm that the current model of youth detention is failing to meet its goal to "rehabilitate and reintegrate children and young people who have offended" and to "reduce criminal offending by young people, to improve community safety, and to provide opportunities for young people to turn their lives around and live productively in the community".⁷¹

It is not acceptable for any system to fail in its intent so significantly. It highlights that our current model of detention is not working as intended.

Following the *Royal Commission into the Detention and Protection of Children in the Northern Territory*, the Northern Territory Government committed to a public articulation of its Youth Justice model, philosophy, standards and service requirements. Following significant community input and co-design the 'Model of Care in Detention' was published. The model of care is publicly available with an associated Evaluation Plan.⁷²

The Northern Territory Detention Model of Care is built around the needs of young people. It consists of three parts:

⁶⁸ Ibid., 13.

⁶⁹ The British Medical Association (BMA) is a registered trade union for doctors, the Royal College of Paediatrics and Child Health (RCPCH) is the professional body for paediatricians, and the Royal College of Psychiatrists is the main professional organisation of psychiatrists in the United Kingdom (UK).

⁷⁰ Queensland Parliament 2022, *Question on Notice No. 1270*. <https://documents.parliament.qld.gov.au/tableoffice/questionsanswers/2022/1270-2022.pdf>

⁷¹ Queensland Government 2022, *Basics of youth detention*, accessed on 28 May 2023 <https://www.qld.gov.au/law/sentencing-prisons-and-probation/young-offenders-and-the-justice-system/youth-detention/about-youth-detention/basics-of-youth-detention>

⁷² The Northern Territory Government, Department of Territory Families, Housing and Communities 2023, *Youth Detention Centres Model of Care*. Accessed 5 October 2023. <https://tfhc.nt.gov.au/youth-justice/youth-detention-centres/model-of-care>

1. An operating philosophy based on six core principles.
2. An organisational framework that articulates the resources that will be employed to bring the model of care to life, translating the operating philosophy into the service model.
3. A service model that defines service standards for each element: connected to culture, family and community, connected to support, connected to opportunity and safe and secure.

The publicly available model articulates key youth justice service standards including how:

- the clear philosophy directly shapes the organisational design and service model features – from which infrastructure design is then derived
- young people being ‘connected to opportunity’ and ‘connected to culture, family and community’ whilst in detention is the overarching aim of critical importance
- a standard day for detainees occurs, including a commitment to 13 hours of unlock time per day, and how this is linked to a published evaluation and monitoring framework including independent oversight
- detention occurs within a broader continuum of Youth Justice service delivery with an emphasis on family focused interventions that address the life circumstances of young people
- a dedicated emphasis on the people that are employed and operate within the facilities meet key competencies aligned to the Youth Justice philosophy – covering their skills, capabilities and motivations (with nine ‘personal attributes’ providing a standard for all staffing decisions)
- clear expectations on detention centres to have partnerships that mean they are part of the community service delivery landscape where support and relationships follow young people back into community to provide enhanced ‘through care’ and long-term case management
- an understanding of the importance in separating relational and procedural security, as well as positive behaviour support, in the context of physical and dynamic security – so that safety is not delivered through increasingly punitive and counterproductive responses.

There is no comparable public document available in Queensland, with detention centre operations and broader Youth Justice services operating under a myriad of laws, policies, procedures, frameworks and commitments.

There is significant opportunity for Queensland to make advancements in its response to youth offending behaviours and crime if it were to define its operating model more holistically and transparently – including the connections between the various services that

young people such as the two boys experience. A clearly articulated purpose statement for the state that flows into tangible and pragmatic operating guides, role descriptions, procedures and training across multiple systems is necessary.

Other matters

Commencement of the *Inspector of Detention Services Act 2022*

On 1 July 2023, the *Inspector of Detention Services Act 2022* (IDS Act) and the *Inspector of Detention Services Regulation 2023* commenced. Staff from the Office of the Queensland Ombudsman has committed to supporting the Inspector’s functions under the IDS Act. *The IDS Act seeks to improve detention services with a focus on promoting the humane treatment of detainees and prevention of harm. The IDS Act sets out a framework for review of detention services, inspection of places of detention and independent and transparent reporting. This preventative focus will examine the systems and the lived experiences of people detained. Specific IDS functions include:*

- *inspecting places of detention in Queensland, including youth detention centres, adult prisons and watch-houses*
- *preparing and publishing standards for inspections*
- *reporting to the Legislative Assembly on inspection visits and making recommendations for improvement.*⁷³

Staffing pressures

The cases reviewed by the Board highlight the significant challenges detention centres face in attracting and retaining the staff required to function in accordance with current policies and procedures. Staff shortages directly led to isolation and treatment that ran counter to the objectives and principles of the Youth Justice and Human Rights Acts. The two boys were denied the opportunity for a rehabilitative and transformative experience in detention. Instead, their experiences are likely to have caused further harm and impacted their physical and social and emotional wellbeing.

The Queensland Government has committed to building two new youth detention centres – one in Cairns and another in Southeast Queensland. It is important for the system to consider how staffing issues will be overcome to ensure young people receive youth detention services that are vastly improved from their current quality.

The Board considers that a clearer articulation of the role and purpose of the youth justice workforce is required to ensure Queensland attracts, supports and retains valued employees that can make tangible positive differences to the lives of young people. Workforce reform is needed that values key capabilities likely to drive behaviour change in young people.

⁷³ The Queensland Ombudsman 2023, *Detention inspection: About this service*. Accessed 5 October 2023. <https://www.ombudsman.qld.gov.au/detention-inspection/about-this-service>

Concluding comments

Children and young people subject to child protection and youth justice interventions are often experiencing marginalisation and recriminalisation by a system that should protect and support them. As a result, young people known to the youth justice system have poorer outcomes, and the community’s frustration with repeat offending is increasing.

Young people in detention are experiencing confinement and extended separations because of staffing shortages. This is directly restricting their access to human connection, education, rehabilitative programs, exercise, fresh air and sunlight, and is contributing to escalating behaviour patterns. Punitive responses to these behaviours contribute to the recriminalisation of children and young people with lifelong negative impacts. Through its work over the last two years, and specifically in the case of these two boys, the Board has found:

1. the need for clearer early-intervention support services for young people that would prevent their escalation into the youth justice system. This includes the need for clearer accountability for youth justice prevention across all elements of our community and government service systems. Specifically, the education, health, housing, child safety and justice systems must work together on this accountability to identify and prevent young people’s offending
2. the need for an improved, or more explicit, detention model of care. This would recognise how ‘detention services’ address trauma and correct causes of offending. It would recognise how poor internal detention processes contribute to escalated behaviour, further criminalisation of young people and a loss of hope that is driving anti-social behaviours and loss of lives
3. the need for improved workforce design in youth justice – including the skill mixes, capabilities and values of detention centre staff, as well as the attraction and retention strategies for the workforce
4. the need for improved support structures for young people that exit detention – across multiple life-domains and portfolios of government and particularly for children such as these two boys who had limited or absent family and community connections.

The Board also finds that its process of building cross-agency life-story timelines for these boys has shed light on significant missed opportunities to address youth offending. It is unfortunate that these boys’ stories only came to light because of their deaths. If Queensland sought to better understand how to prevent reoffending, it would be entirely possible to replicate the Board’s process for young people in the youth justice system. Selecting a sample of the current or past young people on the Serious Report Offender Index and conducting a system and practice review would lead

to critical learnings and confirmation on this cohort of young people that could drive systemic changes.

In consulting with Government Departments on the proposed recommendations, the Department of Youth Justice, Employment, Small Business and Training advised that it would *continue to publish comprehensive information about the youth detention centre operating model and policy framework, noting there is substantial information available on both the Department’s website and the Your rights, crime and the law website*. This information includes the youth detention philosophy which flows into a series of operational policies, frameworks and procedures. The Department undertook that *This information will be expanded upon as the Department continues to implement its practice reform agenda*. This practice reform agenda includes ongoing work on a range of workforce strategies and plans to support the safe and capable operations of Queensland youth detention centres.

Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice

The Department of Youth Justice, Employment, Small Business and Training:

- 2.1 Takes immediate action to articulate Queensland’s Detention Operating Model, and Government commits to publishing this model.
- 2.2 Produce a workforce strategy for Queensland youth detention centres for immediate effect, and for inclusion into the Detention Operating Model for Queensland’s new detention centres.

Recommendation 3

Reappraising the response to youth crime and the purpose of youth justice

The Queensland Government:

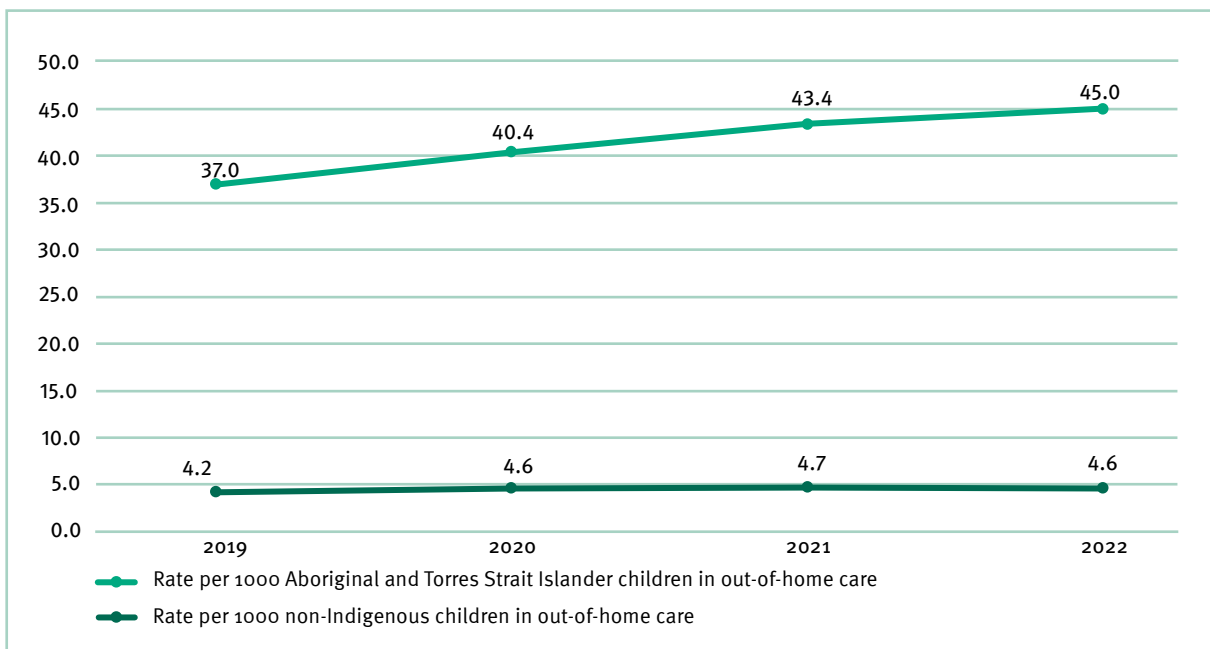
- 3.1 Immediately fund and introduce improved reporting on youth detainees time out of cells (in alignment with the Report on Government Services reporting that already occurs for adults) and agree to champion this measure for inclusion in nationally consistent reporting with other jurisdictions.
- 3.2 Commission the Board to utilise its review process to review a sample of cases of young people on the Serious Repeat Offender Index and advise Government on the common system issues and opportunities to prevent and reduce reoffending for young people in this cohort.

Chapter 4

Improving research on the needs of First Nations communities

Improving research on the needs of First Nations communities

Aboriginal and Torres Strait Islander young people and children were over-represented in the cases reviewed by the Board during 2022–23. Of the 60 cases, 28 (47%) identified as Aboriginal and Torres Strait Islander. Since the commencement of the current child death review model in July 2020, First Nations children and young people have been consistently over-represented. This reflects the wider over-representation in Queensland’s child protection system.



Graph 4: Rate per 1000 children in Queensland in out-of-home care as of 30 June 2019 to 2022. Source: *Report on Government Service 2023*, 16 Child Protection Services, Table 16A.

In previous years, the Board has made recommendations that sought to address over-representation of First Nations children and young people in the child protection system. The aim has been to improve the cultural responsiveness of service delivery to First Nations children and their families. Over the course of its meetings throughout 2022–23, the Board identified the need for culturally safe research into best practices for working with Aboriginal and Torres Strait Islander families that is either led by or conducted in partnership with Aboriginal and Torres Strait Islander people and incorporates the voices of children, young people, their families and communities.

Of the 28 cases, 19 children and young people had active involvement by Child Safety at the time of their deaths. This included Investigation & Assessment (I&A), support services cases, Intervention with Parental Agreement (IPA), and various child protection orders. The nine remaining children had involvement with Child Safety in the 12 months prior to their deaths but not at the time they died. Twenty of the 28 children had been living at home with their families or guardians.

The case records reviewed by the Board commonly noted concerns about socio-economic disadvantage, domestic and family violence and substance misuse, including alcohol misuse and parental mental health as compounding challenges. The Board has observed in line with the Australian Institute of Family Studies (AIFS) that the drivers of over representation of First Nations children and young people in the child protection system are often multi-faceted and connected to the legacy of colonisation, and past assimilation policies and practices.⁷⁴ Cultural disconnection, identity disruption, isolation from communities and intergenerational trauma are significant contributing factors. Furthermore, discrimination, poverty, and lack of access to services, in particular in rural, remote, and discrete communities can have disproportionately negative impacts on Aboriginal and Torres Strait Islander people.⁷⁵

Appropriate alcohol and drug intervention strategies must be sensitive to this context and respond to an individual's cultural needs. The Board notes that there is a significant lack of research into the drivers of problematic alcohol and drug use within Aboriginal and Torres Strait Islander families. While these issues occur across all cultures, research and responses need to be tailored and safe for intended audiences.⁷⁶ The Board believes that a stronger evidence base is needed that has been led, created, and designed by First Nations professionals and champions the voices of First Nations children, young people, their families, and communities.

⁷⁴ Australian Institute of Family Studies 2020, *Child protection and Aboriginal and Torres Strait Islander children*, <https://aifs.gov.au/resources/policy-and-practice-papers/child-protection-and-aboriginal-and-torres-strait-islander>

⁷⁵ The Australian Bureau of Statistics has published data pertaining to the 10 most disadvantaged Local Government Areas (LGA) are: Woorabinda (Queensland), Cherbourg (Qld), Belyuen (NT), West Daly (NT), Yarrabah (Qld), Kowanyama (Qld), Wujal Wujal (Qld), East Arnhem (NT), Doomadgee (Qld) and Central Desert (NT). See [Socio-Economic Indexes for Areas \(SEIFA\), Australia, 2021 | Australian Bureau of Statistics \(abs.gov.au\)](#)

⁷⁶ See Chapter 5: *Strengthening child safety practice in response to parental substance and methamphetamine use* for further detail on this topic.

The need for First Nations-led research

Aboriginal and Torres Strait Islander peoples are a heavily researched cohort and are considered to be the most researched peoples in the world.⁷⁷ There are concerns that, despite this, there have been limited to no corresponding benefits or improvements for Aboriginal and Torres Strait Islander peoples.⁷⁸ Research methodologies and practices often derive from Western concepts, which can mean that the *researcher maintains control of the depth and type of interaction and manages data gathering and analysis.*⁷⁹ Research led by Aboriginal and Torres Strait Islander people allows determination of what the purpose and objectives of the research are, how it progresses, and how research outcomes will be of benefit to Aboriginal children, young people, their families and communities.

The Board raised the need for tailored research to better understand the dynamics, impact and best practice responses for working with First Nations families. Not enough research available to the Board was conducted by, or in partnership with, Aboriginal and Torres Strait Islander people. The Board found that *policy responses to Aboriginal and Torres Strait Islander disadvantage have too often been focused on responding to the symptoms of trauma, rather than prioritising healing to address the cause.*⁸⁰

In the health sciences, the Board noted that there is strong commentary on the need and benefits for research that is conducted by and for Aboriginal and Torres Strait Islander peoples. Significant groundwork has been achieved in the development of guidelines for undertaking ethical research in partnership with Aboriginal and Torres Strait Islander peoples, including but not limited to the work of the Lowitja Institute and the National Health and Medical Research Council. These principles and guidelines can readily inform research in other domains.

Children and young people have often been excluded and their voices left unheard within research. The Board observed that some research designs seem to imply that children and young people are unable to participate in making important decisions that affect them.⁸¹

A recent example of First Nations-led research is that by Australia's National Research Organisation for Women's Safety (ANROWS) in partnership with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP). This research examines the impact of domestic and family violence on First Nations families in contact with the Queensland child protection system, and how services can better support families *to heal from their experiences and break the intergenerational cycle of distress.*⁸² The experiences of children and young people are also included in this research, being mindful that service delivery can often be focused on adults.

This research is led by Aboriginal and Torres Strait Islander researchers using a participatory action research methodology, a collaborative and iterative process that aims to *elevate Indigenous voice and self-determination by generating knowledge by and for Indigenous people, families, and communities.*⁸³ This ensures that there is focus on cultural safety and inclusion of cultural values and protocols in research processes. The Board looks forward to the findings of this research project upon completion.

Having Aboriginal and Torres Strait Islander peoples involved in all aspects of research is crucial to achieving successful and meaningful outcomes.

77 The Queensland Government, National Health and Medical Research Council 2018, *Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples*. Accessed 5 October 2023. <https://www.nhmrc.gov.au/research-policy/ethics/ethical-guidelines-research-aboriginal-and-torres-strait-islander-peoples>

78 Ibid.; Bainbridge R, Tsey K, McCalman J, Kinchin I, Saunders V, Lui FL, Cadet-James Y, Miller A & Lawson K 2015, 'No one's discussing the elephant in the room: contemplating questions of research impact and benefit in Aboriginal and Torres Strait Islander Australian health research', *BMC Public Health*, 15, 696.

79 Biin D, Canada D, Chenoweth J & Neel L 2021, *Pulling Together: A Guide for Researchers*, Hiik'al. BCcampus. <https://opentextbc.ca/indigenizationresearchers/>

80 Healing Foundation, *Leading Our Way: Queensland Aboriginal and Torres Strait Islander Healing Strategy 2020-2040*. <https://www.dcssds.qld.gov.au/resources/campaign/supporting-families/leading-healing-our-way.pdf>

81 Langhout R and Thomas E 2010, 'Imagining Participatory Action Research in Collaboration with Children: an Introduction'. *American Journal of Community Psychology*, 46: 60-66. <https://onlinelibrary.wiley.com/doi/10.1007/s10464-010-9321-1>

82 Australia's National Research Organisation for Women's Safety, *New Ways for Our Families: Designing an Aboriginal and Torres Strait Islander cultural practice framework and system responses to address the impacts of domestic and family violence on children and young people*. https://anrowsdev.wpenginepowered.com/wp-content/uploads/2022/04/Morgan-et-al-RR1_NewWaysOurFamilies.pdf

83 Ibid.

*...self-determination starts by empowering Aboriginal and Torres Strait Islander peoples to make decisions about the things that affect them directly, about their trauma and healing. Governments need to allow the community to lead solutions. This requires governments and other service providers to relinquish control and share decision-making power with Aboriginal and Torres Strait Islander peoples.*⁸⁴

In response to consultation, the Department of Child Safety, Seniors and Disability Services confirmed its commitment to *Breaking Cycles – An action plan: co-designing, developing and implementing services with and for Aboriginal and Torres Strait Islander children and families 2023–25*. *Breaking Cycles* was co-designed with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) and commits the Department to work with QATSICPP to address Aboriginal and Torres Strait Islander data sovereignty and establish a Safe and Supported data sovereignty working group with subject matter experts across the Department. Representatives of DCSSDS regularly attend national Safe and Supported meetings to share progress made under the relevant action plans and to coordinate a nationally consistent approach to data sovereignty. Through this work the Department of Child Safety, Seniors and Disability Services is working to implement the principles of Aboriginal and Torres Strait Islander data sovereignty in the child safety research program. The Board commends the Department for this work and recommends broader adoption of this approach across Government.

Concluding comments

The over representation of Aboriginal and Torres Strait Islander children in the child protection system and child death statistics remain a significant focus for the Board. The Board is calling for culturally safe research into best practices for working with Aboriginal and Torres Strait Islander families and addressing the multiple complexities some Aboriginal and Torres Strait Islander families are facing.

Recommendation 4

Improving research on the needs of First Nations communities

The Queensland Government strengthens its policies and commits to ensuring that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

⁸⁴ Healing Foundation, *Leading Our Way: Queensland Aboriginal and Torres Strait Islander Healing Strategy 2020-2040*. <https://www.dcssds.qld.gov.au/resources/campaign/supporting-families/leading-healing-our-way.pdf>

Chapter 5

Strengthening child
safety practice in
response to parental
substance and
methamphetamine use

Strengthening child safety practice in response to parental substance and methamphetamine use

Problematic alcohol and drug use⁸⁵ was regularly identified as a child protection concern in the cases the Board has reviewed.⁸⁶ Of the 170 cases reviewed by the Board from 1 July 2020 until 30 June 2023, methamphetamine use was prevalent in 32.94% of cases. The Board also observed a high prevalence of polysubstance use by parents.

Children are impacted by a parent or caregiver's problematic alcohol and drug use in profound ways. Direct exposure can significantly harm a child's physical, emotional and mental health. Moreover, indirect and environmental exposure can pose significant secondary risks to children. Children who were exposed to problematic alcohol and drug use often became known to the child protection system, repeatedly for a combination of concerns that the Board commonly observed across cases. Housing instability and domestic and family violence were often among such common experiences.

While practitioners often articulated awareness of parental polysubstance use and concerns about their capacity to parent safely, this did not always trigger effective responses towards mitigating risk to children.

The consequences of parental methamphetamine use can include impaired decision making that results in children's exposure to unsafe environments with access to drugs or drug paraphernalia, unsafe driving while under the influence, exposure to poor ventilation or unsafe temperatures for extended periods, unsafe sleeping practices, and basic care needs not being met (i.e., nutrition, hydration, hygiene, clothing, medical care). Parents who regularly use methamphetamines can show extreme and unpredictable mood fluctuations, violent behaviours, and lack of impulse control. This pattern of behaviour has been shown to impede parent-child attachment and reduces parents' emotional availability.

The Board received evidence that parents using methamphetamines experience high levels of parental and psychological distress, which can persist even during abstinence. They also display depressive symptoms and dysfunctional parenting practices (e.g.,

indifferent and overreactive tendencies). Although they can experience strong feelings of guilt and self-doubt towards their children, they also tend to perceive their children as highly demanding. Consistent with the typical binge and crash cycle of methamphetamine use, parents cycle through periods of euphoric-wakefulness, irritability and volatility, and lethargy and depression. Additional vulnerabilities include financial strain, unemployment and periods of incarceration. There is also an inter-generational component, whereby their children learn dysfunctional behaviours and relationships.

The Board observed that children whose parents regularly used substances were harmed or were at unacceptable risk of harm. This occurred as a result of the following factors:

- exposure in utero and/or environmental exposure to harmful substances
- exposure to criminal activity, especially drug-related offending
- not meeting basic care needs such as food, drink, shelter, appropriate clothing, personal hygiene, and medical care
- not enough age-appropriate supervision
- unsafe sleeping practices
- inconsistent, erratic, and dangerous parental behaviour
- emotional unavailability of parents to their children, resulting in emotional neglect
- developmental delays from limited stimulation
- insecure attachments to parent/caregiver.

Children of parents who use alcohol and drugs did not always have access to safe and protective care, severely impacting their physical and emotional development. Parents consistently prioritised funding, obtaining and using alcohol and drugs over the needs of their children.⁸⁷ In several cases, children were in the care of a parent who was driving under the influence, exposed to unsafe persons during drug deals, had access to dangerous drugs, and lived in proximity to drug paraphernalia.

⁸⁵ The terminology problematic or harmful drug and or alcohol use, as used throughout this report, is consistent with the terminology recognised in the *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*. See <https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan>

⁸⁶ Alcohol and drug foundation 2023, *Polydrug use*. Accessed 5 October 2023. <https://adf.org.au/reducing-risk/polydrug-use/>

⁸⁷ Child Safety 2023, *Living with alcohol and other drugs use*. Accessed 5 October 2023. <https://cspm.csyw.qld.gov.au/practice-kits/alcohol-and-other-drugs/working-with-parents-1/seeing-and-understanding-1/living-with-aod-use>

Polysubstance abuse by parents can result in the exposure of a child to inconsistent and unpredictable parenting behaviours. As a result of their using, a parent's presentation can oscillate between manic, impulsive and overly attentive behaviours and emotional withdrawal, flat affect, and limited to no responses towards their child.⁸⁸ Such lack of emotional regulation can substantially impact a child's developing ability and competency to regulate their own emotions and significantly disrupt attachments with parents and caregivers.⁸⁹ Problematic alcohol and drug use is not only a risk factor for emotional abuse. The Australian Childhood Maltreatment Study (ACMS) found that family substance problems double the risk for multi-type maltreatment.⁹⁰

Cumulative harm

Exposure to parental substance use can have lifelong impacts on a child. Young children are particularly vulnerable to emotional harm, with exposure to parental substance use before age three linked to insecure and disorganised attachment⁹¹ and delayed speech and language development.⁹² Even minor exposure can have compounding effects over time, resulting in cumulative harm.⁹³

Heightened vulnerability of infants and very young children

Infants and very young children, due to their absolute dependence on their caregivers, are especially vulnerable to the harms of problematic alcohol and drug use. The Board reviewed cases of infants going without food and water, left in dirty nappies, confined for extended periods in cots, not given attention or physical touch, and missing medical appointments. Such neglect, even over relatively short periods of time, can be fatal. Therefore, it is vital that care is provided by a safe adult who is consistently responsive to the infant or young child's needs.⁹⁴

Practitioners must consider how the necessities of life might be met for an infant or child if the parent's capacity to keep the child safe is impaired due to their substance use.

Newborn baby's story: exposure in utero and unsafe neonatal period

Newborn Baby was born to a mother who had been experiencing multiple complex issues including methamphetamine (ice) addiction, untreated mental health issues, homelessness and limited family and social supports.

Newborn Baby's mother had been referred to multiple health services in relation to antenatal/postnatal care and concerns about substance use. However, the services reported difficulties engaging her.

At birth, Newborn Baby did not have signs of withdrawal but soon developed feeding and breathing difficulties and remained in hospital for several weeks. During this time, Newborn Baby was assessed as 'Safe' due to the increased visibility at the hospital. However, hospital staff had been voicing concerns for Newborn Baby's safety due to Mother's sporadic visitation and non-engagement with specialised feeding education.

Newborn Baby was eventually discharged from hospital into their mother's care. Two weeks later, Newborn Baby passed away after reportedly being unsettled and having difficulties feeding. At the time, Mother had been visiting a known drug associate.

88 Ibid.

89 Shadur J and Hussong A 2020, 'Maternal Substance Use and Child Emotion Regulation: The Mediating Role of Parent Emotion Socialization', *Journal of Child and Family Studies* 29, 1589–1603. <https://link.springer.com/article/10.1007/s10826-019-01681-5>

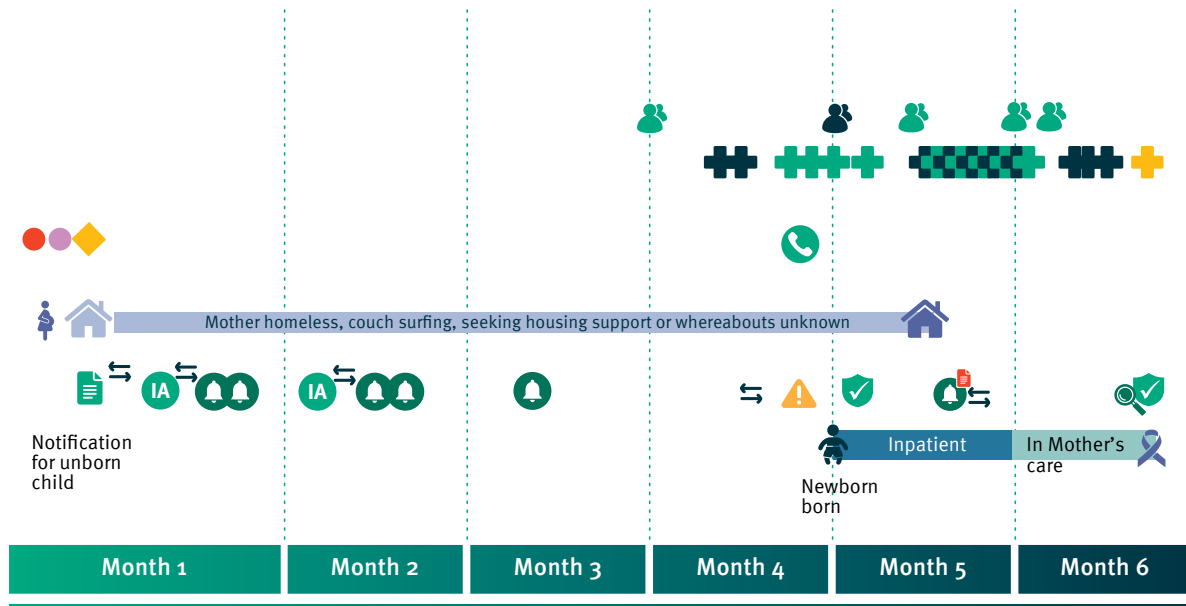
90 Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology. <https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/>

91 Barnard M and McKeganey N 2004, 'The impact of parental problem drug use on children: what is the problem and what can be done to help?', *Addiction*, 99(5), 552-559.

92 Dunn MG, Tarter RE, Mezzich AC, Vanyukov M, Kirisci L & Kirillova G 2002, 'Origins and consequences of child neglect in substance abuse families', *Clinical Psychology Review*, 22(7), 1063-1090.

93 Broadley K 2014, 'Equipping child protection practitioners to intervene to protect children from cumulative harm: Legislation and policy in Victoria, Australia', *Australian Journal of Social Issues*, 49(3), 265-284.

94 Child Safey 2022, *Safety Planning*. Accessed 5 October 2023. <https://cspm.csyw.qld.gov.au/practice-kits/alcohol-and-other-drugs/safety-assessment-and-safety-planning>



- Agencies informed that Mother is pregnant
- Contact with police
- Mother reported missing
- Mother arrested / charged
- Notification
- Information requested or shared
- Investigation and Assessment (I&A)
- Additional notified concerns - Child Concern Report / Notification
- Safety assessment - SAFE
- Home visit
- Secondary service referral: engagement / limited or no engagement
- Reports that Mother is homeless / couch surfing
- Mother secures accommodation
- Queensland Health: Presentation or contact / unsuccessful contact or failure not attended / scheduled after newborn's death
- Unborn Child High Risk Alert
- Newborn born
- Newborn dies
- Child Safety's first contact with Mother

Figure 6: Timeline of system touchpoints for Newborn Baby

Demographic overview and prevalence of methamphetamine use in Queensland

Methamphetamines are one type of a class of drugs called amphetamines. They have a stimulatory effect on the central nervous system, with the most potent form of methamphetamine known as crystal methamphetamine, or ice. Consequently, people using methamphetamines are much more susceptible to developing dependence and experiencing a range of associated harms. Australia ranked third highest for consumption of methamphetamines globally.⁹⁵ The prevalence of methamphetamine use in Queensland is on par with national use in Australia and its use is associated with more social marginalisation and disadvantage, compared to parents who use other drugs, such as alcohol, tobacco, and cannabis,^{96,97} higher likelihood of polysubstance use, and co-occurring mental health concerns.⁹⁸

The proportion of people in Queensland aged at least 14 years of age who reported having used methamphetamines in the previous 12 months for non-medical purposes fell from 2.9% in 2001 to 1.5% in 2016 to less than the national average of 1.3% in 2019.⁹⁹ The Australian Criminal Intelligence Commission's National Wastewater Drug Monitoring Program (NWDMP) Report noted that although national data showed that the average excretion of methamphetamine in wastewater was higher in cities, relative to regional areas, this pattern was reversed in Queensland.¹⁰⁰ Nevertheless, the level of detection of methamphetamine in regional wastewater remained steady in regional Queensland from the second half of 2020 to the end of 2022, compared to a consistent

increase in metropolitan areas of Queensland.

In Queensland, data collated in March 2021 showed that an estimated 42% of children in Out of Home Care had at least one parent who had a record of methamphetamine use.¹⁰¹

In Australia during 2021, methamphetamines accounted for 8.2% of all drug-related hospitalisations (12,400)¹⁰² and were the principal drug of concern in 24% of treatment episodes.¹⁰³ The most common cause of methamphetamine-related death was accidental drug toxicity, although suicide and accidents comprised more than half of all these deaths.¹⁰⁴ Although methamphetamine-related harms occur across the population in Australia and globally, these harms are disproportionately high for people and communities from lower socio-economic backgrounds.¹⁰⁵ In the Australian context, First Nations people are disproportionately impacted by lower socio-economic factors: an estimated one-third of the health gap between First Nations people and non-First Nations people is attributable to lower levels of schooling, employment status, hours of employment, housing adequacy and income.¹⁰⁶ For First Nations Australians, these structural risk factors are further aggravated by the individual-level risk factors that apply to all individuals regardless of their cultural identity, such as adverse childhood experiences, trauma, grief and loss.¹⁰⁷

95 Australian Criminal Intelligence Commission 2023, *National Wastewater Drug Monitoring Program, Report 19*. <https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports>

96 Semple, S Grant I & Patterson TL 2005, 'Utilization of Drug Treatment Programs by Methamphetamine Users: The Role of Social Stigma', *The American Journal on Addictions*, 14(4), 367–380. <https://onlinelibrary.wiley.com/doi/abs/10.1080/10550490591006924>

97 Ward B, Kippen R, Reupert A, Maybery D, Agius PA, Quinn B, Jenkinson R, Hickman M, Sutton K, Goldsmith R and Dietze PM 2021, 'Parent and child co-resident status among an Australian community-based sample of methamphetamine smokers', *Drug Alcohol Review*, 40(7), 1275–1280. <https://onlinelibrary.wiley.com/doi/10.1111/dar.13155>

98 National Centre on Substance Abuse and Child Welfare 2021, *Supporting children affected by parental methamphetamine*. <https://ncsacw.acf.hhs.gov/files/meth-tip-sheet-children.pdf>

99 AIHW 2020, *National Drug Strategy Household Survey*. <https://www.aihw.gov.au/reports/illegal-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary>

100 Australian Criminal Intelligence Commission 2023, *National Wastewater Drug Monitoring Program, Report 19*. <https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports>

101 The Queensland Cabinet and Ministerial Directory 2021, *Demand increases for family support and child protection*. <https://statements.qld.gov.au/statements/92939>

102 AIHW, 2023, *Illicit drug use*. Accessed 5 October 2023. <https://www.aihw.gov.au/reports/illegal-use-of-drugs/illegal-drug-use>

103 AIHW, 2023, *Australia's mothers and baby: Maternal Age*. Accessed 5 October 2023. <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/overview-and-demographics/maternal-age>

104 Darke S, Kaye S and Johan D 2017, 'Rates, characteristics and circumstances of methamphetamine related death in Australia: a national 7 year study', *Addiction*, 112(12), 2191–2201. <https://onlinelibrary.wiley.com/doi/10.1111/add.13897>

105 United Nations Office on Drugs and Crime 2020, 'Drug use and consequences', *World Drug Report 2020*. https://wdr.unodc.org/wdr2020/field/WDR20_Booklet_2.pdf

106 AIHW, 2022, *Determinants of health for Indigenous Australians*. Accessed 5 October 2022. <https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health>

107 Lee WC, Fang SC, Ying-Yeh C, Liu HC, Huang MC & McKetin R 2023, 'Exploring the mediating role of methamphetamine use in the relationship between adverse childhood experiences and attempted suicide', *Addictive Behaviors*, 123, 107060–107060. <https://www.sciencedirect.com/science/article/abs/pii/S0306460321002458?via%3Dihub>

Alcohol and drug informed practice

Both National¹⁰⁸ and Queensland¹⁰⁹ strategies to address problematic alcohol and drug use advocate a harm minimisation approach. The approach aims to reduce 1) demand, 2) harm and 3) supply.¹¹⁰ The second aim, harm reduction, is about providing support services to people, their families and their communities to minimise the negative effects of alcohol and drug use.¹¹¹

From the child protection system's perspective, the priority for any intervention is to ensure that children are safe. Harm reduction in this context means first and foremost that risk to the child must be minimised and continually managed. This means that a child's short- and long-term safety is the primary objective when working with a family impacted by parental substance use. This is in accordance with the *Child Protection Act 1999*'s Paramount Principle:

*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.*¹¹²

Ensuring a child's safety in the context of parental substance use does not always need to result in the child's removal from their parents' care. There are many Australians who engage in substance use – particularly alcohol – where there is no evidence available that they are posing safety risks to their children, for example because they have utilised their safety and support networks (e.g., arranging alternative supervision from a family member). Where concerns exist in the child protection system, skilled practitioners must conduct robust risk assessments to determine the likelihood a child might suffer harm which will inform decision making about ongoing child protection interventions.

Once a child's safety needs have been determined, the intervention for parents should focus on both reducing substance use and improving parenting skills.¹¹³ Evidence suggests that such dual treatments are more effective in a child protection context than approaches that address drug use alone.^{114,115}

In the cases it reviewed the Board noted that children did not always receive the support and intervention they and their parents needed to help keep them safe, despite the best intentions of the systems around them. The child's interests were not always held at the centre of practice. This resulted in the children continuing to be exposed to hazardous parenting practices in dangerous environments without additional supports, where the significant risks of ongoing harm were not fully understood, and as such were insufficiently mitigated and addressed.

A significant number of cases involved children under three years old whose parents had engaged in methamphetamine use (38% of the 170 cases reviewed by the Board in its three years of operation). From reviewing these cases, the Board noted that further research is needed to better understand how behaviours indicative of methamphetamine use might be recognised and responded to effectively in frontline practice.

¹⁰⁸ Australia Government Department of Health and Aged Care 2017, *National Drug Strategy 2017–2026*, 13. <https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf>

¹⁰⁹ The Queensland Mental Health Commission (QMHC) 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022–2027*, 17. <https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan>

¹¹⁰ The QMHC 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022–2027*, 17. <https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan>

¹¹¹ Ibid.

¹¹² *Child Protection Act 1999*, Section 5A: Paramount Principle.

¹¹³ Ward B, Moller C, Maybery D, Weimand B, Krause M, Dietze P, Harvey P, Kippen R, McCormick F, Lloyd-Jones M & Reupert A 2022, 'Interventions to support parents who use methamphetamine: A narrative systematic review', *Children and Youth Services Review*, 139.

¹¹⁴ Neger E & Prinz R 2015, 'Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations', *Clinical psychology review*, 39, 71–82.

¹¹⁵ Ward B, Moller C, Maybery D, Weimand B, Krause M, Dietze P, Harvey P, Kippen R, McCormick F, Lloyd-Jones M & Reupert A 2022, 'Interventions to support parents who use methamphetamine: A narrative systematic review', *Children and Youth Services Review*, 139.

Baby's story: the dangers of limited safety planning

Baby lived with their mother and two siblings. Baby's parents had a long history of polysubstance use, poor mental health, and criminal offending, which included drug trafficking and led to periods of imprisonment.

Soon after Baby's birth, Child Safety opened an Intervention with Parental Agreement (IPA) with the family. As part of the casework, child protection practitioners developed an ongoing safety plan with the family which requested that Baby's mother would not use or deal drugs while caring for Baby. The plan, however, did not spell out how mother might achieve this goal and what assistance she may require. Baby's death occurred during a night their mother was using drugs at her home alongside several other adults. It appears that the safety plan did not help to increase the safety of Baby as it relied too heavily on mother's capacity to independently change her long-established patterns of substance use.

The Board noted the following themes and patterns in child protection risk assessments and associated Impacts on children from their parents' drug use:

- **Challenges identifying cumulative harm** – chronic emotional abuse and neglect caused by repeated exposure to parental drug use often remained unaddressed. Cumulative harm is often less visible and takes additional effort to identify, including direct observations of the child. In consideration of resourcing constraints, the Board noted that practitioners do not always have the resources to pursue this.
- **Difficulty recognising impacts on children from patterns of problematic substance use by parents** – behaviours were evaluated as individual incidents rather than repeated habits.
- **Missed opportunities to investigate extent and type of drug use and associated impacts** – where parents disclosed polysubstance use, follow up conversations about the extent and type of drug use often did not go beyond eliciting superficial information and did not sufficiently explore the impacts on children.
- **Acceptance by workers when parents advised they were unwilling to address their substance use** – many parents were pre-contemplative about addressing their alcohol and drug use and denied any negative impacts on their child/ren.
- **Acceptance of information from parents at face-value** – working with parents who use substances at levels that present harm to their children requires practitioners to use a level of scepticism.¹¹⁶ Accounts from the parents were often given more weight than the accounts from members of the safety and support network.
- **Overreliance on inadequate family arrangements or support networks** – informal arrangements with family members or friends were considered sufficient to care for a child when their parent was intoxicated. Often practitioners did not confirm that people who had agreed to care for a child were safe and sober to do so.
- **Overly optimistic practice** – a parent's ability and willingness to adhere to established safety plans was frequently overestimated. Some safety plans did not sufficiently take into account a parent's past behaviour in the context of problematic substance use.

The systemic difficulties to accurately ascertain risks to children from problematic alcohol and drug use as outlined above require greater education and resources across the child protection system to increase children's safety and protection.

¹¹⁶ Hader Clinic Queensland, *Why addicts lie and how to deal with it*. Accessed 5 October 2023. <https://haderclinicqld.com.au/why-addicts-lie-and-how-to-deal-with-it/>

Young Boy's story: safeguarding children facing multiple household challenges

Young Boy was the only child born to young parents. The family resided with several family members and friends while they were facing challenges to obtain stable accommodation. The records state that Young Boy had been present while the parents used and dealt drugs and had witnessed his father perpetrate domestic and family violence against his mother.

In the year prior to Young Boy's death, several child protection risk assessments identified all of the above challenges in relation to concerns about Young Boy's immediate safety. However, the records contained little information on how practitioners considered the impacts these potentially traumatic experiences might have had on Young Boy. There was also limited information on what strategies and interventions could have been deployed to increase the family's safety. During the time Child Safety was working with Young Boy and his parents, multiple extended family members offered to care for him.

No ongoing intervention was open in the months prior or at the time of Young Boy's death. Young Boy remained in the care of his parents without any support to scaffold his safety, nor did his parents receive targeted support to help address the challenges that they were facing, which likely had been caused at least in part by their ongoing substance use. Young Boy died in a car crash where his father may have been driving while under the influence of drugs.

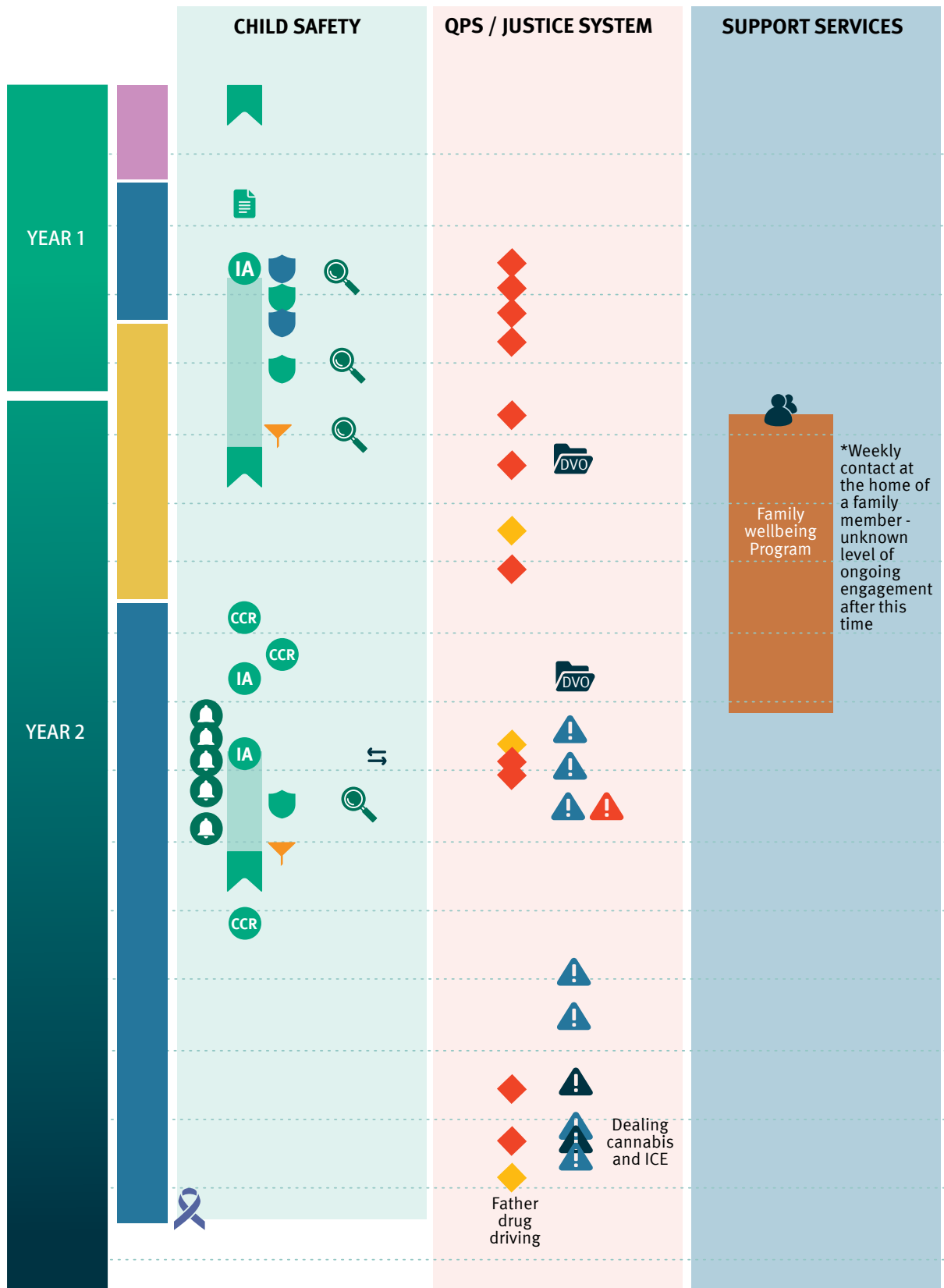









Figure 7: Timeline of system touchpoints for Young Boy




CHILD SAFETY

-  Notification
-  Child Concern Report
-  Investigation and Assessment
-  Home visit
-  Safety Assessment – **Safe** / **Safe with Immediate Safety Plan**
-  Additional notified concerns - Child Concern Report / **Notification**
-  I&A outcome substantiated
-  Risk evaluations: **moderate** / high
-  Safety Assessment: **Safe with plan** / **Unsafe**
-  Information requested or shared
-  Young Boy died


QPS / JUSTICE SYSTEM

-  Domestic Violence Order
-  Arrested / charged
-  QPS street check / caution
-  DVO breach / incident with QPS response
-  Drug intelligence
-  Mother suicidal

YOUNG BOY'S LIVING ARRANGEMENTS

-  Maternal family's house with mother
-  Friend's house with both parents
-  Paternal family's house with parents

SUPPORT SERVICES

-  Family wellbeing program

The Board's case observations suggest that practitioners require greater support to determine a threshold at which problematic substance use means there is no parent able and willing to care for and protect their child. In some cases, this may mean that there is ongoing intervention to address the child protection concerns and, in some instances, the child may need to be removed from their parents' care while safety concerns are addressed.

Recent system responses to alcohol and other drug use

On 14 October 2022, the Queensland Government released *Achieving balance: The Queensland Alcohol and Other Drugs Plan (2022–2027)* (*Achieving balance*). It is a whole-of-government plan that puts into action the Queensland Government's commitment to preventing and reducing use of alcohol and drugs.

Achieving balance includes some priority actions which focus on the needs of families. These include:

- improvement in coordination across systems to build capacity and increase culturally appropriate, evidence-informed family supports and interventions
- improvement of prevention and early intervention through earlier identification and provision of appropriate child, youth and family services for children and young people experiencing vulnerabilities associated with parental alcohol and other drug use.¹¹⁷

Responding to methamphetamine use and harms

In 2023, the Board commissioned the University of Queensland's Poche Centre for Indigenous Health to conduct a literature review and present findings in a research report that examines the demographics and impact of methamphetamine use on infants and young children, with particular consideration of the Queensland context. The research report details what is known about methamphetamine use within families who have been in contact with the child protection system and comments on how the child protection system in Queensland could engage in a whole-of-system effort to recognise and respond to the care and protection needs of young children in families with parental methamphetamine use.

The Board provided 33 de-identified case reviews to identify how best practice interventions could be applied to prevent child deaths in the future. The research report aims to generate tangible guidance to practitioners in relation to assessment of parental capacity in the context of methamphetamine use and the implications for targeted intervention programs. Findings from the report are summarised briefly in the below section.

The research confirmed that recognition of parental methamphetamine use, and its impact on children, is difficult for practitioners. Where methamphetamine use was identified in the 32 cases studies, there was often little recorded evidence showing how practitioners might have responded to or address the concerns. Possible reasons for this include:

- underappreciation of the risk of parental methamphetamine use to children
- insufficient information about the extent and patterns of the parent/s' use
- a lack of understanding about how methamphetamine use is compounded by other challenges
- unaddressed stigma towards parents and families who use methamphetamines.

This then resulted in missed opportunities to intervene. The research suggests that there are opportunities for stronger and more effective system responses to families where methamphetamine use by parents has been identified. This can include:

- ongoing guidance and support to frontline staff to develop a better understanding of the impacts and harms on children from parental methamphetamine use
- investment in time-effective and collaborative information sharing
- minimising stigma by leveraging existing resources, programs and initiatives
- considering the development of a stepped approach response across the child protection system, including the development of a Queensland-specific model of therapy that is based on current best evidence family therapies.

¹¹⁷ The QMHC 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*, 24. <https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan>

Parents who use methamphetamine are often engaged in a set of behaviours that include staying awake, having multiple sex partners, exhibiting erratic and bizarre behaviours, and experiencing extreme euphoria followed by painful withdrawal symptoms, such as depression, paranoia, irritability or delusions. In addition to these risks associated with the use of methamphetamine itself, parents who use methamphetamines become exposed to increasingly risky situations over time, such as being out late at night while seeking or dealing drugs, engaging in criminal activities to support drug use, or involvement in prostitution.

A relatively unique feature of methamphetamine use is that the trajectory from initial, or low risk, use to highly problematic use and dependence is often rapid.

Modifying the trajectory of parental methamphetamine use is difficult, especially for parents who are using ice. One natural history study found that the only an estimated 5% of people who had been using ice had been able to maintain sobriety for three years without a form of treatment or formal rehabilitation program.¹¹⁸ The success with which abstinence from methamphetamines can be achieved does appear to improve with treatment, with one study showing 39% of people maintained abstinence for 12 months after treatment.¹¹⁹

Appropriate alcohol and drug interventions must also respond to people's cultural needs. Such responses cannot be implemented effectively without self-determination. For First Nations families, some of the ongoing impacts of colonisation can contribute to multiple adverse experiences. This can include engagement in substance use and experiences of homelessness.¹²⁰ Cultural disconnection, identity disruption, isolation from communities and intergenerational trauma are significant contributing factors which are perpetuated by ongoing discrimination, poverty and lack of access to services.¹²¹

Concluding comments

The Queensland Government's *Action on ice plan of 2018* has invested more than \$100 million over five years to address the impact of ice on Queensland communities. The overall intent is to reduce the burden imposed by ice use on emergency services, community services, law enforcement and the health system, and the staff that work within them, across the public, private and non-government sectors. The key features of this plan are:

- Increased community awareness about the consequences of ice use, along with a dependable and reputable information hub for guidance on seeking assistance and support.
- Improved availability and augmented funding for efficient, adaptable, and culturally fitting services for treatment, recovery, and support for both individuals and families. This included \$1.7 million over three years to Lives Lived Well for residential recovery units, improved co-ordinated outreach and intensive care management support for families in Logan and its surrounds engaged in the child protection system.
- A criminal justice system attuned to the requirements of those impacted by ice, encompassing stringent penalties for those involved in supplying alcohol and other drugs (AoD) substances.

118 Campillo, R 2022, 'My Experience and Recovery from Meth Addiction', *Missouri Medicine*. 119(6): 500. <https://pubmed.ncbi.nlm.nih.gov/36588652/>

119 Breckt M & Herbeck D 2015, 'Time to relapse following treatment for methamphetamine use: a long-term perspective on patterns and predictors', *Drug and Alcohol Dependence*, 139, 18-25

120 AIHW 2016, *Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014*. <https://www.aihw.gov.au/reports/homelessness-services/exploring-drug-treatment-homelessness-2011-2014/notes>

121 Australia Government Department of Health and Aged Care 2017, *National Drug Strategy 2017–2026*, 26-7. <https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf>

The *Queensland Alcohol and Other Drugs Plan 2022–2027* translates the Queensland Government’s dedication into concrete steps for preventing and decreasing problematic alcohol and drug use. It recognises that the consumption of substances is integrated into the lives of many individuals, spanning a spectrum from occasional usage to high levels of dependency. While the majority of use adheres to responsible and recommended standards, injurious utilisation can emerge at any stage, impacting communities and people of various ages. The repercussions of harmful use extend to individuals, families, communities, and the economy.

The Queensland plan also acknowledges, however, that the extensive ramifications can be averted or lessened. It recognises that successfully minimising AoD-related harm in Queensland will require a multi-level approach across the three pillars of supply reduction, demand reduction and harm reduction. To that end, it specifies five priorities and three focus areas for investment. The five priority areas are:

1. prevention and early intervention
2. enhanced treatment and support systems
3. expanded diversion programs
4. reducing stigma and discrimination; and
5. reducing harm.

The three focus areas aim to address: vulnerabilities at the individual and family level; harm and safety at the community level; and increased impact at the systems level. The stated focus of this plan on vulnerable families and improving system-level impacts means that there is a clear opportunity to specifically explore how the child protection system might more effectively engage with a range of other systems.

In consulting with Government on the proposed recommendation, the Department of Child Safety, Seniors and Disability Services advised that it has integrated a Drug and Alcohol Practice Kit within the Child Safety Practice Manual. This kit aims to provide practitioners with expert advice and guidance to inform their practice with parents who are using drugs and alcohol. The Department further advised that the Drug and Alcohol Practice Kit is currently being reviewed to ensure it contains contemporary information and advice. The Board considers this a good opportunity for its recommendation to be implemented in this Department, but considers more work, and consistent work, is required across other human services.

Problematic alcohol and drug use is a significant concern for Queensland children. The complexity of issues that occur alongside substance use can make it difficult for practitioners to accurately assess the ongoing risk to children. This is particularly important when working with young children. Understanding the direct and indirect risks while accounting for each child’s individual circumstances, is essential to keeping children safe.

Recommendation 5

Strengthening child safety practice in response to parental substance and methamphetamine use

The Queensland Government invests in a practice guide that will support frontline practitioners in their risk assessments of children whose parents’ substance use is problematic. This practice guide should cover:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services that must be implemented to ensure a child’s safety.

Chapter 6

Increasing system visibility
of children and young people
in the context of coercion
and parental deception

Increasing system visibility of children and young people in the context of coercion and parental deception

Exposure to domestic violence is a significant issue for Australian children and families. It *occurs when a child sees or hears acts of violence towards other family members in the child's home*.¹²² Typically, these acts are attributable to a parent or caregiver, or another family member. They are often physical, but they may also be verbal, sexual, or involve threats or coercion. The *Australian Child Maltreatment Study* (ACMS) published in April 2023 found that 39.6% of Australians aged 16 years and over had experienced exposure to domestic and family violence when they were children.¹²³ Among 16–24-year-olds surveyed in the study, this rate rose to 43.8%.¹²⁴

In 2022–23, 37 (62%) of children whose deaths were reviewed had experienced domestic and family violence.¹²⁵ Almost always underpinning the experiences of these children and their families was coercive control, a repetitive and insidious pattern of abuse and behaviours used to create a climate of fear, isolation and intimidation.¹²⁶ The Board noted cases where the system did not effectively respond to the needs of children and young people where parents and family members actively sought to keep their protection needs invisible. The Board observed that parents had used methods of parental deception and disguised compliance to mislead the system and keep intervention at a minimum. In his independent report to the *Inquest into the death of Mason Jet Lee*, Andrew Whitaker defined disguised compliance as:

*A parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.*¹²⁷

¹²² Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology, 7. <https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/>

¹²³ Ibid.

¹²⁴ Ibid.

¹²⁵ For most children, no direct correlation was established between their experience of domestic and family violence and their death.

¹²⁶ Hill, J 2020, *See what you made me do: The dangers of domestic abuse that we ignore, explain away or refuse to see*, Sourcebooks.

¹²⁷ Coroners Court of Queensland 2020, 'Report of Dr Andrew Whitaker', *Inquest into the death of Mason Jet Lee*, 58. https://www.courts.qld.gov.au/_data/assets/pdf_file/0009/651636/cif-lee-mj-20200602.pdf

Child's story

The Board reviewed the case of a 11-year-old boy who died after not receiving medical support. His parents were no longer in a relationship and the boy had been spending time between both parents' households. Child protection reports had been received about the boy and his brother from infancy across both households. Both parents were reported to have been avoidant of authorities, transient and dismissive towards offers by support services to engage with them. Concerns included domestic and family violence (DFV), parental alcohol and substance use, mental illness, criminal activity, transience, forcing the child to engage in animal cruelty, physical and emotional abuse of the children, and insufficient supervision. The Board noted the extent of the emotional trauma the boy had suffered throughout his life.

For the time period the boy lived with one parent, records often noted conversations between workers and the parent in which they minimised and outright dismissed the workers' concerns by declaring that things were fine, and that workers should instead be talking to the other parent as they had been the one who posed a safety risk. This was interspersed with aggressive, hostile, and threatening responses towards staff. Records indicate that this parent successfully minimised and dismissed concerns in response to attention from Child Safety, the primary school, QPS, and Queensland Health, as detailed below:

- Two Investigations and Assessments (I&A) were unsubstantiated by Child Safety following verbal statements by the parent and their new partner that dispersed concerns about the children's safety. In the course of the second I&A, the children were interviewed three months after an incident of domestic and family violence, but they did not disclose any information and instead said they were not going to talk about what happened. The time lapse may have allowed for the parent to ensure that the children did not disclose abuse and for physical injuries to heal. Ongoing intervention did not eventuate after the parents advised that they would not be accepting support from a service.
- QPS visited the household more than 20 times in the year prior to the boy's death. This included alerts about domestic and family violence, animal cruelty, drug activity, and noise complaints. The parent was reported to display aggressive and antagonistic behaviour towards Police – leading to dynamics that made it more difficult to assess the child's wellbeing.
- Throughout his life, the boy had been enrolled in more than 10 different primary schools. The boy had been observed to be unable to sit still and concentrate in class. Erratic and disruptive behaviours that indicated emotional trauma had been noted by staff, who also reported that the boy had disclosed feelings of being scared of their parent, especially when they were drunk. The school reported these concerns to Child Safety once, and later confirmed that the boy had been mentioning almost daily that he felt worried or scared at home.
- Queensland Health had also been involved, mainly through treatment of "accidental" injuries, including failures to address medical issues where in one case the referral was closed.

At the time of death, there was no open child protection intervention. The Board considered that concerns had been assessed in isolation, that evidence from professional notifiers was disregarded, and the voices of the children were missed or minimised. Where opportunities to identify the safety and wellbeing of the boy existed, records suggest the parent had used distractions, delays and aggression to hinder investigation.

Those who perpetrate coercive control upon their family create a *web of rules or codes, rituals of defence, modes of enforcement, sanctions and forbidden places*. Those subjected to it often report complete isolation from their family, friends, and other support networks, and are *frequently deprived of money, food, access to communication or transportation, and other survival resources*.¹²⁸

Parents often extend the use of coercive tactics and control strategies to the systems designed to keep children and families safe. The climate of fear can result in children too afraid to disclose harm or to speak to trusted adults. Parents can use deceptive strategies by appearing, on the surface, to be jovial and open to engaging with agencies, only to minimise the reported concerns so as to maintain unmitigated control of what happens *behind closed doors* of the family home. Others might create and reinforce control by isolating the family, moving frequently, preventing contact with extended family, changing schools or daycare centres, or repudiating engagement with support services.

In 2021–22, the Board analysed a sample of cases to identify recurring issues and improvements in responses provided to families who are known to the child protection system and experiencing domestic and family violence. The Board's findings were detailed in its report: *Reviewing the child protection system's response to violence within families: Findings from an analysis of child death reviews involving domestic and family violence*. Learnings from the cases considered by the Board in 2022–23 show that the key findings from the report (see below) remain highly relevant. This year the Board saw that:

- All forms of domestic and family violence and lethality indicators are not always recognised or understood by agencies and therefore the associated risks to children may not be obvious.
- Children's voices and views are not always appropriately sought or heard when the system responds to parents, thus minimising the harm the children may have experienced.

Cross agency collaboration and information sharing is important for maintaining 'visibility' of perpetrator behaviours, understanding and minimising risks their behaviours pose to children, and addressing comorbid risk factors. This is particularly important in considering that children, young people and their families impacted by domestic and family violence can often experience other types of maltreatment. The ACMS found that two

out of three children who have suffered maltreatment experience more than one type of maltreatment, and one in four Australians experience three to five types of maltreatment.¹²⁹

While the household might have received a response from government – that is Police, Child Safety, health services, crisis accommodation housing and a whole range of services – too often systems geared their responses towards parents, while the children were seen as a third party. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability found in its public hearing 33 that a *[father's] behaviours were explained away, excused or accepted because he had the care of two children with disability*. For example, it was suggested that *[father] was doing a good job of parenting but had a different standard to others*,¹³⁰ while the boys themselves were often not directly consulted.

*We know that children are impacted simply by living in a household of fear, and a household with stress; it impacts them deeply.*¹³¹

The needs of children experiencing coercive control as part of domestic and family violence are not always recognised astutely by practitioners. While overt acts of violence and physical harm may be easier to identify, the subtleties of coercive control and its impacts on a child can be overlooked if staff are not attuned to recognising warning signs and common behavioural patterns indicate that the children might be fearful. This can include a child's inability to regulate emotions, frequent behavioural escalations, high levels of anxiety and stress, nightmares or inability to sleep, emotional withdrawal or numbness, reluctance to talk about what is happening at home for fear of retribution, and an inability to learn at school.¹³² The infographic below illustrates some of these observations for a case the Board has reviewed.

¹²⁸ Ibid.

¹²⁹ Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology. <https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/>

¹³⁰ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2023, *Report on public hearing 33: Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study)*, 121. <https://disability.royalcommission.gov.au/publications/report-public-hearing-33-violence-abuse-neglect-and-deprivation-human-rights-kaleb-and-jonathon-case-study>

¹³¹ Luke Twyford, Child Death Review Board Chairperson quoted by ABC News Brisbane, 8 December 2022, *Report shows 69 children known to Queensland's child protection system died between 2021-2022*, Accessed 5 October 2023. <https://www.abc.net.au/news/2022-12-08/qld-report-69-children-known-to-sustem-died-2021-2022/101750996>

¹³² Government of Western Australia, Department of Communities 2021, *Child Development and Trauma Guide*. <https://www.wa.gov.au/system/files/2021-11/Child-Development-And-Trauma-Guide.pdf>

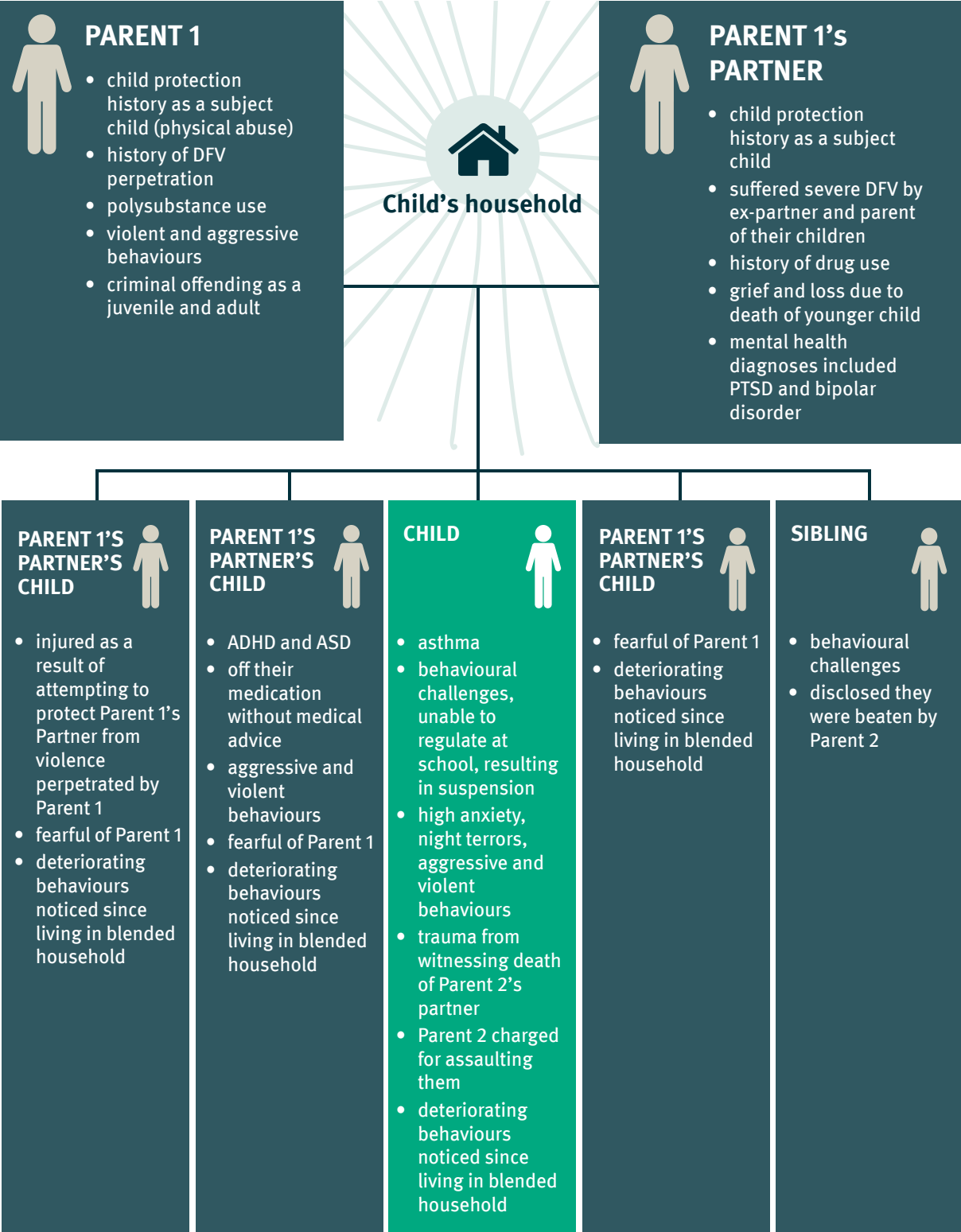


Figure 8: Child's Household

Paying careful attention to a child’s voice and behaviours – including what they are not saying – and assessing if there is presence of cumulative harm due to ongoing exposure to domestic and family violence requires significant skill and resourcing. Alertness to the controlling tactics a parent may use, be it against their own children, stepchildren, partner, ex-partner or extended family members, and indeed child protection staff, comprises an essential element of a holistic child safety assessment.

When a child is not talking, workers must reflect on what might be stopping them from engaging in a free narrative about their lives and home. What is it they are not saying and what do their behaviours suggest? Besides careful consideration of a child’s behaviours, it requires talking to extended family and other important people in their lives such as teachers, therapists or medical professionals who can provide collateral information and identify if the child’s behaviours have changed over time. The observations by teachers and school staff who often see children regularly are valuable for informing assessments about the impacts of coercive tactics as part of domestic and family violence, and the safety and wellbeing of a child more generally.

In several cases the Board reviewed, extended family and friends had voiced concerns about the parents’ situation and their capacity to care for the children, as had been asked of them in the safety and support plan. In response, parents had then been able to placate the system through disguised compliance. In one example, by agreeing to adhere to a safety plan with professionals while at the same time telling family members or friends, they had no intention to do so and were only telling workers what they thought they wanted to hear.

The Board has observed that professionals, family members and friends who raise concerns about the safety and wellbeing of children are often also willing to offer strategies for workable interventions and actively offer to help find an alternative solution.

System coercion by parents

The Board considered cases where parents had used tactics of parental deception to shape and control the dominant narrative, and to successfully downplay the concerns of the child protection system. In one case, this occurred despite evidence from Police and a teacher who had repeatedly witnessed the children’s fear responses and agitated behaviours. Instead, the child protection system focused on limited verbal disclosures by the children which created the illusion of an absence of concerns. Inadvertently, this may have contributed to the children’s invisibility: while superficial engagement and platitudes by parents were accepted at face-value, children often remained in environments of ongoing harm and unmitigated risk.

Parents who are skilled at deception often seek to preserve a closed family system and limit external responses, including offers of support. In this and in other cases, the Board found that children had complied with a parent’s coercive control tactics. For example, fear generated from a parent’s use of threats can prevent a child from making disclosures about their experiences or seeking help. In one case, a child, after being interviewed by officers, said they were worried about what they had disclosed and about their parent getting *mad*. Parental deception in the context of coercive control can prevent children and young people from getting the help they need early. As ACMS data shows, an experience of maltreatment is associated with a 2.8 times increase in the odds of developing one of four common mental disorders and an increase in health service use across life, including a 2.4 times higher chance of being admitted to hospital for a mental disorder.¹³³ Early and appropriately targeted support for children raised in physically or emotionally unsafe homes has the potential to positively change the mental health trajectory of a child. The system must ensure that children are not deprived of access to support by parental deception.

¹³³ Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, ‘The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report’, *Australian Child Maltreatment Study*, Queensland University of Technology. <https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/>

Deny, Attack, and Reverse Victim and Offender

DARVO, meaning “Deny, Attack, and Reverse Victim and Offender,” summarises a consistent reaction and manipulation tactic used by perpetrators of abuse or other types of wrongdoing. It works by shifting the focus away from the original issue and attacking the actual victim. It attempts to switch the roles of victim and perpetrator to allow the actual offender to receive sympathy and compassion, publicly or privately, as well as to avoid consequences for their actions.

The formalised DARVO meaning was first introduced by a psychologist named Jennifer J. Freyd in the 1990s. Freyd worked to build an understanding of how and why those accused of abuse respond to these accusations. Individuals can use DARVO as a reaction, but entire institutions may employ the strategy as well. Elements of the process can be formally or informally integrated into corporate policy.

In DARVO, the abuser will deny, minimise, and justify their actions and use a process shown to sway personal and public opinion quickly. The use of these manipulation techniques can happen so subtly that many people will miss the warning signs. Instead, they will fall into the pattern of manipulation where all evidence is criticised. An abuser may use DARVO in the following ways:

1. Deny

The first step of the process is for the abuser to deny whatever wrongdoing they are accused of. They will completely refuse that any element of the abuse happened in the way they are accused. They will remain steadfast in their assertion. Depending on the abuse in question, an abuser might say these things:

- “This situation never happened.”
- “I never did that.”
- “This is a lie.”
- “I’m a good person who couldn’t engage in this kind of behaviour.”
- “I’m a friend to women, and people know this isn’t me.”

At this point, the denial is clear and simple.

2. Attack

Once the denial is established, the accused goes on the offensive. Here, the abuser does everything in their power to attack the other person. One way to achieve this is by questioning their motivation, mental health, and stability, attacking their intelligence, honesty, and morality, and attacking their actions (past and present). The abuser could attack the victim in countless ways by saying:

- “You’re crazy.”
- “You’re a psycho.”
- “You’re an alcoholic or a drug addict.”
- “You’ve made these claims before.”
- “You asked for this/wanted me to do it.”
- “You never said ‘no.’”

The victim will never be treated with respect or value. They will be demeaned and disparaged.

3. Reverse Victim & Offender

At this point, the perpetrator will attempt to switch roles with the victim. Rather than accepting responsibility for their actions, they aim to make the original victim into the perpetrator. This reversal is done in many ways depending on the situation and accusation. At times, the attempt seems to lack outward validity and rationality, but that part seems unimportant. Many aspects of DARVO rely on feelings more than facts.

Ultimately, frontline workers can find themselves entangled in the perpetrator’s manipulation if they are not skilled and experienced in identifying the signs of coercive and controlling behaviours.

While at times applying deception and disguised compliance, parents who use coercive control in their personal relationships can be equally intimidating, avoidant, controlling, aggressive and potentially violent towards frontline child protection practitioners, health professionals, police officers, teachers, and support workers. For example, records describe a parent as *aggressive, antagonistic, immediately uncooperative, unwilling to provide information, very hostile, and trying to goad police into a fight.*

Coercive control can involve repeated attempts to threaten and intimidate and, more insidiously, it can involve manipulation and gaslighting.¹³⁴ The Board has observed parents using agencies' complaint mechanisms, family court and custody processes to exert control over the narrative and by extension, an ex-partner and co-parent. Frontline child protection practitioners can feel significantly challenged, vulnerable and fearful for their own safety when attempting to engage parents who use tactics of coercive control as part of domestic and family violence. This can impact workers' ability to confidently assess the safety and wellbeing of a child. The Board noted in one case that a family support service had closed a referral because the workers feared for their safety when attempting to engage Father, who was a single parent of several children. As a result, the children did

not receive the support they likely needed to experience increased safety in the home.

The system holds a responsibility to ensure that frontline child protection staff are regularly upskilled, appropriately resourced, safe within their locations where they are required to work, and supported to respond to the challenging and controlling behaviours that people who have perpetrated domestic and family violence may exhibit. Therefore, worker safety must be prioritised and addressed.

System responses unintentionally enabling coercive control by the offending parent

The Board noted the system at times unintentionally enabled parents to maintain control of the family through coercive practices that could include deception and disguised compliance. This resulted in less attention on children's behaviours and voices, and in particular, when the children seemed guarded and reluctant to talk freely about their families and their lives together.

Child and their sibling's stories

The Board reviewed a case in which two children and their mother were at high-risk of serious harm or lethality from the father's violence. There had been multiple physical assaults, emotional and verbal abuse, non-lethal strangulation, threats to kill the mother and the children if she left, isolation from others, financial abuse, and deprivation of liberty by barricading/locking mother and the children in rooms. Mother had a Police Protection Notice and Domestic Violence Order, the child's paternal grandmother had a Police Protection Notice and the maternal grandfather had an Apprehended Violence Order (NSW). Despite displaying such extreme violence, the father was able to deceive the system and as a result was assessed as the 'safer' parent. For example:

- Following a short period of time living in their mother's care, the children started living with their grandparents, in the same household as father. The family's living arrangements (supported throughout Child Safety's involvement) and no contact conditions under the Domestic Violence Order (DVO) which prevented the father from approaching the mother now restricted the mother from regularly seeing the children. This disempowered the mother and reinforced the father's control.
- The father kept reporting that the mother had intellectual impairments and mental health diagnoses, creating a narrative of her diminished parenting capacity; however, health professionals had advised there were no diagnoses and that her issues likely stemmed from the impact of the father's abuse. Despite their advice, the father's perspective was prioritised throughout child protection records and impacted the children's opportunities to be with their mother.

A visualisation to the timeline of service delivery to Child and their sibling can be found at Figure 9.

¹³⁴ Hill, J 2020, *See what you made me do: The dangers of domestic abuse that we ignore, explain away or refuse to see*, Sourcebooks.

A responsibility exists to ensure that interactions with parents and families do not unintentionally enable and allow deceptive and controlling patterns of behaviour to continue.

The Queensland Government has acknowledged the need to address coercive control as part of recent initiatives to reduce rates of domestic and family violence in Queensland:

- In December 2021, The Women’s Safety and Justice Taskforce released their first report *Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland*. Eighty-nine recommendations were made in the report, including a recommendation to criminalise coercive control. The Queensland Government supported the recommendations in principle and since then, legislative reforms have been introduced into Parliament to address coercive control. The Board acknowledges that this needs to be reflected in the practice guidance child protection practitioners regularly access.
- The *Domestic and family violence common risk and safety framework (CRASF)* has been designed for government and non-government agencies to enhance the safety of Queenslanders. It seeks to support the self-determination of those who have experienced domestic and family violence and acknowledges that subjection to coercive control can impact the self-confidence and self-determination of victim-survivors. The CRASF was revised in 2021 to include coercive control factors in its risk assessment and safety planning tools. This framework provides a foundation that can enable frontline practitioners to identify and respond to parental deception.

Concluding comments

Domestic and family violence continues to be one of the most significant challenges that children and families experience. The Board has noted cases where parents were able to extend their power and control to the very system designed to try and protect their children and support their families. Despite system involvement, often they continued to maintain closed family systems, where their children were left invisible and exposed to environments of violence, abuse, and neglect. Even where parents did accept offers of support, the Board noted ongoing issues with workforce capacity, including a lack of timely access to behaviour change programs and suitable domestic and family violence accommodation options. Individual review agencies continue to note opportunities to strengthen domestic and family violence informed practice in the workforce. The Department of Child Safety, Seniors and Disability Services confirmed that it has engaged Social Care Solutions to deliver a state-wide forum in November 2023 in relation to decision making in practice (with links to issues relating to cognitive bias, halo effect, confirmation bias, difficult conversations, noise impacting decision making and disguised compliance). The forum will also provide participants with a session in relation to domestic and family violence practice and mental health, with a focus on parental deception and the use of systems in coercion and control.

Ongoing reform work must continue to focus on building the capacity of the system to respond collectively and collaboratively to the varied needs of children and families experiencing domestic and family violence. This includes efforts towards upskilling and resourcing staff and supporting individual worker safety.

Recommendation 6

Assisting workers to recognise and respond to parental deception

The Queensland Government invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence (the frontline practitioners involved should include child protection, health services, education, law enforcement, courts staff and secondary services).

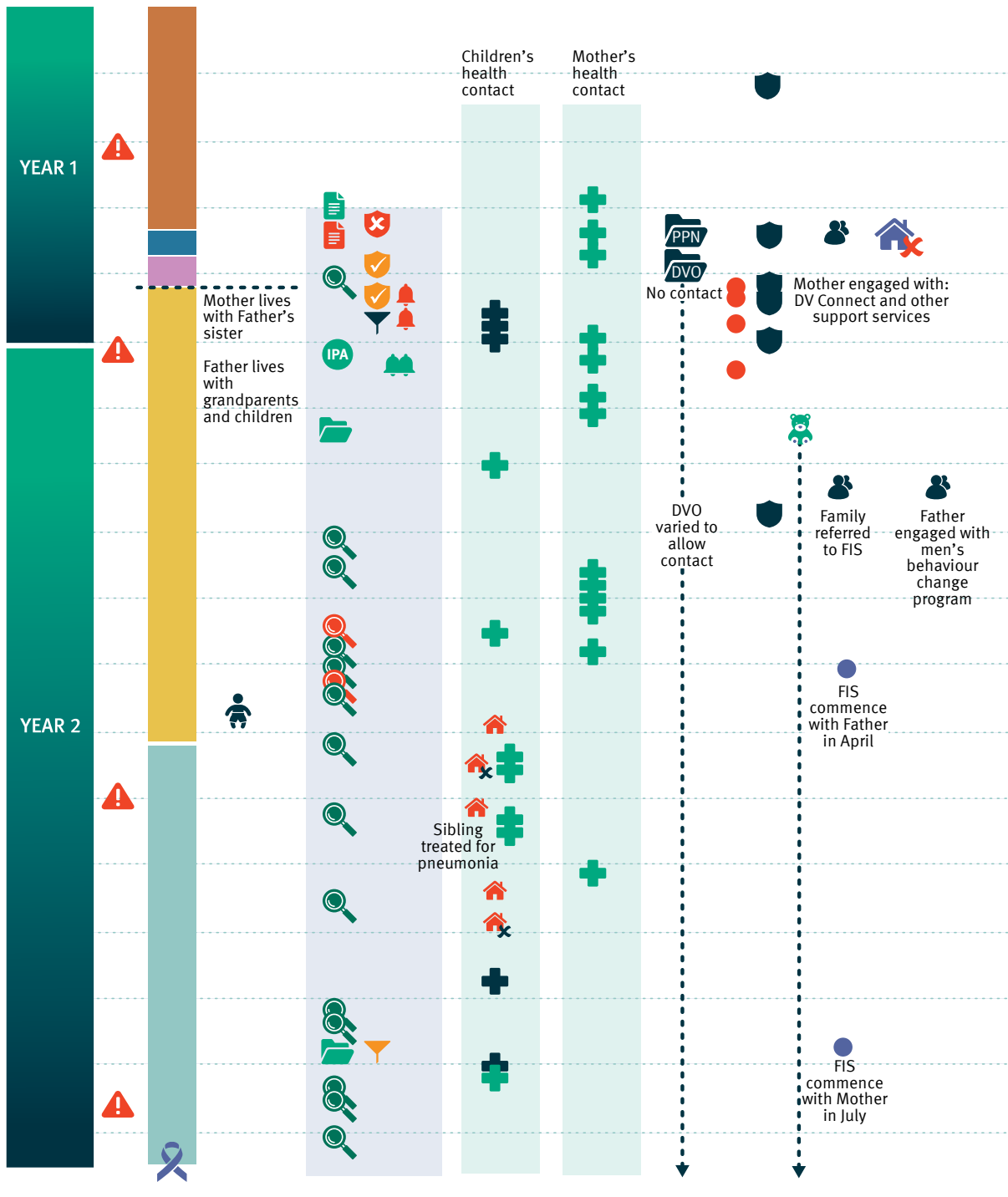







Figure 9: Timeline of service delivery to Child and their sibling

	Notification	
	Temporary orders granted	
	Intervention with parental agreement	
	Case plan developed	
	Home visit successful / unsuccessful	
	Family discussed at High Risk Team meeting	
	Children attend day care	
	Mother expresses self-harm or suicidal behaviours	
	Risk evaluations: moderate / high	
	Drug screen: meth / cannabis negative	
	Family Intervention Service (FIS) activity	
	Police response / contact	
	Safety Assessment: Safe with plan / Unsafe	
	Police-logged protection order	
	Health home visit: Family declines follow-up	
	Health appointment / ED presentation	
	- engaged	
	- does not engage	
	Service engagement	
	Mother secures short-term accommodation at shelter	
	Sibling born	

CHILDREN'S LIVING ARRANGEMENTS

	Both parents
	Foster care
	Mother
	Father and grandparents
	Both parents and grandparents

Chapter 7

Monitoring recommendations

Monitoring recommendations

The Board monitors the actions taken in response to the recommendations it has made in the previous years. This chapter reports on the 16 recommendations made by the Board.

The Board made six recommendations in 2021–22. These were tabled in Parliament in the *Child Death Review Board Annual Report 2021–22*, on 8 December 2022. The Government provided its response on 9 August 2023.

In its response, the Queensland Government “commends the valuable work of the Board” and acknowledges “that it is the collective responsibility of more than one government department to promote the safety, wellbeing and best interests of children and young people”.¹³⁵

Five recommendations were supported or supported in principle. *Recommendation 3. Continuity of care for children with complex needs* was designated for “further consideration”.

The Board made ten recommendations in 2020–21. These were tabled in Parliament in the *Child Death Review Board Annual Report 2020–21*, on 17 February 2022. The government response tabled on the same day accepted or accepted-in-principle all ten recommendations.

Copies of the two previous the Board annual reports and respective government responses are available from <https://www.cdrb.qld.gov.au/reports-and-publications/>.

As part of the Board’s monitoring functions, the Chair wrote to the Chief Executives of agencies on 1 September 2023 requesting an update on the implementation of any recommendation on which they were identified as lead agency. The relevant agency responses largely pertain to how they intend to implement the recommendations, rather than provide a progress update. The Board intends to seek further implementation update in mid-2024 for inclusion in *Child Death Review Board Annual Report 2023-24*.

The Board is pleased to report that eight of the ten recommendations from the Annual Report 2020–21 have now been completed. One (recommendation 5) is in progress, and one (recommendation 10) has been closed without implementation. For the Annual Report 2021–22, one of the six recommendations (Recommendation 4) has been marked as ‘complete’. All other recommendations from the Annual Report 2021–22 remain ‘in progress’.

¹³⁵ Queensland Government 2023, *Government Response to the Child Death Review Board 2021–22 Annual Report*, 3.

Annual Report 2021–22 recommendations

In 2022–23, the Queensland Government provided a response to the six Recommendations tabled in the Board's 2021–22 Annual Report. Full versions of the *CDRB 2021–22 Annual Report* and government response are available from <https://www.cdrb.qld.gov.au/reports-and-publications/>.

Workforce reform to ensure service accessibility and delivery (Recommendation 1: 2021–22)



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

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

Status: In progress

Government response

The Queensland Government supported this recommendation in principle, noting the significant role the non-government sector plays regarding the human services workforce, alongside government. It stated that it would consider how best to give effect to the intent of Recommendation 1 particularly in relation to recognising the overlap and competition that exists between departmental portfolios, and establish ways to help children, families and carers receive quality support. This will be considered in the context of the current industrial relations framework set out in the *Industrial Relations Act 2016*, which promotes collective bargaining as the primary mechanism for setting wages and conditions; and noting there is already a level of wage parity that exists among a number of Queensland Government agencies.

The Queensland Government acknowledged the significant workforce issues impacting the human services sector across the country. It pointed to *Good People. Good Jobs Queensland Workforce Strategy 2022–32* as the first whole-of-government workforce strategy produced by the Queensland Government. The Strategy identifies the workforce pressures faced by Queensland and will be delivered through three, multi-year action plans. The Queensland Workforce Strategy highlights the shared responsibility between all levels of government, employers, industry, individuals, education and training providers and communities.

The Queensland Government reported that at a national level, the Community Services Ministers are working collaboratively to address the workforce pressures facing child protection and family support systems across the country through the delivery of *Safe & Supported: the National Framework for protecting Australia's children 2021–2031* (Safe & Supported), and implementation of the associated Action Plans. The First Action plan includes work to develop a national approach or strategy for a sustainable and skilled children and families services workforce.

The Board's observations

When the Board approached Government for an update on the actions in September 2023, we received individual agency workforce actions – which although necessary and important – are counter to these recommendations' explicit focus that Government must work holistically to address workforce shortages. While it is evident that leading agencies Youth Justice and Child Safety have reflected on how they can reform their internal workforces, the intent of Recommendation 1 was to inspire a whole-of-government response to workforce challenges. The Board hopes future implementation updates addresses the need for workforce reform at the State and National level. Recommendation 1 will remain 'in progress' at this time.

Workforce reform to ensure service accessibility and delivery (Recommendation 2: 2021–22)



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

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

Status: In progress

Government response

The Queensland Government supported Recommendation 2 recognising the importance of local community and culturally safe responses in building a strong human services workforce to ensure service accessibility and delivery. It stated that for Aboriginal and Torres Strait Islander communities, this requires working in partnership with First Nations peoples and organisations to design and deliver services that meet identified needs and priorities.

Key initiatives currently supporting the intent of this recommendation include:

- Local Decision Making Bodies (LDMBs) are being established by DTATSIPCA as part of the Local Thriving Communities reform with the aim of empowering First Nations communities to influence and co-design how services are delivered to communities. Engagement with LDMBs across Queensland will inform development of regional and remote workforce strategies.
- As a key action under the Queensland Government's *Workforce Strategy 2022–32* (noted above), the Queensland Government is implementing *Paving the Way – First Nations Training Strategy* and is supporting the development of Queensland's Aboriginal and Torres Strait Islander workforce and improving job outcomes through training and skills development.
- DCSSDS is implementing *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families 2017–37*. Principle 2 of *Our Way* is 'ensuring that Aboriginal and Torres Strait Islander peoples and organisations participate in and have control over decisions that affect their children, and includes building the capacity of community-controlled organisations; facilitating the participation of Aboriginal and Torres Strait Islander families and children in decisions; delegating one or more statutory child protection functions or decisions in relation to an Aboriginal or Torres Strait Islander child to the Chief Executive Officer of an Aboriginal or Torres Strait Islander entity when certain requirements are met; and recognising the role of Aboriginal and Torres Strait Islander communities to drive local solutions to local issues.
- The Queensland Government has committed to ensuring that Aboriginal and Torres Strait Islander children, young people or families can access their supports through an Aboriginal and Torres Strait Islander community-controlled organisation (ATSICCO) if they wish to do so. There is a 10-year timeframe for transitioning investment to that sector to enable this to occur. The Department will work closely with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), regions, Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCOs) and mainstream providers to plan and execute the transition of investment. This includes collaboration with QATSICPP to develop a workforce strategy for the ATSICCO sector.
- The Queensland Government is also developing a new, whole-of-government First Nations Economic Strategy, planned to be released in 2023–24, to support economic participation and self-empowerment for Aboriginal and Torres Strait Islander Queenslanders. The strategy will link with workforce, skills and training strategies and identify emerging opportunities, working in co-design with a First Nations Economic Committee, to support workforce development across the state, including at a regional and community level.

The Board's observations

The Board welcomes the actions being taken and would like to see how these specific efforts address workforce shortages in regional and remote communities of Queensland. The Board encourages further investigation into the repurposing of unspent funding for long-term vacant positions to place-based service design as part of the *First Nations Economic Strategy*, planned to be released in 2023–24.

Recommendation 2 remains 'in progress' reflecting that the Board will continue monitoring efforts towards achieving a culturally safe, local workforce available to all children and families living in regional and remote Queensland.

Continuity of care for children with complex needs (Recommendation 3: 2021–22)



The Board recommended that the Queensland Government develops a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours that recognises that multiple government departments come into contact with these young people, and there is no single responsible owner for the assessment and response required to address the complex needs. The model should:

3.1 Be informed by a study of child death, serious injury or other relevant cases where the children were identified to have complex needs manifesting in high-risk behaviours to establish:

- commonalities with their trajectory into tertiary systems
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model.

3.2 Include an early intervention stream that provides a pathway for professionals working closely with children and families, such as schools, to trigger a case management response. The response should focus on:

- addressing the social, emotional, cultural and health and wellbeing needs of children and their families which contribute to their behaviours
- supporting the child's family and carers for the continuation of positive family functioning, behavioural guidance and treatment at home
- coordinating health-based assessments and treatments
- working with the child's school to ensure the child is engaged in education; and
- providing access to informal and formal respite for children and families.

3.3 Include a tertiary stream that provides a specialised accommodation service for children that meets the underlying causes of high-risk behaviours that are a danger to themselves or others that is:

- underpinned by a culturally appropriate case management response addressing the social, emotional, health and wellbeing issues of children and their families contributing to the behaviours
- authorised by a clear and appropriate legal framework that clarifies if, when and how restrictive practices can be used, and how the system will be monitored with effective oversight to ensure decisions and actions are in the best interests of the young person; and
- integrates ongoing access for the child to family, culture and education.

Status: In progress

Government response

The Queensland Government designated Recommendation 3 as *for further consideration*. It recognised that children with high-risk behaviours require specialised support, together with the importance of early interventions to support the social, emotional, health and wellbeing needs of children, young people and their families before their behaviours escalate or reach a crisis point.

The Queensland Government stated that it provides a range of supports for children with complex needs who are engaging in high-risk behaviours through the health, education, child protection, and youth justice systems and that a number of initiatives are currently underway to improve the responses to children and young people with complex needs, including from a continuum of care perspective, and that it recognises that more can be done.

The Queensland Government outlined a strong interest in working with the Queensland Family and Child Commission and Child Death Review Board to further explore this recommendation over the next 12 months, with a particular focus on:

- better understanding the trajectories of children and young people
- providing for more coordinated and integrated responses
- considering which targeted early interventions could best support children, young people and their families.

Child Safety continues to utilise Intensive Family Support (IFS) services for case management of children who are at risk of entering the child protection system or families with complex support needs. Some IFS providers are trialling two evidence-based models: Functional Family Therapy-Child Welfare and Functional Family Therapy-Case Management. Three trial sites are demonstrating positive outcomes for families with complex needs that require a therapeutic response to address multiple challenges within family relationships. IFS providers also participate in Local Level Alliances to bring together agencies working with vulnerable families and identify gaps in support services within local communities.

Government is currently reviewing the authorisation framework for the use of restrictive practices with NDIS participants under the *Disability Services Act 2006* (Qld), including the potential expansion of that framework to include the use of restrictive practices with NDIS participants who are children. A key aim of the framework is limiting the use of restrictive practices to circumstances where it is necessary to protect a person from harm. It is expected that the NDIS Review and the Disability Royal Commission will produce recommendations of relevance to working with children with complex needs. Child Safety will work with Queensland Government Agencies as required once the final reports are released.

Child Safety is also working with Youth Justice and other responsible agencies to consider opportunities to improve supports for children with disability who are at risk of intersecting with the youth justice system.

The Board's observations

The Board acknowledges the Queensland Government's concerns about restrictive practices and shares Child Safety's value in safeguarding the rights of people with disabilities, including children, by limiting the use of restrictive practices.

The Board would like to see insight that children may be exhibiting complex needs for reasons other than a disability or mental health concern. Evidence suggests trauma, maltreatment and other adverse childhood experiences are significant contributing factors in the manifestation of high-risk behaviours. These children are often ineligible for NDIS support and need alternative support mechanisms to help keep them, their families, and their communities safe.

The Board is committed to working with the QFCC and the Queensland Government to improve support for children with complex needs. As such, Recommendation 3 remains 'in progress' at this time.

Responding to domestic and family violence (Recommendation 4 2021–22)



The Board recognises there is significant reform occurring in the area of domestic and family violence. *The Board recommended* that within this reform, the Queensland Government include a focus on:

- children as specific victims of domestic and family violence in their own right
- culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence
- the role of fathers and fathering, as promising points for behaviour change intervention.

Status: Complete

Government response

The Queensland Government supported this recommendation noting there is significant reform being undertaken to improve responses to domestic and family violence.

The Department of Justice and Attorney-General (DJAG), as the agency leading the implementation of Recommendation 4, has completed the following actions:

- Improving service system responses through the revised *Domestic and Family Violence Common Risk and Safety Framework*, which recognises children as victims of domestic and family violence in their own right.
- Enhancing High Risk Teams to improve the safety of victim-survivors at high risk of harm of domestic and family violence, including funding for six new Victim Assist Queensland roles.
- *The Domestic and Family Violence Protection (Combatting Coercive Control) and Other Legislation Amendment Act 2023* commenced on 1 August 2023. Among changes to support adult victims, the *Youth Justice Act 1992* has been amended to provide a mitigating factor for child offenders who are victims of domestic violence or have been exposed to domestic and family violence.
- In 2022–23, \$6.6 million was provided to 24 organisations for counselling children impacted by domestic and family violence. This funding will increase to \$7.7 million in 2023–24.
- Administrating \$4.355 million over 2020–25 for the Legal Aid Queensland Youth Legal Advice Hotline and \$6.225 million over 2020–25 for the Legal Aid Queensland and Aboriginal and Torres Strait Islander Legal Service Youth Justice Legal Advocacy Program to deliver free youth specific legal assistance.
- From 1 July 2023, staged trials of specialist perpetrator intervention programs have commenced roll out, including a second youth perpetrator intervention program and programs designed for Aboriginal and Torres Strait Islander people.
- From 2023–24, \$2.4 million per annum will be allocated to Men’s Support Services to provide culturally appropriate support to Aboriginal and Torres Strait Islander men to address concerns related to the use of violence.

DJAG has several additional activities underway including establishing three new High-Risk Teams in Townsville, Redlands and Rockhampton. The new teams will have a First Nations Cultural Advisor embedded in each. A standalone Domestic and Family Violence Perpetrator Strategy is currently being developed – the whole of government strategy will be the first of its kind in Australia. DJAG also intends to facilitate a community-led project to design and pilot a perpetrator intervention program specifically tailored to meet the needs of Aboriginal and Torres Strait Islander peoples through an embedding healing approach.

The Board’s observations

The Board acknowledges the Queensland Government’s actions to improving domestic and family violence responses and the multi-faceted approaches taken to date. The Board welcomes the support of co-designed, community-based, culturally safe prevention and intervention programs. The delivery of the *Domestic and Family Violence Common Risk and Safety Framework* and supported prevention and intervention programs is ongoing. The Board looks forward to following their success, particularly for where they result in benefits for children and families.

The Board records Recommendation 4 as ‘complete’ on the basis that focus has been given to the issues raised to the extent possible within the reforms to date.

Ongoing improvements in Queensland’s response to, and prevention of, Domestic and Family Violence will continue to be an area considered by the Board.

Promoting the safety of infants and unborn children (Recommendation 5: 2021–22)



The Board recommended that the Queensland Government:

- extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to:
 - supporting and monitoring the wellbeing and development of an infant within the family home; and
 - addressing families’ health and psychosocial needs and wellbeing as they arise.
- implements or expands initiatives to create safer sleep environments for all priority Queensland populations by:
 - supplementing home visiting with tiered support strategies using the family’s existing resources
 - upscaling multimodal safe sleeping programs to provide an acceptable, feasible, safe, and culturally appropriate initiative for families
 - implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.

Status: In progress

Government response

The Queensland Government supported Recommendation 5 in principle noting the alignment with the existing *First 2000 Days* program. It reported that as of August 2023, there are two Hospital and Health Services that have been funded to execute a home visiting program. These programs demonstrated increased parental capacity to support their child’s early development. It also confirmed that two safe sleeping initiatives (Connecting2U and Pepi-pod) have been trialled and further roll-out is being considered.

Since accepting Recommendation 5 in principle, Queensland Health has begun considering activities in response to the recommendation as part of the *First 2000 Days* program. The *First 2000 Days* program of work includes the extension of health home visiting programs and the promotion of safer sleeping initiatives.

The Board’s observations

The Board welcomes the extension of health home visiting programs and the implementation of two safe sleeping initiatives trials.

The Board notes that Queensland Health has begun consideration of the recommendation and expects the outcomes of this consideration in the 2023–24 financial year.

Recommendation 5 remains ‘in progress’.

Promoting the safety of children with disability (Recommendation 6: 2021–22)



The Board recommended that the Queensland Government engages with the Commonwealth Government to improve access for vulnerable children and families to the NDIS by:

- demonstrating the cost benefit of establishing state-based positions across Queensland to help vulnerable children and parents with disability access the NDIS system and receive services – these positions need to be based in universal or secondary services with which children and parents engage
- improving the mechanisms by which children and parents with complex needs can enter and access the NDIS – including consideration of an appropriate agreement that allows prescribed state professionals to refer children and parents to the NDIS on their behalf.

The Board expects the outcomes of the engagement to be reported back to it by August 2023.

Status: In progress

Government response

The Queensland Government supported Recommendation 6 in principle, noting that:

- supporting access to the NDIS is primarily the responsibility of the Commonwealth Government
- implementation of the recommendation is reliant on working with the Commonwealth Government on access to a national program
- there is a strong likelihood of significant recommendations of relevance arising from the Independent Review of the NDIS, which is due to report in October 2023 and that therefore a report back to the Board by August 2023 will not be able to be achieved
- the Queensland Government has already committed funding to the Assessment and Referral Team (ART) Program, which continues to support at risk children and young people to access the NDIS, as well as building the capability of Queensland Government agencies to navigate the NDIS access pathway more effectively.

The Government confirmed that it continues to work with the Commonwealth Government and other NDIS governing partners to improve NDIS access and to advocate for simpler and more effective access processes that ensure vulnerable and complex cohorts can access the NDIS and receive the supports they need. It stated that the Independent Review of the NDIS is currently underway, and that DCSSDS has a role in supporting Queensland Government engagement with the Commonwealth Government through the Disability Reform Ministerial Council and the NDIS Executive Steering Committee to improve access for vulnerable children and families to the NDIS. This advocacy will continue and is a key priority for Queensland, including during the NDIS Review.

Government outlined how as part of the 2023–24 Queensland Budget, government invested a total of \$16.2 million over four years and \$2 million per annum ongoing to:

- support at-risk-children and young people to access the NDIS until December 2024
- establish and maintain a specialist disability assessment team to support people with complex needs navigating multiple mainstream services systems to access NDIS services from January 2025.

The Board's observations

The Board has noted the Queensland Government's ongoing advocacy for the Commonwealth Government to create simpler and more effective access processes.

The Board specifically notes that the funding announced by Government is necessary to ensure Queensland children can access the NDIS but that this funding is time limited. Keeping track of this expenditure, and the NDIS plans created for young people during this time, would constitute the cost-benefit/return-on-investment assessment called for in the Board's recommendation.

The Board agrees that the outcomes of the Independent Review of the NDIS is likely to shape how the Queensland Government might best support vulnerable children and their families, and strong Queensland advocacy in relation to the improving the mechanisms by which children and parents with complex needs can enter and access the NDIS would meet the Board's recommendation.

Recommendation 6 will remain 'in progress' at this time.

Annual Report 2020–21 recommendations

In 2021–22, the Queensland Government provided a response to the ten recommendations tabled in the Board’s 2020–21 Annual Report. Full versions of the 2020–21 Annual Report and government response are available from <https://www.cdrb.qld.gov.au/reports-and-publications/>.

2020–21 Recommendation 1:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs¹³⁶ strengthens its model of funded secondary services. This is to:

1.1 determine whether the model meets the needs of referred children and families by reviewing the:

- efficacy of services in terms of improving outcomes for children and families and diverting them away from needing Child Safety intervention
- equity of access for the families who are intended to benefit from these services.

To do this, the perspectives of children, families and communities should be gathered and used to inform findings. For example, in implementing Recommendations 1 and 2 of the Queensland Audit Office’s report, this can be done by speaking with communities and Aboriginal and Torres Strait Islander peoples to identify barriers and enablers to equitable access and active efforts (such as cultural safety and practical supports) to help families to participate.

Findings from the agency’s evaluations of these services and the Queensland Family and Child Commission’s evaluations of the reform program could also inform this work.

The Board also recommends: The Department of Children, Youth Justice and Multicultural Affairs strengthens its model of funded secondary services and:

1.2 develops and implements best practice and culturally responsive strategies to improve outcomes for children and families

1.3 supports and strengthens referral and reporting pathways for professional and mandatory notifiers by:

- developing guidance for relevant agencies and services about responding to concerns for a child if a referred family is not successfully engaged by these services
- requiring a referrer from a mandatory reporting agency to be advised by these services of case closure because of a family’s non-engagement.

Status: Complete

Government response

The Queensland Government accepted Recommendation 1.1 and 1.2. A review of secondary services was regarded as timely, particularly the delivery of services for Aboriginal and Torres Strait Islander Queenslanders. The Queensland Government noted that delivery of Recommendation 1.2 would be guided by *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families*.

Recommendation 1.3 was accepted in principle, noting that at the time, Child Safety was reviewing how it might respond to reported concerns about children through its intake processes. This included working with mandatory notifiers.

In the Board’s 2021–22 Annual Report, Child Safety reported:

- Intensive Family Support (IFS) services had transitioned to an outcomes-focused performance framework on 1 July 2022, which included evaluation of consent rates and achievement of family case plan goals.
- The Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS) program was subject to an evaluation, completed in December 2021.
- Continued monitoring and reporting of the proportion of families who receive support from IFS and FWS services who subsequently become the subject of an investigation by Child Safety.

¹³⁶ The then Department of Children, Youth Justice and Multicultural Affairs is now the Department of Child Safety, Seniors and Disability Services. This report refers to child safety function as ‘Child Safety’ throughout, irrespective of the current department name.

- Funds had been identified to implement a workforce development strategy for the Aboriginal community-controlled organisation sector. This includes reform of workforce profiles of service providers to reflect the communities they serve.
- Child Safety, through Family Matters Queensland, was continuing to implement *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037 (Our Way)* to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system.
- Expansion of the email feedback mechanism regarding family engagement to both IFS and Family and Child Connect (FaCC) services to Queensland Health and Department of Education referrals.
- A review of the services available to refer families subject to intake reports to ensure that families have access to early intervention.

2022–23 Actions and agency response

In 2022–23, Child Safety reported new data against the outcomes-focused performance framework for IFS. While the target had been set to 40%, the data report stated that 50.4% of eligible families are closing cases following intervention with an IFS with all or the majority of their case plan goals marked as “achieved”. This figure is similar for both First Nations families (50.7%) and non-Indigenous families (50.3%). Voluntary engagement with an IFS has also improved, with 71.3% of eligible families agreeing to engage. A higher percentage of First Nations families (75.7%) agreed to engage with an IFS service than non-Indigenous families (69.9%).

Child Safety continued to partner with Family Matters Queensland to deliver *Our Way* and address the over-representation of Aboriginal and Torres Strait Islander families in the child protection system. One action implemented throughout the last year is delegated authority: one or more functions or powers in regard to an Aboriginal or Torres Strait Islander child that had been the delegation of the chief executive (Child Safety) under the *Child Protection Act 1999* is now transferred to a Chief Executive Officer (CEO) of an Aboriginal or Torres Strait Islander entity. The second implementation phase of *Our Way*, which is called *Breaking Cycles (2023–2031)*, has commenced. This whole-of-government action plan was co-designed with key First Nations entities, including the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) and aligns with key government commitments including *Closing the Gap*, *Path to Treaty* and *Local Thriving Communities*. Guided by the *Our Way Strategy* and the Aboriginal and Torres Strait Islander Child Placement Principle, organisations have been supported to develop Cultural Practice Frameworks and to trial and implement the Family Matters Reflective Practice Toolkit.

(1.3) FaCC and IFS models are being updated to require services to report back to professional reporters on whether families have engaged or not following a referral to their service, to ensure information sharing and determine the need for any further responses. This is similar to the way that secondary services report this information back to Child Safety.

The Board’s observations

Child Safety has transitioned to outcomes-focused evaluation of its funded secondary services. Results from this initial year of monitoring appears positive, especially in regard to equity of access. The Board records Recommendation 1.1 as ‘complete’.

Work towards completion of Recommendation 1.2 included efforts made towards participation and partnership by engaging First Nations peak bodies and secondary service providers. Noting Child Safety’s ongoing commitment to continuous improvement for best practice and culturally responsive strategies to improve outcomes for children and families, the Board records Recommendation 1.2 as ‘complete’.

The new requirement to report engagement outcomes back to professional notifiers is expected to fulfill Recommendation 1.3. The Board records Recommendation 1.3 as ‘complete’ pending the implementation of the new referral requirements.

2020–21 Recommendation 2:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs improves its ability to undertake effective child protection history reviews at intake to support decisions about whether a child is suspected to be in need of protection. This must include strengthened intake processes to make sure staff are able to give proper consideration to:

- complex or lengthy child protection histories (information about a family recorded on the data system)
- indicators of cumulative harm (refer Recommendation 3), particularly when frequent child concern reports are recorded
- patterns of parental behaviour (acts or omissions– refer Recommendations 3 and 4)
- cultural factors.

To support this, Child Safety’s *Workload Management Manual* should include guidance on reasonable workloads for intake.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that Child Safety was reviewing its intake processes, particularly different ways of reviewing previously recorded information about the child or family. In 2021–22, Child Safety reported it had undertaken a Multiple Event Review trial where a third consecutive intake received within 12-months would prompt four additional questions to aid an officer’s decision making. Staff reported a positive impact on their ability to understand the cumulative impacts of child protection history, and improved confidence and capabilities in risk assessment. Child Safety were seeking to further embed Multiple Event Review questions and improve visibility of child protection histories in the new IT system (known as Unify) under development. The mandatory training on intake processes for new Child Safety Officers was reported to be under review.

2022–23 Actions and agency response

In 2022–23, Child Safety has continued to develop guidance to support risk assessment decision making at intake. This guidance will be available to staff at the time of the Unify system launch in mid-2024. Once implemented, Unify will also present a child’s departmental history in a timeline formation to assist staff in identifying cumulative harm. The review of mandatory training for the Child Safety Officer (CSO) role has also been completed. Formerly two-weeks long, the training is now three-weeks in duration and includes four days dedicated to assessing risk and safety. Non-mandatory training on cumulative harm continues to be available and delivered across the State.

The Board’s observations

The Board acknowledges the multifaceted approach Child Safety has taken to strengthen its practitioners’ ability to undertake effective child protection history reviews at intake. This includes the opportunity to engage in a more nuanced consideration of cumulative harm in the context of multiple intake events, via the guidance provided through four targeted additional questions. Furthermore, Child Safety’s approach has incorporated an extension of the mandatory training for CSO’s with a strong focus on assessing risk and safety and made available ongoing professional development. The incorporation of visual timelines to illustrate child protection histories has capitalised on technological solutions.

The Board considered that Child Safety has taken sufficient action in response to Recommendation 2 and will consider the recommendation ‘complete’ noting the launch of Unify in 2024.

2020–21 Recommendation 3:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs develops additional guidance for assessing cumulative harm. This is intended to:

- assist staff to decide whether a notification should be recorded on the basis of cumulative harm
- make sure screening and response priority decision-making tools adequately reference indicators of cumulative harm
- be used in developing information technology platforms.

This work should take into account the reviews by Child Safety and interstate jurisdictions on decision tools and cumulative harm. Any updates to decision tools must take into account intergenerational trauma for Aboriginal and Torres Strait Islander families as a result of past policies and the legacy of colonisation.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that Child Safety had delivered additional training to staff about assessing cumulative harm and were exploring new approaches to reviewing multiple reports of concern during the intake process. In 2021–22, Child Safety revised practice and guidance training resources following an internal review paper on cumulative harm. Risk assessment guidance for staff had been updated in mid-2022 and included strengthened content on cumulative harm. This was in the context of the discontinuation of the Structured Decision-Making tools to allow staff greater application of their expertise and interpretation of a child's history in their risk assessment decision making. Several training products had also been updated to improve practitioner knowledge and identification of cumulative harm.

2022–23 Actions and agency response

In 2022–23, Child Safety has increased mandatory and non-mandatory cumulative harm training for staff and incorporated visual depictions of child protection histories into its forthcoming IT system, Unify, which aims to illustrate and make more visible cumulative impacts of harm on children, young people and their families. In addition, Unify will generate a prompt if a third (or more) intake event has been generated for a child or young person within 12 months. This functionality seeks to prompt practitioners to consider the impacts of cumulative harm on the child.

The Board's observations

The Board notes Child Safety's ongoing actions to improve the assessment of cumulative harm. The Board anticipates that the mandatory training Child Safety provides to staff on identifying and responding cumulative harm will help staff to will better assess and articulate harm, and unacceptable risk of, to children. The Board notes the design functions to improve risk assessment, particularly the identification of cumulative harm, being built into Unify.

The Board considers that Child Safety has improved its capability to identify and assess cumulative harm and will consider the recommendation 'complete' noting the launch of Unify in 2024.

2020–21 Recommendation 4:

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs builds the capability of Child Safety Officers on assessing whether a parent is ‘able and willing’, as it applies to making decisions about whether a parent can keep their child safe. This is to:

- build understanding about cultural differences in parenting, family structures and child-rearing practices
- promote consistency in its application across decision points at intake, during investigation and assessment, and for interventions with parental agreement
- address how to identify and respond to patterns of concerning parental behaviour (acts or omissions – that is, continuing to act in a way that harms a child, or not taking reasonable action to protect a child)
- address ongoing practice issues with failing to apply perpetrator pattern-centred domestic and family violence practice (including by misidentifying victims of violence as failing to protect their child)
- (separately to parents who actively avoid or disengage from services) strengthen assessments of, and responses to, parents who do not engage with services due to:
 - limited supply of, and timely access to, supports and services in regional and remote areas
 - (for Aboriginal and/or Torres Strait Islander families) a lack of cultural safety within services or lack of active efforts taken by services to help families overcome barriers to their participation
- recognise the importance of children’s views about the safety of their home environment and their parents’ willingness and ability to meet their needs.

The findings of the Board and the Queensland Family and Child Commission’s systemic review of intervention with parental agreements may be used to develop this training.

Status: Complete

Government response

The Queensland Government accepted this recommendation acknowledging the need to encourage consistent practice in assessing a parent as ‘able and willing’. The Queensland Government noted that Child Safety had commenced a review of its Child Safety Officer training. This largely related to risk assessment, particularly responding to specific risks posed by exposure to domestic and family violence. The review will also look at guidance on the Aboriginal and Torres Strait Islander Placement Principle to ensure cultural factors are considered during the risk assessment process.

In 2021–22, Child Safety reported the Child Safety Practice Manual had been updated to include greater guidance regarding the assessment of a parent as ‘able and willing’. Child Safety recently made a decision to move away from the use of structured screening tools such as the Family Risk Evaluation and the Family Risk Revaluation tools. To promote greater flexibility for practitioners in the application of their professional assessment skills, *Cultivating Risk Assessment* learning circles had been completed by all senior team leaders and senior practitioners, with the program to be rolled out to all Child Safety Officers by December 2022. Child Safety also advised that several training programs had been updated in response to this recommendation, particularly training for Child Safety Officers in their first year of practice and training in domestic and family violence-informed practice.

2022–23 Actions and agency response

In 2022–23, Child Safety completed its review of mandatory training for the Child Safety Officer role. The training is now three-weeks in duration and includes a dedicated day focusing on domestic and family violence-informed practice. Non-mandatory training on domestic and family violence-informed practice is also available to all staff.

The Board’s observations

The Board notes that across the two reporting years, Child Safety has taken action to increase the capacity of staff to assess whether a parent is able and willing to care for and protect their child from harm. Efforts have primarily taken the form of increased training for staff. Within this training, attention has been given to domestic and family violence-informed practice.

The Board will close Recommendation 4 noting that Child Safety has taken multiple actions to improve its workforce’s risk assessment decision making abilities, however, the Board caveats that quality risk assessment is essential to child protection practice and is likely to be an ongoing matter for continuous monitoring and improvement.

2020–21 Recommendation 5:

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs and Queensland Health addresses the ongoing barriers and enablers to seeking, weighting and engaging expert advice from health professionals (including Aboriginal and Torres Strait Islander community-controlled health services). This is to include:

- mapping the structural and relational barriers and enablers. This will be informed by discussions with frontline workers and findings from the Board, Queensland Health and Child Safety internal agency review reports and other sources of external review
- developing actions to address the findings and act on opportunities to improve inter-agency coordination more broadly
- increasing the capacity of the Child Safety Officer (Health Liaison) positions to:
 - facilitate access to expertise from health professionals about the health needs of children and the impact of parental mental illness on a child’s safety
 - work with Child Safety regional intake services to educate staff on health systems and to facilitate local relationships with hospital and health services and Aboriginal and Torres Strait Islander community-controlled health services
 - support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.

Status: In progress

Government response

The Queensland Government accepted this recommendation, noting Child Safety and Queensland Health’s commitment to collaboration towards continuously improving inter-agency coordination and responses to children and their families with specific health needs.

In 2021–22, Child Safety and Queensland Health reported the establishment of a cross-agency working group to define, design and implement key activities that meet the intent of Recommendation 5. At this time, the working group had progressed a mapping exercise that captured the enablers and barriers to seeking, weighting and engaging expert advice from health professionals. Four priority areas were identified: Hospital Liaison Officer capacity, maternity/neonatal, child health and mental health, alcohol and other drugs.

At the time, the Board received information that future activities of the working group would be determined through stakeholder engagement, which included a co-agency workshop which was to be held in September 2022, and consultation with Aboriginal and Torres Strait Islander community-controlled health services.

2022–23 Actions and agency response

In 2022–23, Child Safety and Queensland Health’s cross-agency working group facilitated a state-wide focus group session on the four identified priority areas at the Queensland Health 13th Annual Child Protection Liaison Officer and Child Protection Advisor Conference. The focus group’s subsequent paper, *Seeking, weighting and engaging health findings*, was released internally in December 2022 with the aim to promote local Hospital and Health Service and Child Safety Service Centre awareness.

Queensland Health activities in the past 12 months have included:

- Publishing an internal Queensland Health interactive child protection contact list (including a map) to improve inter-agency coordination between Queensland Health employees and their local Child Protection Units and Child Safety Regional Intake Services (RIS) and Child Safety Service Centres (CSSC).
- In consultation with Child Safety, Queensland Health is currently updating their *Responding to an Unborn Child High Risk Alert guideline* and accompanying *High Risk Alert* forms to strengthen communication and joint agency coordination processes to enable a more effective response for unborn children who are “reasonably suspected to be in need of protection after their birth”.
- On 4 September 2023, Children’s Health Queensland officially launched the *Supporting all Families Everyday* (SaFE) Child Protection online education modules, designed to address the child protection education training needs of all Queensland Health staff.
- Continued cross-agency collaboration and implementation of Child Safety’s Unify system.

Board's observations

The Board notes both agencies have taken steps to identify barriers and enablers to seeking, weighting and engaging expert advice from health professionals. The actions taken to date speak to improvements in relationships between agencies at an officer-level and appear likely to improve inter-agency coordination more broadly, however, the Board would like to see evidence of strengthened practice before closing this recommendation. Further activities may need to be taken to address the following parts of the recommendation:

- Promoting advice seeking from Aboriginal and Torres Strait Islander community-controlled health services and further embedding of cultural expertise in practice.
- Deep consideration and response to the recommended changes to Child Safety Officer (Health Liaison) positions.

The Board would like to see evidence that efforts have been made towards growing the stakeholder relationship between CSSC's and the Aboriginal and Torres Strait Islander community-controlled health services in their catchment, as well as changes to CSO (Health Liaison) role descriptions reflecting proposed duties.

The Board will continue to record Recommendation 5 as 'in progress' at this time.



2020–21 Recommendation 6:

The Board recommended the Queensland Mental Health Commission's *Shifting minds* Strategic Leadership Group (SLG), as the senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland, developed a targeted response to youth suicide.

This group, with the support of the Queensland Suicide Prevention Network (once formed), should consider the findings of the research commissioned by the Board into suicide prevention and effective child protection and mental health systems, specifically to:

- establish a shared professional development program on the acute and long-term effects of adverse childhood experiences
- provide Queensland data that can be rapidly given to agencies
- map pathways to services to identify structural barriers to delivering an accessible, comprehensive and integrated continuum of care
- identify the need for new investment to expand services for infants and pre-school children with mental health presentations (and their carers)
- promote service models designed by Aboriginal and Torres Strait Islander communities to effectively engage Aboriginal and Torres Strait Islander children and their families
- investigate multisystemic therapy (MST) for consumers who currently do not have their needs met by child and adolescent mental health services or Evolve Therapeutic services
- undertake routine reviews of policies and procedures of agencies providing services to children to make sure they promote inter-sectoral collaboration and consistency in responses.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting the shared priority focus area of child and youth mental health identified by the cross-agency *Shifting minds* Strategic Leadership Group. The Queensland Government also flagged that, at the time, the Queensland Suicide Prevention Network was under formation and a review of *Every life: A Queensland Suicide Prevention Plan 2019–2029 (Every Life)* was due for review. The Queensland Government envisioned that the development of a targeted cross sectoral response to youth suicide would support a phased implementation of suicide prevention in Queensland.

In 2021–22, the Queensland Mental Health Commission (QMHC) reported they were continuing to progress the coordination and oversight of whole-of-government suicide prevention priorities. This included the collaborative renewal of *Shifting minds*, and development of phase two of *Every life*. Scoping and preliminary consultation was reported to have commenced to inform a project plan to support the cross-sectoral development of a targeted response to youth suicide prevention. Concurrently, work was reported to be underway to address specific areas identified by the research into youth suicide which had been commissioned by the Board previously: *Highly vulnerable infants, children and young people: a joint child protection mental health response to prevent suicide*. This was to include the development of a workforce competency framework for the human services and education workforce.

2022–23 Actions and agency response

In 2022–23, the QMHC continued developing a targeted response to youth suicide, with activities undertaken against each of the recommendation’s criteria. Activities included:

- In October 2022, the delivery of a capability framework for non-health workers and volunteers engaging with young people who are experiencing vulnerability.
- Conducting an analysis to identify gaps in the available professional development resources to identify what is needed to address the acute and long-term effects of adverse childhood experiences.
- In September 2023, phase two of *Every life* was released, which contains actions aligned with Recommendation 6. Shared objectives relate to increased monitoring and reporting of suicide data, mapping of locations with a higher frequency of suicide, promoting service models designed and delivered by First Nations people and promoting supports that use a whole-of-family and kin approach.
- Commenced the *Reforming Suicide Surveillance Project*, which aims to enhance the availability and accessibility of data for suicide, suicide attempts and crises. This will enable government agencies and other services to mobilise supports, monitor trends, and investigate and respond to localised risk factors for suicide.
- Undertook a range of community consultations to understand the barriers and challenges to accessing services and supports. Findings regarding structural barriers were reported in the *Every life Phase Two Consultation* report. Identified issues are also being addressed through the implementation of *Better Care Together: A plan for Queensland’s state-funded mental health, alcohol and other drug services to 2027 (Better Care Together)*.
- Significant new investment in expanding services for infants, pre-school children and their parents across the continuum of care to reduce barriers and increase accessibility, including over the next five years through *Better Care Together*. Investment is intended for expanded community-based perinatal and infant mental health treatment services and new public mother and baby beds to increase access to state-wide specialist inpatient treatment for severe perinatal mental health disorders.
- Partnered with DTATSIPCA to deliver community-led initiatives under the *Thriving Local Communities* initiatives. Initiatives aim to improve mental health, social and emotional wellbeing of First Nations peoples.
- Funding an evaluation of *Pinangba*, an Aboriginal and Torres Strait Islander-led service delivery which takes a holistic, all-family approach to alcohol and other drug rehabilitation.
- Continued investigation of Multisystemic Therapy (MST), including reviewing existing research and evidence on the effectiveness of MST and consultation with interstate counterparts. While QMHC advises the evidence for MST is strong, their initial investigation suggests implementation can be challenging and resource intensive, particularly in regional and rural areas.
- Driving continuous improvement and consistency of response across government through the *Suicide Prevention Strategic Oversight Group* and the *Queensland Suicide Prevention Network*.

The Board’s observations

The Board welcomes the efforts taken by the QMHC to address all aspects of Recommendation 6. It is beneficial to see that the QMHC has collaborated across government departments to promote a targeted, consistent response to youth suicide. Noting that several initiatives are ongoing or long-term strategies, the Board will record this recommendation as ‘complete’.

2020–21 Recommendation 7:

The Board recommended: The Department of Children, Youth Justice and Multicultural Affairs:

7.1 immediately examines why less than 60% of young people under community supervision by Youth Justice considered eligible for a medium- to long-term suicide risk management plan have not had one developed.

7.2 reviews its suicide risk management policies and procedures to:

- address barriers to developing and implementing medium- to long-term culturally responsive suicide risk management plans (examining the results from 7.1)
- establish mechanisms similar to the Suicide Risk Assessment Team approach used in youth detention centres to assist Child Safety and Youth Justice community supervision staff to better identify and respond to suicide risk. This is intended to provide staff with expert, multidisciplinary support when responding to a young person at risk of suicide
- ensure the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide, and that culturally responsive supports are provided to children who experience the suicide of a person known to them.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting an independent audit of all aspects of the approach to managing youth suicide risk was recently conducted within the Youth Justice portfolio. The review was expected to result in procedural updates and additional training opportunities for staff to strengthen suicide risk management with the youth justice system.

In 2021–22, Child Safety reported they had progressed scoping and engagement with internal and external stakeholders regarding suicide prevention. A suicide prevention working group had been established to develop an action plan for Child Safety, including review of policies and procedures. For the same period, Youth Justice reported the completion of a 2020 independent audit of suicide risk management within the portfolio. The findings revealed significant practice opportunities to improve their response and management of suicide risk. Key areas for review included clarifying timeframes for risk management plan completion, establishing processes to review and refer to existing medium to long-term plans, developing improved information sharing processes between detention and community staff and reviewing practice resources for staff. A working party had been formed to assist with the implementation of the audit's recommendations.

2022–23 Actions and agency response

In 2022–23, Child Safety informed the Board that staff now have access to non-mandatory eLearning training courses on understanding suicide and non-suicidal self-injury. Youth Justice reported undertaking the following actions to improve the resources and policy framework regarding suicide prevention:

- Updates to the *Identifying, recording and managing suicide risk operational policy and procedure* occurred in April 2022, requiring all staff who have contact with young people to complete the approved online suicide risk training within one month of commencing work and renew the training every two years.
- A new two-part eLearning module 'Working with Young People: Understanding Suicide' and 'Responding to Suicide Risk' has been developed for all youth justice roles including restorative justice staff.
- Development of a practice resource, *Suicide Prevention Toolkit for Youth Justice staff*, in October 2021.
- Restorative Justice Convenor training now includes specific guidance about maintaining a focus on mental health and suicide prevention throughout the conference process.

The Board's observations

The Board recognises that since Recommendation 7 was made, an immediate review of medium- to long-term suicide risk management plans for young people under community supervision was undertaken. The review has led to improved suicide prevention policies and practice resources, supplemented with accompanying training for staff. The Board will close Recommendation 7 at this time but would appreciate the provision of data showing the percentage of eligible young people under community supervision on a medium- to long-term suicide risk management plans.

2020–21 Recommendation 8:

The Board recommended the Queensland Mental Health Commission and the Queensland Family and Child Commission develop and deliver youth-friendly messages to raise awareness about mental health services for children and young people, and about their right and ability to consent to and access these.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that both Commissions would co-design strategies to meaningfully engage young people about available mental health services and their right to access these. The process for this would centre around consulting young people directly. The increasing wait times for mental health assessment and support was raised as a possible barrier to the success of this recommendation, noting that increased help seeking would need to be matched with timely and appropriate service provision.

In 2020–21, the QFCC and QMHC reported an agreement to deliver this. At that time, actions taken by the QFCC and QMHC included:

- Stakeholder consultation with the mental health support sector and young people.
- Contracting headspace to run a social media campaign on young people accessing and consenting to have their own Medicare card. The QFCC ran a supporting digital media campaign to promote headspace's campaign.
- QFCC staff and youth advocates worked with an external animator to develop two videos to raise awareness on mental health supports through a 'Let's have this convo, together' campaign.
- A third digital animation had been drafted addressing consent and parental access to information by mental health services providers.

The QFCC and QMHC reported their intention to conduct evaluations of the above campaigns.

2022–23 Actions and agency response

In 2022–23, the QFCC and QMHC delivered a third animation to help young people understand more about youth mental health support services and their ability to access them. As with the previous two animations, storyboard concepts were created by young people. A webpage was created to support the animations' key mental health messages, available at <https://www.qfcc.qld.gov.au/mentalhealth>. The QMHC funded the QFCC \$3,000 to promote the animations through a social media advertising campaign. Engagement with the campaign over its 26-day duration was positive, with 268,957 users reached through Facebook and Instagram and 9,137 link clicks to the supporting Mental Health webpage. Key stakeholders, including the Department of Education, Headspace, Stride, and Youth Justice also circulated the animations on their own public-facing websites and digital platforms. Stakeholders provided the QFCC with positive feedback about the content.

The Board's observations

The Board notes the creation of three animations and accompanying media campaigns towards the delivery of Recommendation 8 over the two reporting periods. The Board commends the seeking of input of young people into the creation process and thus amplifying their voices across multiple digital platforms. The level of engagement with the content will likely have increased awareness about mental health services for children and young people, and about their right and ability to consent to and access these services.

The Board will record this recommendation as 'complete'.

2020–21 Recommendation 9:

The Board recommended: The Department of Education undertakes an audit of a sample of schools to make sure:

- suicide postvention plans are up to date and comply with departmental policy, part of which is having an Emergency Response Team that includes a representative from the local mental health service
- plans are tailored to meet the specific cultural needs of the individual school community
- the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide and culturally responsive supports are provided to children who experience the suicide of a person known to them.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting Education’s commitment to continue strengthening its approach to suicide prevention and postvention. Improvement will inform the recommendation audit of suicide postvention plans in a sample of schools. A number of other strategies within Education’s coordinated approach to reducing suicide were acknowledged, including Suicide Prevention and Postvention Training for guidance officers and alerts from the QFCC when there is a suspected suicide of a child in Queensland.

In 2021–22, Education reported Recommendation 9 as complete, following an audit of 42 suicide postvention plans from schools across the state. Learnings from the audit will be used to inform DoE’s resources (including the Student Learning and Wellbeing Framework and Supporting Students’ Mental Health and Wellbeing procedure) and the support available to schools around the development and ongoing review and implementation of their plans. Education committed to providing the findings of the report into a report to be provided to Board by August 2022.

2022–23 Actions and agency response

- In 2022–23, Education provided a further update on the implementation of the audits’ recommendations, including the development of a new Suicide Postvention Plan template for use by Queensland state schools. Education has been working with Be You¹³⁷ to develop the new template which includes an overarching statement that the suicide of a peer, family or community member is a risk factor for suicide
- space for schools to indicate key cohorts in their student community who may be at greater risk (i.e., Aboriginal students and Torres Strait Islander students)
- links to key Be You fact sheets specific to postvention responses for Aboriginal students and Torres Strait Islander students to ensure a school’s postvention response is culturally responsive
- a requirement to include all members of the Emergency Response Team and their contact details.

When finalised and approved, the new template will be published for use by school staff in response to suicide risk and events. An accompanying communication plan had been developed to ensure schools know how to access advice and support when updating their Suicide Postvention Plan. Education committed to providing the Board with a copy of the Suicide Postvention Plan template when it has been finalised. This is expected to occur in late 2023.

The Board’s observations

The Board is satisfied that Education has taken appropriate action to deliver Recommendation 9. The Board appreciates Education’s commitment to sharing a copy of the new Suicide Postvention Plan template and will record this recommendation as ‘complete’.

¹³⁷ Be You a national mental health initiative led by Beyond Blue with delivery partners Early Childhood Australia and Headspace. Be You supports education providers to support children’s and young people’s mental health in early learning services and schools. More information about Be You is available at their website: www.beyou.edu.au

2020–21 Recommendation 10:

The Board recommended that the Queensland Family and Child Commission extends its suicide notification process about children enrolled (or previously enrolled) in state schools to also include children enrolled in Catholic or independent schools. This will require consultation with, and the support of, the non-state schooling sector.

For children not enrolled in either a state or non-state school, opportunities to notify the agency most closely linked with the family should also be explored as part of this work.

Status: Closed – not implemented

Government response

The Queensland Government accepted this recommendation in principle, noting that implementation is reliant on the support of the non-state schooling sector. The QFCC would consult with the non-state schooling sector to extend its suicide notification process and explore opportunities to notify other agencies with close links to families not enrolled in state or non-state schools.

Previous agency response

In 2021–22, the QFCC reported consultation had commenced with the Department of Education, the Queensland Catholic Education Commission (QCEC) and Independent Schools Queensland (ISQ) on the approach to implement this recommendation and the perceived benefits of the model for students in non-state schools.

2022–23 Actions and agency response

In 2022–23, the QFCC continued consultation with the Department of Education, the QCEC and ISQ. Consultation raised the following barriers to implementing Recommendation 10:

- There is no central register for enrolment of children at non-state schools. This means that the QFCC is unlikely to have access to accurate information about the correct school to notify of a student suicide.
- The operation of non-state schools is not centrally directed by the QCEC and ISQ, meaning that individual memorandums of understanding (MOUs) would need to be developed with each non-state school governing bodies or boards, and individual notification and referral systems established.
- schools are often already aware of student suicide through contact with police, families and communities.

QFCC advised that it would not be able to progress with the implementation of Recommendation 10 without significant new resources for the Commission and likely for independent schools. On this basis it recommended the closure of Recommendation 10.

The Board's observations

The Board acknowledges the actions that the QFCC has undertaken to determine the feasibility of implementing Recommendation 10.

The Board will record Recommendation 10 as 'closed – not implemented'.

Chapter 8

Governance

Governance

The Board held six meetings in 2022–23. The Chair presided at all meetings and a quorum¹³⁸ was present at all meetings. Meetings were:

- **Meeting 12** – 24 August 2022. At this meeting, the Board reviewed 13 cases.
- **Meeting 13** – 2 November 2022. At this meeting, the Board reviewed 12 cases and received a presentation on recent and ongoing QFCC initiatives by Jaime Blackburn, Executive Director, Government Relations and Corporate Services, QFCC.
- **Meeting 14** – 7 December 2022. At this meeting, the Board reviewed 5 cases and received a presentation of the QFCC's Intervention with Parental Agreement (IPA) Project by Zara Berkovits, Director, System Reviews, QFCC. Presentation followed by questions and discussion.
- **Meeting 15** – 15 February 2023. At this meeting, the Board reviewed 10 cases.
- **Meeting 16** – 26 April 2023. At this meeting, the Board reviewed 14 cases.
- **Meeting 17** – 21 June 2023. At this meeting, the Board:
 - reviewed 6 cases
 - received a presentation on findings from the Australian Child Maltreatment Study by Dr Divna Haslam PhD, MPAS, Queensland University of Technology
 - received another presentation regarding the interim findings of the Board's commissioned research into service delivery to young children whose parents use methamphetamine by Professor Anthony Shakeshaft, Professional Research Fellow, Poche Centre for Indigenous Health, University of Queensland
 - Natalie Lewis, Commissioner, QFCC attended the meeting and contributed to discussions.

Child Death Review Board members

The Board consists of a Chair and 11 members. Members include both government and non-government persons with a requirement that government members not constitute a majority. The *Family and Child Commission Act 2014* sets out requirements for the Board's composition, such as the appointment of an Aboriginal or Torres Strait Islander person as the Chair or Deputy Chair, and membership that comprises specialist knowledge in relevant fields.¹³⁹ In 2022–23, the Board members held professional expertise across child protection, family law, maternal, family and child health and mental health, education, justice systems and child advocacy.



¹³⁸ See *Family and Child Commission Act 2014*, s. 29ZF.

¹³⁹ *Family and Child Commission Act 2014*, s. 29W-29Y.

The Child Death Review Board Chair: Mr Luke Twyford

Mr Luke Twyford was appointed as the Board Chair in March 2022. Luke's career spans more than 20 years across Commonwealth, New South Wales and Northern Territory governments in the areas of reform, research and evidence, integrity, audit, governance and complaints management. Prior to joining the QFCC, Luke worked for nine years with the Northern Territory Government, leading critical reform of the child protection and youth justice system and its legal frameworks.

Luke holds a Bachelor of Laws with Honours from the University of Wollongong. He has extensive experience providing evidence to courts, inquiries and commissions. Luke's parents fostered a number of children throughout his childhood, with his own lived experience and those of his foster brothers and sisters profoundly shaping the perspective he brings to his work and his passion in advocating for the safety and wellbeing of children and young people.

Deputy Chair: Professor Jody Currie

Professor Jody Currie is a Professor of Practice (Indigenous Health) at QUT. Jody was most recently Chief Executive Officer of the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane. Jody established ATSICHS Brisbane as a Nationally Registered Early Childhood Education provider, a Nationally Registered Housing Provider, and a Registered National Disability Insurance Scheme Provider.

Jody is a Yugambah person with traditional ties to the country between the Logan and Tweed Rivers. Since attaining her Bachelor of Arts (BA) in Gender Studies, Jody embarked on her career in health and human service delivery. Jody has a particular focus in child protection and health, working in several senior positions in both the community and government sector.

Ms Simone Jackson

Ms Simone Jackson is a proud Kamilaroi woman from Southwest Queensland and an accomplished Government Executive with over 20 years' experience as a public servant and over the past 11 years has worked in Senior Government roles. Simone has worked in roles relating to justice and human services across two jurisdictions (Queensland & Northern Territory). Simone is currently the Chief Executive Officer, Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health) and is responsible for the Aboriginal community-controlled health response operating across West Moreton, over three clinical sites, Ipswich, Booval, and Laidley. Kambu Health also has Amaroo Kindergarten and a Long Day Centre, Children, and family services as well as operating programs funded through numerous state and commonwealth departments. Simone has been a member of the Queensland Parole Board since 2017.

Ms Margie Kruger

Ms Margaret (Margie) Kruger is a solicitor and practises in the area of family law and child protection law. Margie has worked in the area of child protection in service delivery to children and families, policy and the Court, both as a social worker and lawyer for 36 years. Margie was admitted to practice as a Barrister of the Supreme Court of Queensland in May 2000 and was subsequently admitted to practice as a Solicitor in October 2000. Margie is also admitted as a practitioner to the High Court of Australia.

Margie is the Deputy Chair of the Queensland Law Society Family Law Committee and has previously been a member of the Queensland Law Society Children's Committee. Margie was a Board Member of the Child Protection Practitioners Association of Queensland (CPPAQ) from 2010 to 2020 and Chair of CPPAQ from 2014 to 2016. Prior to commencing practice as a lawyer in 2000, Margie was a social worker with the Queensland Government working in the area of child safety.

Mr Bruce Morcombe OAM

Mr Bruce Morcombe OAM is the co-founder of the Daniel Morcombe Foundation which he established with his wife, Denise, after the abduction and murder of their son in December 2003. The Foundation's vision is *Today we build a future where children are free from harm and abuse*. The Morcombes advocate passionately for the education of children and young people on how to stay safe in both physical and online environments and for the support of young victims of crime. They continue to drive to deliver child safety messages to as many Australian schools as possible. The Day for Daniel is held annually as a national day of action to educate children about personal safety. In 2012, Bruce and Denise were recognised as Queensland's Australian of the Year nominations, and both received Medals of the Order of Australia in 2013. In 2020, they were named as Queensland Greats for their tireless dedication to child safety advocacy.

Ms Shanna Quinn

Ms Shanna Quinn is a barrister, mediator and trainer with experience across Australia and Asia, specialising in family law. With extensive experience as a forensic social worker and counsellor, Shanna has focused her career on family law matters (parenting and property), domestic violence and child protection, including clients from diverse cultural, socio-economic and religious backgrounds. Shanna's multi-disciplinary background provides a unique and integrated approach to all areas of her work. As a barrister and mediator, her background as a forensic social worker makes her particularly equipped to deal with sensitive and complex child-related matters.

Professor Jeanine Young AM

Professor Jeanine Young AM is Professor of Nursing, University of the Sunshine Coast. Jeanine is a registered nurse, registered midwife and qualified neonatal nurse. Jeanine has worked in Australia and the United Kingdom in midwifery, neonatal intensive care, paediatrics and community child health. Jeanine's primary focus as an academic researcher is public health in the early years and specifically strategies to reduce mortality and improve health outcomes for children and families experiencing social vulnerabilities. Jeanine has a special interest in infant care practices; in particular breastfeeding and safer infant sleep, including parent-infant bed-sharing which formed the basis of her doctoral studies.

Jeanine works in partnership with government, industry, safety and regulatory bodies, and communities in translating evidence into practical advice for parents. Recently this included the Queensland Health Safer Infant Sleep Clinical Guideline (2022), which Jeanine co-led in collaboration with the Queensland Paediatric Quality Council and Queensland Clinical Guidelines Unit, and the Best Practice Guide for the design of safe infant sleeping environment. Jeanine was made a Member of the Order of Australia for her work in June 2020.

Government members

Government appointments to the Board are based on a position rather than the person. As different officers occupy the nominated Board position within an agency, they automatically become the agency's Board member.

Child Safety

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Child Safety) is the Chief Practitioner. Dr Meegan Crawford is the Chief Practitioner for the Department of Children, Youth Justice and Multicultural Affairs, Queensland. After graduating as a social worker, Meegan commenced her career over 30 years ago as a Child Safety Officer. Meegan has worked in a variety of roles in the department including Senior Team Leader, Senior Training Officer, Manager, Director and Executive Director and has worked as an academic and research assistant for Griffith University. As the Chief Practitioner Meegan reports directly to the Director General and has oversight of the teams responsible for child death and serious injury reviews; child safety complaints; child safety training; operational policy, practice development and guidance; delegated authority; NDIS interface; sexual abuse and exploitation, and partnerships and projects.

Youth Justice

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Youth Justice) is held by the Assistant Chief Operating Officer, Youth Justice Statewide Services, Operations and Commissioning. Mr Darren Hegarty held the role of Assistant Chief Operating Officer and the Youth Justice representative on the Board for meetings 7, 8, 10 and 11, while Youth Justice existed within the Department of Children, Youth Justice and Multicultural Affairs. Darren has led a number of positive and significant reforms for children and young people in both the youth justice and child protection systems. These include the Youth Justice Strategy and Action Plans, Out of Home Care Reinvestment program, including Queensland's first Mental Health Recovery Residential, improved service delivery frameworks within Child Safety, targeted outcomes for Aboriginal and Torres Strait Islander families, stronger engagement with community Elder groups and Aboriginal and Torres Strait Islander service providers, and the re-focused investment in Intensive Family Support for children and young people. Darren has extensive experience in providing innovative approaches to solving complex problems within the human services sector.

Queensland Health

The Board position within Queensland Health is held by the Medical Director of Child and Youth Mental Health Services, Children’s Health Queensland. Dr Stephen Stathis held the position of Medical Director of Child and Youth Mental Health Services, Children’s Health Queensland and was the Queensland Health representative on the Board throughout 2021–22. Stephen obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child & Adolescent Psychiatry and Forensic Psychiatry. Stephen is currently the Medical Director of Child and Youth Mental Health Services, Children’s Health Queensland. He also acts as the Clinical Advisor to the Mental Health Alcohol and Other Drugs Branch for child and youth mental health. Stephen has extensive experience working among vulnerable and marginalised young people within the community. His clinical interests include ‘bridging the gap’ between paediatrics and psychiatry, mental health policy and strategic planning, gender dysphoria, consequences of early childhood trauma and abuse, and adolescent forensic psychiatry.

Department of Education

The Board position within the Department of Education is held by the Executive Director for Student Protection and Wellbeing. Ms Hayley Stevenson has held a number of roles since commencing with the Queensland Department of Education in 2002 and is currently the Assistant Director-General for Disability, Inclusion and Student Services. In this role, Hayley is responsible for leading the development and statewide implementation of key initiatives related to Student Wellbeing, Behaviour, Engagement, Respectful Relationships, Student Protection and Suicide Prevention, Disability Strategy and Inclusion. Hayley is committed to providing schools with the resources they need to embed support for student safety wellbeing into their everyday work.

Queensland Police Service

The Board position within the Queensland Police Service is the Detective Superintendent Child Abuse and Sexual Crime Group. Detective Superintendent Denzil Clark commenced with the Queensland Police Service (QPS) in January 1988 and has served the past 33 years as a detective in various positions across the QPS. Denzil has worked as an investigator in regional child protection units, criminal investigation branches, various units within Crime and Intelligence Command and at the Crime and Corruption Commission. In 2018 Denzil was promoted to Detective Superintendent, Child Abuse and Sexual Crime Group which includes the key roles of State Child Protection and Investigation Unit (CPIU) Co-ordinator and QPS Child Safety Director. Denzil has twice been awarded the Commissioner’s Certificate and has also received a number of other operational and corporate awards in recognition of his contribution to policing. In 2021 Denzil completed a Graduate Diploma of Executive Leadership.

Attendance

Member	Agency	Meeting 12 24/8/2022	Meeting 13 2/11/2022	Meeting 14 7/12/2022	Meeting 15 15/2/2023	Meeting 16 26/4/2023	Meeting 17 21/6/2023
Luke Twyford	QFCC (Chair)	Present	Present	Present	Present	Present	Present
Prof. Jody Currie	Non-government (Deputy Chair)	Present	Present – via video call	Apology	Present	Present	Present
Simone Jackson	Non-government	Present	Present – via video call	Present	Present	Apology	Present
Bruce Morcombe OAM	Non-government	Apology	Present	Present – via video call	Present	Present – via video call	Present
Prof. Jeanine Young AM	Non-government	Present	Present	Present	Present	Present	Present
Shanna Quinn	Non-government	Present – via video call	Present – via video call	Present – via video call	Present – via video call	Present – via video call	Present – via video call
Margaret Kruger	Non-government	Present	Present	Apology	Present	Present	Apology
Dr Meegan Crawford	Child Safety	Present	Present	Present	Present	Present	N/A
Charmaine Matebau		N/A	N/A	N/A	N/A	N/A	Present
Hayley Stevenson	Education	Present	Present	Present	Present	Apology Proxy – Lisa Shields	Present
Dr Stephen Stathis	Queensland Health	Present	Present	Present	Present	Apology Proxy – Ross Alcorn	Present
Darren Hegarty	Youth Justice	Apology Proxy – Pele Ware	Apology Proxy – Pauline Zardo	Apology	Apology Proxy – Pauline Zardo	Apology Proxy – Elizabeth Howe	Present
Denzil Clark	Police	Present	Present	Apology Proxy – Glen Donaldson	Present	Apology Proxy – Stephen Blanchfield	Apology Proxy – Stephen Blanchfield

Table 8: Attendance at the Board in 2022–23

Conflicts of interest

The Board members disclosed a personal interest relating to a review as required by legislation¹⁴⁰ on three occasions. Examples of interests disclosed included non-Government members being appointed to another board that pertains to children or families, and Government members' participation in the agency's internal review process. After consideration of each disclosure, the Board agreed that there was no conflict of interest arising in relation to the matter, and the member was able to participate.

No members were asked to be absent from the case discussion for which they declared a potential conflict of interest.

Stakeholder engagement

The Board continued to maintain professional relationships with a range of stakeholders throughout 2022–23. Stakeholders supported the Board by:

- providing insights into the experiences of individuals, families or communities or contributed expertise on matters that affect them
- contributing data, research or expertise to inform the Board's work
- undertaking internal agency reviews and provided insights into relevant legislation, policies, procedures and practices
- carrying out similar review functions in other Australian jurisdictions
- implementing, or assisting in the implementation of, system change recommended by the Board
- sharing the Board's key messages to a wider audience.

A cross-agency working group was established in 2020 to develop operational guidelines for agency reviews following the death or serious physical injury of a child. Chaired by the Board Secretariat, the group met twice during 2022–23 to monitor the number of upcoming internal agency reviews and discuss death review processes and emerging issues.

The Board is also a member of the Australian and New Zealand Child Death Review & Prevention Group. Through this group, the Board is able to engage and share learnings with similar interstate entities.

In 2022–23, the Board commissioned one research contract. The research focused on best practices for practitioners working with children whose parents use methamphetamine. The findings of this research contributed to *Chapter 5: Strengthening child safety practice in response to parental substance and methamphetamine use* and the research is expected to be released in full in late 2023.

¹⁴⁰ Family and Child Commission Act 2014, s. 29ZJ.

Promoting our work

The Board maintains a website at www.cdrb.qld.gov.au which provides information about its structure, functions and work.

In the past year, the Chair issued two media releases discussing research previously commissioned by the Board. The two research pieces were about Sudden Unexpected Deaths in Infancy, and Domestic and Family Violence. Full versions of both media releases are available at www.cdrb.qld.gov.au/news-and-updates

Information requests

Pursuant to S29P of the *Family and Child Commission Act 2014*, the Board Chair is able to request information to support the Board to carry out its reviews.

The Chair used S29P information request powers on two occasions in 2022–23:

- The Chair wrote to Child Safety requesting the child protection history relating to a young person's cultural family.
- The Chair wrote to a foster carer agency:
 - seeking a summary of the service delivery offered to a child and their foster carers, including respite opportunities
 - requesting details of the foster carer agency's engagement with Child Safety during their service delivery to a child
 - inviting the provider to raise any specific issues they felt critical for foster carer support agencies.

On both occasions, the entities supplied the requested information within timely manner.

Risk management

The Secretariat, on behalf of the Board, maintains the Board strategic risk register in compliance with the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*. These require that all accountable officers and statutory bodies establish and maintain appropriate systems of internal control and risk management. The Board strategic risk register captures and monitors strategic and operational risks for the Board. For purposes of accountability, it is presented quarterly to the QFCC's Audit and Risk Management Committee.

Member farewell and recruitment

Board members are appointed for a term of three years. Several Board members' terms concluded on 30 June 2023. Non-Government members Professor Jeanine Young, Margie Kruger, Shanna Quinn, and Bruce Morcombe finished their term with the Board following the conclusion of Meeting #17. Deputy Chair Professor Jody Currie also retired at this time.

With the next three-year appointment terms commencing July 2023, the QFCC partnered with the Department of Justice and Attorney-General between January and June 2023 to undertake a significant recruitment process. There was a strong aspiration to increase Aboriginal and Torres Strait Islander membership on the Board. The QFCC led a digital and media campaign to encourage applications from across Queensland and provided advice to the Department of Justice and Attorney-General to support assessment of applicants' expertise and knowledge.

Appendices

Appendix 1—Child Death Review Process

Internal agency reviews

The purpose of internal agency reviews is to facilitate ongoing learning, promote accountability and improve child protection services to children and young people. Agencies promote collaboration by sharing learnings and recommendations from their reviews.

Chapter 7A (Internal agency reviews following child deaths or injuries) of the *Child Protection Act 1999* outlines the legislative responsibilities of reviewing agencies.

The agencies required to undertake reviews are:

- the Department of Education
- the Department of Child Safety, Seniors and Disability Services (Child Safety)
- the Department Youth Justice, Employment, Small Business and Training (Youth Justice)
- Queensland Health (Hospital and Health Services)
- the Queensland Police Service
- the Director of Child Protection Litigation (DCPL).

The reviews conducted by the DCPL have a different scope to those conducted by other review agencies.^{141,142}

Focus, purpose and processes of the Child Death Review Board

The focus and purpose of the Board's reviews is to identify opportunities for continuous improvement in systems, legislation, policies and practices. The Board receives and considers all internal agency review report findings and adopts a high-level focus to identify system improvements that can increase children and young peoples' safety and wellbeing and prevent future child deaths.¹⁴³ It does not investigate the deaths of individual children or make findings about the actions of individuals.¹⁴⁴

In 2022–23, the Board met six times to review trends and emerging system issues across 60 cases. For 15 of these cases, the Board conducted in-depth reviews (categorised and referred to as Level 3 reviews), where it was identified that children's experiences of the system provided the greatest opportunity for learnings and recommendations about improvements to systems, policies, practices and legislation.

For these reviews, the Board collates multiple agencies' information and findings to develop visual timelines of childrens' engagement with the system in the 12 months prior to their death. Timelines provide a narrative infographic of the child's experiences and aim to stimulate rigorous and in-depth discussions about system collaboration and improvements. Cases that were categorised as Level 1s and 2s are reviewed by the Board to monitor and report on recurring issues and trends within the Queensland child protection system.

¹⁴¹ See *Child Protection Act 1999*, s. 245H and 245I for details of requirements for reviews, and s. 245K for further details on the scope of a relevant agency review.

¹⁴² See *Child Protection Act 1999*, s. 245J for details of requirements for the Director of Child Protection Litigation reviews and s. 245L for further details on the scope of those reviews.

¹⁴³ *Family and Child Commission Act 2014*, s. 29A.

¹⁴⁴ *Family and Child Commission Act 2014*, s. 29A(3) and 29H(5).

Appendix 2—Glossary of terms and acronyms

Term or acronym	Meaning
Agencies and organisations	
Board members/ members	Members of the Child Death Review Board
The Board	Child Death Review Board
DCSSDS/Child Safety	Department of Child Safety, Seniors and Disability Services. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.
DoE/Education	Department of Education
ODCPL	Office of the Director of Child Protection Litigation. The ODCPL supports the functions of the Director of Child Protection Litigation (DCPL) including by conducting the child death and serious physical injury reviews.
QAO	Queensland Audit Office
QFCC	Queensland Family and Child Commission
QH/Health	Queensland Health
QMHC	Queensland Mental Health Commission
QPQC	Queensland Paediatric Quality Council
QPS/Police	Queensland Police Service
Review agencies	These are the agencies required to undertake reviews following the death or serious physical injury of a child as defined in section 245B – see <i>relevant agency</i> - of the <i>Child Protection Act 1999</i> . These are: the Department of Education (DoE), the Department of Child Safety, Seniors and Disability Services (Child Safety), the Department of Youth Justice Employment, Small Business and Training (Youth Justice), Queensland Health (Hospital and Health Services) and the Queensland Police Service. The term ‘review agencies’ also includes the Director of Child Protection Litigation defined in section 245] of the <i>Child Protection Act 1999</i> (noting its review scope is different to that of the other review agencies).
DYJESBT/Youth Justice	The Department of Youth Justice, Employment, Small Business and Training. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.

Term or acronym	Meaning
Child protection terms	
See www.cswm.qld.gov.au/childsafety/child-safety-practice-manual/quicklinks/glossary-terms	
Child concern report (CCR)	A child concern report is a record of child protection concerns received by Child Safety that does not meet the threshold for a notification.
Child in need of protection	This is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering from harm, and does not have a parent able and willing to protect the child from the harm (<i>Child Protection Act 1999</i> , section 10).
Aboriginal and Torres Strait Islander Child Placement Principle	The Aboriginal and Torres Strait Islander Child Placement Principle aims to keep children connected to their families, communities, culture and country and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children’s care and protection. The Principle centres on five elements: prevention, partnership, participation, placement and connection.
Child Safety Officer (CSO)	A child safety officer is authorised, under the <i>Child Protection Act 1999</i> , to: <ul style="list-style-type: none"> • deliver statutory child protection services, such as investigating and assessing allegations of suspected child abuse and neglect • intervene to ensure the safety and wellbeing of children subject to ongoing intervention, in accordance with legislation, policies and procedures.
Cumulative harm	This refers to harm to a child caused by a series or combination of acts, omissions or circumstances that may have a cumulative effect on the child’s safety and wellbeing. The acts, omissions or circumstances may apply at a particular point in time or over an extended period, or the same acts, omissions or circumstance may be repeated over time.
Domestic and family violence	Domestic and family violence is behaviour by a person towards another person with whom the person is in a relevant relationship. It includes behaviour that is: physically or sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the other person and causes them to fear for their safety or wellbeing or that of someone else.
Family and Child Connect (FaCC) service	Family and Child Connect is an easily accessible referral point for agencies working with families who may need support. Families can also contact FaCC services directly for advice and help. A principal child protection practitioner is based at each FaCC service to identify and respond to serious concerns that may need Child Safety intervention. A specialist domestic and family violence practitioner also works with each FaCC service to advise on and assist with domestic and family violence matters.
Family Wellbeing Service (FWS)	The Aboriginal and Torres Strait Islander Family Wellbeing Service is a program co-designed with the community-controlled sector and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak. Family Wellbeing Services are designed to make it easier for Aboriginal and Torres Strait Islander families across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and to build their capacity to safely care for and protect their children.
Harm	In this context, harm refers to any detrimental effect of a significant nature on a child’s physical, psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation. Harm can be caused by a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances (<i>Child Protection Act 1999</i> , section 9).
Intake	Intake is the first phase of the child protection continuum and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child or unborn child, or when a request for departmental assistance is made.
Intake enquiry	An intake enquiry may be a request for information or relate to child wellbeing issues or child protection concerns. It is one type of departmental response to information received at the intake phase.

Term or acronym	Meaning
Intensive Family Support (IFS) programs	Intensive Family Support programs provide case management to families at risk of entering the statutory child protection system.
Intervention with parental agreement (IPA)	This refers to ongoing intervention with a child who is considered in need of protection, based on the agreement of the child's parent/s to work with the department to meet the child's safety and protection needs.
Investigation and assessment	Investigation and assessment is the second phase of the child protection continuum. An investigation and assessment is the departmental response to all notifications and is the process of assessing the child's need for protection where there are allegations of harm or risk of harm to a child (<i>Child Protection Act 1999</i> , section 14).
Non-government organisation	In this context, this refers to a not-for-profit organisation that receives government funding specifically for the purpose of providing community support services.
Notification	A notification is recorded when information is received about a child who may be harmed or at risk of harm that requires an investigation and assessment response. A notification is also recorded on an unborn child if there is reasonable suspicion that they will be at risk of harm after they are born.
Out-of-home care	This refers to placements of children, subject to statutory child protection intervention, using the authority of the <i>Child Protection Act 1999</i> , section 82(1). Out-of-home care includes placements with a licensed care service, an approved or kinship carer, or another entity.
Parent able and willing	This refers to a parent who has both the ability and willingness to protect their child from harm (<i>Child Protection Act 1999</i> , section 10). A parent may be willing to protect a child, but not have the means or capacity to do so. For example, a parent with a diagnosed mental illness may express a willingness to protect their child; however, due to factors related to the mental illness, may not be able to do so. Alternatively, a parent may have the means and capacity to protect a child but may not do so. A child safety officer must clearly assess the parent's motivation and ability to protect the child. In circumstances where a child resides across two households, the ability and willingness of both parents to protect the child needs to be assessed.
Placement	This refers to when a child is placed in an out-of-home care living arrangement due to intervention by the department.
Regional intake service	This is the contact point for reporting concerns about a child. There are seven regional intake service locations across Queensland. They receive incoming calls and reports, assess the information and decide how to respond.
Other	
Adverse childhood experience (ACE)	Adverse childhood experiences can include abuse, neglect and household dysfunction. 'Adverse childhood experience' is generally seen as a mental health term, where the more a child experiences, the greater the likelihood of negative impacts on the child's physical and mental health. These include negative impacts on gene function and brain structure.
Child Death Register	The Queensland Child Death Register records the deaths of all children and young people who die in Queensland. It is maintained by the QFCC.
Post-traumatic stress disorder (PTSD)	Post-traumatic stress disorder is a treatable anxiety disorder that occurs when fear, anxiety and memories of a traumatic event remain and interfere with how people cope with everyday life.
Sudden unexpected death in infancy (SUDI)	Sudden unexpected death in infancy is a category of death where an infant dies suddenly, usually during sleep, and with no immediately obvious cause.

Appendix 3—Remuneration of the Child Death Review Board

Child Death Review Board (the Board)					
Act or instrument	Family and Child Commission Act 2014				
Functions	Undertake systemic reviews following the deaths of children connected to the child protection system and make recommendations to improve the child protection system and to prevent the deaths of children.				
Achievements	The Board met on six occasions in 2022–23. A total of 60 child deaths were reviewed in this period. One research project was commissioned.				
Financial reporting	The Board is audited as part of the Queensland Family and Child Commission. Accounts are published in the annual report.				
Remuneration					
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved sub- committee fees if applicable	Actual fees received
Chair (government)	Luke Twyford	6	\$0	N/A	\$0
Deputy Chair (non-government)	Jody Currie	5	\$4500	N/A	\$4500
Member (non-government)	Simone Jackson	5	\$4500	N/A	\$4500
Member (non-government)	Margaret Kruger	4	\$4500	N/A	\$4500
Member (non-government)	Bruce Morcombe OAM	5	\$4500	N/A	\$4500
Member (non-government)	Shanna Quinn	6	\$4500	N/A	\$4500
Member (non-government)	Jeanine Young AM	6	\$4500	N/A	\$4500
Member (government)	Meegan Crawford	5	\$0	N/A	\$0
Member (government)	Charmaine Matebau	1	\$0	N/A	\$0
Member (government)	Hayley Stevenson	5	\$0	N/A	\$0
Member (government)	Lisa Shields	1	\$0	N/A	\$0
Member (government)	Stephen Stathis	5	\$0	N/A	\$0
Member (government)	Ross Alcorn	1	\$0	N/A	\$0
Member (government)	Darren Hegarty	1	\$0	N/A	\$0
Member (government)	Pele Ware	1	\$0	N/A	\$0
Member (government)	Pauline Zardo	2	\$0	N/A	\$0
Member (government)	Elizabeth Howe	1	\$0	N/A	\$0
Member (government)	Denzil Clark	3	\$0	N/A	\$0
Member (government)	Glen Donaldson	1	\$0	N/A	\$0
Member (government)	Stephen Blanchfield	2	\$0	N/A	\$0
Number of scheduled meetings/sessions	6				
Total superannuation paid (non-government)	\$2835.12 (\$472.52 per non-government member)				
Total out-of-pocket expenses	\$828.51 (accommodation, meal allowances and member taxi fares/parking)				



Child Death Review Board

Queensland **Family & Child** Commission