Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Public Hearing Report

Public hearing 33

Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study)

Brisbane
8 to 10 May 2023

Commissioners

Dr Alastair McEwin AM

Ms Andrea Mason OAM

The Honourable John Ryan AM

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Preface

Acknowledgement of Country

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, seas and waters of Australia, and pays respect to First Nations Elders past, present and emerging. We recognise First Nations peoples' care for people and country, including First Nations men, women and children whose words and voices led to the establishing of this Royal Commission. We also acknowledge the Traditional Custodians of the lands on which the Royal Commission's offices are located in Brisbane, Canberra and Sydney.

Content warning

The report contains information that may be distressing to readers. It includes accounts of violence against, and abuse and neglect of children and young people with disability. If you need support to deal with difficult feelings after reading this report, the following services are available to help you.

Blue Knot Foundation offers specialist counselling support and a referral service for anyone affected by the Disability Royal Commission. For support, please call their national hotline on 1800 421 468 (they are open every day).

Contact details for further resources are as follows:

- Lifeline: 13 11 14
- Beyond Blue: 1300 224 636
- 1800Respect: 1800 737 732

Findings and recommendations

In this report we make three findings and five recommendations.

Finding 1

Kaleb and Jonathon experienced violence, abuse, neglect and the deprivation of their human rights, in the care of their father, Paul Barrett, between 2000 and 27 May 2020.

Finding 2

The violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced in the care of their father, Paul Barrett, was preventable.

Finding 3

The State of Queensland through the departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett, could and should have done more to prevent Kaleb and Jonathon from experiencing violence, abuse, neglect and the deprivation of their human rights, having regard to the particular departments' or agencies' powers and responsibilities.

Recommendation 1

The State of Queensland should provide training and resources to its employees and agents who have any responsibilities relevant to children and young people with disability directed, but not limited to:

a. the influence of unconscious and conscious bias, and
b. how discrimination occurs

in responses, actions and decisions concerning children and young people living with disability at risk of experiencing violence, abuse and neglect.

Recommendation 2

The State of Queensland should take active and immediate steps to incorporate the voices and experiences of people with disability, particularly children and young people, and their representative organisations, in the child protection system, with a focus on:

a. representation and/or membership on relevant committees which make decisions concerning children and young people with disability

b. developing and/or reviewing policies and practices concerning children and young people with disability

c. reviewing and/or responding to occurrences and risks of violence, abuse and neglect of children and young people with disability, and

d. developing training materials or delivering training to Queensland public sector employees whose duties, functions and powers concern children with disability in the child protection scheme.

Recommendation 3

The State of Queensland should review section 13E(1)(d) of the *Child Protection Act 1999* (Qld) to consider:

a. whether it should apply to all Queensland Police officers and

b. if not, why it should not apply to all Queensland Police officers.

Recommendation 4

The State of Queensland should expand the operation of the Child Advocate scheme to provide advocacy services to children and young people with disability who are at risk of entering the child protection scheme.

Recommendation 5

5.1 The State of Queensland on behalf of the departments and agencies that engaged with Kaleb and Jonathon should acknowledge and apologise for their omissions in preventing the violence, abuse, neglect and deprivation of their human rights.

5.2 The State of Queensland should conduct an independent review into the powers and responsibilities of all the departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett to examine:

a. the response to the violence, abuse, neglect and deprivation of Kaleb and Jonathon's human rights
b. what each department or agency could and/or should have done to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced
c. whether the current policies and practices are sufficient to prevent the nature and extent of the violence, abuse, neglect and deprivation of human rights occurring to children with disability.

5.3 An independent review should commence at the earliest opportunity.

5.4 The findings and any recommendations of an independent review should be made public and published in an accessible format.

5.5 The State of Queensland should consider making an offer of redress to each of Kaleb and Jonathon, including but not limited to additional supports and assistance each of them may require immediately and on an ongoing basis.

Part 1. Introduction and overview of the hearing, findings and recommendations

1. Between 8 and 10 May 2023, the Royal Commission held its thirty-third and final substantive public hearing in Brisbane, before Commissioners Dr Alastair McEwin AM, Andrea Mason OAM and the Honourable John Ryan AM. Public hearing 33 was conducted as a case study about the violence, abuse, neglect and the deprivation of human rights of two young men with disability, Kaleb and Jonathon (pseudonyms). In this report we refer to the hearing as ‘Public hearing 33’ or the ‘hearing’.

2. At the time of this hearing, Kaleb was 22 years old and Jonathon was 20 years old. Kaleb and Jonathon both live with significant global developmental delay,[1] intellectual disability and autism.[2] Kaleb and Jonathon have limited verbal communication. Their father, Paul Barrett,[3] was the sole carer for most of their lives.

3. On 26 May 2020, staff at Jonathon’s school attempted to call Paul Barrett to check on Jonathon’s welfare.[4] There was no answer and they left a message.[5] On 27 May 2020, Queensland emergency services found Kaleb and Jonathon in their home ‘locked in a room, naked and no bedroom furnishings’.[6] Paul Barrett was found deceased in another room.[7] It is not known how long Paul Barrett was deceased before his body was found. When Queensland Police attended the home, they observed faeces on the floor of the spare bedroom and main bedroom, Kaleb and Jonathon’s bedroom was completely bare with doorhandles removed, and Kaleb and Jonathon were naked.[8] Kaleb and Jonathon were admitted to hospital and treated for severe malnutrition and Kwashiorkor.[9] They remained in hospital for two weeks.[10]

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1 Exhibit 33-1, DRC.2000.0014.0118 (**Agreed Facts**), [34(a)], [96]; Exhibit 33-144, QLD.0002.0027.0263_E, p 1; Exhibit 33-330, QLD.0010.0033.0013, p 5; Exhibit 33-332, QLD.0010.0033.0011, p 1; Exhibit 33-176, QLD.0021.0058.0001, p 4.

2 Agreed Facts, [34(c)], [96], [116]; Exhibit 33-144, QLD.0002.0027.0263_E, p 1; Exhibit 33-342, QLD.0001.0026.0053, p 20; Exhibit 33-330, QLD.0010.0033.0013, p 5; Exhibit 33-332, QLD.0010.0033.0011, p 1; Exhibit 33-176, QLD.0021.0058.0001, p 5.

3 In this report we also refer to Paul Barrett by his name or as the ‘father’.

4 Agreed Facts, [322]; Exhibit 33-199, QLD.0005.0026.1360, p 24.

5 Agreed Facts, [322]; Exhibit 33-199, QLD.0005.0026.1360, p 24.

6 Agreed Facts, [325(b)]; Exhibit 33-312, QLD.0007.0032.0096, p 2.

7 Agreed Facts, [324–325]; Exhibit 33-312, QLD.0007.0032.0096, pp 1–2.

8 Agreed Facts, [326]; Exhibit 33-313, QLD.0008.0029.0431, p 7.

9 Agreed Facts, [327]; Exhibit 33-334, QPG.9999.0002.1389_E, p 1; Exhibit 33-335, QPG.9999.0002.1383_E, p 1; Kwashiorkor is a disease characterised by severe protein deficiency. It is very rare in developed countries like Australia. It is a disease mostly found in developing countries with high rates of poverty and food scarcity. Poor sanitary conditions can also help set the stage for this form of malnutrition. Kwashiorkor can affect people of all ages but it’s most common in children, especially between the age of three to 25 five years: Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 8 May 2023, P-4 [20–25].

10 Agreed Facts, [327], [342]; Exhibit 33-334, QPG.9999.0002.1389_E, p 1; Exhibit 33-335. QPG.9999.0002.1383_E, p 1.

4. The Royal Commission also commenced an investigation. We held this hearing to examine Kaleb and Jonathon's experiences over two decades and specifically to ask why each of them experienced violence, abuse, neglect and a deprivation of human rights over their lives.

Agreed Facts and the evidence

5. Counsel Assisting, Ms Kate Eastman AM SC and Ms Gillian Mahony, conducted the hearing using Agreed Facts. These Agreed Facts are reproduced at **Appendix A** with **Appendix B** being the glossary to the Agreed Facts.

6. At the commencement of the hearing, Counsel Assisting said they had conferred with the legal representatives for the State of Queensland (**Queensland**) to agree on the facts for the hearing. The Agreed Facts set out key events and incidents based on many thousands of documents, together with some photographs and videos produced by Queensland departments and agencies covering Kaleb and Jonathon's lives since 2000. The Queensland legal representatives agreed with the facts in principle, but reserved the opportunity to make further comments and submissions in relation to the agreed facts after Counsel Assisting's submissions were provided for the hearing.[11]

7. We found the use of the Agreed Facts to be helpful and fair, in circumstances where the hearing was conducted over three days and covered a significant period of time.

8. The Agreed Facts identify particular Queensland departments and agencies. For the purpose of this report, we use the expression 'Queensland departments and agencies' for convenience. Where we wish to identify a particular department or agency, we identify them by name. As the names of many of the Queensland departments and agencies changed during the period Kaleb and Jonathon were in their father's care, we include a glossary of terms and abbreviations in **Appendix C** to this report.

9. The Agreed Facts were further based on contemporaneous records prepared by and maintained for the most part by Queensland Government officers and employees. We have no reason to doubt the veracity or reliability of Queensland's records.

10. Thirteen witnesses gave evidence. This included nine witnesses from Queensland departments, agencies and independent statutory bodies; two witnesses from the National Disability Insurance Agency (**NDIA**) and two witnesses who had or have direct experience with Kaleb and Jonathon. We address their evidence in this report. We extend our appreciation to all witnesses who appeared at the hearing.

11 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 8 May 2023, P-6 [39–45].

11. The Agreed Facts reveal the nature and extent of the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced when living with Paul Barrett. We did not hear Paul Barrett's version of the events and his interests were not represented at the hearing. However, based on the available evidence, Paul Barrett's treatment of his sons failed to meet the standard of care expected of a parent. Kaleb and Jonathon were deprived of their basic and fundamental human rights as children.

12. Paul Barrett's actions cannot be viewed in isolation or detached from systems that should have protected Kaleb and Jonathon. This hearing provided an opportunity to understand the family's circumstances and specifically their interaction with Queensland departments and agencies, and later the NDIA.

13. Counsel Assisting used a life course approach to examine how and why Kaleb and Jonathon experienced violence, abuse, neglect and the deprivation of their human rights from birth into their adulthood.[12] Specifically, the hearing examined whether the violence, abuse, neglect and deprivation of human rights experienced by Kaleb and Jonathon was preventable. Child protection systems exist to intervene where a child is experiencing or is at risk of experiencing harm.[13] We wanted to understand the responsibilities and actions of relevant Queensland departments and agencies to prevent and safeguard Kaleb and Jonathon from the violence, abuse and neglect that resulted in a deprivation of their human rights. Following Kaleb and Jonathon's life courses was also an opportunity to consider the importance of a human rights approach. This included the rights of the child and the application of the 'best interests of the child' principle in all decisions and actions concerning children.

14. The hearing also provided an opportunity to look forward and to hear about the changes in each of Kaleb and Jonathon's lives following their father's death.

The parties' submissions

15. Following Public hearing 33, Counsel Assisting prepared written submissions dated 7 June 2023.[14] On 28 June 2023, we received submissions in response from Queensland,[15] as well as the Australian Government making representations on behalf of the NDIA, the Department of Social Services and the Attorney-General's

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12 See Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 25 [88]–30 [104], 91 [269]–112 [334].

13 Exhibit 8-26.15, EXP.0055.0001.0001, p 1.

14 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023.

15 Submissions by the State of Queensland (Queensland) in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001; Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0089.

Department.[16] The Queensland Family and Child Commission (**QFCC**) and State of Victoria also provided comments. On 17 July 2023, Counsel Assisting provided a submission in reply to some aspects of Queensland's submissions described as 'Contextual Matters'.[17]

16. We considered all of the submissions in reaching our findings, and making our recommendations when preparing this report. If we do not refer to or expressly address any submission, it should not be assumed that we overlooked or failed to consider the matters raised in the submissions. The approach we have taken with respect to the findings and recommendations means it has not been necessary to address every point raised by Counsel Assisting or the parties with leave to appear, which are listed in **Appendix E**.

17. We thank all counsel and their instructing solicitors who appeared at the hearing. We also thank those who assisted the Royal Commission by preparing documents, statements, and submissions for the hearing. We acknowledge they all worked under tight time frames.

Overview of findings

18. Counsel Assisting submitted it was open for us to make 21 findings with respect to Queensland, its department and agencies.[18] After considering all the submissions, we are satisfied it is only necessary to make the following three findings:

    Finding 1: Kaleb and Jonathon experienced violence, abuse, neglect and the deprivation of their human rights, in the care of their father, Paul Barrett, between 2000 and 27 May 2020.

    Finding 2: The violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced in the care of their father, Paul Barrett, was preventable.

    Finding 3: The State of Queensland through the departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett, could and should have done more to prevent Kaleb and Jonathon from experiencing violence, abuse, neglect and the deprivation of their human rights, having regard to the particular departments' or agencies' powers and responsibilities.

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16 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001.

17 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 17 July 2023; Submissions by the State of Queensland (Queensland) in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 4 [11]–10 [43].

18 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 10 [15], 141 [432]–142 [436], 161 [512]–162 [514], 186 [599]–188 [602], 201 [664], 209 [703]–210 [705], 221 [752–754], 232 [799–801].

19. These three findings recognise the nature, extent and harm experienced by Kaleb and Jonathon. The findings highlight that the risk of violence, abuse and neglect for children with disability requires active attention and action by family, friends, the community, and all government departments and agencies that come into the lives of children. These findings recognise the importance of effective policies and practices to safeguard children from the risk of violence, abuse and neglect.

20. Living with a disability should not justify or excuse violence, abuse, neglect or deprivation of rights. These findings assist in understanding what happened to Kaleb and Jonathon. They also provide an opportunity to put in place measures that ensure what happened to them, never happens to any other child with disability.

21. In addition to these three principal findings, Counsel Assisting proposed a further 18 findings with respect to particular Queensland departments and agencies.

22. Queensland raised a number of issues in its submissions about the conduct of the hearing, procedural fairness and its concerns that adverse findings would be made about individuals, including the witnesses who gave evidence for six departments or agencies. We have taken these concerns into account in determining whether it is necessary to make any additional findings. We note Queensland accepted some but not all of the 18 additional findings proposed by Counsel Assisting. Where Queensland did address findings and recommendations, it proposed amendments to the wording of some findings and opposed some findings. We also note Queensland's advice that '[w]here there is not a detailed response [to a proposed finding] it should be assumed that such a finding is accepted.'[19]

23. We have carefully considered all the submissions and reached the conclusion that is not necessary for us to make the additional 18 findings, as standalone or separate findings for the following reasons.

24. First, Queensland was on notice prior to the hearing of the three proposed findings which are now Findings 1 to 3 and were described by Counsel Assisting as 'indicative findings'. Queensland's in principle agreement with the Agreed Facts and the additional evidence it sought to rely on, was directed to these three indicative findings.[20]

19 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 4 [13].

20 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 8 May 2023, P-6 [39–45].

25. Secondly, while the departments and agencies engaged with the family at different times, in different ways and all exercised particular functions and powers, our findings are directed to the State of Queensland, not its separate departments or agencies, where those departments or agencies have no independent legal personality and are an emanation of the crown in right of the State of Queensland. In the circumstances, it is not necessary to make separate and additional findings on a department or agency basis, given Finding 3.

26. Thirdly, Finding 3 makes a finding that Queensland through its departments or agencies could have 'done more' to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon each experienced, having regard to the particular departments' or agencies' powers and responsibilities. Below we refer to some specific situations where particular departments or agencies have conceded more could have been done.

Recommendations with respect to Queensland

27. Counsel Assisting also proposed 11 recommendations with respect to the Queensland departments and agencies.[21] Queensland accepted some of the recommendations and opposed others. Consistently with the approach we take to the findings, we will not make recommendations directed to particular Queensland departments or agencies. In Part 7, we make five recommendations directed to Queensland.

Findings and recommendations with respect to the NDIA

28. Counsel Assisting did not seek any findings with respect to the NDIA. However, the Australian Government's submissions did raise some factual issues that required our consideration. We have addressed those issues in this report.

29. Counsel Assisting also did not seek recommendations for the NDIA, but identified issues for the NDIA to consider. We considered these submissions and the Australian Government's submissions in response. We have not made recommendations but have identified areas of concern regarding child representatives/nominees and the opportunities for the NDIA to contribute to the prevention of violence, abuse, neglect and the deprivation of a participant's rights with respect to under-utilisation in National Disability Insurance Scheme (**NDIS**) plans.

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21 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 142–143 [437], 162 [515], 188 [603–604], 201 [665], 210 [706], 221–222 [755], 232 [802], 285 [1021], 288–289 [1031], 299 [1076].

Findings about individuals

30. Counsel Assisting did not seek findings against any individuals. They explained the focus of the hearing was on systemic issues. Accordingly, we do not make any findings with respect to any individuals.

31. We considered Queensland's submissions and its contentions with respect to procedural unfairness and denial of natural justice to witnesses. It was Queensland's decision to provide statements from six witnesses for this hearing. The Royal Commission did not require any witnesses from the various departments or agencies to give evidence. Queensland provided the statements after it had the benefit of the Agreed Facts with the three indicative findings and with knowledge the hearing had been fixed for three days. Queensland provided the statements on the day before the hearing commenced and during the course of the hearing.

32. We accepted the statements and heard from the Queensland witnesses, notwithstanding we had very little prior notice or opportunity prior to the commencement of the hearing to review the information. Given that the content of the statements addressed matters beyond the Agreed Facts and introduced a range of new issues for the Royal Commission to consider, it was appropriate that each of the witnesses was examined in the time available. Contrary to Queensland's submission, Counsel Assisting were not required to provide the Queensland witnesses with the questions they would be asked in advance of an examination. As we followed the evidence, Counsel Assisting's questions were directed to matters raised by the witnesses in their statements or matters arising from the proposed findings or Agreed Facts.

33. Further, procedural fairness was accorded as Counsel Assisting conducted their examination based on matters arising from Queensland's witnesses' own statements, the other witnesses' statements made available to Queensland prior to the hearing, the Agreed Facts and materials referenced therein, as well as the indicative findings. We observed all of the Queensland witnesses were well equipped to answer Counsel Assisting's and our questions. They told us if they were unsure or required the opportunity to take a question on notice. At the conclusion of the evidence of the following witnesses, Senior Counsel for Queensland was asked if she had further questions for the witnesses before they were excused:

    - Dr Meegan Crawford, Regional Executive Director, Brisbane Moreton Region, Department of Children, Youth Justice and Multicultural Affairs, Queensland[22]
    - Ms Hayley Stevenson, Acting Assistant Director-General, Department of Education, Queensland[23]

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22 Transcript, Alastair McEwin (Commissioner) and Kathryn McMillan (Counsel), Public hearing 33, 10 May 2023, P-166 [10–25].

23 Transcript, Alastair McEwin (Commissioner), Kathryn McMillan (Counsel) and Hayley Stevenson, Public hearing 33, 10 May 2023, P-193 [14]–P-194 [33].

- Mr Denzil Clark, Detective Superintendent, Queensland Police Service[24]
- Ms Michelle Bullen, Executive Director, Inclusion, Programs and Strategy, Department of Seniors, Disability Service and Aboriginal and Torres Strait Islander Partnerships, Queensland,[25] and
- Ms Chantal Raine, General Manager, Service Delivery, Housing and Homelessness Services, Department of Communities, Housing and Digital Economy, Queensland (as the Department of Housing was known at the time of the hearing).[26]

34. In circumstances where Queensland provided detailed statements on the eve of and during the hearing, and where all parties knew the hearing was listed for 3 days, we do not accept Queensland's criticisms of Counsel Assisting completing the examinations in one day is well founded or that Queensland or any witnesses were denied procedural fairness or natural justice.

35. With respect to any adverse comments about a witness' evidence, it is appropriate for Counsel Assisting to make submissions with respect to the reliability of the evidence and what weight we should give to the evidence. We have not been asked to make findings about individuals, including the six Queensland witnesses who appeared in their capacity as representatives of Queensland departments or agencies, and not in a personal capacity.

36. Queensland's contentions with respect to the requirements of *Browne v Dunn*[27] appear to be misplaced and based on a misconception that findings will be made about the credit or reputations of the individuals. None of the findings proposed by Counsel Assisting in their submissions called for a finding that identified or was directed to any of the six individuals who gave evidence.

37. In any event, Queensland has availed itself of the opportunity to make submissions in response and address any criticisms with respect to the oral evidence provided by its witnesses in its submissions. We have considered these submissions.

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24 Transcript, Alastair McEwin (Commissioner), Kathryn McMillan (Counsel) and Denzil Clark, Public hearing 33, 10 May 2023, P-235 [15]–P-236 [29].

25 Transcript, Alastair McEwin (Commissioner) and Kathryn McMillan (Counsel), Public hearing 33, 10 May 2023, P-246 [22–34].

26 Transcript, Alastair McEwin (Commissioner), Public hearing 33, 10 May 2023, P-261 [23–26].

27 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 7 [31–32]; *Browne v Dunn* (1893) 6 R67, H.L.

Part 2. Concepts of violence, abuse, neglect and deprivation of rights

38. We accept the descriptions of 'violence', 'abuse', 'neglect' and 'deprivation of human rights' developed in Counsel Assisting's submissions.[28]

39. 'Violence' is the use or threatened use of force, or the unjust use of power, that causes or is likely to cause harm or fear of harm to a person or group of people with disability. In the context of children, all forms of violence against children, however light, are unacceptable.[29]

40. Violence is not confined to physical violence. It includes psychological violence, coercion, and arbitrary deprivation of liberty. Violence includes coercive control, enforcing isolation from family and friends, repeated humiliation or degradation, and threats to harm family members. Any of these forms of violence may be perpetrated in the context of domestic or family violence.

41. 'Abuse' is acts or omissions that cause or are likely to cause direct or indirect harm to a person or group of people with disability. It can occur as single or repeated incidents or a pattern of behaviour over a period of time. Abuse of people with disability can include:

    - threats, intimidation, and behaviour insulting or humiliating the person
    - disability-specific abuse, including removing, denying or withholding necessary assistance and care
    - exclusion and isolation
    - forced and entrenched segregation
    - deprivation of human rights and personal dignity
    - denial of autonomy over significant or everyday decisions.

42. 'Emotional abuse' is damage to the child's emotional well-being. It may occur because of a failure to advance the child's best interests, in the treatment of the child including exclusion, isolation from family, peers and community and deprivation of love and care.

43. 'Neglect' is the failure to provide physical, emotional, social and cultural wellbeing and development of a person or group of people with disability or a failure to maintain the conditions or circumstances to support a person. Neglect can occur where natural and

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28 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 45 [164]–47 [167], 63 [205–206], 67 [217–218], 86 [247–249].

29 Committee on the Rights of the Child, *General comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, (18 April 2011), p 8 [17].

systemic safeguards fail to protect a person from violence and abuse. Neglect of a child includes:

- physical neglect, being a 'failure to protect a child from harm, including through a lack of supervision, or a failure to provide the child with basic necessities including adequate food, shelter, clothing and basic medical care'[30]
- psychological or emotional neglect, through the 'lack of any emotional support and love, chronic inattention to the child… exposure to partner violence, drug or alcohol abuse'[31]
- neglect of children's physical or mental health through withholding essential medical care.[32]

44. For the purpose of this hearing, a deprivation of human rights means the rights of the child and a young person recognised by the *Convention on the Rights of the Child* (***CRC***)[33] and from July 2008, the *Convention on the Rights of Persons with Disabilities* (***CRPD***).[34]

45. We also refer to the nature of 'harm'. On each occasion Kaleb and Jonathon experienced violence, abuse, neglect and a deprivation of rights, they also experienced harm. For a child, harm is 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.'[35] The harm can be a result of a single act, omission or circumstance or series of acts, omissions or circumstances. [36] A person can cause harm in this context by physical, psychological or emotional abuse or neglect.[37]

46. Counsel Assisting submitted there was cumulative harm as a result of neglect stemming from Kaleb and Jonathon's circumstances of intergenerational poverty, parental substance abuse, social isolation, and lack of access to adequate medical

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30 Committee on the Rights of the Child, *General Comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN/CRC/C/GC/13, (18 April 2011), p 9, [20(a)].

31 Committee on the Rights of the Child, *General Comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN/CRC/C/GC/13, (18 April 2011), p 9, [20(b)].

32 Committee on the Rights of the Child, *General Comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN/CRC/C/GC/13, (18 April 2011), p 9, [20(c)].

33 *Convention on the Rights of the Child*, opened for signature 20 November 1987, 1577 UNTS 3 (entered into force 2 September 1990).

34 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

35 *Child Protection Act 1999* (Qld) s 9(1).

36 *Child Protection Act 1999* (Qld) s 9(4).

37 *Child Protection Act 1999* (Qld) s 9 (3)(a).

and disability support services.[38] They submitted there were persistent experiences of harm with respect to:

a. being isolated and confined to their room in humiliating and degrading conditions of detention, including as a way to address their supervision
b. being insufficiently supervised or unsupervised
c. being exposed to violence by Paul Barrett against their mother and his partners
d. being left in soiled nappies and withheld toileting assistance
e. not having adequate or nutritious food or support for their eating behaviours
f. not having basic furnishings in their home
g. not having appropriate clothing
h. being exposed to an unhygienic and unsafe home environment
i. being exposed to Paul Barrett's intoxication
j. lacking access to basic and essential medical care and support. [39]

47. We acknowledge our descriptions are broad and also reflect a human rights approach.

48. In its submissions Queensland has referred to the *Child Protection Act 1999* (Qld) (***Child Protection Act***) and referred us to the current four identified 'abuse types', being physical abuse, psychological/emotional abuse, sexual abuse and neglect. Queensland also refers to three 'harm types', being physical, emotional or psychological.[40]

49. There is no dispute that the *Child Protection Act* identifies these abuse and harm types. We also accept the Department of Child Safety operated by reference to the *Child Protection Act* definitions and classifications.[41] However, this hearing was not directed to or confined by the *Child Protection Act.* Contrary to Queensland's submissions, it was apparent that Dr Crawford, understood the context in which the concepts of violence, abuse, neglect and harm were used in the hearing with respect to Kaleb and Jonathon's experiences described in the Agreed Facts.

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38 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 127 [384]

39 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 127–128 [384].

40 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 27 June 2023, SUBM.0033.0002.0001, p 16 [70].

41 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 27 June 2023, SUBM.0033.0002.0001, pp 36–37 [175]. See also *Child Protection Act 1999* (Qld) s 3.

Approaches taken in this hearing

50. Unlike other hearings of this Royal Commission, this case study did not focus on particular incidents or events. Rather, it was an opportunity to adopt a life course approach. This was apparent from the reliance on Agreed Facts that traversed a period of 20 years.

Life course approach

51. The 'life course' of a person refers to their experiences during their life and within their social environment and historical context.[42] A life course approach recognises all aspects of people's lives are interconnected and interdependent. A person's biological, relational, cultural, institutional, environmental and social influences can impact on their life trajectories and outcomes. While each person's life course is unique, we can observe patterns across groups of people who share common circumstances or experiences. We accept Counsel Assisting's submission that this hearing provided the opportunity to take a life course approach to examine Kaleb and Jonathon's experiences during various periods, from perinatal, early childhood, middle childhood, adolescence, through their transition to adulthood and, now their experiences as young men.

52. We also accept the life course approach provided a framework to identify what influences throughout Kaleb and Jonathon's lives put them at risk of experiencing the violence, abuse, neglect and deprivation of their rights, and what factors protected against it, while they were in their father's care.

53. The Agreed Facts reveal there were many influences in Kaleb and Jonathon's life pathways. We accept Counsel Assisting's submission these influences included, but were not limited to:

    a. individual characteristics and influences, being the nature of their respective disability, their ages when particular events occurred and their socio-economic circumstances
    b. relationships with their father, mother, broader family, at school, their immediate social networks, neighbours and throughout the community
    c. the systems and settings, being the extent to which they came into contact with government services including child protection, health, housing, disability services and later the NDIA

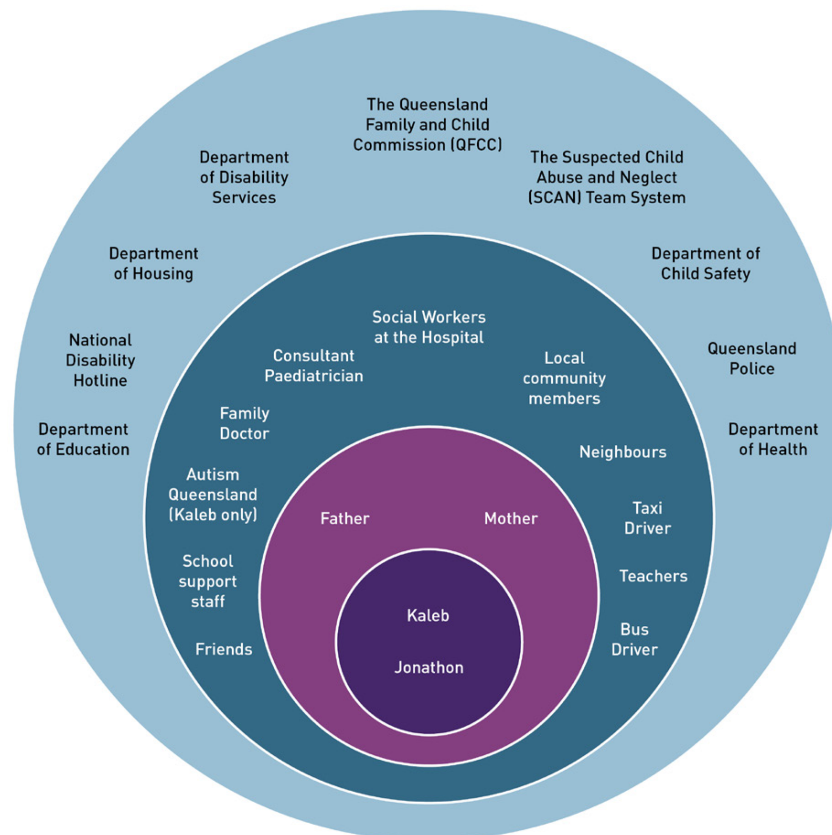
42 See generally Janet Giele & Glen H Elder Jr, *Methods of life course research: Qualitative and quantitative approaches*, Sage, 1998, pp 22–23; Duane F Alwin, 'Integrating varieties of life course concepts', 2012, vol 67(2), *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*. See also Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 25–30 [88–104].

d. the broad social, economic and policy circumstances relevant to their lives. For example, the rollout of the NDIS impacted on their opportunity to access, and their actual access to, disability support services. Another social influence was the impact of the COVID-19 pandemic, which impacted on their day-to-day interactions with community and for Jonathon, attendance at school and contact with teachers.

54. We reproduce below Figures from Counsel Assisting's submissions, with a correction to the identification of one agency.[43]

55. Figure 1 depicts the relational and systems influences in Kaleb and Jonathon's lives between 2000 and 2018. As Counsel Assisting explained, these influences were not static and changed over time. For example, Jonathon is included although he was born in 2003. Also, Figure 1 identifies their mother as a relational influence in their lives. Their mother was not involved in their lives from around early 2005. From that point on that relational influence ceased.[44]

Figure 1: Kaleb and Jonathon's relational and systems influences 2000–2018



43 In the original diagram, the QFCC was referred to as 'The Queensland Families and Child Commission'. The new diagram contains the QFCC's correct name, 'The Queensland Family and Child Commission'.

44 Agreed Facts, [89(b)]; Exhibit 33-173, QLD.0002.0027.0086_E, p 1.

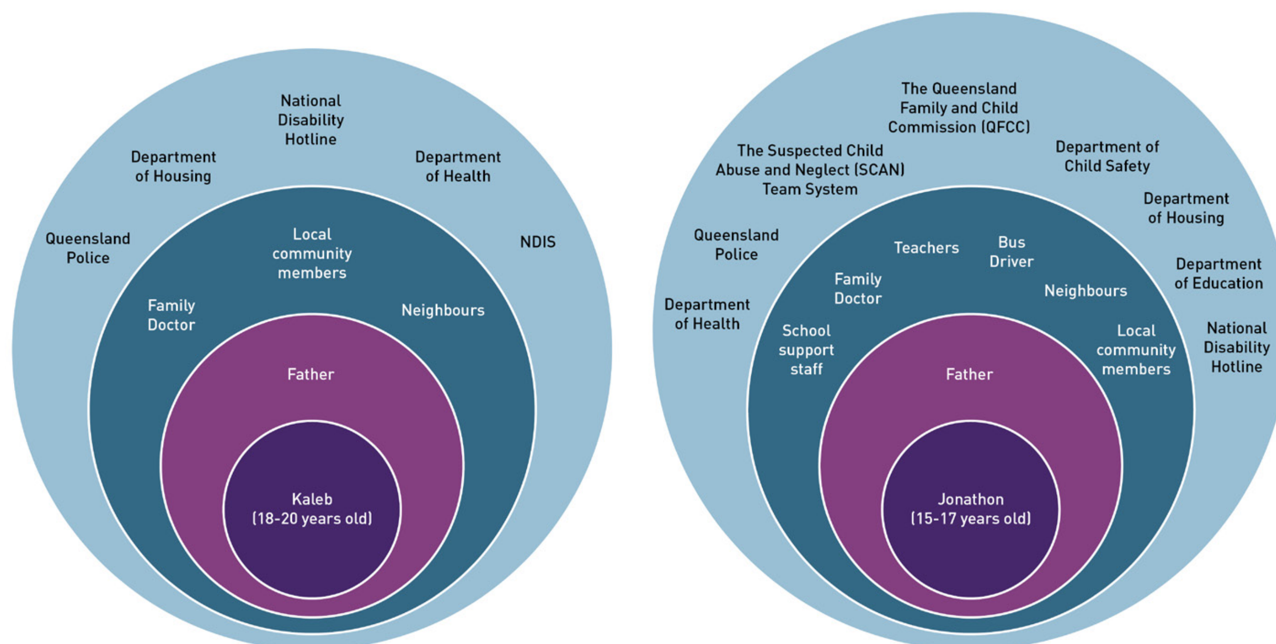
56. The outer, light blue ring of Figure 1 represents institutions, including government department and agencies which had contact with, or oversight of, Kaleb and Jonathon.

57. The next teal ring represents a mixture of relational and systems influences in Kaleb and Jonathon's lives. They are professionals who had more frequent contact with Kaleb and Jonathon at different points in the relevant period. They are also members of the community, neighbours and friends, who crossed Kaleb and Jonathon's paths.

58. The next violet ring of Figure 1 represents Kaleb and Jonathon's immediate family, who had day-to-day contact with Kaleb and Jonathon. The evidence shows their immediate family, in particular, their father, played a significant role in Kaleb and Jonathon's relationship and interactions with those in the outer rings of the graphic.

59. Figure 2 summarises the relational and systems influences in Kaleb and Jonathon's lives between 2018 up to their father's death in 2020.

Figure 2: Kaleb and Jonathon's relational and systems influences 2018–2020



60. The outer, light blue ring of Figure 2 represents institutions, including government department and agencies which had contact with, or oversight of, Kaleb and Jonathon from 2018 to 2020. Kaleb's outer ring shows that between 2018 to 2020, after he turned 18, the institutional involvement from the Department of Education, Department of Disability Services, QFCC, SCAN, and Department of Child Safety ceased. Jonathon's institutional involvement during this time was generally similar to those he had prior to 2018.

61. The next, teal ring of Figure 2 represents a mixture of relational and systems influences in Kaleb and Jonathon lives from 2018 to 2020. As an adult, Kaleb's contact with community, friends and professionals was less than when he was under 18. For example, he no longer had contact with teachers and his support services from Autism Queensland ceased. There were less safeguards for the oversight of his day-to-day living activities and conditions. Jonathon, by contrast, was still under 18 years old and had more points of contact in the community than Kaleb, including teachers, school support staff and the bus driver who took him to and from school.

62. The next violet rings of Figure 2 represent Kaleb and Jonathon's immediate family, who had day-to-day contact with Kaleb and Jonathon from 2018 to 2020. For Kaleb and Jonathon, their family was each other and their father.

63. On the whole, Figure 2 demonstrates Kaleb and Jonathon's diminishing relational and systems contacts as they got older.

64. The approach demonstrates the multi-dimensional and inter-connected factors that affect a person's life. It highlights there will rarely be one or an exclusive cause of violence, abuse, neglect or one person/entity responsible.

65. This approach assists in understanding the interactions and to identify the factors that give rise to risks of violence, abuse, neglect and the deprivation of human rights. By examining these relational and systems influences, as well as Kaleb and Jonathon's individual and social influences, we can identify:

    - what interventions, supports and systemic responses could and should have been implemented to have prevented Kaleb and Jonathon experiencing violence, abuse, neglect and a deprivation of their human rights
    - what interventions, supports and systemic responses should be implemented to prevent and respond to like-situations in the future.

66. As Counsel Assisting submitted, understanding violence, abuse and neglect for people with disability also requires recognising conscious and unconscious bias in the form of ableism. Ableism and negative stereotypes are a cause of violence, abuse and neglect. Ableism describes the attitudes, beliefs and behaviours towards people with

disability that treat them as 'different', 'other', and 'special'.[45] And, importantly in this context of Queensland systems, ableism is more than just negative and prejudiced attitudes about people with disability; it occurs when prejudice is accompanied by the power to discriminate against, repress or limit the rights of others.[46]

67. People with disability may be perceived as a burden on their family and the broader community. These attitudes may operate to assume people with disability are not capable or entitled to the same human rights as people without disability, or that people with disability should not exercise choice and control in their lives. These attitudes may result in accepting or normalising violence, disrespect and discrimination against people with disability.[47]

Queensland's response to the life course approach

68. Queensland submitted a life course approach is a unique method to analyse and understand Kaleb and Jonathon's experiences and welcomed a wholistic view.[48] However, Queensland submitted we should apply the life course approach with caution and avoid 'hindsight bias', in particular when considering whether to make certain findings about how particular Queensland departments and agencies assessed Kaleb and Jonathon's circumstances while in their father's care, and what responses these departments and agencies could or should have had.[49]

69. Queensland submitted it would be unsafe for us to apply current views, standards and practices to actions and events to this case study.[50] It also reminded us that we have the benefit of reviewing information as collectively shared between Queensland departments and agencies, which was not necessarily available to them independently or was available on a limited basis.[51]

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45 See for example Shane Clifton, *Hierarchies of power: theories and models of disability and their implications for violence, abuse, neglect, and exploitation of people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, October 2020, pp 15–16; Rosemary Kayess and Therese Sands, *Convention on the Rights of Persons with Disabilities: Shining a light on social transformation*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, September 2020, p 10.

46 See the similar definition of racism in the *Racism. It Stops With Me* campaign of the Australian human rights commission: 'Racism. It Stops With Me' *Australian Human Rights Commission*, web page. <https://itstopswithme.humanrights.gov.au/commit-to-learning>.

47 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 45 [163].

48 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 10 [44].

49 For example, Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 34 [161–165].

50 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 10 [45].

51 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 10 [46].

70. Queensland submitted a preferred approach should be to undertake an analysis of the case study exercising fair judgment with regard to Queensland's conduct at particular times, and acknowledging changing views, standards and practices across the duration of the case study.[52]

71. We do not accept that Counsel Assisting's use of the life course approach in their submissions resulted in a lack of fairness or was informed by hindsight bias.

72. 'Hindsight bias' has been described in the following way:

> Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities. Hindsight bias stems from (a) cognitive inputs (people selectively recall information consistent with what they now know to be true and engage in sensemaking to impose meaning on their own knowledge), (b) metacognitive inputs (the ease with which a past outcome is understood may be misattributed to its assumed prior likelihood), and (c) motivational inputs (people have a need to see the world as orderly and predictable and to avoid being blamed for problems). Consequences of hindsight bias include myopic attention to a single causal understanding of the past (to the neglect of other reasonable explanations) as well as general overconfidence in the certainty of one's judgments. New technologies for visualizing and understanding data sets may have the unintended consequence of heightening hindsight bias, but an intervention that encourages people to consider alternative causal explanations for a given outcome can reduce hindsight bias.[53]

73. Counsel Assisting's use of the Agreed Facts, the three proposed findings, the examination of the evidence and their submissions do not evidence an approach infected by hindsight bias.

74. Counsel Assisting did not suggest there was a single cause or that any one action or decision would have prevented the violence, abuse, neglect and deprivation of human rights. Counsel Assisting encouraged us to consider the totality of actions and measures to safeguard Kaleb and Jonathon available to Queensland departments and agencies as well as the NDIA, at various times in their lives.

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52 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 10 [45], 11 [50], 16 [70].

53 See Neal J. Roese & Kathleen D. Vohs, 'Hindsight Bias', (2012), vol 7 (5), *Perspectives on Psychological Science*, p 411. See also Mikaela Spruill & Neil A Lewis Jr, 'How Do People Come to Judge What Is "Reasonable"? Effects of Legal and Sociological Systems on Human Psychology', (2023), vol 18 (2), *Perspective on Psychological Science*. See also Harry L. Hom Jr, 'Perspective-taking and hindsight bias: When the target is oneself and/or a peer', (2023), *Current Psychology*, pp 13987–13988.

Human rights approach

75. Counsel Assisting explained why the hearing was intended to take a human rights approach with a particular emphasis on children and young people with disability.[54] This approach is consistent with the Royal Commission's terms of reference.

76. We will not repeat the detail provided in Counsel Assisting submissions[55] and we understand Queensland did not challenge the identification of relevant human rights and their application to children with disability.

77. We accept the CRC and the various guiding comments made by the Committee on the Rights of the Child, established by Article 43 of the *CRC* (**CRC Committee**) explaining the importance of applying the 'best interests of the child' principle.[56] This includes, the right of the child to have his or her best interests assessed and taken as a primary consideration when different interests are being considered.[57] As to the application of the best interests principle, the CRC Committee said 'action', includes all the 'decisions, but also all acts, conduct, proposals, services, procedures and other measures' undertaken by public and private bodies and which directly or indirectly impact children as a group or a single child'.[58]

78. The CRC Committee recognised:

> Inaction or failure to take action and omissions are also 'actions', for example, when social welfare authorities fail to take action to protect children from neglect or abuse.[59]

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54 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 30 [105]–43 [156].

55 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 28 June 2023, pp 30 [105]–43 [156].

56 See also, Roberta Ruggiero, 'Article 3: The Best Interest of the Child' in Monitoring State Compliance with the UN Convention on the Rights of the Child, Children's Well-Being: Indicators and Research, vol 25, Springer, 2022; Michael Freeman, A commentary on the United Nations Convention on the Rights of the Child, Article 3: The best interests of the child, Martinus Nijhoff Publishers, 2007; United Nations Children's Fund, Implementation Handbook for the Convention on the Rights of the Child, Handbook, 3rd ed, 2007).

57 See Committee on the Rights of the Child, *General comment no. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, 62nd sess, UN CRC/C/GC/14, (29 May 2013).

58 Committee on the Rights of the Child, *General comment no. 14 (2013) on the right of a child to have his or her best interests taken as a primary consideration (art. 3, para . 1)* UN CRC/C/GC/14, (29 May 2013), [17].

59 Committee on the Rights of the Child, *General comment no. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, UN CRC/C/GC/14, (29 May 2013), [18].

79. The CRC Committee said the concept of the best interests of the child, 'cannot be used to justify practices … which conflict with the child's human dignity and right to physical integrity'.[60] The best interests of the child 'are best served through prevention of all forms of violence and the promotion of positive child-rearing'.[61]

80. In General Comment no. 9 on the rights of children with disabilities, the CRC Committee observed children with disabilities are more vulnerable to all forms of abuse be it mental, physical or sexual in all settings, including the family, schools, private and public institutions, inter alia alternative care, work environment and community at large. [62] The CRC Committee said the best interests principle covers all aspects of care and protection for children with disability in all settings.[63]

81. The CRC Committee's General Comment no. 7 on implementing child rights in early childhood expressly recognised the particular interests of children with disability. The CRC Committee said:

> Discrimination against children with disabilities reduces survival prospects and quality of life. These children are entitled to the care, nutrition, nurturance and encouragement offered other children. They may also require additional, special assistance in order to ensure their integration and the realization of their rights.[64]

82. The Royal Commission considered the *CRPD* in all public hearings. Article 7 of the *CRPD* specifically concerns the rights of children with disability. It states:

> (1) States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
>
> (2) In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
>
> (3) States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given

60 Committee on the Rights of the Child, *General comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN CRC/C/GC/13, (18 April 2011), [61].

61 Committee on the Rights of the Child, *General comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN CRC/C/GC/13, (18 April 2011), [61(a)].

62 Committee on the Rights of the Child, *General comment no. 9 (2006) on the rights of children with disabilities*, 43rd sess, UN CRC/C/GC/9, (29 September 2006), [42].

63 Committee on the Rights of the Child, *General comment no. 9 (2006) on the rights of children with disabilities*, 43rd sess, UN CRC/C/GC/9, (29 September 2006), [29].

64 Committee on the Rights of the Child, *General comment no. 7 (2005) Implementing child rights in early childhood*, 40th sess, UNCRC/C/GC/7/Rev.1 (20 September 2005), [11(b)(ii)].

due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.[65]

Queensland Human Rights Act

83. A further reason to consider a human rights approach in this hearing was the operation of the *Human Rights Act 2019* (Qld) (***Human Rights Act***), which commenced on 1 January 2020. Mr Scott McDougall, Commissioner, Queensland Human Rights Commission (**QHRC**) gave evidence and provided an overview of the features of the *Human Rights Act*. [66] There are 23 human rights included in *Human Rights Act.* The rights draw on some international human rights conventions binding on Australia, including the *International Covenant on Civil and Political Rights* (***ICCPR***)[67] and in part the *International Covenant on Economic, Social and Cultural Rights* (***ICESCR***).[68]

84. The *Human Rights Act* had no retrospective application and applied to the circumstances in this case study for a limited period after 1 January 2020. However, understanding the *Human Rights Act* and how the Queensland departments and agencies will apply the human rights principles in the future was materially relevant to the issues we examined. During this hearing, we asked the Queensland departments and agencies about their approach and practices with respect to the *Human Rights Act*.[69] It was apparent there was a high level of awareness about the *Human Rights Act* and the obligation to act consistently with human rights.

85. It is not necessary for us to make any findings about the relevance of the *Human Rights Act* to Kaleb and Jonathon. We acknowledge the importance of legislative human rights protections for children and young people with disability in Queensland.

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65 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), art 7.

66 Transcript, Scott McDougall, Public hearing 33, 8 May 2023, P-61 [35]–P-72 [40].

67 *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

68 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

69 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-93 [44]–P-95 [25], Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-246 [3–20]; Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-52 [15]–P-57 [9]; Transcript, Scott McDougall, Public hearing 33, 8 May 2023, P-62 [41]–72 [35]; Exhibit 33-34, 'Statement of Shayna Smith', 28 April 2023, [8–10], [19–56], [61–90]; Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, [29–38]; Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, [10]; Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, [19], [162–163]; Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, [44–47]; Exhibit 33-71, 'Statement of Chantal Raine', 5 May 2023, [47–50]; Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, [44]; Exhibit 33-77, 'Statement of Frank Tracey', 9 May 2023, [28–32].

In its submission, Queensland told us there will be an independent review of the *Human Rights Act* that will occur as soon as practicable after 1 July 2023 and the terms of reference for the review include consideration about remedies and whether additional human rights should be included, such as the *CRC*.[70]

86. Queensland also stated its commitment to ensuring an appropriate service response to children and parents with disability across all child protection phases and respecting, protecting and promoting each child's rights under the *Human Rights Act*. [71]

NDIS service providers and the Human Rights Act

87. We also wanted to understand a unique feature of the *Human Rights Act* with respect to the duties imposed on a registered provider of supports or a NDIS registered provider under the *National Disability Insurance Scheme Act 2013* (Cth) (***NDIS Act***), when the provider is performing functions of a public nature in Queensland.[72] These providers are 'public authorities' for the purpose of the *Human Rights Act*. Like all public authorities, this means these service providers must act or make a decision in a way that is not incompatible with human rights and they must give proper consideration to a relevant human right when making a decision.[73] The *Human Rights Act* includes arrangements for complaints about NDIS service providers who are 'public entities' to be referred to the NDIS Quality and Safeguards Commissioner.[74]

88. Counsel Assisting asked the NDIA representatives if the NDIA had turned its mind to the effect of the *Human Rights Act* on registered NDIS providers.[75] Dr Sam Bennett, General Manager, Policy, Advice and Research, NDIA said he was not aware of any specific consideration the NDIA has given to the implications of the *Human Rights Act*.[76] Dr Bennett referred to 'human rights legislation more generally' and the *CRPD* as matters which inform the NDIA developing their position around supported decision making. [77] Mr Desmond Lee, Acting General Manager, National Delivery, NDIA agreed with Dr Bennett's comments.[78]

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70 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 80 [351].

71 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 82 [366] and generally at Appendix 1 at pp 81–88.

72 *Human Rights Act 2019* (Qld) ss 9(2), (5).

73 *Human Rights Act 2019* (Qld) s 58(1).

74 *Human Rights Act 2019* (Qld) s 73(5).

75 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-124 [46]–P-125 [17].

76 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-125 [23–24].

77 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-125 [25–30].

78 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-125 [33].

89. Counsel Assisting submitted it is open for the NDIA to consider the implications of the *Human Rights Act* on NDIS service providers, the manner in which the NDIA engages with those providers, and the extent to which these matters are reflected in NDIA actions, policies or practices.[79]

90. In its response, the Australian Government submitted a finding of a breach of the *Human Rights Act* is not in the remit of the NDIA.[80] This was not the issue raised in Counsel Assisting's submission.

91. The Australian Government further submitted if Counsel Assisting were suggesting that the NDIA need be aware of, and would or should have some responsibility in respect of, the full scope of legal obligations imposed on service providers by the legislation of all states and territories and the Commonwealth, this would be impractical and unreasonably burdensome.[81]

92. Again, this submission misstates Counsel Assisting's submissions which were focused on the *Human Rights Act* which gives effect to human rights in the same international treaties identified in the objects of *NDIS Act* including the *ICCPR*, the *ICESCR*, the *CRC* and the *CRPD*.[82]

93. We were not asked and we do not make any findings with respect to the NDIA and the *Human Rights Act.* We make the observation that the extent to which the NDIA has a role and responsibilities to give effect to these human rights standards in its work, it is not 'impractical and unreasonably burdensome' for the NDIA to be aware of and consider how a human rights approach may improve decision making and advance the rights of people with disability who participate in the NDIS and their relationships with service providers.

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79 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 297 [1062].

80 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 4 [8].

81 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 4 [8].

82 *National Disability Insurance Scheme Act 2013* (Cth) s 3(1)(a), (i)(i–iii).

Part 3 Kaleb and Jonathon

94. Kaleb and Jonathon were at the heart and centre of this hearing. They did not give evidence at the hearing. Counsel Assisting said in the opening address they met and visited Kaleb and Jonathon prior to the hearing and stressed Kaleb and Jonathon were at the centre of the hearing and its preparations.[83] We relied on the Agreed Facts and the evidence given by their friend and neighbour, Ms Lisa Hair, and Alexis (a pseudonym) from the service provider who has worked with and supported Kaleb and Jonathon after Paul Barrett's death, Service Provider A (a pseudonym).

95. The Agreed Facts set out the key dates and milestones in Kaleb and Jonathon's lives. We refer to the Agreed Facts and Counsel Assisting's submissions for a more complete account of the chronology. The following is intended to be a brief summary.

Kaleb

96. Kaleb was born in 2000.[84] His mother had a history of interactions with child protection agencies relating to her other children.[85] At the time of Kaleb's birth, she lived with an intellectual impairment, anxiety and a depressive illness.[86] At the time of Kaleb's birth, his parents' accommodation was 'questionable and unstable'.[87] Kaleb was identified as a child at risk of neglect.[88] His parents were offered support, including a Residential Early Parenting Service.[89]

Kaleb's health and disability

97. Kaleb was diagnosed by a consultant paediatrician with 'significant global developmental delay' at 1 year and 8 months old.[90] The consultant paediatrician viewed Kaleb appeared to have a significant degree of intellectual disability.[91]

98. Kaleb also lives with Autism Spectrum Disorder (**ASD**).[92] Between the ages 13 and 18, Kaleb received services from Autism Queensland funded by the Department of Disability Services.[93]

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83 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 8 May 2023, P-7 [1–5].

84 Agreed Facts, [8]; Exhibit 33-155, QLD.0002.0027.0155_E, p 1; Exhibit 33-134, QLD.0002.0027.0751_E, p 1.

85 Agreed Facts, [14(a)]; Exhibit 33-120, QLD.0002.0027.2035_E, p 3.

86 Agreed Facts, [14(b)]; Exhibit 33-120, QLD.0002.0027.2035_E, p 3.

87 Agreed Facts, [14(c)]; Exhibit 33-120, QLD.0002.0027.2035_E, p 3.

88 Agreed Facts, [9]; Exhibit 33-120, QLD.0002.0027.2035_E, pp 1–3.

89 Agreed Facts, [13]; Exhibit 33-121, QLD.0002.0027.0021_E, pp 1–2; Exhibit 33-131, QLD.0002.0027.0413_E, p 1; Exhibit 33-122, QLD.0002.0027.0016_E, p 1; Exhibit 33-123, QLD.0002.0027.0403_E, p 1.

90 Agreed Facts, [34(a)]; Exhibit 33-144, QLD.0002.0027.0263_E, p 1.

91 Agreed Facts, [34(b)]; Exhibit 33-144, QLD.0002.0027.0263_E, p 1.

92 Agreed Facts, [91(b)], [116], [194], [197], [199]; Exhibit 33-174, QLD.0002.0027.0087_E, pp 1, 3; Exhibit 33-342, QLD.0001.0026.0053, p 20; Exhibit 33-247, AQS.9999.0003.0001, pp 1, 4–6; Exhibit 33-248, QLD.0020.0050.1360, pp 1, 6; Exhibit 33-34, 'Statement of Shayna Smith' 28 April 2023, at [19].

93 Agreed Facts, [199]; Exhibit 33-248, QLD.0020.0050.1360, p 1; Exhibit 33-247, AQS.9999.0003.0001, pp 5–6, 41.

99. Kaleb was non-verbal or had very limited verbal communication while in his father's care. By the age of 4, the Child Advocacy Service records indicated it assessed Kaleb as non-verbal.[94]

Kaleb's education

100. In June 2001, Kaleb started attending a Special Education Development Unit (**SEDU**).[95] Kaleb attended public schools operated by the Department of Education.[96] In September 2004, at the age of 4, Kaleb started attending an Early Childhood Development Program (**ECDP**).[97] The ECDP was hosted at a Queensland Department of Education school (**School 1**). The following year, on 23 January 2006, Kaleb commenced at School 2.[98] On or about 27 January 2006, Kaleb was verified through the Department's Education Adjustment Program (**EAP**) as requiring significant educational adjustments at school in the category of intellectual disability.[99] School 2 was designated a special school.[100]

101. At 10 years old, a teacher at School 2 informed the Department of Child Safety that Kaleb attended speech language therapy during the year but he did not display 'an interest in talking' and 'simply chooses not to talk'.[101] The records note the teacher considered he could 'verbalise clearly about food and drink'.[102] Ms Hair observed in her time as Kaleb's neighbour between 2018 to 2020, he said a few words. He would ask for a 'dink, dink, dink'.[103]

102. Kaleb remained at School 2 until he graduated at the end of 2018. He was 18 years of age.[104] There are no records of Kaleb participating in any post school activities such as work, volunteering or further study, from the time he left school to his father's death.

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94 Agreed Facts, [79(c)]; Exhibit 33-331, QLD.0010.0033.0002, p 6.

95 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [24]. An SEDU provides multidisciplinary support for children with disability and their families, prior to school, and are available to children aged 0 to 5 years of age. They are operated by the Queensland Department of Education and hosted in public schools.

96 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [16].

97 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [24(b)]. Similar to an SEDU, an ECDP is run by the Queensland Department of Education and provides multidisciplinary support for children with disability and their families, prior to school, and are available to children aged 0 to 5 years of age.

98 Agreed Facts, [104]; Exhibit 33-268, QLD.0008.0029.0150, p 1.

99 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [27].

100 Agreed Facts, Appendix A.

101 Agreed Facts, [180(b)]; Exhibit 33-236, QLD.0002.0027.1556_E, p 2.

102 Agreed Facts, [180(b)]; Exhibit 33-236, QLD.0002.0027.1556_E, p 2.

103 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [5], [9–10]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-15 [21–25].

104 Agreed Facts, [199]. See generally, Exhibit 33-247, AQS.9999.0003.0001, p 41.

Kaleb's housing

103. In around March 2004, Kaleb, Jonathon and their father moved into a 2-bedroom home, managed by the Department of Housing (the **home** or **house**).[105] Kaleb was 3 years old and Jonathon was 12 months old.[106] Kaleb and Jonathon continued to live in this home until 27 May 2020.

Kaleb's care

104. Records suggest that Paul Barrett had been Kaleb and Johnathon's primary carer since at least April 2003,[107] and their sole carer since at least February 2005.[108]

105. Prior to 27 May 2020, there were two periods of time in Kaleb's life when he was removed from his father's care.

106. First, from September 2000 to September 2002, Kaleb lived with foster carers, following orders made by the Childrens Court of Queensland.[109] In around September 2001, when Kaleb was about 14 months old, Paul Barrett started to care for him three and a half days a week.[110] From 15 January 2002, when Kaleb was about 18 months old, his father cared for him five days a week.[111] A case plan from the time provided Kaleb's mother would have contact with him once a week.[112] Two days later, Paul Barrett called the Department of Child Safety asking for them to pick up Kaleb.[113] When an officer from the Department of Child Safety arrived, the officer considered Paul Barrett was intoxicated.[114]

107. The second time was between 29 May 2010 and 4 June 2010. Kaleb and Jonathon were removed from their father's care after Queensland Police and the Department

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105 Agreed Facts, [78]; Exhibit 33-318, QLD.0001.0026.1460, p 2. In this report we focus on this residence, which was managed by the Department of Housing. This residence is called 'Home 2' in the Agreed Facts.

106 Agreed Facts, [78]; Exhibit 33-318, QLD.0001.0026.1460, p 2.

107 Agreed Facts, [65(a)]; Exhibit 33-167, QLD.0002.0027.0702_E, p 2.

108 Agreed Facts, [89]; See Exhibit 33-86, QLD.0002.0027.0086_E, p 1.

109 Agreed Facts, [24], [30]; Exhibit 33-129, QLD.0002.0027.0800_E, p 1; Exhibit 33-156, QLD.0002.0027.1819_E, p 2.

110 Agreed Facts, [31]; Exhibit 33-156, QLD.0002.0027.1819_E, p 2; Exhibit 33-139, QLD.0002.0027.0300_E, p 1.

111 Agreed Facts, [33]; Exhibit 33-141, QLD.0002.0027.0287_E, p 1; Exhibit 33-140, QLD.0002.0027.0294_E, p 1.

112 Agreed Facts, [32]; Exhibit 33-143, QLD.0002.0027.0277_E, p 1.

113 Agreed Facts, [42]; Exhibit 33-152, QLD.0002.0027.1836_E, p 1.

114 Agreed Facts, [42]; Exhibit 33-152, QLD.0002.0027.1836_E, p 1.

of Child Safety received information concerning their care and treatment.[115] On 28 May 2010, Queensland Police attended the family home.[116] Kaleb was 9 years old and Jonathon was 7 years old. Queensland Police observed Jonathon 'was caged in a room with a wooden child safety gate nailed to the door frame'.[117] His room was 'bare with a mattress on the floor and a sheet of plastic "protecting" it. There was no bed-clothing. There was a toy, of sorts, and a lounge against the wall'.[118] On the same evening Kaleb was 'locked in his room in complete darkness'.[119] Kaleb had a brown substance on his fingers. The house smelt of faeces.[120] On the day the children were removed, a child safety officer viewed the house was 'unliveable for the children'.[121]

108. Paul Barrett consented to Kaleb and Jonathon being removed from his care for a period of 5 days.[122] He signed a Care Agreement, pursuant to the *Child Protection Act*.[123]

Jonathon

109. Jonathon was born in 2003.[124] Around this time, a hospital worker notified the Department of Child Safety about concerns they had for Jonathon's welfare when he was released from hospital into the care of his parents.[125]

110. Jonathon has always lived with his brother. For almost all his life he lived in the home managed by the Department of Housing, which the family moved into in 2004.

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115 Agreed Facts, [160–168]; Exhibit 33-206, QLD.0002.0027.1621_E, p 2; Exhibit 33-210, QLD.0002.0027.0581_E, pp 1–4; Exhibit 33-211, QLD.0021.0057.0001, pp 1–4; *Child Protection Act 1999* (QLD) (as in force at time) ss 51Z–51ZI; Exhibit 33-206, QLD.0002.0027.1621_E, p 2; Exhibit 33-223, QLD.0002.0027.1604_E, pp 3–4; Exhibit 33-212, QLD.0002.0027.0036_E, pp 1–6; Exhibit 33-215, QLD.0008.0029.0069, pp 1–7; Exhibit 33-216, QLD.0002.0027.1598_E, pp 1–6; Exhibit 33-221, QLD.0002.0027.1610_E, p 3; Exhibit 33-220, QLD.0002.0027.1614_E, p 2; Exhibit 33-224, QLD.0002.0027.1589_E, p 1.

116 Agreed Facts, [154]; Exhibit 33-202, QLD.0008.0029.0576_E, pp 3–4; Exhibit 33-207, QLD.0002.0027.0558_E, pp 1–2; Exhibit 33-208, QLD.0002.0027.0563_E, pp 9–23.

117 Agreed Facts, [154(b)]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4.

118 Agreed Facts, [154(c)]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4.

119 Exhibit 33-202, QLD.0008.0029.0576_E, p 4.

120 Agreed Facts, [154(a)]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4.

121 Agreed Facts, [157(a)]; Exhibit 33-206, QLD.0002.0027.1621_E, p 1.

122 Agreed Facts, [160]; Exhibit 33-206, QLD.0002.0027.1621_E, p 2; Exhibit 33-210, QLD.0002.0027.0581_E, pp 1–4; Exhibit 33-211, QLD.0021.0057.0001, pp 1–4; *Child Protection Act 1999* (QLD) (as in force at time) ss 51Z–51ZI.

123 Agreed Facts, [160]; Exhibit 33-206, QLD.0002.0027.1621_E, p 2; Exhibit 33-210, QLD.0002.0027.0581_E, pp 1–4; Exhibit 33-211, QLD.0021.0057.0001, pp 1–4; *Child Protection Act 1999* (QLD) (as in force at time) ss 51Z-51ZI.

124 Agreed Facts, [2], [52]; Exhibit 33-163, QLD.0008.0029.0155, p 1.

125 Agreed Facts, [53]; Exhibit 33-163, QLD.0008.0029.0155, pp 1, 3.

Jonathon's health and disability

111. Jonathon was assessed at 2 years old 'as having global developmental delay with almost certain intellectual impairment'.[126] In 2008, he was diagnosed with global developmental delay with an underlying intellectual disability.[127] After a period of hospitalisation in August 2015, Jonathon was diagnosed with epilepsy when he was 12 years old. He was referred to the general paediatrics service at the hospital for treatment.[128]

112. Jonathon was consistently observed as non-verbal throughout the time he was in his father's care. Notes of a meeting between Paul Barrett and representatives of the Department of Child Safety identified Jonathon was still not speaking at almost two years old.[129] The Child Advocacy Service assessed Jonathon when he was 2 years old. It opined he was non-verbal but indicated his needs by picking up an object.[130]

113. Ms Hair knew Jonathon from when he was about 14 to 17 years old.[131] She considered Jonathon was non-verbal, and she could get his attention by doing 'hand tapping'.[132] She said Paul Barrett had informed her Jonathon learnt some sign language but she never saw Paul Barrett use sign language to communicate with him.[133]

114. Jonathon's teacher at School 1 assessed in early 2020 that Jonathon's primary mode of communication was body language.[134]

Jonathon's education

115. Jonathon also attended public schools operated by the Department of Education.[135] Jonathon commenced at School 1 in February 2006.[136] He turned 3 years of age in his first year at that school.

116. Around 2006, Jonathon also started attending the ECDP at School 1.[137]

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126 Agreed Facts, [96]; Exhibit 33-330, QLD.0010.0033.0013, p 5; Exhibit 33-332, QLD.0010.0033.0011, p 1; Exhibit 33-176, QLD.0021.0058.0001, p 4.

127 Exhibit 33-330, QLD.0010.0033.0013, p 1.

128 Exhibit 33-330, QLD.0010.0033.0013, p 3.

129 Agreed Facts, [91(d)]; Exhibit 33-174, QLD.0002.0027.0087_E, p 2.

130 Exhibit 33-330, QLD.0010.0033.0013, p 5.

131 Agreed Facts, [2]; Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [2], [6].

132 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [9]; Transcript, Lisa Hair, 8 May 2023, P-15 [27–30].

133 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [9]; Transcript, Lisa Hair, 8 May 2023, P-15 [32] –P-16 [7].

134 Exhibit 33-100, QLD.0005.0060.0091_E, p 4.

135 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [16].

136 Agreed Facts, [108]; Exhibit 33-196, QLD.0002.0027.0055_E, p 4.

137 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [39]; Agreed Facts, [108]; Exhibit 33-156, QLD.0002.0027.0055_E, p 4.

117. In January 2009, Jonathon started attending School 2 in kindergarten.[138] He was about 6 years old.[139] Jonathon was also verified through the Department's EAP as requiring significant educational adjustments at school in the category of intellectual disability and he was also provided adjustments of a similar nature to Kaleb. [140]

118. Jonathon remained enrolled at School 2 until his father's death on 27 May 2020.[141] From 30 March 2020, COVID-19 restrictions were in place, limiting school attendance to children of essential workers.[142] Jonathon began home-learning.[143] From 20 April 2020, Jonathon could have attended school as a 'vulnerable student' but did not.[144]

Jonathon's care

119. As described above at [107–108], Jonathon was removed from his father's care on one occasion, between 29 May 2010 and 4 June 2010.

120. In February 2019 Department of Child Safety did an immediate safety assessment and considered Jonathon was 'UNSAFE'.[145] However, Jonathon was not removed from his father's care because:

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138 Agreed Facts, [144]; Exhibit 33-341, QLD.0004.0028.3597, p 1.

139 Agreed Facts, [144]; Exhibit 33-341, QLD.0004.0028.3597, p 1.

140 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [41–42].

141 Agreed Facts, [331(a)]; Exhibit 33-319, QLD.0003.0027.6906_E, p 6.

142 Agreed Facts, [311]; 'Student free days for Queensland state schools next week', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 26 March 2020. <https://statements.qld.gov.au/statements/89596>; Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>.

143 Agreed Facts, [312]; QLD.0004.0028.3597, p 46; QLD.0019.0051.0001, p 6.

144 Agreed Facts, [314], [315], [320]; Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>; Queensland Government: The Queensland Cabinet and Ministerial Directory, *Initial Term 2 school arrangements for Queensland announced*, media release, 13 April 2020; Queensland Government: The Queensland Cabinet and Ministerial Directory, *Support for every family,* media release, 19 April 2020; Exhibit 33-341, QLD.0004.0028.3597, pp 45; '2020: School calendar: Queensland state schools', *Department of Education*, web page. < www.education.qld.gov.au/about/Documents/2020-school-calendar.pdf>; Queensland Government: The Queensland Cabinet and Ministerial Directory, *Queensland success leads sensible steps back to school,* media release, 4 May 2020.

145 Exhibit 33-294, QLD.0002.0027.1354_E, p 5.

> Given [Jonathon's] significant disability and high level of care required, it was assessed that a multidisciplinary approach would be needed, and therefore any safety planning would need to occur during business hours.[146]

121. Child Safety After Hours did not have the resources available outside of business hours to place Jonathon with a carer who had the experience or skills to meet his needs.[147] The Department of Child Safety considered Jonathon's interests would be met by collaborative effort with the NDIS and speciality disability staff in the department.[148]

122. Department of Disability Services provided services to Kaleb and Jonathon at various times.[149] These services included occupational therapy, speech therapy and physiotherapy,[150] developmental therapy supports for Jonathon,[151] the speech and language pathologist who Kaleb and Jonathon were working with at school,[152] respite services for the family,[153] 'support linking' services rather than direct support services,[154] and assistance with accessing transport for the children to attend school. At the time, Kaleb was 4 years old and Jonathon was 2 years old.

Ms Hair's evidence

123. Ms Hair told us about when and how she came to know Kaleb and Jonathon. Ms Hair provided a statement dated 20 April 2023 and gave oral evidence on 8 May 2023.[155]

124. Counsel Assisting submitted we may rely on Ms Hair's observations of Paul Barrett's behaviours and Kaleb and Jonathon's living conditions and care, to make findings

146 Exhibit 33-294, QLD.0002.0027.1354_E, p 5.

147 Exhibit 33-294, QLD.0002.0027.1354_E, p 5.

148 Exhibit 33-294, QLD.0002.0027.1354_E, p 5.

149 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 210 [707]–211 [709], 212 [712], 213 [717], 214 [720], [722]; Agreed Facts, [91A], [95B], [95C(a)], [109], [173(d)], [177], [182], [194–197], [199–200]; Exhibit 33-176, QLD.0021.0058.0001, pp 4–6; Exhibit 33-185, QLD.0020.0050.1761, pp 1–3; Exhibit 33-232, QLD.0002.0027.1567_E, p 1; Exhibit 33-235, QLD.0020.0050.1776, pp 1–4; Exhibit 33-240, QLD.0002.0027.0587_E, p 1; Exhibit 33-247, AQS.9999.0003.0001, pp 1–6, 41; Exhibit 33-248, QLD.0020.0050.1360, pp 1, 6; Exhibit 33-186, QLD.0002.0027.0081_E, pp 2–3, See also Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [11].

150 Agreed Facts, [91A], [95B]; Exhibit 33-176, QLD.0021.0058.0001, pp 4–5.

151 Exhibit 33-186, QLD.0002.0027.0081_E, p 3.

152 Exhibit 33-240, QLD.0002.0027.0587_E, p 1.

153 Agreed Facts, [95B]; Exhibit 33-176, QLD.0021.0058.0001, p 5.

154 Agreed Facts, [177]; Exhibit 33-235, QLD.0020.0050.1776.

155 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-11 [41]–P-31 [42].

concerning Kaleb and Jonathon's experiences of violence, abuse and neglect. Queensland submitted Ms Hair's observations should not be treated as fact, where her evidence is untested.[156]

125. Ms Hair was not cross-examined and her evidence was not challenged during the hearing by any of the parties with leave to appear.[157] Ms Hair's observations were also broadly consistent with Queensland agencies' and departments' direct observations of Paul Barrett's patterns of behaviours and Kaleb and Jonathon's circumstances over the whole period of the case study. It is particularly relevant that Ms Hair's description of Kaleb and Jonathon's bedroom, lack of access to clothes and nutritious food, and conditions of the home, were consistent with observations and concerns recorded between 2018 and 2020 by Department of Housing,[158] Jonathon's school and teacher's aides,[159] and the Department of Child Safety,[160] and the conditions in which Kaleb and Jonathon were found in May 2020.[161]

126. Ms Hair's evidence assisted our inquiry and we acknowledge her genuine care and affection for Kaleb and Jonathon. Ms Hair's recollection of Paul Barrett's treatment of his children and her observations about Paul Barrett's use of his networks of friends and engagement with government agencies,[162] provided a perspective that assisted us to understand Kaleb and Jonathon's limited engagement with their local community and the absence of aged-peer and social networks.

156 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 14 [61], 23 [100].

157 Transcript, Alastair McEwin (Commissioner) and Kate Eastman SC (Counsel Assisting), Public hearing 33, 8 May 2023, P-31 [30–37].

158 Agreed Facts, [232–233], [302–305], [353–355]; Exhibit 33-342, QLD.0001.0026.0053, pp 1, 3–4; Exhibit 33-303, QLD.0001.0026.0083, pp 2–3; Exhibit 33-302, QLD.0001.0026.2539, pp 1–4; Exhibit 33-301, QLD.0001.0026.2998; Exhibit 33-306, QLD.0001.0026.3120, pp 1–7; Exhibit 33-307, QLD.0001.0026.2677, pp 6–7; Exhibit 33-304, QLD.0001.0026.0146, pp 1–10; Exhibit 33-318, QLD.0001.0026.1460, pp 3–12,

159 Agreed Facts, [92–93], [123], [126], [234], [321]; Exhibit 33-177, QLD.0002.0027.0090_E, pp 2–4; Exhibit 33-178, QLD.0002.0027.0094_E, p 1; Exhibit 33-196, QLD.0002.0027.0055_E, pp 4, 6–7; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-272, QLD.0005.0028.0352, pp 1–2; Exhibit 33-311, QLD.0005.0028.0154, p 1.

160 Agreed Facts, [286–287], [292]; Exhibit 33-293, QLD.0002.0027.1327_E, pp 3–6; Exhibit 33-294, QLD.0002.0027.1354_E, pp 1–5.

161 Agreed Facts, [325–327]; Exhibit 33-312, QLD.0007.0032.0096, pp 1–2; Exhibit 33-313, QLD.0008.0029.0431, pp 7, 9; Exhibit 33-334, QPG.9999.0002.1389_E, p 1; Exhibit 33-335, QPG.9999.0002.1383_E, p 1.

162 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, [15–35]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-18 [46]–P-28 [27].

Ms Hair's involvement with Kaleb and Jonathon

127. Ms Hair moved into the house next door to Kaleb and Jonathon when they were teenagers. Ms Hair recalled thinking Kaleb was around 8 years old based on his height.[163] She was surprised to find out he was about 16 years old.[164]

128. Ms Hair described Kaleb and Jonathon's communication styles.[165] Kaleb understood a lot of words, but would not use a lot of sounds. Ms Hair would communicate with Jonathon doing what she described as 'hand tapping'.[166] Ms Hair said:

> He would always come up and I would put my hands up like that and just tap. And you just carry on conversation while he's tapping.[167]

129. Ms Hair felt Kaleb 'had a lot of potential'.[168] She described one occasion, she saw Kaleb playing ball and socialising with her son. Ms Hair had not realised Kaleb had the social capacity.[169] Kaleb would also make his own decisions on certain things. For instance, he would come out of his room to get a glass of water if he was thirsty.[170] Ms Hair however, observed Paul Barrett yelling at Kaleb when he went to get a drink of water, and she thought this would have had an impact on Kaleb's confidence.[171]

130. Kaleb and Jonathon both loved her dog.[172] Jonathon enjoyed a bubble machine she set up to blow bubbles across the fence.[173] Kaleb loved chickens.[174]

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163 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [6].

164 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [6].

165 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [9–10].

166 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [9]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-15 [29–30].

167 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-15 [29–30].

168 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [14].

169 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [14]; Transcript, Public hearing 33, 8 May 2023, P-18 [17–29].

170 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [14].

171 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [15].

172 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [12–13]; Transcript, Public hearing 33, 8 May 2023, P-17 [40]–P-18 [15].

173 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [7]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-14 [25–27].

174 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [10];Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-16 [12–23].

131. Ms Hair recalled during school holidays and weekends, Kaleb and Jonathon's father locked them in their bedroom.[175] On some occasions she could see they were locked in their room for the whole day, and into the night.[176] She would play relaxation music loudly so Kaleb and Jonathon could hear it.[177] She would also whistle, and Jonathon would whistle back.[178]

132. Ms Hair shared her observations of Kaleb and Jonathon's treatment by their father between 2018 to May 2020. She recalled seeing from her kitchen window Kaleb and Jonathon locked in their bedroom for 'very long amounts of time'.[179] She said Paul Barrett had removed the door handle so Kaleb and Jonathon could not open the door.[180]

133. She also described their bedroom as having 'nothing in there except for a blow-up mattress'.[181] Paul Barrett told Ms Hair they could not have furniture in their bed room because of Jonathon's seizures.[182] She said she did not understand why Kaleb at least could not sleep on a bed or in the lounge room.[183] They did not have a blanket in winter and Ms Hair stated 'Kaleb would have red legs because he would – and swollen legs from curling up to be warm in winter'.[184]

134. She said when they were locked in their room they were unable to access water, food or the toilet unless Paul Barrett gave them access.[185]

175 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [21–22]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [15–25].

176 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [22]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-22 [7–11].

177 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [23]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-22 [17–21].

178 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [23]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-22 [17–21].

179 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [9–21], [37–40], [47–49], P-22 [1–11]. See generally Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [21–22].

180 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [21]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [23–35].

181 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-19 [26–33]. See also Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [17–18].

182 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [17]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-19 [35–38].

183 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [17].

184 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-20 [1–14].

185 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [22]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-22 [7–11].

135. Ms Hair described one time when Paul Barrett opened the door to the boy's bedroom and seeing Kaleb 'slipping in faeces and urine'[186] in his bedroom. She stated he 'couldn't stand up and walk'. She said 'Paul was yelling at him to get out the door and go to the shower to get ready for school'.[187]

136. Ms Hair described their morning routine, when before school, Kaleb and Jonathon's father would get them up, into the shower and turn it on.[188] He would leave Kaleb and Jonathon in the shower and not do any 'soaping or scrubbing'.[189] The water used would be cold even in winter.[190] Ms Hair recalled Kaleb and Jonathon's father telling her he had turned the gas off, which she thought was because he wanted to save money.[191]

Ms Hair's recollection of Paul Barrett's treatment of Kaleb and Jonathon

137. Ms Hair said she saw Kaleb and Jonathon's father being rough with them.[192] On many occasions she would see him shove them in and out of the car, and yell at them.[193] Ms Hair observed Kaleb and Jonathon would usually be wearing only nappies, and would only have clothes on if they were going to school, or elsewhere.[194]

138. Ms Hair also saw Kaleb and Jonathon's father give them an open cold can of casserole to eat.[195] On another occasion, he gave them raw sausages in a sealed packet. They were unable to open these.[196]

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186 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [20].

187 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [20].

188 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [25]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [12–24].

189 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [13–24].

190 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [25]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [26–31].

191 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [25]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [26–35].

192 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [24]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-22 [47]–P-23 [11].

193 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [24]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [1–7].

194 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [27].

195 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [28]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-24 [1–5].

196 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [28]; Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [28]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-24 [1–15].

139. Ms Hair saw and heard Kaleb and Jonathon's father call them names such as '[redacted]' and '[redacted]' and '[redacted]'.[197] Ms Hair said she saw Paul Barrett shoving Kaleb and Jonathon out of the car, yelling at them and calling them names like '[redacted]'.[198] She did not recall ever hearing Kaleb and Jonathon's father call them by their own names.[199] His moods were volatile and unpredictable.[200]

140. Ms Hair believed Kaleb and Jonathon's father drank alcohol every day, usually a minimum of two casks of port a day.[201] He also smoked marijuana 'and I think some other things that we're not sure about.'[202] The Royal Commission prepared an Aide Memoire describing Paul Barrett's spending patterns between 2016 and 2020 based on a review of available financial records.[203] There is a consistency in the Paul Barrett's spending patterns and Ms Hair's recollections.

141. According to Ms Hair, Paul Barrett would pay other people, including herself, to do jobs around the house.[204]

142. Ms Hair did some cleaning and cooking for the family. She considered Paul Barrett 'built a web of people around him and his relationships were very transactional.'[205]

143. She also observed Paul Barrett was averse to help including from respite services, and kept government services 'at a distance'.[206] She considered this was because it would mean other people would see what things were like in the home. Ms Hair's view was Paul Barrett only let people into the home whom he trusted.[207] Further, it appeared to her he knew how to manipulate government services.[208] For example, he told Ms Hair when the Department of Child Safety were coming, 'you just have to fill the fridge with food'.[209]

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197 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [6–7].

198 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [24].

199 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-23 [9–11].

200 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [35]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-27 [48]–P-28 [7].

201 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [35]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-27 [40]–P-28 [1].

202 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-27 [46].

203 Exhibit 33-78, DRC.2000.0014.0093, pp 1–12.

204 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [19]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [4–7].

205 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [32].

206 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [30–31]; See also Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-26 [3–30].

207 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [30]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-26 [22–24].

208 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [31]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-26 [26–36].

209 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [31]. See also Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-26 [26–36].

After Paul Barrett's death

144. While the three findings are concerned with the period up to 27 May 2020, we also heard evidence about the action taken by Queensland departments and agencies and the NDIA following Paul Barrett's death and over the past two years. This evidence was also relevant to the life course approach. The evidence reveals some very significant changes in Kaleb and Jonathon's circumstances from where and how they live, the support available to them and the opportunities for their future.

145. This part of our report provides a brief summary of the events following Paul Barrett's death and Kaleb and Jonathon's current circumstances.

Support for Kaleb and Jonathon after Paul Barrett's death

146. On 27 May 2020, Kaleb and Jonathon were admitted to hospital.[210] While they were in hospital, various Queensland departments and agencies and the NDIA stepped in and acted quickly to support them with respect to accommodation and support services in readiness for their release and a life without their father.

147. On 27 May 2020, the Director-General of the Department of Disability Services notified the then Acting Public Guardian of Paul Barrett's death, and seeking the assessment of Kaleb and Jonathon.[211] They also notified the NDIS Quality and Safeguards Commissioner, the NDIA and the Department of Child Safety.[212]

148. On 28 May 2020, the Department of Child Safety contacted the Suspected Child Abuse and Neglect team (**SCAN**) referring a matter concerning Jonathon's safety.[213]

149. A social worker from the hospital contacted the NDIA about Kaleb and Jonathon.[214] The NDIA identified Jonathon was not a participant and initiated an 'immediate access decision' based on information provided by the social worker.[215] The NDIA also initiated an urgent plan review meeting for Kaleb.[216]

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210 Agreed Facts, [327]; Exhibit 33-334, QPG.9999.0002.1389_E, p 1; Exhibit 33-335, QPG.9999.0002.1383_E, p 1; Exhibit 33-313, QLD.0008.0029.0431, p 9.

211 Agreed Facts, [328]; Exhibit 33-314, QLD.0020.0050.1616, p 1.

212 Exhibit 33-81, QLD.9999.0074.0010, p 2.

213 Agreed Facts, [330]; Exhibit 33-316, QLD.0003.0027.6901_E, pp 1–5.

214 Exhibit 33-12, CTD.8000.0012.1809, p 30.

215 Exhibit 33-12, CTD.8000.0012.1809, p 30.

216 Exhibit 33-12, CTD.8000.0012.1809, p 30.

150. By this stage, the hospital had located Kaleb and Jonathon's mother and an aunt.[217] Kaleb and Jonathon's mother had 'expressed a desire to become their carer'.[218] Their mother had provided written consent on Jonathon's behalf for the NDIA to obtain information from other government departments, health professionals and service providers about Jonathon.[219]

151. On 1 June 2020 a planning meeting took place for Kaleb and Jonathon involving representatives from Queensland Health (including the social worker, a speech therapist and a dietitian) and representatives from Jonathon's school.[220]

152. On about 3 June 2020, the NDIA approved a plan for Kaleb, being his fourth plan.[221]

153. On about 4 June 2020, the NDIA approved a plan for Jonathon, his first plan.[222]

154. When Kaleb and Jonathon were discharged from hospital on 10 June 2020, the Department of Disability Services provided them with short-term accommodation and specialist disability support. [223]

155. Between 10 June 2020 to 21 August 2020, the Department of Disability Services coordinated Kaleb and Jonathon's transition to supported independent living with Service Provider A.[224] This involved:

- working with the NDIS to establish plans for Kaleb and Jonathon, including Supported Independent Living budgets[225]
- investigating suitable properties, and taking Jonathon and Kaleb to inspect these properties[226]
- liaising with the Department of Housing about the possibility of obtaining Kaleb and Jonathon's belongings from their family home. [227]

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217 Exhibit 33-12, CTD.8000.0012.1809, p 30.

218 Exhibit 33-12, CTD.8000.0012.1809, p 30. See also Agreed Facts, [334]; Exhibit 33-322, QLD.0003.0027.6885_E, p 2. Kaleb and Jonathon's mother was assessed as not having the capacity to care for Jonathon.

219 Exhibit 33-12, CTD.8000.0012.1809, p 35.

220 Exhibit 33-12, CTD.8000.0012.1809, pp 30–31.

221 Exhibit 33-12, CTD.8000.0012.1809, p 31. See Exhibit 33-357, CTD.8000.0012.5698_E, pp 1–5.

222 Exhibit 33-12, CTD.8000.0012.1809, p 31.

223 Exhibit 33-81, QLD.9999.0074.0010, p 2.

224 Exhibit 33-81, QLD.9999.0074.0010, p 2; Submissions by Queensland in response to Counsel Assisting's Submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 70 [315]; Submissions of Counsel Assisting the Royal Commission in Response to submissions by Queensland, 17 July 2023, p 10 [40(h)].

225 Exhibit 33-81, QLD.9999.0074.0010, p 2.

226 Exhibit 33-81, QLD.9999.0074.0010, p 2; Exhibit 33-340, QLD.0020.0050.0020, p 1.

227 Exhibit 33-81, QLD.9999.0074.0010, p 2; Exhibit 33-338, QLD.0020.0050.0098, p 1.

156. The Department of Disability Services also provided support for Kaleb and Jonathon to establish routines including attending school and activities outside of school.[228] They liaised with Queensland Health services and Kaleb and Jonathon's General Practitioner (**GP**) in relation to their health requirements following discharge from hospital.[229] This included arranging nutrition plans, dental appointments and fortnightly GP visits.[230] The Department of Disability Services also requested referrals for Kaleb and Jonathon to visit an Autism specialist.[231]

157. The Department of Disability Services engaged with the Office of Public Guardian and the Department of Child Safety in respect of other matters which would have been important for Kaleb and Jonathon at the time.[232] This included visits with their mother, and the funeral arrangements for their father.[233]

Guardianship arrangements for Kaleb

158. The Agreed Facts[234] and the evidence of Ms Shayna Smith, Public Guardian, Office of the Public Guardian, Queensland[235] described the guardianship arrangements for Kaleb and Jonathon.

159. On 3 June 2020, the Queensland Civil and Administrative Tribunal (**QCAT**) appointed the Public Guardian as interim guardian for Kaleb[236] and the Public Trustee as administrator for all financial matters.[237] At the time the order was made to appoint the Public Guardian, Kaleb was an adult.[238]

160. On 2 September 2020, the QCAT made a further order appointing the Public Guardian as his guardian for decisions relating to the provision of services, including in relation to the NDIS.[239] QCAT also appointed the Public Trustee as Kaleb's administrator for all financial matters on this date.[240]

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228 Exhibit 33-81, QLD.9999.0074.0010, p 2; Exhibit 33-340, QLD.0020.0050.0020, p 1.

229 Exhibit 33-81, QLD.9999.0074.0010, p 2; Exhibit 33-340, QLD.0020.0050.0020, p 1.

230 Exhibit 33-81, QLD.9999.0074.0010, p 2.

231 Exhibit 33-340, QLD.0020.0050.0020, p 1.

232 Exhibit 33-81, QLD.9999.0074.0010, p 2.

233 Exhibit 33-81, QLD.9999.0074.0010, p 2.

234 Agreed Facts, [333], [346–347], [349–350].

235 See Exhibit 33-34, 'Statement of Shayna Smith', 28 April 2023; Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-48 [43]–P-61 [3].

236 Agreed Facts, [333(a)]; Exhibit 33-321, QPG.9999.0002.1368_E, p 1.

237 Agreed Facts, [333(b)]; Exhibit 33-321, QPG.9999.0002.1368_E, p 1.

238 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-50 [30–33].

239 Agreed Facts, [347(a)]; Exhibit 33-343, QPG.9999.0002.1524_E, p 1.

240 Agreed Facts, [347(b)]; Exhibit 33-343, QPG.9999.0002.1524_E, p 1.

161. On 31 March 2021, QCAT appointed the Public Guardian as Kaleb's guardian for restrictive practices decisions. The appointment was to remain in force for two years unless QCAT ordered otherwise.[241]

162. The Public Guardian's responsibility for Kaleb is centred around supported decision-making, otherwise substituted decision-making and advocacy.[242] In relation to Kaleb, the Public Guardian assists Kaleb in making service provision decisions.[243] When a decision needs to be made, the Public Guardian will see whether Kaleb understands his choices and whether he can communicate effectively what he might want in relation to that decision.[244]

Guardianship arrangements for Jonathon

163. On 4 June 2020, the Childrens Court made a temporary order in respect of Jonathon.[245] On 9 June 2020, the Childrens Court ordered Jonathon into the chief executive's custody.[246] Jonathon's mother was not allowed to make contact other than when an approved person was present.[247]

164. After Jonathon turned 18, QCAT appointed the Public Guardian as Jonathon's guardian for health care and provision of services, including in relation to the NDIS. QCAT also appointed the Public Trustee as Jonathon's administrator for all financial matters. [248]

165. In relation to Jonathon, the Public Guardian also assists Jonathon make service provision decisions. The Public Guardian makes decisions with respect to restrictive practices.[249] Similarly to outlined above, the Public Guardian is required pursuant to its Structured Decision Making Framework (**SDMF**) to consider Jonathon's views and wishes when making decisions on his behalf, even if he is unable to communicate his views and wishes verbally.[250]

241 Agreed Facts, [349]; Exhibit 33-346, QPG.9999.0005.1476, p 1.

242 Exhibit 33-34, 'Statement of Shayna Smith', 28 April 2023, at [17(a)].

243 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-50 [49–50].

244 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-51 [10–13].

245 Agreed Facts, [336]; Exhibit 33-323, QLD.0003.0027.6951_E, p 1.

246 Agreed Facts, [338(b)]; Exhibit 33-329, QLD.0003.0027.6806_E, p 1.

247 Agreed Facts, [338(c)]; Exhibit 33-329, QLD.0003.0027.6806_E, p 1.

248 Agreed Facts, [350(a)]; Exhibit 33-347, QPG.9999.0007.0053, p 1.

249 Exhibit 33-34, 'Statement of Shayna Smith', 28 April 2023, at [64].

250 Exhibit 33-34, 'Statement of Shayna Smith', 28 April 2023, at [59(a)]; Exhibit 33-35, QPG.9999.0008.0001, G5.1–G5.2.

166. A restrictive practice is currently in place for Jonathon.[251] Ms Smith said Jonathon ‘needed a longer period of time to be able to have a chance to develop the skills to be able to respond to that positive behaviour support.’[252]

167. As such, there is still an approved restrictive practice in place of locking the pantry door for Jonathon.[253] Ms Smith acknowledged, in practice, this meant there is also an ‘indirect restriction’ for Kaleb.[254]

168. Ms Smith said Queensland is the only Australian jurisdiction where a public guardian may make a restrictive practice decision.[255] She said ‘from the outset there’s an inherent tension’ as the guardian who is tasked with the protection of rights and interests of Kaleb and Jonathon is the very person deciding on ‘restricting those rights and interests’.[256]

169. Ms Smith also explained how her decision making is informed by a human rights approach. For example, the restrictive practice was placed for a short period of time and was accompanied by strategies such as constant supervision, advice from a specialist and redirection.[257]

Kaleb’s and Jonathon’s circumstances in May 2023

170. Kaleb and Jonathon currently live together in a suburban home, leased from the Department of Housing. They have full-time support from an NDIS service provider, Service Provider A.[258]

171. Alexis has worked with Kaleb and Jonathon’s service provider (Service Provider A) from around June 2020. Alexis knows Kaleb and Jonathon. She told us about their circumstances at the time of the hearing and the supports provided by Service Provider A. Service Provider A stated 15 staff members work with Kaleb and Jonathon on a regular basis to provide them with full-time supports.[259] Service Provider A provides a number of other supports to Kaleb and Jonathon including food preparation,

251 Transcript, Alexis, Public hearing 33, 8 May 2023, P-42 [45].

252 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-56 [39–40].

253 Transcript, Alexis, Public hearing 33, 8 May 2023, P-42 [45–47].

254 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-57 [1–9].

255 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-52 [42–43].

256 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-52 [44–46].

257 Transcript, Shayna Smith, Public hearing 33, 8 May 2023, P-54 [6–10].

258 Transcript, Alexis, Public hearing 33, 8 May 2023, P-33 [4–9].

259 Exhibit 33-6, ‘Statement of General Manager concerning Kaleb, Service Provider A’, 24 January 2023, at [2]; Exhibit 33-7, ‘Statement of General Manager concerning Jonathon, Service Provider A’, 24 January 2023, at [2]. See generally, Transcript, Alexis, Public hearing 33, 8 May 2023, P-35 [36]–P-36 [5].

personal care, such as showering, toileting, personal grooming, and tasks requiring fine motor skills.[260] They require support with administering medication, community access, personal banking as well as being taken to any medical appointments.[261]

172. The supports provided to both Kaleb and Jonathon assist them to build their skills and give them choice and control over their daily activities.[262]

173. Alexis' description of Kaleb and Jonathon's home, the furnishings, amenities, their environment and their routines[263] is in stark contrast to the conditions they endured in their father's care. They have their own separate, decently-sized bedroom with their own single beds, mattress, bed frames, linen, quilts and pillows.[264] Kaleb and Jonathon both have wardrobes full of clothes and keep some of their favourite toys with them.[265]

174. The evidence shows Kaleb and Jonathon's circumstances since May 2020 have improved significantly. A safe home environment with disability supports have been critical to this improvement.

175. We also recognise that Kaleb and Jonathon are young people, whose futures should involve further opportunities to learn, build their abilities, to engage with people their own age and to develop their own social networks. We heard their social lives over the past three years have been largely limited to themselves and their relationships with support workers. Alexis told us she hoped to look for a day program or service for Kaleb and, with time, possibly Jonathon.[266] We encourage those supporting Kaleb and Jonathon to consider enhancing their opportunities to build their social networks and independence.

176. Below we include Figures 3 and 4, which are two photos of Kaleb and Jonathon in 2023. Both of the photos show Kaleb and Jonathon's backs as they look out into a green field with trees in the background and a blue sky. One of the young men wears black sneakers, black shorts, a sleeveless grey shirt. His hair is short. The other young man wears black sneakers, blue shorts and a white t-shirt and his hair is short.

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260 Transcript, Alexis, Public hearing 33, 8 May 2023, P-35 [48–50]–P-36 [1]; Exhibit 33-6, 'Statement of General Manager concerning Kaleb, Service Provider A', 24 January 2023, at [3]; Exhibit 33-7, 'Statement of General Manager concerning Jonathon, Service Provider A', 24 January 2023, at [3].

261 Transcript, Alexis, Public hearing 33, 8 May 2023, P-36 [2–5].

262 Transcript, Alexis, Public hearing 33, 8 May 2023, P-36 [19–20].

263 Transcript, Alexis, Public hearing 33, 8 May 2023, P-33–P-38, P-40 [5–10].

264 Transcript, Alexis, Public hearing 33, 8 May 2023, P-33 [27–29].

265 Transcript, Alexis, Public hearing 33, 8 May 2023, P-33 [29–33].

266 Transcript, Alexis, Public hearing 33, 8 May 2023, P-46 [17–24].

Figures 3 and 4: Photos of Kaleb and Jonathon in 2023[267]

267 Exhibit 33-9, DRC.9999.0216.0003; Exhibit 33-11, DRC.9999.0216.0004.

Part 4 Findings

Finding 1: Violence, abuse, neglect and deprivation of rights experienced by Kaleb and Jonathon

177. For the reasons set out below, we make Finding 1.

> **Finding 1**
>
> Kaleb and Jonathon experienced violence, abuse, neglect and the deprivation of their human rights, in the care of their father, Paul Barrett, between 2000 and 27 May 2020.

178. We accept Counsel Assisting's submission that Finding 1 is supported by the particular incidents, patterns of conduct and the totality of the evidence.

179. In this part, we set out the grounds on which we find Kaleb and Jonathon experienced violence, abuse, neglect and the deprivation of their human rights between 2000 and 27 May 2020.

180. We then address Queensland's contentions with respect to this finding. Queensland accepted Finding 1 is open but sought the following qualification in how the finding should be expressed:

    Kaleb and Jonathon experienced violence, abuse, neglect and a deprivation of their human rights on <u>numerous occasions over the period they were in</u> Paul Barrett's care between 2000 and 27 May 2020.[268]

    (Underlining identifies Queensland's proposed qualification)

181. For the reasons we explain below, we do not agree the qualification is necessary or appropriate.

Violence

182. The evidence in the hearing disclosed violence in a wide range of forms against Kaleb and Jonathon while in their father's care. Counsel Assisting described this violence in their submissions.[269]

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268 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 13 [60].

269 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 45 [164]–63 [204].

183. Paul Barrett's treatment of Kaleb and Jonathon and their mother involved violence or threatened violence. Paul Barrett pleaded guilty and was convicted[270] in relation to the charge of behaving in a disorderly manner in a public place in relation to the incident on 21 November 2002 at a Queensland hospital.[271] Paul Barrett arrived at the maternity outpatient's section of a hospital where Kaleb and his mother were waiting. He was intoxicated and behaved in a highly erratic manner. He pushed Kaleb's stroller but due to his intoxication was unable to properly coordinate his ability to push the stroller. The stroller fell over while Kaleb was sitting in it. Security arrived to contain the situation. Paul Barrett threw punches and pushed at security. He yelled and screamed.[272]

184. Queensland received reports of Paul Barrett using physical violence against Kaleb and Jonathon. On 10 January 2015, Queensland Police received a report from a camper at a camping ground about Kaleb and Jonathon's welfare.[273] Queensland Police later attended the campsite and observed Kaleb and Jonathon.[274] The attending officers recorded Kaleb and Jonathon 'could not speak but appeared ok and fed but had poor hygiene and smelt of urine'.[275] Records from the attendance note Queensland Police did not identify any child harm.[276]

185. On 19 January 2015, the family was on a camping trip (**2015 Camping Trip**). A community member informed Crime Stoppers and raised concerns that Kaleb and Jonathon were left unsupervised and kept in a tent for most of the day in very hot conditions (almost 37 degrees Celsius).[277] The community member reported the nappies smelt very bad and were not changed regularly;[278] their father would wash them once a day by throwing a bucket of bore water over them; he did not use soap or do any 'scrubbing';[279] on two occasions the youngest boy hid behind someone at the campground, but the father 'grabbed him and on one occasion kicked him very hard up the backside';[280] and they had heard their father 'laying into' either Kaleb or Jonathon. One of the boys was 'making a noise in the tent and the father went into the tent and started smacking him loudly'.[281] On 22 January 2015, some 3 days later,

270 Agreed Facts, [47]; Exhibit 33-157, QLD.0008.0029.0512, p 2.

271 Agreed Facts, [45]; Exhibit 33-157, QLD.0008.0029.0512, pp 4–6.

272 Agreed Facts, [44]; Exhibit 33-158, QLD.0008.0029.0151; Exhibit 33-157, QLD.0008.0029.0512, p 3.

273 Agreed Facts, [208]; Exhibit 33-258, QLD.0008.0029.0610, p 1; Exhibit 33-260, QLD.0008.0029.0027_E, p 1.

274 Agreed Facts, [209]; Exhibit 33-259, QLD.0008.0029.0612, p 1; Exhibit 33-260, QLD.0008.0029.0027_E, p 1.

275 Exhibit 33-114, QLD.0008.0064.0001, p 5.

276 Exhibit 33-115, QLD.0008.0064.0009, p 4.

277 Exhibit 33-114, QLD.0008.0064.0001, p 5.

278 Exhibit 33-114, QLD.0008.0064.0001, p 5.

279 Exhibit 33-114, QLD.0008.0064.0001, p 5.

280 Exhibit 33-114, QLD.0008.0064.0001, p 5.

281 Exhibit 33-114, QLD.0008.0064.0001, p 5.

Queensland Police officers attended the camping ground.[282] They spoke with Paul Barrett who informed the officers both children have autism[283] and he received support from their school.[284]

186. The Queensland Police officers observed Kaleb and Jonathon, wearing soiled nappies.[285] Paul Barrett claimed the nappies were changed regularly.[286] Queensland Police records set out there were 'nil child protection concerns' and no evidence of a criminal offence being committed or evidence of significant harm or risk of significant harm to Kaleb and Jonathon.[287]

187. On 7 August 2018, when Kaleb was 17 years old and Jonathon was 14 years old, the Department of Child Safety received a notification of Paul Barrett 'whacking' into Kaleb and Jonathon with his hand. The notifier said they had not seen it 'but heard the father hit the children' and believed he hit them 'on their backsides'.[288]

188. Kaleb and Jonathon experienced violence in their living conditions. We refer to Counsel Assisting submissions which detail Queensland's departments and agencies' observations of Kaleb and Jonathon being confined in their sparsely furnished bedroom, and being physically restrained from moving in and around their home.[289] For example, when 7-year-old Jonathon was caged in his bare room, and 9-year-old Kaleb was locked in his room in complete darkness, in a house smelling of faeces.[290] A child safety officer described the house as 'unliveable for the children'.[291]

189. As referred to above at [131–135] and [138], Ms Hair also observed similar conditions which constituted violence. As their neighbour, she saw Kaleb and Jonathon, who were teenagers, locked in their room for long periods on weekends and school holidays, without access to water, food or the toilet unless their father gave it to them.[292] She

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282 Exhibit 33-114, QLD.0008.0064.0001, p 5.

283 Exhibit 33-114, QLD.0008.0064.0001, p 5.

284 Exhibit 33-115, QLD.0008.0064.0009, p 5.

285 Exhibit 33-114, QLD.0008.0064.0001, p 5.

286 Exhibit 33-114, QLD.0008.0064.0001, pp 5–6.

287 Exhibit 33-114, QLD.0008.0064.0001, p 6.

288 Exhibit 33-276, QLD.0002.0027.1483_E, p 3.

289 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 50 [182]–56 [190]; Agreed Facts, [154(a–c)], [204], [325–326]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4; Exhibit 33-250, QLD.0008.0029.0678, p 3; Exhibit 33-312, QLD.0007.0032.0096, p 2; Exhibit 33-313, QLD.0008.0029.0431, p 7.

290 Agreed Facts, [154(a–c)]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4.

291 Agreed Facts, [157(a)]; Exhibit 33-206, QLD.0002.0027.1621_E, p 1.

292 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [21–22]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [8–30].

saw them on a mattress on the floor without pyjamas or a blanket, even in winter.[293] She saw Kaleb slipping in his faeces and urine on the floor of his bedroom, when his father unlocked their bedroom to get him ready for school.[294] Ms Hair observed Kaleb and Jonathon being left in soiled nappies, and Jonathon removing his nappy overnight.[295]

190. Ms Hair told the Royal Commission about Paul Barrett giving the boys an 'open, cold can of casserole' and, on another occasion, raw sausages in a packet, which they could not open.[296]

Abuse

191. The evidence disclosed abuse in a range of forms. Counsel Assisting described this abuse in their submissions.[297] We accept Counsel Assisting's submissions that violence perpetrated against Kaleb and Jonathon in the form of leaving them in isolating, humiliating and degrading conditions of detention, treating them inhumanly and using physical restraints on them, also constituted abuse.

192. Paul Barrett's abuse of Kaleb and Jonathon was also evident in repeated accounts of the children's poor hygiene, particularly when arriving at school. Kaleb was described as arriving at school with a strong smell of urine on his clothes, body and hair.[298]

193. On 23 May 2018, School 2 staff observed Jonathon was coming to school 'smelling of strong dog odour'.[299] Both children attended school with saturated and soiled nappies.[300] The school teachers washed and bathed the children. Paul Barrett sought to explain the situation to Child Safety officers. He is reported as saying 'the boys have to wear nappies and that they leak, and the boys cannot be trained due to the significant disabilities. There are things that could improve due to cleanliness'.[301]

293 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-19 [46]–P-20 [10].

294 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [9–30]; Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [20].

295 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [26].

296 Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [28]; Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-24 [1–19].

297 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 63 [205]–67 [216].

298 Agreed Facts, [92], [231]; Exhibit 33-177, QLD.0002.0027.0090_E, p 4; Exhibit 33-199, QLD.0005.0028.1360, p 30

299 Agreed Facts, [234(a)]; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-272, QLD.0005.0028.0352, pp 1–2.

300 Agreed Facts, [123] [257(c)]; Exhibit 33-177, QLD.0002.0027.0090_E, p 4; Exhibit 33-178, QLD.0002.0027.0094_E, p 4; Exhibit 33-196, QLD.0002.0027.0055_E, pp 1, 6–7; Exhibit 33-223, QLD.0002.0027.1604_E, p 5; Exhibit 33-283, QLD.0002.0027.1423_E, p 6.

301 Exhibit 33-286, QLD.0008.0029.0636, p 3; Agreed Facts, [263].

194. Queensland received reports and information that Kaleb and Jonathon were left in unchanged nappies and not given support to change their nappies or go to the bathroom.[302] A community member observed faeces smeared all over the children's bedroom on a regular basis.[303]

Neglect

195. The evidence disclosed Kaleb and Jonathon experienced chronic neglect in their father's care. Counsel Assisting described this neglect in their submissions.[304]

196. There were occasions when the children were left without supervision when they were infants[305] and as they became older.[306]

197. There were occasions where Queensland, through its departments and agencies, observed unexplained physical injuries to Kaleb and Jonathon. This included bruising and scratching.[307]

198. There were numerous occasions when Kaleb and Jonathon did not attend medical appointments or have access to health care.[308] The Agreed Facts revealed they each had a number of medical conditions that required ongoing management and support from health and allied health professionals.

199. There were numerous occasions recording Kaleb and Jonathon were provided with inadequate food, insufficient support for their eating behaviours, and inadequate supervision concerning their eating.[309] Kaleb was described as very hungry and

302 Exhibit 33-169, QLD.0002.0027.0659_E, p 2; Exhibit 33-180, QLD.0008.0029.0173, p 2.

303 Exhibit 33-180, QLD.0008.0029.0173, p 2; Agreed Facts, [97].

304 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 67 [217]–86 [246].

305 Agreed Facts, [68]; Exhibit 33-168, QLD.0002.0027.0678_E, pp 1–2.

306 Agreed Facts, [294]; Exhibit 33-117, QLD.0008.0029.0653; Exhibit 33-296, QLD.0002.0027.1349, pp 1–5; Exhibit 33-290, QLD.008.0029.0630, p 1.

307 Agreed Facts, [125(a–b)], [126], [136], [249]; Exhibit 33-192, QLD.0002.0027.0069_E, pp 1, 3; Exhibit 33-196, QLD.0002.0027.0055_E, p 5; Exhibit 33-279, QLD.0004.0028.0883, p 1.

308 Agreed Facts, [73–74], [77], [80–85], [195]; Exhibit 33-330, QLD.0010.0033.0013, pp 1–7; Exhibit 33-332, QLD.0010.0033.0011, pp 1–9; Exhibit 33-331, QLD.0010.0033.0002, pp 1–9; Exhibit 33-247, AQS.9999.0003.0001, pp 18, 20–21; Exhibit 33-286, QLD.0008.0029.0636, p 3.

309 Agreed Facts, [92–93], [146(b)], [147(b)], [173(f)], [235], [237(a)]; Exhibit 33-177, QLD.0002.0027.0090_E, p 4; Exhibit 33-178, QLD.0002.0027.0094_E, p 1; Exhibit 33-205, QLD.0002.0027.1643_E, p 1; Exhibit 33-200, QLD.0008.0029.0054, p 4; Exhibit 33-269, QLD.0004.0028.4429, p 1; QLD.0002.0027.1567_E, p 1; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-272, QLD.0005.0028.0352, p 2.

thirsty.[310] Their food lacked nutritional value.[311] The school supplemented food.[312] There were occasions when Kaleb and Jonathon regularly digested foam rubber, a fur like substance and rocks/pebbles which was evidenced by their bowel motions.[313]

200. On 19 May 2020, a teachers' aide at Jonathon's school observed he had 'lost lots of weight' and believed he was not taking his 'Epilim medication for his seizures for a many [sic] weeks now.'[314] Shortly after Kaleb and Jonathon were diagnosed with 'severe malnutrition, Kawshiorkors'.[315]

201. There were other reports of Kaleb and Jonathon being provided with inadequate and poor-quality food.[316] A community member claimed they saw Paul Barrett 'shove cans of baked beans and spaghetti down their throats' for dinner so they can go back to their rooms.[317]

202. Kaleb and Jonathon lived in inadequate shelter and without basic furnishings. When the family first moved into the home in 2004, it was 'in a clean, undamaged and working condition'.[318] By late 2005, the Department of Housing observed a deterioration in the hygiene of the home describing it as 'messy & dirty' with 'a smell'.[319] In a home visit in May 2010, Queensland Police recorded the home smelt

310 Exhibit 33-177, QLD.0002.0027.0090_E, p 4.

311 Agreed Facts, [146(b)], [147(b)]; Exhibit 33-205, QLD.0002.0027.1643_E, p 1; Exhibit 33-200, QLD.0008.0029.0054, p 4.

312 Agreed Facts, [175(b)], [237]; Exhibit 33-178, QLD.0002.0027.0094_E, p 1.

313 Agreed Facts, [146(b)], [147(b)], [180(e)], [190–191], [234(b)]; Exhibit 33-205, QLD.0002.0027.1643_E, p 1; Exhibit 33-200, QLD.0008.0029.0054, p 4; Exhibit 33-236, QLD.0002.0027.1556_E, p 2; Exhibit 33-244, QLD.0004.0028.6708, p 2; Exhibit 33-245, QLD.0004.0028.3558, p 1; Exhibit 33-246, QLD.0004.0028.3559, p 1; Exhibit 33-199, QLD.0005.0028.1360, p 30.

314 Agreed Facts, [321]; Exhibit 33-311, QLD.0005.0028.0154, p 1.

315 Agreed Facts, [327], Exhibit 33-334, QPG.9999.0002.1389_E, p 1; Exhibit 33-335, QPG.9999.0002.1383_E, p 1.

316 Agreed Facts, [97(c)], [181(c)], [246(b)]; Exhibit 33-169, QLD.0002.0027.0659_E, p 1; Exhibit 33-180, QLD.0008.0029.0173, p 2; Exhibit 33-238, QLD.0002.0027.1545_E, p 1; Exhibit 33-277, QLD.0002.0027.1462_E, p 3.

317 Agreed Facts, [242]; Exhibit 33-276, QLD.0002.0027.1483_E, p 3.

318 Exhibit 33-71, 'Statement of Chantal Raine', 5 May 2023, at [18].

319 Agreed Facts, [64(a)], [101], [103], [211], [215], [219], [230], [260], [263], [292(a–b)], [298]; Exhibit 33-181, QLD.0002.0027.0966_E, p 2; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-342, QLD.0001.0026.0053, p 8; Exhibit 33-283, QLD.0002.0027.1423_E, p 3; Exhibit 33-286, QLD.0008.0029.0636, p 3; Exhibit 33-293, QLD.0002.0027.1327_E, p 5; Exhibit 33-169, QLD.0002.0027.0659_E, p 2; Exhibit 33-267, QLD.0001.0026.0240_E, p 1; Exhibit 33-293, QLD.0002.0027.1327_E, p 7; Exhibit 33-182, QLD.0002.0027.0964_E, p 1; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-342, QLD.0001.0026.0053, p 8; Exhibit 33-342, QLD.0001.0026.0053, p 4; Exhibit 33-342, QLD.0001.0026.0053, p 4.

of faeces.[320] Queensland departments and agencies further observed the house was unclean, littered with rubbish and debris, or had a smell of faeces or urine in 2014,[321] 2015,[322] 2017,[323] and 2018.[324]

203. In February 2019, the family home was 'chaotic and unhygienic' with an 'overwhelming smell of faeces'. There were several piles of faeces in a room.[325] In June that year, contractors for the Department of Housing attended the family home for planned works. The contractors informed the Department of Housing they put their works on hold because there were health and safety concerns relating to the condition of the house.[326]

204. Below we reproduce photos which Counsel Assisting extracted from the contractor's video footage of the home. There appears to be dirt all over the floors. Figure 3 is of the lounge room where there is an orange-red chair which has brown marks on it. Figure 4 is the kitchen with a bench and oven. In both images, there is rubbish and debris on the floor. There appears to be dirt all over the floors. Figure 5 is of the hallway in the family home. There also appears to be dirt on the floor. Figure 6 is of the bathroom sink, which appears unclean. Figure 7 is a photo of the floor area beneath the bathroom sink. There appear to be dirt marks all over the floor and wall tiles.

205. After receiving the contractor's video, the Department of Housing wrote to Paul Barrett and described the home as being 'in poor condition, with clutter, rubbish and belongings throughout causing a health and safety concern'.[327]

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320 Agreed Facts, [154a]; Exhibit 33-202, QLD.0008.0029.0576_E, pp 3–4.

321 Agreed Facts, [204]; Exhibit 33-250, QLD.0008.0029.0678, pp 3–5.

322 Agreed Facts, [211], [215]; Exhibit 33-257, QLD.0002.0027.1508_E, p 3. Exhibit 33-342, QLD.0001.0026.0053, p 8.

323 Exhibit 33-1, DRC.2000.0014.0118, [230]; Exhibit 33-342, QLD.0001.0026.0053, p 4.

324 Agreed Facts, [232]; QLD.0001.0026.0053, pp 3–4.

325 Agreed Facts, [287]; Exhibit 33-293, QLD.0002.0027.1327_E, p 4; Exhibit 33-294, QLD.0002.0027.1354_E, p 3.

326 Agreed Facts, [302]; Exhibit 33-342, QLD.0001.0026.0053, p 1; Exhibit 33-303, QLD.0001.0026.0083, p 3; Exhibit 33-302, QLD.0001.0026.2539, pp 1–4.

327 Agreed Facts, [302–303]; See generally Exhibit 33-342, QLD.0001.0026.0053, p 1; Exhibit 33-303, QLD.0001.0026.0083, p 3; Exhibit 33-302, QLD.0001.0026.2539, pp 1–4; Exhibit 33-301, QLD.0001.0026.2998; Exhibit 33-303, QLD.0001.0026.0083, p 2.

Figure 3: Living room on 4 June 2019;[328] **Figure 4: Kitchen on 4 June 2019**[329]

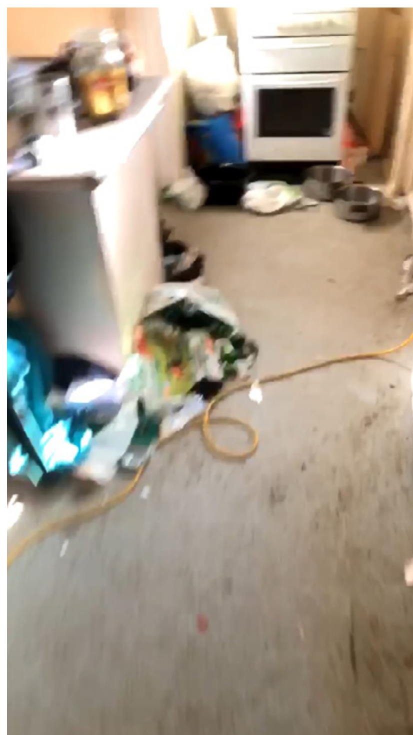


Figure 5: Hallway to bathroom on 4 June 2019[330]

328 Exhibit 33-301, QLD.0001.0026.2998.

329 Exhibit 33-301, QLD.0001.0026.2998.

330 Exhibit 33-301, QLD.0001.0026.2998.

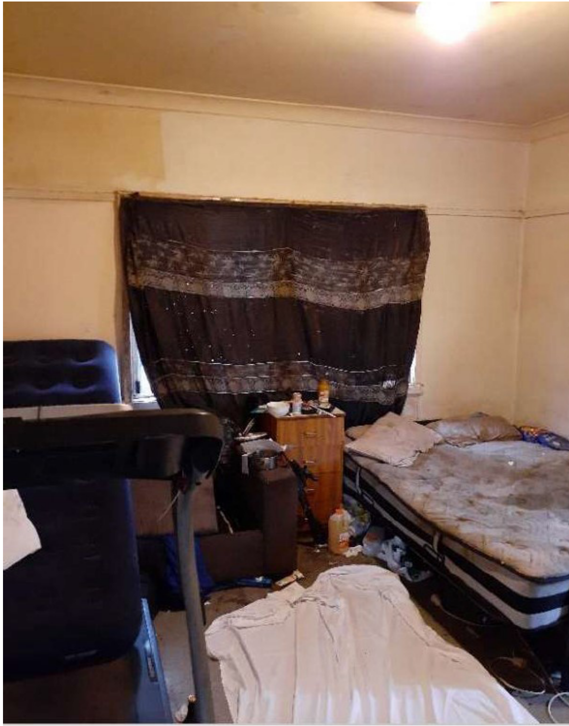
Figures 6 and 7: Bathroom on 4 June 2019[331]

206. When Queensland Police found Kaleb and Jonathon on 27 May 2020, the home was in a similar state. Faeces were on the floor in the spare and main bedrooms. Kaleb and Jonathon's room was completely bare and doorhandles were removed.[332] Below we reproduce photos which Counsel Assisting displayed during their opening. Figure 8 is Paul Barrett's room on 28 May 2020. On the right side of the photo, there is a mattress with stains and no bedding. Beside the mattress are bedside draws. Rubbish and bottles are on the bedside drawers and on the floor. There is a white sheet on the floor. On the left-side of the photo, there is a blue blow-up mattress. It is resting against the far wall and on top of a treadmill. Figure 9, we infer, is a photo of Kaleb and Jonathon's bedroom on 28 May 2020. You cannot see the whole room in the photo. There is a window, paint appears to be removed from the walls. There are open nappies on the floor.

331 Exhibit 33-301, QLD.0001.0026.2998.

332 Agreed Facts, [326(a–b)]; Exhibit 33-313, QLD.0008.0029.0431, p 7.

Figure 8: Paul Barrett's room 28 May 2020; Figure 9: Kaleb and Jonathon's bedroom 28 May 2020



207. Ms Hair's evidence about the lack of furnishings in the family home and its poor hygiene[333] was consistent with Queensland departments' and agencies' observations of the home between 2018 and 2020.

208. Kaleb and Jonathon had a limited social network. Neither of their school records suggest they had close relationships or friendships with students of their own ages.[334]

209. Paul Barrett controlled and limited Kaleb and Jonathon's access to community and supports provided or funded by Queensland departments and agencies. Consistently with Ms Hair's evidence,[335] Paul Barrett resisted assistance and support from

333 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-21 [9–30]; Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [17–20], [26].

334 Kaleb and Jonathon's respective student profiles at School 2 recorded they each participated in school activities including, fun runs, school camps, and school sleepovers; Exhibit 33-95, QLD.9999.0070.0007, pp 11–13; Exhibit 33-341, QLD.0004.0028.3597, pp 42–43, 46–48.

335 Transcript, Lisa Hair, Public hearing 33, 8 May 2023, P-[3–24]; Exhibit 33-5, 'Statement of Lisa Hair', 20 April 2023, at [30–31].

Queensland departments and agencies for his sons.[336] The Agreed Facts describe Paul Barrett's abusive and aggressive behaviours and reaction to those seeking to assist him and support his children. For example:

a. on 13 August 2010, the Principal of School 2 approached Paul Barrett about the supports for Kaleb and Jonathon. He was unreceptive and became abusive stating, 'don't you ████ bring anyone in here, I do not need the support'.[337]

b. on 16 December 2013, Autism Queensland contacted Paul Barrett to discuss the funding application. It is reported Paul Barrett 'became very angry and upset about the possible support' and 'made it perfectly clear that he did not want the money or any form of support due to previous experiences'.[338] Notwithstanding Paul Barrett's response, Kaleb did receive funding for Autism Queensland's support services.[339] Although these supports were provided at school only.[340]

210. In a health context, there was evidence Kaleb and Jonathon lacked access to basic and essential medical care and essential disability supports in their father's care. This included:

- non-attendance at scheduled medical appointments, including physiotherapy, audiology, ophthalmology, general paediatrics appointments and appointments at the Child Advocacy Service and Endocrine Clinic.[341]
- non-attendance at any Queensland Health Service appointments for about 4 years between 2005 and 2010[342]
- no records of Kaleb attending appointments after the age of 10, other than to hospital emergency departments[343]
- no record to show Jonathon attended any appointment between approximately 7 and 15 years old, other than admission to public hospitals after seizures.[344]

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336 Agreed Facts, [211], [261(a)], [288]; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-283, QLD.0002.0027.1423_E, p 4; Exhibit 33-293, QLD.0002.0027.1327_E, p 3; Exhibit 33-293, QLD.0002.0027.1327_E, p 4; Exhibit 33-294, QLD.0002.0027.1354_E, p 3.

337 Agreed Facts, [173(a)]; Exhibit 33-232, QLD.0002.0027.1567_E, pp 1–2.

338 Agreed Facts, [196]; Exhibit 33-247, AQS.9999.0003.0001, p 3.

339 Agreed Facts, [197], [199]; Exhibit 33-247, AQS.9999.0003.0001, p 4; Exhibit 33-248, QLD.0020.0050.1360, p 1.

340 Exhibit 33-247, AQS.9999.0003.0001, pp 1–41.

341 Agreed Facts, [73–74], [77], [80–82]; Exhibit 33-330, QLD.0010.0033.0013, pp 1–7; Exhibit 33-332, QLD.0010.0033.0011, pp 1–2.

342 Exhibit 33-330, QLD.0010.0033.0013, pp 4–5; Exhibit 33-331, QLD.0010.0033.0002, pp 6–8.

343 Exhibit 33-331, QLD.0010.0033.0002, pp 8–9.

344 Exhibit 33-330, QLD.0010.0033.0013, pp 2–4.

211. In an education context, there was long term and almost daily interaction between the school staff and the children. Ms Stevenson accepted Kaleb and Jonathon experienced neglect.[345] Ms Stevenson accepted the staff of School 2 needed to bathe Kaleb and Jonathon and provide clothes every day which indicated they were experiencing neglect. She accepted that if Kaleb and Jonathon required such care at school, then the staff at School 2 knew the boys were subject to neglect.[346] Ms Stevenson appropriately accepted that Kaleb and Jonathon's presentation at school over many years was a sign of actual or potential violence, abuse, neglect and deprivation of their rights while in their father's care.[347]

212. Dr Crawford agreed Kaleb and Jonathon experienced neglect over their life course and the Department of Child Safety's 'investigation and assessment outcomes reveal that' through 'substantiated outcomes'.[348] It was put to her the neglect did not require substantiated outcomes, to which she responded 'it is conveyed in our assessments'.[349]

213. For those agencies that engaged with Kaleb and Jonathon less frequently, there was a more guarded response in their evidence. Detective Superintendent Clark considered 'neglect' in the context of children meant a 'failure to provide core services to that child which is detrimental for their physical, psychological or emotional wellbeing'.[350] It was appropriate for him to consider the nature of neglect in the context of pursing a criminal prosecution under section 364 of the *Criminal Code Act 1899* (Qld) (***Criminal Code***). He also wanted to make the point that the Queensland Police did not have the skills or expertise to make the assessment of neglect and would seek the advice of Child Safety.[351] However, he did accept the indicia for neglect could include 'their physical state', it could be 'the state of the house', 'relationship between parents and the child', 'lack of food, clothing or other forms of care or medical support'.[352] After some examination, Detective Superintendent Clark appeared to accept Kaleb and Jonathon experienced neglect.[353]

214. Mr Francis (Frank) Joseph Eugene Tracey, Health Service Chief Executive, Children's Health Queensland, accepted, with the benefit of hindsight, Kaleb and Jonathon's absence of continual attendance and non-attendance at medical appointments was indicative of ongoing neglect.[354]

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345 Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-188 [33–37].

346 Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-173 [34]–P-174 [10].

347 Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-188 [26–31].

348 Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-146 [42]–P-147 [2], P-159 [1–10].

349 Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-159 [9–16].

350 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-199 [12–16].

351 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-235 [10–13].

352 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-199 [20–28].

353 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-225 [11–16].

354 Transcript, Francis (Frank) Eugene Tracey, Public hearing 33, 10 May 2023, P-256 [19–24].

Paul Barrett's behaviours

215. Ms Hair's account is consistent with the descriptions of Kaleb and Jonathon's treatment recorded in the Agreed Facts and observed by Queensland departments and agencies.

216. Queensland departments and agencies directly observed Paul Barrett drinking or being intoxicated while caring for Kaleb and Jonathon. On 2 April 2003, the Child Advocacy Service did a home visit. Paul Barrett told the Child Advocacy Service he drank six to eight glasses a day.[355]

217. The Agreed Facts describe:

- many occasions from September 2002 when Paul Barrett used alcohol and/or was affected by alcohol.[356] The Department of Child Safety was concerned his use of alcohol might affect his ability to meet the complex needs of the children.[357]
- Paul Barrett behaving aggressively with very intense yelling, screaming and swearing directed to the teacher who asked him to change Jonathon's nappy before sending him to school. [358] Paul Barrett attended the school and it was reported he was physically and verbally abusive and smelling of alcohol. The principal and groundsman were called to deal with the situation.[359]
- Paul Barrett was abusive towards the school about the Department of Disability Services support telling them 'don't you [redacted] bring anyone in here, I do not need the support'.[360]
- The Agreed Facts record members of the community notified the Department of Child Safety about Paul Barrett exposing Kaleb and Jonathon to his alcohol and drug abuse.[361]

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355 Agreed Facts, [61(a)]; Exhibit 33-330, QLD.0010.0033.0013, p 7.

356 Agreed Facts, [42], [95], [100A], [105(c)], [178]; Exhibit 33-152, QLD.0002.0027.1836_E, p 1; Exhibit 33-179, QLD.0002.0027.0101_E, p 1; Exhibit 33-176, QLD.0021.0058.0001, pp 5–7; Exhibit 33-236, QLD.0002.0027.1556_E, pp 1–2; Exhibit 33-184, QLD.0002.0027.0957_E, p 2; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-257, QLD.0021.0058.0001, p 6.

357 Agreed Facts, [142(b)]; Exhibit 33-197, QLD.0002.0027.1654_E, p 2.

358 Agreed Facts, [123]; Exhibit 33-196, QLD.0002.0027.0055_E, pp 4, 6–7.

359 Exhibit 33-196, QLD.0002.0027.0055_E, pp 4, 6–7.

360 Agreed Facts, [173]; Exhibit 33-232, QLD.0002.0027.1567_E, pp 1–2.

361 Agreed Facts, [49(a)], [53], [64(e)], [118], [181(e)], [202(b)], [246(c)]; Exhibit 33-159, QLD.0008.0029.0169, p 1; Exhibit 33-163, QLD.0008.0029.0155, p 2; Exhibit 33-169, QLD.0002.0027.0659_E, p 2; Exhibit 33-186, QLD.0002.0027.0081_E, p 3; Exhibit 33-188, QLD.0002.0027.1684_E, pp 1–2; Exhibit 33-238, QLD.0002.0027.1545_E, p 1; Exhibit 33-239, QLD.0008.0029.0297_E, p 2; Exhibit 33-252, QLD.0002.0027.0110_E, p 1; Exhibit 33-277, QLD.0002.0027.1462_E, p 3.

Deprivation of human rights

218. When we consider the totality of the evidence, we find Kaleb and Jonathon were denied the following rights:

- respect for their physical and mental integrity on an equal basis with others
- to be consulted and supported about matters concerning them or to express their views
- access to a range of in-home, support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community
- access to community services and facilities for children to play
- an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions
- to be able to live within their home free from all forms of exploitation, violence and abuse [362]
- at times when there were missed appointments, access to adequate health care.[363]

Queensland's submissions concerning Finding 1

219. Queensland contends the evidence before us does not support Finding 1 '*as worded* by Counsel Assisting'.[364] First, it submitted there were gaps in the evidence to support a finding they experienced violence, abuse, neglect and deprivation of human rights over the whole 20-year period.[365]

220. Secondly, Queensland submitted we should not accept, at face value, evidence of reports and allegations of violence, abuse and neglect as matters of fact unless satisfied the conduct occurred on the balance of probabilities. This was particularly

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362 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 86 [249].

363 Committee on the Rights of the Child, *General comment no. 13 (2011) on the right of the child to freedom from all forms of violence*, UN/CRC/C/GC/13, (18 April 2011), pp 8–9 [20]. Agreed Facts, [73–74], [77], [80–85], [195]; Exhibit 33-330, QLD.0010.0033.0013, pp 1–7; Exhibit 33-332, QLD.0010.0033.0011, pp 1–2; Exhibit 33-331, QLD.0010.0033.0002, pp 2–9; Exhibit 33-286, QLD.0008.0029.0636, p 3; Exhibit 33-330, QLD.0010.0033.0013, pp 1–6; Exhibit 33-331, QLD.0010.0033.0002, pp 2–9.

364 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 13 [57], [59], 25 [118].

365 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 13 [57].

in light of the seriousness of the allegations relating to violence, abuse and neglect. Queensland stated the credibility of persons making these reports and allegations, and the reliability of their reports and allegations, were not tested to any civil or criminal standard.[366]

221. Thirdly, Queensland contended the oral evidence of its witnesses as to whether reports Kaleb and Jonathon experienced violence, abuse or neglect occurred as a matter of fact had limited, if any, weight. These witnesses were not personally involved in any of these instances.[367]

222. It is correct to say Kaleb and Jonathon experienced violence and abuse on *numerous occasions*. It is also correct to say there were gaps in Queensland's observations of Paul Barrett being violent or abusive to Kaleb and Jonathon, or recording conditions of neglect.

223. However, our finding is not based on a count of the number of incidents or the frequency of incidents of violence, abuse and neglect. Nor is our finding based on separating incidents of violence from incidents of abuse, and incidents of neglect.[368] Our finding relies on the totality of the evidence, not a measure of the severity of a single or isolated incident. The incident-by-incident approach which Queensland adopted perpetuates the idea that maltreatment is episodic and denies the intense likelihood that the impact of exposure to chronic maltreatment may not be visible at the time of the exposure; rather it will present over time.[369] The evidence reveals ingrained and habitual behaviour that resulted in cumulative harm.

224. It is important to understand these concepts as they concern children, particularly children with disability. Violence, abuse, neglect and deprivation of rights are not confined to one-off incidents that result in immediate or visible physical harm to a child with disability. Applying a life course approach, violence, abuse, neglect and deprivation of rights may occur as part of a continuous course of conduct, exposure to coercive control or a failure to act.

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366 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 23 [99–101].

367 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 24 [111], 25 [115].

368 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 16 [71]–19 [80].

369 Exhibit 33-61, DRC.9999.0212.0001, p 8.

225. We have considered Dr Crawford's evidence addressing the nature of cumulative harm[370] and agree that cumulative harm is apt to describe both the nature and the effect of some forms of violence, abuse, neglect and deprivation of rights. Cumulative harm cannot be separated from the effect of neglect or the effect of the deprivation of human rights that occurs over a life course. Cumulative harm may manifest in life long trauma. Cumulative harm must necessarily include the deprivation of a person's dignity, autonomy and equal treatment. We found this aspect of Dr Crawford's evidence of considerable assistance and consistent with a life course approach.

226. Queensland submitted there was a 'reasonable and available inference' to draw from gaps in evidence of Kaleb and Jonathon experiencing violence, abuse, neglect and deprivation of human rights that there were temporary periods of time where Paul Barrett's ability to care for Kaleb and Jonathon had improved'.[371] It also submitted there was no interrogation of what clusters of observed violence, abuse, neglect and deprivation of human rights mean.[372]

227. We reject these submissions. These submissions ask us to consider Finding 1 by refence to the number of incidents or the frequency of incidents of violence, abuse and neglect, which we do not accept for reasons outlined above.

228. Moreover, there was no evidence to support Queensland's submission that there was generally an improvement in the children's circumstances or Paul Barrett's capacity improved generally or for particular periods. To the contrary, the nature of reports and Queensland's direct observations of violence, abuse and neglect during 'clusters' and their similarities throughout the time Kaleb and Jonathon were in Paul Barrett's care, suggests these circumstances and behaviours were ongoing. For example, there were striking similarities in descriptions of the poor hygiene of the family home in 2010, 2018 and 2020,[373] and reports and observations of Kaleb and Jonathon being locked in their room or the doorhandle to their room being removed in 2010, 2016 and 2020.[374]

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370 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at pp 13–14 [29–32]; Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-145 [21]–P-146 [48], P-149 [46]–P-150 [1].

371 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 13 [59], 22 [94].

372 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 20 [82].

373 Agreed Facts, [154] [232], [242], [246], [251], [326]; Exhibit 33-202, QLD.0008.0029.0576_E, pp 4–6; Exhibit 33-206, QLD.0002.0027.1621_E, pp 1–2; Exhibit 33-342, QLD.0001.0026.0053, pp 3–4; Exhibit 33-276, QLD.0002.0027.1483_E, p 3; Exhibit 33-277, QLD.0002.0027.1462_E, p 3; Exhibit 33-313, QLD.0008.0029.0431, p 7.

374 Agreed Facts, [154(b)], [223], [325b], [326(a–b)]; Exhibit 33-202, QLD.0008.0029.0576_E, p 4; Exhibit 33-342, QLD.0001.0026.0053, p 6; Exhibit 33-312, QLD.0007.0032.0096, p 2; Exhibit 33-313, QLD.0008.0029.0431, p 7.

We also observe in the periods between 'clusters' of observed and reported violence, abuse and neglect, there Kaleb and Jonathon had an ongoing lack of access to medical care and very limited access to disability supports.

229. With respect to Queensland's submission that we ought not accept at face value, reports and allegations of violence against, abuse and neglect of Kaleb and Jonathon, we agree reliance on an allegation or report on its own would be an unsound basis for making this finding. However, Counsel Assisting Submissions do not rely on a single report or allegation to suggest Finding 1 is open to us. They rely on direct observations, and reports to Queensland's departments and agencies, which reflected consistent concerns about Paul Barrett's treatment of his children, their care and living standards.

230. It is unnecessary for us to address Queensland's submission concerning the limited weight which should be given to its witnesses' oral evidence to determine whether reports of Kaleb and Jonathon experiencing violence, abuse and neglect, in fact occurred. Finding 1 is open to be made based on the Agreed Facts, contemporaneous records, and Ms Hair's evidence, which we consider are reliable.

Finding 2: The violence, abuse, neglect and deprivation of rights experienced by Kaleb and Jonathon was preventable

231. For the reasons set out below we make Finding 2.

> **Finding 2**
>
> The violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced in the care of their father, Paul Barrett, was preventable.

232. We accept Counsel Assisting's submission there was nothing about Kaleb or Jonathon's age, disability or their personal circumstances that made it inevitable they should individually and together experience violence, abuse, neglect or a deprivation of their human rights.[375]

233. Queensland accepted it was open for us to make this finding.[376]

375 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 89 [261–262].

376 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 25 [119].

Finding 3: Queensland departments and agencies could or should have done more to prevent the violence, abuse, neglect or deprivation of their human rights

234. For the reasons set out below, we make Finding 3.

> **Finding 3**
>
> The State of Queensland through the departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett, could and should have done more to prevent Kaleb and Jonathon from experiencing violence, abuse, neglect and the deprivation of their human rights, having regard to the particular departments' or agencies' powers and responsibilities.

235. This finding modifies the finding sought by Counsel Assisting in their submissions. Counsel Assisting sought a finding to the effect that the Queensland departments and agencies could or should '*have acted'* to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon each experienced, having regard to the particular departments' or agencies' powers, responsibilities and actions.

236. Queensland objected to Finding 3 on the grounds:

- there was no causal evidence or submissions by Counsel Assisting as to the steps and actions Queensland departments and could or should have taken and how, on the balance of probabilities this would have prevented the violence, abuse, neglect and deprivation of Kaleb and Jonathon's human rights[377]
- Queensland's departments and agencies took positive actions[378]
- the finding was not open with respect to each of Queensland's departments and agencies who interacted with the family but only 'some' of them. Queensland appeared to accept it was open for us to find Department of Child Safety and Department of Education 'should or could have done more'.[379] However, did not consider this finding was open with respect to the Department of Disability

377 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 26 [124], 27 [134].

378 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 26 [125], 27 [129], [131].

379 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 30 [144]; Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-161 [5–15]; Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-189 [1–11].

Services, Queensland Health, Queensland Police and the Department of Housing.[380] We understand this submission was made in the event we considered it unnecessary for there to be causal evidence that specific steps by certain Queensland departments and agencies, on the balance of probabilities, would have prevented Kaleb and Jonathon's experiences of violence, abuse, neglect and deprivation of human rights.

237. Queensland also pointed to some of the additional findings directed to specific departments. For example, Queensland argued Finding 3 was inconsistent with a proposed finding that the Department of Child Safety 'should have done more' to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon each experienced.[381]

238. We do not consider the phrases 'could and should have acted' or 'could and should have done more' are inconsistent or the propositions advanced by Counsel Assisting were not understood by Queensland. The proposed finding was clear. However, we are persuaded on all of the evidence that Queensland, through its departments and agencies could and should have done more and for this reason we made the finding in this form. Dr Crawford agreed the Department of Child Safety 'could have done more'.[382]

239. We have considered Queensland's submissions with respect to an absence of causal evidence with respect to each department or agency.[383] The submission misapprehends the life course approach which is not directed to a cause and effect analysis which may be appropriate for an incident by incident analysis, but this was not the purpose of the case study. We are not seeking to make findings that any person, department or agency breached a common law or statutory duty with respect to Kaleb and/or Jonathon.

240. Counsel Assisting described the numerous individual, relational, systems, and social influences putting Kaleb and Jonathon at risk of violence, abuse and neglect while in their father's care. These risk factors were interrelated and changed over time. These risk factors required consideration of Kaleb and Jonathon's past experiences of violence, abuse and neglect,[384] limited communication and independent access to

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380 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 28 [133–136], 29 [139–140], 29 [143], 30 [145].

381 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 25–26 [120–128].

382 Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-160 [45]–P-161 [19].

383 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 26 [124–125].

384 See generally Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 91 [269]–93 [276].

information or resources,[385] the history of family violence,[386] Paul Barrett's personal circumstances and responsibilities,[387] social isolation, particularly during the early stages of COVID-19 lockdowns,[388] and social influences.[389]

241. The risk factors for violence, abuse and neglect are not definitive and their presence does not necessarily mean violence, abuse and neglect will occur.[390] We accept Counsel Assisting's submission that Queensland, through its departments and agencies, was aware of an overwhelming amount of evidence exposing Kaleb and Jonathon to violence, abuse and neglect while in their father's care.[391]

242. In several instances, these risks factors constituted actual occasions of violence, abuse and neglect of Kaleb and Jonathon. In the circumstances, and having regard to Queensland departments' and agencies' responsibilities, Queensland could and should have done more to prevent the violence, abuse and neglect that occurred to Kaleb and Jonathon.

243. We accept Counsel Assisting's submission that context is important in considering our findings and we should consider that the Queensland departments or agencies engaged with Kaleb, Jonathon and Paul Barrett at different times and in different ways over the 20-year period. Each Queensland department or agency had different powers and responsibilities and, for some, their powers and/or responsibilities changed over time.[392] We note Queensland has also urged us to have regard to these circumstances.[393]

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385 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 93 [277]–96 [287].

386 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 102 [305]–103 [307].

387 See generally Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 96–98 [288–294], 102 [302–303].

388 See generally Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 104 [308]–105 [313].

389 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 104 [308]–112 [334].

390 'Risk and protective factors for child abuse and neglect', *Australian Institute of Family Studies*, web page, May 2017. <www.aifs.gov.au/resources/policy-and-practice-papers/risk-and-protective-factors-child-abuse-and-neglect>; Leah Bromfield, Alister Lamont, Robyn Parker & Briony Horsfall, Australian Institute of Family Studies, *Issues for the safety and wellbeing of children in families with multiple and complex problems: The occurrence of domestic violence, parental substance misuse, and mental health problem*, NCPC, Report no 33, March 2010, p 3.

391 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 90 [266].

392 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 90 [265].

393 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 26 [121].

244. We also accept that Queensland departments and agencies took 'positive action at various times'.[394] We have referred to supports provided to Kaleb and Jonathon by School 2 with respect to their hygiene, hunger and wellbeing.[395] We have referred to the occasion Queensland Police acted to remove the children from Paul Barrett's care in 2010.[396]

245. There were also occasions where the Department of Child Safety intervened. For example, we refer to Dr Crawford's evidence of four occasions, including after Paul Barrett's death, when the Department of Child Safety intervened to address child protection concerns.[397] These included:

- in 2000, when the Department of Child Safety took Kaleb temporarily into its care while the parents were supported to address child protection concerns.[398]
- in 2003, when the Department of Child Safety opened a 'Child Protection Follow-Up' (now called an Intervention with Parental Agreement (**IPA**)) for Jonathon.[399] Kaleb was at the time subject to a Child Protection Order (**CPO**) in the form of a protective supervision order.[400]

394 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 26 [125].

395 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 151 [473], 153 [479], [481], 154 [482]; Agreed facts, [196], [231], [237], [238]; Exhibit 33-247, AQS.9999.0003.0001, pp 3, 29, 33; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-272, QLD.0005.0028.0352, pp 1–2; Exhibit 33-274, QLD.0005.0028.0362, pp 1–4; Exhibit 33-269, QLD.0004.0028.4429, p 1; Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [22–23]; Exhibit 33-272, QLD.0005.0028.0352, pp 1–4; Exhibit 33-273, QLD.0005.0028.0359, p 1.

396 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2021, pp 93 [275], 150 [470]. See generally Agreed Facts, [154], [160–168]; Exhibit 33-206, QLD.0002.0027.1621_E, p 2; Exhibit 33-210, QLD.0002.0027.0581_E, pp 1–4; Exhibit 33-211, QLD.0021.0057.0001, pp 1–4; *Child Protection Act 1999* (QLD) (as in force at time) ss 51Z–51ZI; Exhibit 33-212, QLD.0002.0027.0036_E, pp 1–6; Exhibit 33-215, QLD.0008.0029.0069, pp 1–7; Exhibit 33-216, QLD.0002.0027.1598_E, pp 1–6; Exhibit 33-221, QLD.0002.0027.1610_E, p 3; Exhibit 33-220, QLD.0002.0027.1614_E, p 2; Exhibit 33-224, QLD.0002.0027.1589_E, p 1; Exhibit 33-202, QLD.0008.0029.0576_E, pp 3–4; Exhibit 33-207, QLD.0002.0027.0558_E, pp 1–2; Exhibit 33-208, QLD.0002.0027.0563_E, pp 9–23.

397 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27].

398 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27(a)].

399 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27(b)].

400 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27(b)].

- in 2010, when the Department of Child Safety opened an IPA with respect to Kaleb and Jonathon's care.[401]
- in May 2020, after Paul Barrett's death, when the Department of Child Safety took Jonathon into its care.[402]

246. However, we do not accept the submission that this 'positive action' prevents us from making Finding 3. If anything, it highlights the extent to which Kaleb and Jonathon required external supports from Queensland departments and agencies and why more could have been done.

247. The key point made by Counsel Assisting, which we accept, was that Queensland, through the particular departments and agencies, could and should have done more to prevent violence, abuse, neglect and the deprivation of their rights over the life course, to address the violence and abuse that contributed to the long term and chronic neglect of two young people who lived with intellectual disability and were wholly dependent on the people and systems around them to protect them.[403]

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401 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27(c)].

402 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 11 [27(d)].

403 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 118–119 [350].

Part 5 Kaleb and Jonathon's engagement with the NDIS

248. At the time of their father's death, Kaleb had been an NDIS participant since 3 March 2018.[404] Jonathon was not an NDIS participant.[405]

Transitioning to the NDIS

249. We accept the process of transitioning from disability services provided by Queensland to the NDIS was not always smooth. When considering Kaleb and Jonathon's transition to the NDIS, the evidence revealed some of the challenges and barriers that existed during the transition period, which started in mid-2016.

250. Ms Bullen described the then Department of Disability Services' responsibilities prior to 2016 when the transition to the NDIS commenced.[406]

251. Dr Bennett and Mr Lee provided a joint statement to the Royal Commission[407] and gave oral evidence at the hearing.

252. Between 2016 and June 2019, the Department of Disability Services provided the NDIA with data sets to assist Queensland clients who received disability supports and services and those on the Register of Need, to enter the NDIS.[408]

253. During the period from 19 May 2016 to 15 November 2017, the Department of Disability Services, and Department of Education provided various data sets to the NDIA. [409] This was in the context of transitioning clients from state based 'defined and non-defined programs' to the NDIS.[410] Clients of 'defined programs' were not required to provide evidence of their disability to satisfy NDIS access requirements.[411]

254. On 19 May 2016, the Department of Disability Services transmitted data concerning Kaleb and Jonathon as part of the Register of Need.[412]

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404 Exhibit 33-12, CTD.8000.0012.1809, p 20; Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-105 [14–17].

405 Exhibit 33-12, CTD.8000.0012.1809, p 30; Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-104 [1–4].

406 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [11].

407 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023.

408 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [17].

409 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [2–27]; Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 68–69 [305].

410 Exhibit 33-12, CTD.8000.0012.1809, p 19.

411 Exhibit 33-12, CTD.8000.0012.1809, p 10.

412 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [21], [25].

255. On 15 November 2017, the Department of Disability Services transmitted data concerning Kaleb (as a client of the Department of Disability Services and the Department of Health)[413] and Jonathon (as a client of the Department of Health).[414]

256. In its submissions, Queensland accepted the Department of Disability Services was responsible for providing data and assisting children transition to NDIS. However, it considered it discharged its responsibilities with respect to data transmission for the transition of Kaleb and Jonathon to the NDIS.[415]

257. The initial data sets sent to the NDIA did not meet the data standards agreed between the NDIA and Queensland.[416] As a result, the NDIA did not process it.[417] The later data sets, sent in November 2018 did meet the agreed data standards.[418] However, only recorded Kaleb as a client of 'a defined program'.[419] The data also categorised Paul Barrett as Kaleb's 'Other' rather than his father,[420] included three incorrect phone numbers for Paul Barrett,[421] and did not link Kaleb and Jonathon as siblings.[422]

258. On 23 January 2018, the NDIA closed Kaleb's application for access, following a lack of contact with the family.[423]

259. On 12 February 2018, an 'access assessor' from the NDIA contacted Paul Barrett via telephone in relation to Jonathon's access.[424] The access assessor informed Paul Barrett he would need to provide evidence of Jonathon's disability.[425] According to NDIA records, Paul Barrett gave consent to the NDIA for them to contact third parties in relation to Jonathon's application.[426] The access assessor however did not record details of any third parties.[427]

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413 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [22]; Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 68 [305(a)(iii)].

414 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [26]; Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 69 [305(b)(iii)].

415 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 69 [306–307].

416 Exhibit 33-12, CTD.8000.0012.1809, p 19.

417 Exhibit 33-12, CTD.8000.0012.1809, p 19.

418 Exhibit 33-12, CTD.8000.0012.1809, p 19.

419 Exhibit 33-12, CTD.8000.0012.1809, p 19.

420 Exhibit 33-12, CTD.8000.0012.1809, p 20.

421 Exhibit 33-12, CTD.8000.0012.1809, p 19.

422 Exhibit 33-12, CTD.8000.0012.1809, pp 19, 37.

423 Exhibit 33-12, CTD.8000.0012.1809, p 20.

424 Exhibit 33-12, CTD.8000.0012.1809, p 66.

425 Exhibit 33-12, CTD.8000.0012.1809, pp 21, 66.

426 Exhibit 33-12, CTD.8000.0012.1809, p 21.

427 Exhibit 33-12, CTD.8000.0012.1809, p 21.

260. During the telephone call of 12 February 2018, there was also some discussion about Kaleb.[428] The NDIA representative completed a Verbal Access Request with Paul Barrett.[429] The NDIA subsequently verified Kaleb was a client of a 'defined program', and he met the access requirements for the NDIA without formal evidence of his disability.[430]

261. On 12 February 2018, the NDIA wrote to Paul Barrett requesting evidence of Jonathon's disability.[431]

262. On 3 March 2018, Kaleb became an NDIS participant.[432]

263. On 12 March 2018, the NDIA again wrote to Paul Barrett requesting evidence of Jonathon's disability. [433]

264. On 9 April 2018, the NDIA automatically cancelled Jonathon's application for access as it had not received evidence of his disability.

265. On 7 August 2018, Kaleb, and Paul Barrett attended an initial planning meeting with an NDIA Planner (**NDIA Planner 1**) at an NDIA service delivery site.[434] Kaleb was 18 years old by the time of the initial planning meeting. The purpose of this initial meeting would have been to identify necessary and reasonable supports, and identify any of Kaleb's goals as an NDIS participant.[435]

266. During the initial planning meeting, the documents record Paul Barrett informing NDIA Planner 1:

- he would like Kaleb's plan to be 'agency managed',[436]
- Kaleb would be completing school in late 2018.[437] Paul Barrett wanted Kaleb to access a day program for 3 days a week after he finished school,[438]

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428 Exhibit 33-12, CTD.8000.0012.1809, p 20.

429 Exhibit 33-12, CTD.8000.0012.1809, p 20.

430 Exhibit 33-12, CTD.8000.0012.1809, p 20.

431 Exhibit 33-12, CTD.8000.0012.1809, pp 66–67.

432 Exhibit 33-12, CTD.8000.0012.1809, p 20.

433 Exhibit 33-12, CTD.8000.0012.1809, pp 66–67.

434 Exhibit 33-12, CTD.8000.0012.1809, pp 22–23; Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-105 [44]–P-106 [10].

435 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-105 [24–32].

436 Exhibit 33-351, CTD.8000.0012.5330_E, p 13.

437 Exhibit 33-351, CTD.8000.0012.5330_E, p 5.

438 Exhibit 33-351, CTD.8000.0012.5330_E, p 5.

- Kaleb and Jonathon's mother left 4 days after Jonathon was born,[439]
- the Department of Child Safety recommended he leave his full-time job and become the full-time carer for Kaleb and Jonathon,[440]
- teachers at Kaleb and Jonathon's school would sometimes provide overnight support, including when Paul Barrett had to take Jonathon to the hospital and stay overnight.[441].

267. During this call, Paul Barrett asked why Jonathon's access to the NDIS had not been met as both Jonathon and Kaleb were on a defined program.[442] The NDIA planner considered Jonathon should have been identified as a 'defined participant' and sought advice from their local quality team.[443] The local quality team noted Jonathon had not been identified in the state data as a defined participant, this could be queried with the relevant department, but the more 'efficient option' would be for a new access request to be completed.[444]

268. On about 7 August 2018, Paul Barrett executed an Agreement to be Appointed Nominee for Kaleb.[445]

269. On 6 September 2018, the NDIA appointed Paul Barrett as Kaleb's nominee.[446] The appointment did not have an end date. [447] The NDIA included Paul Barrett as a payment nominee which would mean payments relating to Kaleb's transport funding would be paid directly to Paul Barrett's bank account.[448] NDIA Records indicate Paul Barrett had requested this.[449]

270. Kaleb's first plan was approved by the NDIA on 17 August 2018 (**Kaleb's first plan**).[450] Kaleb's first plan contained a budget of $102,070.62 [451] This included funding of $36,858.10 for 'assistance with daily life', and $36,811.17 for 'assistance with social

439 Exhibit 33-351, CTD.8000.0012.5330_E, p 4.

440 Exhibit 33-351, CTD.8000.0012.5330_E, p 4.

441 Exhibit 33-351, CTD.8000.0012.5330_E, p 4.

442 Exhibit 33-12, CTD.8000.0012.1809, pp 22, 67.

443 Exhibit 33-12, CTD.8000.0012.1809, p 22.

444 Exhibit 33-12, CTD.8000.0012.1809, p 22.

445 Exhibit 33-354, CTD.8000.0001.0079, p 1.

446 Exhibit 33-355, CTD.8000.0001.0148, p 3; Exhibit 33-12, CTD.8000.0012.1809, p 24.

447 Exhibit 33-355, CTD.8000.0001.0148, p 3.

448 Exhibit 33-12, CTD.8000.0012.1809, p 24.

449 Exhibit 33-12, CTD.8000.0012.1809, p 24.

450 Exhibit 33-12, CTD.8000.0012.1809, p 60.

451 Exhibit 33-12, CTD.8000.0012.1809, p 61. This is the amount cited in the Review Report. A copy of Kaleb's first plan produced to the Royal Commission sets out $91,380.26 in funding.

and community participation'.[452] It also included $2,321.23 in funding for support coordination.[453]

271. By the conclusion of Kaleb's first plan only $2,797.63 had been used.[454] The only funding accessed was $360.88 for continence products[455] and $2,436.75 for periodic transport payments.[456] These funds were paid directly into Paul Barrett's bank account.[457] There is no evidence of any action taken to assist Kaleb with social and community participation, including attending a day program.

272. Mr Lee agreed the limited funds used out of the plan should have been a 'red flag' to the NDIA.[458]

273. Between October 2018 and March 2019, the Department of Disability Services attempted to contact Paul Barrett to offer assistance for Jonathon's transition to the NDIS. Over this period, there were seven attempts. All were unsuccessful.[459] Each of these attempts were by phone or email.[460] The attempts included phone calls placed to numbers which were no longer current or were incorrect.[461]

274. In its submissions, Queensland contends the Department of Disability Services made reasonable attempts to contact Paul Barrett in order to secure appropriate funding and supports for Jonathon.[462] It submitted we should not find it should have done more. We agree that the Department should not have done more of the same, with respect to manner and mode of contact. The issue is whether the Department considered why their attempts were unsuccessful or were prepared to consider alternative methods.

275. Ms Bullen referred to other examples during the transition period where staff were asked to 'stop stalking people'.[463] Ms Bullen said the level of interaction depended on the extent to which there was a previous relationship with the family concerned.[464] Ms Bullen said regional staff in particular had done 'as much as they could' but it

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452 Exhibit 33-12, CTD.8000.0012.1809, p 61.

453 Exhibit 33-12, CTD.8000.0012.1809, p 61.

454 Exhibit 33-12, CTD.8000.0012.1809, p 61.

455 Exhibit 33-12, CTD.8000.0012.1809, pp 25, 61.

456 Exhibit 33-12, CTD.8000.0012.1809, p 61.

457 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-107 [6–21].

458 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-107 [23–27].

459 Exhibit 33-67, 'Statement of Michelle Bullen', 5 May 2023, at [28].

460 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-239 [38–41].

461 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [21–23].

462 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 28 [136], 68 [304], 69 [308].

463 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [27–35].

464 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [33–34].

wasn't the same in every case.[465] In Kaleb and Jonathon's case, she could not see the Department had done that.[466] There were no attempts to contact Paul Barrett in person.[467] There were no attempts to contact Jonathon directly.[468] Ms Bullen was not aware of any reasons why this would have been the case.[469]

276. On 9 August 2019, Kaleb and Paul Barrett attended a planning meeting (**the second planning meeting**) with a different NDIA Planner (**NDIA Planner 2**).[470] A 'support worker' described as a family friend/neighbour also attended the second planning meeting with them.[471] NDIA Planner 2 did not make any notes identifying this support worker.[472]

277. NDIA Planner 2's observations were Paul Barrett was very hostile at the second planning meeting, swearing throughout the meeting and reluctant to provide information about Kaleb's supports.[473] Paul Barrett also presented with some health concerns including an enlarged tongue.[474] He was having difficulty speaking at the meeting. [475]

278. NDIA records set out during the second planning meeting note Paul Barrett indicated:

- he was unhappy with the lack of communication from the NDIS in relation to Kaleb's first plan,[476]
- he was disappointed with his experience with the NDIS and would prefer to work with the Department of Disability Services (which were no longer providing services),[477]
- he was unaware of the amount of funding in Kaleb's first plan and there had been no implementation meeting.[478] When NDIA Planner 2 discussed the funding amount, he indicated 'the funding was highly unnecessary' and he only wanted funding for continence aids as this was all Kaleb was using,[479]

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465 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [31–33].
466 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [35].
467 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-239 [43–46].
468 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [37–40].
469 Transcript, Michelle Bullen, Public hearing 33, 10 May 2023, P-241 [42–45].
470 Exhibit 33-12, CTD.8000.0012.1809, p 25.
471 Exhibit 33-12, CTD.8000.0012.1809, pp 25–26.
472 Exhibit 33-12, CTD.8000.0012.1809, p 26.
473 Exhibit 33-12, CTD.8000.0012.1809, p 25.
474 Exhibit 33-12, CTD.8000.0012.1809, p 26.
475 Exhibit 33-12, CTD.8000.0012.1809, p 26.
476 Exhibit 33-12, CTD.8000.0012.1809, p 25.
477 Exhibit 33-12, CTD.8000.0012.1809, p 25.
478 Exhibit 33-12, CTD.8000.0012.1809, p 25.
479 Exhibit 33-12, CTD.8000.0012.1809, p 25.

- he was paying the support worker and a cleaner to each attend once a week and making these payments out of his pension,[480]
- NDIA Planner 2 indicated Kaleb's funding could be used for this,[481] he declined this[482] and told the planner he would not access supports even if they were funded,
- as Kaleb's guardian, he did not want to engage with any services and 'would prefer to do it himself',[483] he did not use the previous funding for Support Coordination 'due to this purpose'.[484]

279. There was no record of any consultation or engagement with Kaleb. There was no attempt to ascertain his views about the plan and supports he may have wanted.[485] Kaleb would have graduated school by this point.[486] There is no record of any discussion about post schooling arrangements for Kaleb such as transition to employment or other arrangements. The NDIA does not accept this submission. It suggests funding was included in Kaleb's first NDIS Plan to support his transition out of school, but Mr Barrett refused assistance from the NDIA to utilise these funds.[487] As such, this funding was of limited benefit to Kaleb due to the actions of his father as nominee.

280. NDIA Planner 2 was concerned about Paul Barrett's reluctance to access supports for Kaleb.[488] NDIA Planner 2 raised these concerns with their team leader who is said to have responded they 'can't force people to have supports, it's choice and control'.[489] While people cannot be forced to have supports, in this circumstance, this was not a decision made by Kaleb himself. The question of choice and control, should focus on the person making an access request or participant.

281. At the second planning meeting NDIA Planner 2 printed a new Access Request Form in relation to Jonathon and spoke to Paul Barrett about how to fill it out.[490]

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480 Exhibit 33-12, CTD.8000.0012.1809, p 26.

481 Exhibit 33-12, CTD.8000.0012.1809, p 26.

482 Exhibit 33-12, CTD.8000.0012.1809, p 26.

483 Exhibit 33-351, CTD.8000.0012.5452_E, p 14.

484 Exhibit 33-351, CTD.8000.0012.5452_E, p 14.

485 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-108 [9–20].

486 See Agreed Facts, [199].

487 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 4 [9].

488 Exhibit 33-12, CTD.8000.0012.1809, p 27.

489 Exhibit 33-12, CTD.8000.0012.1809, p 27.

490 Exhibit 33-12, CTD.8000.0012.1809, p 22.

282. On 13 August 2019, the NDIA approved a plan for Kaleb (**Kaleb's second plan**).[491] Kaleb's second plan contained a budget of $8,075.01, comprising:[492]

- $8,073.01 for 'consumables'[493]
- $2.00 for assistance with daily life and social and community participation.[494]

283. On 10 October 2019, Paul Barrett contacted the NDIA with an enquiry about why payments for Kaleb's transport funding had stopped.[495] During this call, Paul Barrett referred to attending the 9 August 2019 planning meeting, that he was not expecting any changes to Kaleb's NDIS plan and would be 'unhappy' if the plan were changed.[496]

284. On 14 November 2019, the NDIA received a call from Mr Barrett concerning Kaleb's NDIS funding and was advised that his NDIS Planner would call him back the same day. The NDIS Planner attempted to call him later that day, however Mr Barrett was not able to be contacted. [497]

285. On 15 January 2020, Paul Barrett telephoned NDIA Planner 2 from hospital, in relation to a request for more funding for Kaleb.[498] An unscheduled plan review took place. A new plan was approved for Kaleb (**Kaleb's third plan**).[499] As at 15 January 2020, the NDIA had made payments towards Kaleb's Second Plan in the sum of $1,365.00 by way of periodic transport payments paid directly to Paul Barrett's bank account.[500] No claims had been made for other supports.[501]

286. Kaleb's third plan contained a budget of $41,077.61.[502] This included $3,530.16 in funding for 36 hours of support coordination services.[503] By the time of Paul Barrett's death on 27 May 2020, $1,365.00 had been used from Kaleb's third plan.[504]

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491 Exhibit 33-12, CTD.8000.0012.1809, p 62.
492 Exhibit 33-12, CTD.8000.0012.1809, p 62.
493 Exhibit 33-12, CTD.8000.0012.1809, p 63.
494 Exhibit 33-12, CTD.8000.0012.1809, p 63.
495 Exhibit 33-12, CTD.8000.0012.1809, p 27.
496 Exhibit 33-12, CTD.8000.0012.1809, p 27.
497 Exhibit 33-12, CTD.8000.0012.1809, p 28.
498 Exhibit 33-12, CTD.8000.0012.1809, p 28.
499 Exhibit 33-12, CTD.8000.0012.1809, p 28.
500 Exhibit 33-12, CTD.8000.0012.1809, pp 29–30.
501 Exhibit 33-12, CTD.8000.0012.1809, p 30.
502 Exhibit 33-12, CTD.8000.0012.1809, p 64.
503 Exhibit 33-12, CTD.8000.0012.1809, p 65.
504 Exhibit 33-12, CTD.8000.0012.1809, p 64.

287. Jonathon's school was also liaising with the Department of Disability Services and Paul Barrett regarding Jonathon's access to the NDIS.[505] The NDIA was not aware of these enquiries.[506] A few weeks before Paul Barrett's death, Jonathon's school records reveal Paul Barrett was asked about Jonathon's access to NDIA. Paul Barrett was 'worried he would lose his carers pension if he accessed NDIS funding.' The school staff are recorded as saying they 'didn't think that was the case but he seemed convinced it was. Paul said he was happy to support [Jonathon] with his network of friends and paid support workers he accessed privately.'[507]

288. On about 3 June 2020, the NDIA approved a plan for Kaleb (**Kaleb's fourth plan**).[508] Kaleb's fourth plan contained a budget of $154,950.55 for funded supports.[509] A copy of Kaleb's fourth plan was not provided to him.[510] The NDIA did not arrange a conversation with Kaleb or an authorised representative to discuss the fourth plan.[511]

289. On about 4 June 2020, the NDIA approved a plan for Jonathon (**Jonathon's first plan**).[512] Jonathon's first plan contained a budget of approximately $323,209.38 for funded supports.[513]

290. The Australian Government submitted that whilst further action could have been taken, characterising the position as the NDIA not taking any action appears to be inaccurate. We acknowledge the contentions raised, however the actions described in the Australian Government's submissions do not directly respond to the matters raised during the call and we do not consider these can be categorised as 'action taken in response' to the matters raised by Paul Barrett. Counsel Assisting's point was directed to the NDIA's actions following Paul Barrett's conduct and whether any steps were taken to examine whether he was appropriate as Kaleb's nominee.

291. With respect to Jonathon, the available evidence suggests he slipped between the gaps. Unlike his brother, he did not receive specific or personal services from the Department of Disability Services in the period prior to the transition to the NDIS. Since at least 2010, he was not a client of the Department of Disability Services, despite living with intellectual disability, attending a special school and requiring

505 Agreed Facts, [241], [308], [318]; Exhibit 33-199, QLD.0005.0028.1360, p 29; Exhibit 33-275, QLD.0005.0028.0346, pp 1–2; Exhibit 33-308, QLD.0005.0028.1056, p 1; Exhibit 33-310, QLD.0005.0028.0127, p 1.

506 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-111 [35–43].

507 Exhibit 33-310, QLD.0005.0028.0127, p 1.

508 Exhibit 33-12, CTD.8000.0012.1809, p 31; Exhibit 33-357, CTD.8000.0012.5698_E.

509 Exhibit 33-357, CTD.8000.0012.5698_E, p 15.

510 Exhibit 33-12, CTD.8000.0012.1809, p 31.

511 Exhibit 33-12, CTD.8000.0012.1809, p 31.

512 Exhibit 33-12, CTD.8000.0012.1809, p 31.

513 Exhibit 33-356, QLD.0020.0050.0033, p 6. This figure is taken from a 'preview' version of Jonathon's first plan.

significant supports. He also did not receive any funding for specialist services, similar to what Kaleb received. Unlike his brother, Jonathon did not transition to the NDIS until after his father's death.

292. Queensland submitted the Department of Disability Services says it made reasonable attempts to offer assistance or supports to Jonathon by it or the NDIS prior to Paul Barrett's death. It rejects responsibility for the delay to secure Jonathon's participation in the NDIS.

NDIA Review

293. On about 11 June 2020, the NDIA Chief Executive Officer (**CEO**) established terms of reference (**Terms of Reference**) for a formal review in relation to:

- Kaleb's transfer into and time as a participant of the NDIS[514] and
- Jonathon's engagement with the NDIA and apparent attempts to access the NDIS.[515]

(**The NDIA review**)

294. The NDIA review was conducted between 11 August 2020 and 23 November 2020.[516] During the hearing, it was put to the NDIA representatives, once Kaleb and Jonathon were out of hospital in their new home, they were considered 'safe' and the review was perceived as less urgent.[517] Dr Bennett said although the NDIA review took longer than anticipated, the five-month timeframe was appropriate considering the level of issues examined.[518]

295. According to Dr Bennett, the focus of the Terms of Reference was the extent to which the NDIA fulfilled their legislative obligations under the *NDIS Act*, and the areas which they could seek to improve.[519] The NDIA review examined information the NDIA held about Kaleb and Jonathon,[520] held interviews with NDIA staff who were available (i.e. those still employed by the NDIA and not on extended leave arrangements),[521] and consulted with Subject Matter Experts and others with relevant experience.[522]

514 Exhibit 33-12, CTD.8000.0012.1809, p 5.

515 Exhibit 33-12, CTD.8000.0012.1809, p 5.

516 Exhibit 33-12, CTD.8000.0012.1809, p 5.

517 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-117 [35–38].

518 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-117 [45–48].

519 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-118 [5–7].

520 Exhibit 33-12, CTD.8000.0012.1809, p 8.

521 Exhibit 33-12, CTD.8000.0012.1809, p 8.

522 Exhibit 33-12, CTD.8000.0012.1809, p 8.

296. The NDIA did not have the ability to compel any information from relevant Queensland agencies.[523] They were aware the QFCC had been tasked to undertake a review in relation to Kaleb and Jonathon's circumstances, and there was an assumption the QFCC review would include matters around Jonathon's access to the NDIS.[524] The NDIA had provided some 'non identifiable' information to the QFCC about policies and procedures, but not detailed information about Jonathon's NDIA access application.[525]

297. As we note below, the QFCC review ultimately contained recommendations relating to the role of the NDIA.[526] The NDIA however only became aware of these following publication of the *Summary report: Keeping school-aged children with disability safe* (**QFCC Summary Report**), and not at the time of the NDIA review.[527]

298. On about 30 April 2021, the NDIA's Chief Counsel and Branch Manager, Internal Reviews and Complaints signed a report outlining the NDIA review's findings and recommendations (the **Review Report**).[528]

The NDIA's findings and recommendations

299. The Review Report sets out a number of findings and recommendations.[529] Many of the recommendations include areas where guidance to NDIA staff and NDIS partners could be improved.

300. First, the Review Report found there was a lack of guidance for NDIA staff in relation to CEO-initiated nominee appointments, such as Kaleb's.[530] In particular, there was a lack of guidance for NDIA staff in situations where a participant does not have capacity to communicate a request or consent to a nominee appointment.[531] Paul Barrett's application to be Kaleb's nominee was initiated and progressed on the basis of Kaleb making the request (which was not correct).[532] The Review Report also identified there was inadequate guidance for staff on identifying where a participant may be at risk due to the nominee not fulfilling their duties.[533] This included how to respond in those circumstances including determining whether a nominee's appointment should

523 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-115 [29–33].

524 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-116 [1–5].

525 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-116 [28–38].

526 See generally Exhibit 33-313, QLD.0019.0051.0001.

527 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-116 [40–46].

528 Exhibit 33-12, CTD.8000.0012.1809, p 4.

529 Exhibit 33-12, CTD.8000.0012.1809, pp 36–52.

530 Exhibit 33-12, CTD.8000.0012.1809, p 38.

531 Exhibit 33-12, CTD.8000.0012.1809, p 38.

532 Exhibit 33-12, CTD.8000.0012.1809, p 23.

533 Exhibit 33-12, CTD.8000.0012.1809, pp 38–39.

be cancelled.[534] The processes in place at the time to review nominee arrangements, predominately focussed on the financial aspects rather than considerations of whether a nominee was fulfilling their broader duties.[535]

301. The Review Report recommended the NDIA consider procedures and processes in respect of nominee arrangements.[536] This included improving staff guidance on identifying where a participant may be at risk due to a nominee not fulfilling their duties, and how to respond in these circumstances.[537]

302. The Review Report also recommended consideration be given to an amendment to the *NDIS Act* and the *National Disability Insurance Scheme (Nominee) Rules 2013* (Cth) (***Nominee Rules***).[538] According to the Review Report, the nominee provisions as presently drafted may not adequately protect participants from risk.[539] In particular, where a nominee reasonably believes they have 'ascertained the best wishes of the participant' or are acting 'to promote the person and social wellbeing of the participant', however may not necessarily be doing so.[540]

303. The Review Report also recommended the NDIA consider their policies and procedures around ensuring participants who do not have capacity to represent themselves are appropriately represented during planning and other discussions.[541]

304. Second, the Review Report found staff should have given greater consideration to the role of Kaleb and Jonathon's mother following the events of 27 May 2020.[542] In particular, the fact she continued to have parental responsibility for Jonathon pursuant to the *NDIS Act*.[543] There was no evidence to suggest she had ceased to have parental responsibility due to any court orders.[544] The only information available to the NDIA, which they acted on, appears to have been Paul Barrett's comments their mother had not been involved in their life since Jonathon was a baby[545] and information provided by the social worker at the hospital.[546]

534 Exhibit 33-12, CTD.8000.0012.1809, pp 38–39.

535 Exhibit 33-12, CTD.8000.0012.1809, pp 38–39.

536 Exhibit 33-12, CTD.8000.0012.1809, p 42.

537 Exhibit 33-12, CTD.8000.0012.1809, p 42.

538 Exhibit 33-12, CTD.8000.0012.1809, p 42.

539 Exhibit 33-12, CTD.8000.0012.1809, p 42.

540 Exhibit 33-12, CTD.8000.0012.1809, p 42.

541 Exhibit 33-12, CTD.8000.0012.1809, p 42.

542 Exhibit 33-12, CTD.8000.0012.1809, p 39.

543 Exhibit 33-12, CTD.8000.0012.1809, p 39.

544 Exhibit 33-12, CTD.8000.0012.1809, p 32.

545 Exhibit 33-12, CTD.8000.0012.1809, p 32.

546 Exhibit 33-12, CTD.8000.0012.1809, p 30.

305. The Review Report found there was no NDIA guidance on how to manage circumstances where parents have not ceased to have parental responsibility but are estranged from their child.[547] For instance, where there are no legal orders revoking custody. The Review Report found staff guidance could be improved on obligations under the *NDIS Act* to ensure parental responsibility is observed, and/or what actions staff should take where parental responsibility was unclear.[548]

306. Third, the Review Report found there were issues in relation to the implementation of all three of Kaleb's plans.[549] Although required under NDIA guidance, there was a lack of implementation activity by staff, and no records of staff assisting Paul Barrett to engage with the NDIS and access funded supports.[550] Despite the significant underutilisation in Kaleb's three plans, there were no records of staff undertaking any monitoring activities, despite this being required under NDIA guidance.[551] Neither did NDIA staff conduct any monitoring activities in respect of Kaleb's plans despite it being clear there were issues with utilisation.[552]

307. The Review Report recommended staff guidance be improved around monitoring plan implementation and escalation where a plan was not being utilised as expected. [553]

308. Fourth, the Review Report noted there were delays with Kaleb and Jonathon's access to the NDIS.[554] This was partly due to issues with the transition data received from Queensland.[555] The Review Report also found Paul Barrett may have benefited from additional support in completing the access process for Jonathon.[556] Especially given the significant period of time before Jonathon became a participant.[557] The Review Report qualified this, setting out:

> Noting the significant underutilisation of [Kaleb's] plan however, the review team considered it is unlikely that Paul Barrett would have accessed supports for [Jonathon] in any event.[558]

547 Exhibit 33-12, CTD.8000.0012.1809, p 34.
548 Exhibit 33-12, CTD.8000.0012.1809, p 39.
549 Exhibit 33-12, CTD.8000.0012.1809, p 38.
550 Exhibit 33-12, CTD.8000.0012.1809, p 38.
551 Exhibit 33-12, CTD.8000.0012.1809, p 38.
552 Exhibit 33-12, CTD.8000.0012.1809, p 38.
553 Exhibit 33-12, CTD.8000.0012.1809, p 42.
554 Exhibit 33-12, CTD.8000.0012.1809, pp 36–37.
555 Exhibit 33-12, CTD.8000.0012.1809, p 37.
556 Exhibit 33-12, CTD.8000.0012.1809, p 37.
557 Exhibit 33-12, CTD.8000.0012.1809, p 37.
558 Exhibit 33-12, CTD.8000.0012.1809, pp 7, 38.

309. The Review Report recommended the NDIA consider the level of support staff provided to assist participants lodge access requests, and this be reflected across agency policy and procedure documents.[559] Further, the NDIA should also consider providing guidance on how to progress access requests in circumstances where a prospective participant does not have capacity to do so, or an authorised representative.[560]

310. Fifth, the Review Report found information was not always recorded accurately or adequately on Kaleb and Jonathon's Customer Relationship Management (**CRM**) files.[561] This included a number of important interactions with their father.[562]

311. The Review Report recommended staff guidance be improved and mandatory aspects of document standards and requirements be reinforced.[563] The Review Report also identified the NDIA could improve their system processes.[564] An improved system could identify and resolve problems with participants' data, including linking participants from within the same family.[565]

Action taken by the NDIA in response to NDIA review recommendations

312. In the lead up to this hearing, the Royal Commission requested the NDIA provide a statement outlining measures taken to address the recommendations in the Review Report.[566] Representatives from the NDIA also provided oral evidence relating to changes to NDIA processes since that time.[567] The NDIA witnesses addressed the actions taken in response to the NDIA Review Report.[568] We have addressed this aspect of the evidence in this Part. We have also considered Counsel Assisting's submissions with proposed recommendations for the NDIA. We do not consider it appropriate or necessary to make standalone recommendations directed to the NDIA in this hearing report, particularly given the wide range of issues concerning the NDIA that have been raised in earlier hearings of this Royal Commission and the forthcoming Final Report. Rather than making recommendations, we have identified where we support the proposed suggestions made by Counsel Assisting and indicated our encouragement to the NDIA to consider the suggestions.

559 Exhibit 33-12, CTD.8000.0012.1809, p 42.

560 Exhibit 33-12, CTD.8000.0012.1809, p 43.

561 Exhibit 33-12, CTD.8000.0012.1809, p 36.

562 Exhibit 33-12, CTD.8000.0012.1809, pp 22, 25, 27–28.

563 Exhibit 33-12, CTD.8000.0012.1809, p 41.

564 Exhibit 33-12, CTD.8000.0012.1809, p 42.

565 Exhibit 33-12, CTD.8000.0012.1809, p 42.

566 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2003.

567 Transcript, Sam Bennett and Desmond Lee, Public hearing 33, 9 April 2023, P-100 [45]–P-129 [10].

568 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2003, [13–191].

313. The week prior to the hearing, the NDIA released its Supported Decision Making Policy.[569] The accompanying Supported Decision Making Policy Implementation Plan (**Implementation Plan**) includes strengthening support around the appointment, operation and review of nominees as an area for action.[570] As Counsel Assisting noted in their submissions, the Implementation Plan refers to the development of a risk assessment process for potential nominees prior to appointment.[571] It also refers to providing options to limit the actions and duties of the nominee, and review these options with the participant at check-ins.[572]

314. We agree with Counsel Assisting's submission that the initiatives in the Supported Decision Making Policy Implementation Plan are important ones, and it is open to the NDIA to take steps to implement these as soon as practicable.

Appointment of nominees

315. As set out above, Kaleb had a nominee appointed to interact with the NDIA and access supports on his behalf.[573] There is no information to indicate Kaleb had any involvement in this process. There is also no information to indicate what level of consideration, if any, was given in respect of Paul Barrett being an appropriate person to fill this role. It does not appear Paul Barrett was subsequently provided any guidance or training on his roles and responsibilities as a nominee, including the duties set out in the *NDIS Act*.

316. Kaleb did not request a nominee, and as such, the appointment was a 'CEO appointed' one.[574] The NDIA informed the Royal Commission a CEO will only in 'rare and exceptional cases' appoint a nominee where a participant has not requested one.[575] The NDIA further indicated, if this occurs, they would consider a participant's wishes and their circumstances (including their formal and informal support networks).[576]

569 National Disability Insurance Agency, *Media Release from the Minister – Participants to have greater say through supported decision making*, media release, Canberra, 4 May 2023; National Disability Insurance Agency, NDIS Supported Decision Making Policy, April 2023.

570 National Disability Insurance Agency, NDIS Supported Decision Making Implementation Plan, April 2023, p 8.

571 National Disability Insurance Agency, NDIS Supported Decision Making Implementation Plan, April 2023, p 8. See also Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 269 [956].

572 National Disability Insurance Agency, NDIS Supported Decision Making Implementation Plan, April 2023, p 8. See also Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 269 [956].

573 Exhibit 33-12, CTD.8000.0012.1809, p 23.

574 *National Disability Insurance Scheme Act 2013* (Cth) ss 86(2)(b), 87(2)(b); *National Disability Insurance Scheme (Nominees) Rules 2013* (Cth) r 3.11.

575 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [125].

576 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [125].

317. Part 4.8 of the *Nominee Rules* sets out matters the CEO must have regard to in considering a prospective nominee. These include matters such as the relationship the person has with the participant,[577] desirability of preserving the participant's family relationships and informal support networks,[578] and any information provided by the prospective nominee about their criminal history.[579] Many of these are also applicable to prospective child representatives and will be discussed below in these submissions.

Review and removal

318. There is no mandated review of a nominee appointment in the *NDIS Act*. Further, the *NDIS Act* does not require nominee appointments to have a fixed term.[580] This allows for a nominee to be appointed for an indefinite term. In this context, at present there is a considerable onus on NDIA staff and partners to be able to identify, through their interactions with a participant or their nominee, where a nominee may not be acting to advance the participant's best interests.

319. The NDIA said since the Review Report, they have prepared resources to help staff identify a participant's 'risk factors and vulnerabilities', and to put in place appropriate supports and mitigation strategies.[581] During his evidence at the hearing, Dr Bennett referred to changes to NDIA operational guidelines.[582] This included having 'plain English' steps for staff to take once concerns of a nominee's ability to fulfil obligations or other risks have been identified.[583]

320. Dr Bennett also spoke about 'triggers' now in place in the NDIA systems which would lead to proactive follow up.[584] Using Kaleb and his father as an example, the absence of any service bookings in the four weeks after plan approval would have triggered a follow up phone call from the NDIA,[585] as would the absence of any payments made against the plan in the six weeks after plan approval.[586]

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577 *National Disability Insurance Scheme (Nominees) Rules 2013* (Cth) r 4.8 (b), (i).

578 *National Disability Insurance Scheme (Nominees) Rules 2013* (Cth) r 4.8 (c).

579 *National Disability Insurance Scheme (Nominees) Rules 2013* (Cth) r 4.8 (e), (g).

580 *National Disability Insurance Scheme Act 2013* (Cth) s 86(4).

581 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [103].

582 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [7–12].

583 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [7–12].

584 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [14–15].

585 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [14–21]. See also Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [102].

586 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [14–21]; Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [102].

321. The underutilisation of plans, such as in Kaleb's first three plans, is now also a feature the NDIA will look at to consider whether there is a 'potential risk of vulnerability'.[587] The NDIA's business systems are automated to identify where a participant has under or over utilised plan funding.[588] Staff are automatically prompted to check in with the participant or their representative.[589]

322. The NDIA also provided evidence about a 'risk assessment' which occurs during the planning process.[590] During this process, participants are guided through questions to determine whether the participant is able to engage with the NDIA.[591] NDIA staff will also evaluate any 'factors which make the participant vulnerable' as well as safeguards in existence.[592] The risk assessment also examines 'financial management capacity' including 'capacity and interests of nominees or child representatives'.[593]

323. The risk assessment processes detailed are important ones. However, the information provided suggests the focus of the exercise is on the participant rather than the nominee themselves. It is unclear as to whether there is any evaluation of the nominee beyond their ability to manage financial matters at this time. The evidence also is unclear on how this process is conducted where a participant has a nominee who may be attending the planning meetings. Such as was the case with Kaleb and his father.

324. Dr Bennett said it remains 'debatable' whether some of the changes to the way the NDIA identifies and responds to risk would have been of value 'in the context of the particular case study' that Public hearing 33 examined.[594]

325. We also note the concession by the NDIA representatives there is nothing to stop a 'Paul Barrett situation occurring again'.[595] We do not make a specific recommendation but note it may be open to the NDIA to consider how an evaluation of the nominee fulfilling their obligations and/or acting in the best interests of the participant be built into their risk assessment processes. The NDIA may consider how such a risk assessment can be conducted with participants who have nominees.

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587 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-124 [15–19].

588 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [91], [102(b)], [105].

589 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [91(d)], [102(b)], [105]; Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-124 [21–29].

590 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [143].

591 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [143].

592 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [143].

593 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [143].

594 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-124 [33–34].

595 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [26–31].

NDIS Act and Nominee Rules

326. Once a nominee has been appointed, they are subject to the duties set out in section 80 of the *NDIS Act*. In particular, they are 'to ascertain the wishes of the participant and to act in a manner that promotes the personal and social wellbeing of the participant.'[596]

327. According to section 80 of the *NDIS Act* however, a nominee will not breach that duty by doing or failing to do something if they reasonably believe they have ascertained the wishes of the participant.[597] Or where the nominee reasonably believes their actions are in fact promoting the personal and social wellbeing of the participant.[598]

328. Given the CEO is to consider any breach of duty when determining whether to cancel or suspend a nominee's appointment,[599] this qualification is significant.

329. In theory, a nominee such as Paul Barrett would not be considered in breach of his duties if he reasonably believed his actions were promoting Kaleb's personal and social wellbeing. We are not suggesting Paul Barrett's actions were in any way reasonable. Counsel Assisting submitted however section 80 of the *NDIS Act* could be seen to operate in such a way where the interests of a nominee are put before those of a participant.

330. Counsel Assisting submitted it was open to the NDIA to give consideration to whether the nominee provisions presently drafted provide adequate protection to participants with nominees.[600] The NDIA notes that a breach of duty is one of several considerations which the CEO is required to consider when deciding whether to cancel or suspend a nominee appointment.[601]

331. In response, the Australian Government submitted the CEO has the power to cancel or suspend a nominee appointment in circumstances where the ability of the person to act as nominee becomes compromised (such as where their interests conflict with those of the NDIS participant), or the CEO has reasonable grounds to believe that the nominee has caused, or is likely to cause, physical, mental or financial harm to the participant.[602] However, its submission in reply does not expressly address whether section 80 needs to be examined or amended.

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596 *National Disability Insurance Scheme Act 2013* (Cth) s 80(1–2).

597 *National Disability Insurance Scheme Act 2013* (Cth) s 80(2–3).

598 *National Disability Insurance Scheme Act 2013* (Cth) s 80(2–3).

599 *National Disability Insurance Scheme (Nominees) Rules 2013* (Cth) r 6.5(a).

600 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 273 [971].

601 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 9 [21].

602 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 9 [21].

332. Counsel Assisting also referred to the different requirements relating to the cancellation or suspension of a nominee appointment as set out in sections 89 to 92 of the *NDIS Act*.[603] The CEO must cancel a nominee appointment where:

- a nominee no longer wishes to act as nominee,[604]
- a participant, who has initially requested a nominee, requests the appointment be cancelled.[605]

333. On the other hand, the CEO may, rather than must, cancel a nominee appointment where a participant with a CEO-initiated appointment nominee requests the appointment be cancelled.[606] The CEO also may, rather than must, suspend an appointment where they have reasonable grounds to believe a nominee has caused or is likely to cause physical, mental or financial harm to the participant.[607]

334. Counsel Assisting submitted there appears to be an inconsistency in the manner in which the *NDIS Act* addresses the cancellation of nominee arrangements in different circumstances. In particular, the different requirements for appointments initiated by the participant, compared to CEO-initiated appointments. They referred to Kaleb, for example, who had his father as a CEO-appointed nominee. If Kaleb had made a request to the NDIA for his father be removed as his nominee appointment, the NDIA would not be under an obligation to automatically do so. Similarly, if there were reasonable concerns his father was causing him physical, financial, or mental harm. The NDIA's obligations would be different if Kaleb had requested his father be appointed as his nominee in the first place.[608]

335. Counsel Assisting submitted it may be open to the NDIA to consider whether the provisions relating to the cancellation or suspension of nominee appointments adequately protect participants, and put their interests before those of the nominee.[609]

336. The NDIA informed the Royal Commission it had been undertaking work on the *NDIS Act* and the *Nominee Rules* in conjunction with the Department of Social Services.[610] This included redrafting the Nominee Rules to emphasise a nominee's role and

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603 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 273 [972].

604 *National Disability Insurance Scheme Act 2013* (Cth) s 89(3).

605 *National Disability Insurance Scheme Act 2013* (Cth) s 89(1).

606 *National Disability Insurance Scheme Act 2013* (Cth) ss 90(1–3).

607 *National Disability Insurance Scheme Act 2013* (Cth) s 91(1).

608 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 273 [974–975].

609 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 174 [976].

610 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [179].

responsibilities in identifying a participant's will and preferences.[611] Dr Bennett said this work has been put on hold pending the findings of this Royal Commission, as well as the NDIS Review announced on 18 October 2022.[612]

337. The NDIA submitted that with the exception of the process to cancel or suspend a nominee appointment, the Supported Decision Making Policy and Implementation Plan contains a number of actions around a more holistic approach to monitoring nominee appointments.[613] However, Counsel Assisting's submissions were specifically concerned with the processes around cancelling or suspending nominee appointments, and how there is a discrepancy based on the type of nominee arrangements.[614]

338. We agree this is an important issue. If a participant has a nominee appointed at the behest of the CEO, and the participant requests the appointment be cancelled, this is not automatic. There should be safeguards in the *NDIS Act* and the *Nominee Rules* to address such a scenario.

Training of nominees themselves

339. During the hearing, the NDIA was asked what steps have been taken for others such as Kaleb and Jonathon's father, to help them understand their obligations as a nominee and the context and system in which they were working in.[615] Dr Bennett noted since the Review Report, the NDIA has published a number of fact sheets including in accessible formats.[616] Dr Bennett also spoke about the development of targeted training for nominees to understand their role in supporting participant decision making,[617] however, he indicated this was yet to occur.[618]

340. It was put to Dr Bennett a lot of this material was a very 'text based ' approach.[619] Dr Bennett indicated as an alternative, a nominee could engage with NDIA staff and partners.[620] The participant could also have a support coordinator funded who would assist the nominee and participant understand supports in the plan, and to develop

611 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [179].

612 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [1–5]; Australian Government, 'About the NDIS review', *NDIS Review*, web page. <About the NDIS Review | NDIS Review>.

613 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 2 June 2023, SUBM.0033.0003.0001, p 9 [23].

614 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 273 [974].

615 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-120 [25–30].

616 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [38–41].

617 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [43–46].

618 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-120 [46].

619 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-120 [48]–P-121 [5].

620 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [7–9].

the participant’s capacity around decision-making.[621] Dr Bennett also referred to the check in process where a plan was not being utilised as an opportunity to offer further supports for the nominee ‘to better discharge their obligations under the legislation’.[622]

341. Counsel Assisting submitted the current processes as outlined by Dr Bennett may likely be of limited utility to an individual in a situation similar to Paul Barrett. It is open for the NDIA to continue steps to develop plain English training to assist nominees with understanding their obligations.

342. In its submissions in reply, the NDIA does not take issue with this submission. It referred to work to promote and develop resources in plain English to increase accessibility through the Operational Guidelines (OG) and the NDIS Supported Decision Making Policy and Implementation Plan.[623]

Child Participants and the Children Rules

343. The majority of children under the age of 18 who want to access the NDIS or services under a plan require a ‘child representative’ to act or make decisions on their behalf.[624]

344. A child may represent themselves where the NDIA is satisfied they have the capacity to make their own decisions, and it is appropriate for them to do so.[625] The CEO needs to make a determination to this effect.[626]

345. Most child participants will have someone who holds ‘parental responsibility’ for them appointed as their representative. The NDIA considers a person to hold parental responsibility if they are:

- the child’s guardian[627]
- the child’s parent, if contradictory orders have not been made under the *Family Law Act 1975* (Cth) or a law of a State or a Territory[628]

621 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [7–12].

622 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-121 [19–21].

623 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 10 [28].

624 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 1.1; *National Disability Insurance Scheme Act 2013* (Cth) s 74(1).

625 *National Disability Insurance Scheme Act 2013* (Cth) s 74(5); Exhibit 33-13, ‘Joint Statement of Dr Sam Bennett and Desmond Lee’, 26 April 2023, at [155].

626 *National Disability Insurance Scheme Act 2013* (Cth) s 74(5)(c).

627 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 4.1(a).

628 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 4.2 parental condition 1.

- another person who the child lives with, spends time with or is responsible for the child's long term or day to day care, welfare and development, pursuant to relevant court orders.[629]

346. In 'exceptional circumstances' the CEO will appoint someone else to be a child's representative.[630] This may occur, where there is doubt about who may hold parental responsibility.[631] This may also occur where it would be unsafe for the child to have parental involvement.[632] If this is the case, the CEO is to consider a range of matters set out in Part 3.5 of the Children's Rules including:

- any preferences of the child[633]
- desirability of preserving the child's family relationships and informal support networks[634] and
- existing arrangements in place between the child and the prospective representative.[635]

347. During the course of this hearing, Counsel Assisting put to the NDIA's representatives the matters set out in Part 3.5 reflect a range of assumptions in relation to functioning families, and parents acting in the best interests of their child.[636] Counsel Assisting also put to the NDIA the *National Disability Insurance Scheme (Children) Rules 2013* (Cth) (**Children Rules**) focus on the maintenance of functioning families.[637] Dr Bennett agreed with these propositions.[638]

348. Counsel Assisting also put the reverse of this to the NDIA, in that if a person does not meet the elements set out in the Children Rules, the matters may be held against them being appointed a representative.[639] Dr Bennett agreed this could be the case.[640]

349. It was also put to the representatives that the Children Rules did not require the NDIA to take into account matters such as the number of times a parents' behaviour has come to the attention of a child safety officer, the number of times the police have

629 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 4.2 parental condition 2.

630 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.3.

631 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.3.

632 Exhibit 33-13, 'Joint Statement of Dr Sam Bennett and Desmond Lee', 26 April 2023, at [156].

633 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.5(a).

634 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.5(b).

635 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.5(d)(i).

636 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-121 [33–39].

637 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-122 [6–7].

638 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P- 121 [33–41], P-122 [6–9].

639 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P-122 [22–25].

640 Transcript, Sam Bennett, Public hearing 33, 9 May 2023, P-122 [22–27].

needed to visit the home, or the extent to which domestic or family violence was operating within a family.[641] Mr Lee agreed these were not matters required to be taken into account.[642]

350. However, the NDIA is required to consider any information provided by a person about their criminal history or suitability to work with children, or any refusal to provide such information.[643]

351. Jonathon and Kaleb's access to the NDIS and any supports funded under their plans was contingent solely on the actions of their father while he was alive.[644] The NDIA accepted such a situation is an example of young people with disability, who depend only on their parents to be able to access services and supports, being at risk.[645]

352. Once a person has been appointed as a child's representative, they are under a duty to ascertain the wishes of the child, and to act in the child's best interests and human rights.[646]

353. The Children Rules further set out:

> where acts or things are done on behalf of a child with disability, the best interests of the child are paramount, and full consideration should be given to the need to:
>
> (i) protect them from harm; and
>
> (ii) promote their development; and
>
> (iii) strengthen, preserve and promote positive relationships between them and their parents, family members and other people who are significant in their life.[647]

354. Counsel Assisting submitted it was open for the NDIA to consider how it can implement such an approach in their interactions with child participants and their representatives. This includes throughout the decision making process for the appointment of child representatives.[648]

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641 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 33, 9 May 2023, P- 123 [39–44].

642 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-123 [39–46].

643 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 3.5(d)(iv–vi).

644 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-113 [14–18].

645 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-113 [20–25].

646 *National Disability Insurance Scheme Act 2013* (Cth) s 76; *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 6.2.

647 *National Disability Insurance Scheme (Children) Rules 2013* (Cth) r 1.4(b).

648 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 278 [996].

355. For young people in situations such as Kaleb and Jonathon, it is imperative they are assisted by and where appropriate, represented by people who will advance their best interests.

356. The NDIA may consider how they can ensure children and young adults are supported to become NDIS participants. Further, how they can be supported to engage with NDIA funded supports. This would include examining how NDIA staff engage with different family dynamics, especially where there are no formal *Family Law Act* orders in place. It is open to the NDIA to examine their role in ensuring children and young adult participants are supported in their transitions from school to life after school.

357. In response the NDIA submitted it supports continuous improvement of access and planning processes for children and young adults, noting that Early Childhood Partners currently engage with child participants, their families and carers by conducting an intake screening at the point of referral to understand the child and family circumstances.[649]

NDIA training and responses for child protection concerns

358. Mr Lee spoke about the NDIA's training program for planners and access officers.[650] Mr Lee said planners and access officers are provided training to look for and identify risks.[651] They are also provided with what he considers clear guidance around 'what to do when there may be risk signals that they detect and how to deal with that'.[652]

359. In response to a question taken on notice, the NDIA further set out:

a. access staff are provided training on how to identify and assess whether there are any risks or safety concerns, particularly in the context of whether an alternative child representative should be appointed,[653]

b. NDIA Planners in the Complex Support Needs Pathway are provided training on state and territory mandatory reporting requirements. The training includes what actions NDIA staff should take where risk of harm to a child is identified.[654] It is unclear how broadly this training is delivered across the NDIA.

649 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 15 [48].

650 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-126 [20–26].

651 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-126 [20–23].

652 Transcript, Desmond Lee, Public hearing 33, 9 May 2023, P-126 [25–26].

653 Exhibit 33-82, CTD.9999.0109.0001, p 2.

654 Exhibit 33-82, CTD.9999.0109.0001, p 3.

360. The NDIA describes allegations of serious harm to a participant as a 'participant critical incident'.[655] When a participant critical incident occurs to a child, the NDIA considers its responsibilities include reporting this to relevant state authorities where appropriate.[656]

361. The Participant Critical Incident Guide sets out NDIA staff and partners are to report concerns to the relevant child protection authorities when they reasonably believe this is necessary to prevent or lessen a serious threat to a child or young person's life, health or safety.[657] NDIA staff and partners are directed to discuss with their line manager and contact their state child protection agency for guidance when they are unsure if they should make a report.[658]

362. A 'best interests' approach means all NDIA staff are encouraged to make reports to child protection authorities when they become aware of harm or suspected harm to a child.

363. The Participant Critical Incident Guide sets out a proactive manner to respond to child protection concerns. It appears to encourage all staff to make notifications where appropriate. It also requires staff to make multiple enquiries when they are unsure if a notification is required.

364. We suggest the NDIA consider whether to develop or improve training materials and guidance materials around child protection matters, to ensure they are consistent, delivered broadly across staff and promote a best interests approach that is informed and recognises the nature and extent of the rights of the child by reference to the *CRC* and *CRPD*.

365. The NDIA is supportive of this suggestion.[659]

655 Exhibit 33-85, CTD.8000.0060.0054, p 5.

656 Exhibit 33-82, CTD.9999.0109.0001, p 4.

657 Exhibit 33-87, CTD.8000.0060.0105, p 15; *National Disability insurance Scheme Act 2013* (Cth) s 60 (3)(e).

658 Exhibit 33-87, CTD.8000.0060.0105, p 15.

659 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 16 [51–52].

Part 6 Queensland investigations and inquiries

366. Following Paul Barrett's death, a number of Queensland departments and agencies undertook a review of their involvement, decisions and actions with respect to the family. There appeared to be no statutory requirement for any Queensland department or agency to conduct a review.

367. Reviews play an important role to inform departments and agencies about why violence, abuse and neglect and deprivation of human rights may have occurred, and what changes or reforms are required to prevent like-occurrences happening in the future.

368. We considered Queensland's departments' and agencies' approach to reviews after Paul Barrett's death and whether these reviews assisted the particular department or agency to understand the risks of violence, abuse, neglect and the deprivation of human rights for children with disability and/or identified areas for improvement in relevant policies and practices.

Department of Education's review

369. On 3 June 2020, the Department of Education completed a Desktop Audit concerning Kaleb and Jonathon.[660] The Desktop Audit recorded the Regional Principal Advisor Student Protection considered a Child Protection Notification should have been made in relation to Kaleb in May 2018 in relation to a lump on his head.[661]

370. Overall, the Desktop Audit found that the School had recorded instances of significant harm but had not made child protection reports. It found that the School was not compliant with Student Protection Policy and the *Child Protection Act.*[662]

371. On 14 June 2020, the Regional Director at the Department of Education informed the Deputy Director-General, State Schools Division at the Department of Education about the school's actions with respect to record keeping, Kaleb and Jonathon, and staff training.

372. The Regional Director informed the Deputy Director-General the school's actions included, 'Compulsory Training for all staff to be provided by Metro Director Strategy and Performance and Regional Student Protection Advisor beginning immediately -

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660 Agreed Facts, [372]; Exhibit 33-320, QLD.0004.0028.0614, p 1; Exhibit 33-325, QLD.0005.0052.0068, pp 1–8; Exhibit 33-326, QLD.0004.0028.0617, pp 1–2.

661 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [154]; Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-174 [19–27].

662 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [155]; Exhibit 33-325, QLD.0005.0052.0068, p 8.

Mandatory Reporting Requirements; OneSchool use; Report writing; Code of Conduct; Child Protection Training; etc.'; and 'Regional Additional Allocation will be used to provide a Business Manager Coach to work with [School 2] to improve understanding of responsibilities and review systems and procedures at the school'.[663]

373. It is not clear from the evidence what remedial measures were implemented and what further action has been taken. Ms Stevenson's statement addressed 'ongoing reform'.[664] The reforms appeared to be directed to adjustments and 'resourcing models'. Ms Stevenson's description of the 'ongoing reform' made no reference to:

a. 'best interests' of the child
b. enhancing the Department's capacity to understand, detect and respond to the risks of violence, abuse and neglect for a student with disability
c. reflecting on the experiences of Kaleb and Jonathon to identify gaps in policies, practices or procedures to safeguard children with disability
d. applying human rights approaches to address and respond to the risks of violence, abuse and neglect for a student with disability
e. considering whether it should offer Kaleb and Jonathon redress for the failures to protect each of them from the ongoing risks of violence, abuse, neglect and deprivation of their human rights.

Queensland Police investigation

374. On 27 May 2020, the Queensland Police opened an investigation into Paul Barrett's death.[665]

375. On 11 June 2020, the Queensland Police finalised its investigation into the suspected harm of Kaleb and Jonathon.[666] Queensland Police determined its 'investigation failed to identify a criminal offence of any nature, against any person or entity to cause the continuance of a Queensland Police investigation.'[667]

376. There was no review directed to the nature and extent of the Police engagement with Kaleb and Jonathon.

663 Agreed Facts, [373]; Exhibit 33-337, QLD.0004.0028.0696, p 2.

664 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [164–175].

665 Agreed Facts, [351], QLD.0005.0028.1259, p 3.

666 Agreed Facts, [352].

667 Agreed Facts, [352]; QLD.0008.0029.0211, pp 1, 16.

Department of Housing's review

377. On 29 May 2020, a Department of Housing staff member conducted an internal review. The review identified at least 12 occasions where Department of Housing staff could have escalated child safety concerns and/or raised child safety concerns to the Department of Child Safety.[668]

378. However, Ms Raine appeared to distance the Department of Housing from this review. She said the review 'was not prepared as a "formal review" by the Department of Housing of the tenancy and action of the department.'[669]

379. Counsel Assisting submitted it is open to the Royal Commission to endorse the findings made by the Department of Housing on 29 May 2020, namely:

    a. the Department of Housing failed to identify that Paul Barrett needed support to maintain his property in a way that was safe and accessible for Kaleb and Jonathon, even though Paul Barrett indicated on many occasions that he was struggling to maintain the property and parent Kaleb and Jonathon. These are missed opportunities to broker support for Paul Barrett through community or other Government agencies.

    b. there were at least 12 occasions where Department of Housing staff could have escalated and/or notified the Department of Child Safety of concerns relating to the care of Kaleb and/or Jonathon but failed to do.[670]

380. Queensland submitted we should not endorse the findings of the internal review and it stressed the review was prepared for a different purpose.[671] We have read and considered the extensive submissions Queensland provided with respect to the proposed finding.[672] As we have indicated above, we do not propose to make any findings directed to the Department of Housing. Despite the force of Queensland's objection to any weight be given to or endorsement, we found the internal review to be helpful evidence and provided us with assistance in understanding the family's circumstances and the Department of Housing's engagement with them.

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668 Agreed Facts, [354]; Exhibit 33-318, QLD.0001.0026.1460, pp 2–12.

669 Exhibit 33-71, 'Statement of Chantal Raine', 5 May 2023, at [35].

670 Agreed Facts, [353–355]; Exhibit 33-318, QLD.0001.0026.1460, pp 2–12.

671 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 53 [230].

672 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 53 [230]–58 [254].

Queensland Family and Child Commission and Child Death Review Board

381. Mr Luke Twyford, CEO and Principal Commissioner, QFCC and Chair, Queensland Child Death Review Board (**CDRB**), prepared a statement and gave evidence at Public hearing 33.

382. The overarching role of the QFCC is to advise Queensland government based on analysis, oversight, reviews, surveys and other works, on the current performance of the Queensland child protection system.[673] The QFCC also has a role in working across traditional government silos to breach those 'silos'[674] to draw out systemic issues and to provide holistic advice on how to make improvements to the safety and wellbeing of Queensland's children and families.[675] The focus is on the system of services provided by relevant agencies to children and young people in need of protection or at risk of harm'.[676] This includes 'preventative and support services to strengthen and support families and prevent harm to children and young people.[677]

383. The QFCC cannot investigate the circumstances of a particular child, young person or family, or advocate on their behalf.

384. The CDRB's functions are to carry out systems reviews following child deaths connected to the child protection system to help identify opportunities for improvement in systems legislation, policies and practices, and to identify preventative mechanisms to help protect children and prevent deaths that may be avoidable.[678] Unlike other QFCC functions, the CDRB has powers to look at individual circumstances.

385. The CDRB is limited to investigating circumstances where a child has passed away whilst the child was known to the child protection system within 12 months prior to the date of death.[679] However, in exceptional circumstances, the Attorney General can also request the CDRB carry out a review of other matters relating to the child protection system where a child has not passed away.[680] For example, where issues relate to a serious physical injury of a child.[681]

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673 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P–79 [11–14]; Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [12].

674 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P–79 [40–48].

675 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P–79 [35–48].

676 *Family and Child Commission Act 2014* (Qld) Schedule 1, s 5.

677 *Family and Child Commission Act 2014* (Qld) Schedule 1, s 5.

678 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [22]; *Family and Child Commission Act 2014* (Qld) s 29D.

679 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P–88 [19–21]; *Family and Child Commission Act 2014* (Qld) ss 29A(1), 29B; *Child Protection Act 1999* (Qld) Chapter 7A.

680 Transcript, Luke Twyford, 9 May 2023, P–88 [23–27]; *Family and Child Commission Act 2014* (Qld) s 29I(1).

681 *Family and Child Commission Act 2014* (Qld) ss 29I (1–2).

386. On 1 June 2020, the Queensland Attorney-General at the time requested the then Principal Commissioner of the QFCC, Ms Cheryl Vardon AO, to:

> commence a system review into the policies and practices of relevant agencies who were involved with [Kaleb] and [Jonathon], as well as those agencies that were not involved but perhaps could have played a role in supporting the family' [**QFCC System Review Request**].[682]

387. On 4 June 2020, the Principal Commissioner of the QFCC, established the Terms of Reference in respect of the QFCC System Review Request (**QFCC Terms of Reference**).[683] The QFCC Terms of Reference specified:

> a. the QFCC was to review legislation, policies and practices that supported coordinated responses between agencies to meet the disability support and protection needs of children at risk of harm.
>
> b. the Child Death Review Board was to establish the system of contact points with the family in the years prior to the younger brother's discovery to examine the effectiveness and appropriateness of responses. This included mapping the interaction of agencies involved with the Family during periods of heightened vulnerability.
>
> c. the Child Death Review Board was to identify gaps and opportunities for system improvements to legislation, policies and practices and recommend changes to strengthen the child protection system and to promote the safety and wellbeing of children.[684]

388. Kaleb and Jonathon's circumstances fell outside of the CDRB's legislative scope to conduct a review.[685] For the CDRB to perform terms of reference 'b' and 'c', it required a direction from the Minister pursuant to section 29I of the *Family and Child Commission Act* 2014 (***FCC Act***).

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682 Agreed Facts, [357]; Exhibit 33-2, QLD.0019.0051.0001, p 17.

683 Agreed Facts, [358]; Exhibit 33-2, QLD.0019.0051.0001, pp 19–21.

684 Agreed Facts, [358]; Exhibit 33-2, QLD.0019.0051.0001, p 19.

685 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-88 [15–37]. Also noting that the CDRB's function is to carry out systems reviews following child deaths connected to the child protection system: *Family and Child Commission Act 2014* (Qld) s 29D(a).

389. On 3 September 2020, the Attorney-General wrote to the Principal Commissioner thanking them for the update on several system reviews, including the one concerning Kaleb and Jonathon.[686] The Attorney-General did not address any referral of the matters to the CDRB.[687]

390. On 2 October 2020, the Attorney General informed the Principal Commissioner she would not refer certain matters outlined in the QFCC Terms of Reference.[688]

391. The effect of this decision is that the review intended to be conducted by the CDRB did not proceed. The reason for this is unclear.

392. In about December 2020, the Principal Commissioner finalised her review in response to the QFCC System Review Request (**the QFCC December 2020 Report**).[689] The QFCC December 2020 Report identified Kaleb and Jonathon by name.[690] It examined, at least at a base level, the circumstances in which they were found on 27 May 2020 and the report expressly referred to their lived experiences which was relevant in making findings about the systemic issues.[691]

393. The QFCC Principal Commissioner considered:

> [Kaleb] and [Jonathon] had high support needs and relied entirely on their father and the system to care for and protect them. However, gaps in system responses meant that at times their father was responsible for meeting their needs alone.[692]

394. In relation to Jonathon's needs during COVID-19, the QFCC Principal Commissioner viewed that he 'should have been assessed as a vulnerable child' when he began learning from home during COVID-19[693] and:

> If he had been, school attendance and supports could have been maintained and his safety and wellbeing more closely monitored. This would have also eased demands on his father.[694]

686 Exhibit 33-57, QLD.9999.0068.0069, p 1.

687 Exhibit 33-57, QLD.9999.0068.0069, p 1; Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [72–73].

688 Exhibit 33-58, QLD.9999.0068.0070, p 1; Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [74–75]; Agreed Facts, [359]; Exhibit 33-2, QLD.0019.0051.0001, p 9.

689 Agreed Facts, [360]; Exhibit 33-2, QLD.0019.0051.0001, pp 1–26.

690 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-91 [12–17].

691 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-91 [12–34].

692 Agreed Facts, [361]; Exhibit 33-2, QLD.0019.0051.0001, p 2.

693 Agreed Facts, [362]; Exhibit 33-2, QLD.0019.0051.0001, p 2.

694 Agreed Facts, [362]; Exhibit 33-2, QLD.0019.0051.0001, p 2.

395. The QFCC December 2020 Report set out the QFCC Principal Commissioner's observations that, as at early 2020, Paul Barrett struggled with the application process for Jonathon's access to the NDIS and refused further contact with the NDIA and NDIS services.[695]

396. The QFCC Principal Commissioner found:

- professionals did not receive enough guidance about how to share information to support NDIS applications for children in the care of parents
- there were limited pathways for direct referrals to the NDIS by professionals on the family's behalf.[696]

397. The QFCC Principal Commissioner considered 'the system did not recognise and respond to the challenges experienced by Paul Barrett in navigating the NDIS access process'.[697]

398. The QFCC Principal Commissioner was informed by the NDIA Kaleb 'was an NDIS participant but had not accessed any of his eligible supports and services'.[698] The QFCC Principal Commissioner viewed:

> There are no mechanisms for responding when a child's funding package is not being used. If there were, further action could be taken to follow up with the family. In the case of the [family], [Kaleb] could have been helped to access the available supports. This may also have provided an opportunity to help the brothers' father to prepare [Jonathon]'s NDIS application.[699]

399. On 14 January 2021, the Principal Commissioner provided the QFCC December 2020 Report to the Attorney-General.[700]

400. On 30 March 2021, the Attorney-General provided the QFCC December 2020 Report to the Department of Child Safety, the Department of Education, the Department of Disability Services and the Premier of Queensland.[701]

401. Also on 30 March 2021, the Attorney-General wrote to the Principal Commissioner stating, inter alia:

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695 Agreed Facts, [363]; Exhibit 33-2, QLD.0019.0051.0001, p 2.
696 Agreed Facts, [364]; Exhibit 33-2, QLD.0019.0051.0001, p 3.
697 Agreed Facts, [365]; Exhibit 33-2, QLD.0019.0051.0001, p 3.
698 Agreed Facts, [366]; Exhibit 33-2, QLD.0019.0051.0001, p 3.
699 Agreed Facts, [366]; Exhibit 33-2, QLD.0019.0051.0001, p 3.
700 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [53]; Exhibit 33-49, QLD.9999.0068.0055, pp 1–2.
701 Agreed Facts, [367]; Exhibit 33-345, QLD.0020.0050.2574, p 4.

> I would ask that any broader discussion regarding the reports be deferred until Government has had the opportunity to formally consider the reports.[702]

402. To Mr Twyford's knowledge, the QFCC December 2020 Report has never been published or publicly released.[703] The decision not to publish was the Attorney-General's under section 22 of the *FCC Act*.[704] The QFCC does not have an explicit power to publish its reports.[705]

403. On 8 July 2021, an officer from the Queensland Department of Justice and Attorney-General verbally requested (over the telephone) the QFCC prepare a summarised version of the report to remove identifying information about Kaleb and Jonathon or their family.[706] That report was required the next day.[707]

404. On 9 July 2021, the QFCC Summary Report,[708] was progressed to the Attorney-General.[709] Receipt was acknowledged by the office of the Attorney-General by email sent 12 July 2021.[710]

405. On 20 August 2021, the new Attorney-General tabled the QFCC Summary Report.[711]

406. On 13 May 2022, Attorney-General wrote to the Honourable Ronald Sackville AO KC, Chair of the Royal Commission.[712] The letter enclosed the Summary Report. It did not enclose the QFCC December 2020 Report. Neither the letter from the Attorney-General to the Royal Commission dated 13 May 2022 or the QFCC Summary Report refer to either Kaleb or Jonathon.[713]

407. The QFCC's review into Kaleb and Jonathon demonstrates its absence of power to compel confidential information and is a deficit in the *FCC Act*. It limits the QFCC's capacity to meet its statutory function of providing oversight of the child protection system. With proper provisions in place that prohibit disclosure and misuse of confidential information, Counsel Assisting submitted there is no reason preventing the QFCC from being conferred powers to compel information relevant to the exercise of its powers.

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702 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [80]; Exhibit 33-59, QLD.9999.0068.0071, p 1.

703 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-91 [41–44].

704 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-91 [46–50]–P-92 [1].

705 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [83].

706 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [55]; Exhibit 33-50, QLD.9999.0068.0057, p 1.

707 Transcript, Luke Twyford, Public hearing 33, 9 May 2023, P-92 [17–34].

708 See Exhibit 33-3, QLD.9999.0066.0003, pp 1–16.

709 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [58].

710 Exhibit 33-38, 'Statement of Luke Twyford', 3 May 2023, at [59]; Exhibit 33-52, QLD.9999.0068.0059, pp 1–2.

711 Agreed Facts, [368]; Exhibit 33-348, QLD.0020.0050.2209, p 1.

712 Agreed Facts, [369]; Exhibit 33-4, QLD.9999.0066.0001, p 1.

713 Agreed Facts, [370]; Exhibit 33-4, QLD.9999.0066.0001, p 1; Exhibit 33-3, QLD.9999.0066.0003, pp 1–16.

408. Queensland informed us that under section 42 of the *FCC Act*, the Attorney-General (as the responsible Minister) must review the effectiveness of the *FCC Act* and table a report about its outcome in the Queensland Legislative Assembly as soon as practicable after the legislative review is finalised. We welcome Queensland's advice that DJAG is currently undertaking a legislative review of the *FCC Act* to ensure it remains appropriate, contemporary and fit for purpose.[714] The matters raised in this case study may assist in addressing appropriate and contemporary approaches, including the human rights of children and young people with disability.

714 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 80 [352–353].

Part 7 Recommendations concerning Queensland

409. Counsel Assisting identified 11 recommendations in their submissions.[715] Eight recommendations were directed to particular Queensland departments and agencies and SCAN, including seven separate proposed recommendations concerning training for specific Queensland departments and agencies and SCAN.[716] Queensland made specific submissions in response to most but not all of these recommendations.[717]

410. We carefully considered the proposed recommendations and submissions in response. We do not consider it appropriate to make recommendations directed to Queensland departments or agencies separately. This is with exception to a mandatory reporting recommendation which is directed to Queensland Police, the reasons for which are outlined below. Instead we consider it more appropriate to make recommendations which apply more generally to Queensland.

Recommendation 1: Training and resources

411. For the reasons set out below we make recommendation 1.

Recommendation 1

The State of Queensland should provide training and resources to its employees and agents who have any responsibilities relevant to children and young people with disability directed, but not limited to:

a. the influence of unconscious and conscious bias, and

b. how discrimination occurs

in responses, actions and decisions concerning children and young people living with disability at risk of experiencing violence, abuse and neglect.

715 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 142–143 [437], 162 [515], 188 [603–604], 201 [655], 210 [706], 221–222 [755], 232 [802], 285 [1021], 288–289 [1031], 299 [1076].

716 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 142–143 [437], 162 [515], 188 [603], 201 [655], 210 [706], 221–222 [755], 232 [802].

717 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 39–40 [187–194], 44 [205–206], 50–52 [223–228], 61–62 [272–275], 69–70 [309–314], 75–79 [344–350].

412. During the hearing and in the submissions, we heard about the nature and influence of unconscious biases on the assessment of risk for children and young people with disability, on decision making when responding to risk, and resulting in the low expectations and acceptance of the explanations of Paul Barrett. We also heard about the importance of frontline employees in the departments and agencies having the relevant skills and understanding of child protection to identify and report where there are risks of harm to a child.

413. When we considered the Agreed Facts and the evidence presented at the hearing, an overwhelming factor in understanding why Kaleb and Jonathon experienced preventable violence, abuse, neglect and a deprivation of their human rights is related to attitudes and assumptions about disability. Our views in this respect have taken into account Kaleb and Jonathon's circumstances prior to May 2020 and the subsequent changes in their lives, access to disability support services, communication abilities, living conditions and circumstances over the past 3 years.[718] Our views in this respect have taken into account Kaleb and Jonathon's circumstances prior to May 2020 and the subsequent changes to their lives, access to disability support services, communication abilities, living conditions and circumstances over the past 3 years.[719]

414. We accept Counsel Assisting's submission that Kaleb and Jonathon encountered assumptions about their disability, which meant:

- they were often not directly consulted when they experienced violence, abuse and neglect or Queensland departments and agencies received reports concerning their care and treatment[720]
- the poor conditions in which they lived and their treatment by their father were normalised by others[721]

718 See Transcript, Alexis, Public hearing 33, 8 May 2023, P-33 [27–32]; Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 7 [2], 21–25 [66–86], 48 [173–175], 50 [182–183], 53–54 [184], [189], 56–62 [192–204], 108 [322].

719 See Transcript, Alexis, Public hearing 33, 8 May 2023, P-33 [27–32]; Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 7 [2], 21 [66], 25 [86], 48 [173], [175], 50 [182–183], 53–54 [184], [189], 56–62 [192–204], 108 [322].

720 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 106 [315]; Agreed Facts, [293]; Exhibit 33-291, QLD.0002.0027.1370_E, pp 1–12; Exhibit 33-293, QLD.0002.0027.1327_E, p 2; Exhibit 33-191, QLD.0008.0029.0009_E, pp 5.

721 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 106 [315]; Exhibit 33-293, QLD.0002.0027.1327_E, p 7; Agreed Facts, [181(c)], [183], [211]; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-238, QLD.0002.0027.1545_E, p 1; Exhibit 33-239, QLD.0008.0029.0297_E, p 2.

- their experiences of abuse and neglect could, and was, at times mistaken for disability-related behaviours[722]
- there were low expectations from Queensland agencies and departments as well as their father and community members, about Kaleb and Jonathon's capacity to communicate, maintain personal care and hygiene, develop any independent skills[723]
- Paul Barrett's behaviours were explained away, excused or accepted because he had the care of two children with disability.[724] For example, it was suggested Paul Barrett was doing a 'good job of parenting' but had 'a different standard to others'.[725]

415. Dr Crawford identified how a 'positive' unconscious bias may have applied in the circumstances.[726] She stated child protection practitioners can feel more reassured a parent is providing appropriate protection and care to a child when they are 'open to intervention, willing to engage, civil in their communications, or perceived themselves to be a victim survivor and to be doing their very best in difficult situations'. She discussed how practitioners' feelings of empathy towards a parent could result in them being hesitant to sufficiently challenge a parent about their parenting practices.[727]

722 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 106 [315]. See Agreed Facts [89(a)], [183], [219], [243(c)], [245(b)]; Exhibit 33-239, QLD.0008.0029.0297_E, p 1; Exhibit 33-267, QLD.0001.0026.0240_E, p 1; Exhibit 33-276, QLD.0002.0027.1483_E, pp 3–4; Exhibit 33-257, QLD.0002.0027.1508_E, p 3; Exhibit 33-239, QLD.0008.0029.0297_E, p 2.

723 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 105 [315] –108 [321], 120 [356–358], 121 [362]–122 [364]; See Agreed Facts, [183], [210], [219], [243], [245], [257], [268]; Exhibit 33-236, QLD.0002.0027.1556_E, p 2; Exhibit 33-239, QLD.0008.0029.0297_E, p 2; Exhibit 33-257, QLD.0002.0027.1508_E, pp 2–4; Exhibit 33-267, QLD.0001.0026.0240_E, p 1; Exhibit 33-276, QLD.0002.0027.1483_E, p 4; Exhibit 33-283, QLD.0002.0027.1423_E, pp 3–7; Exhibit 33-293, QLD.0002.0027.1327_E, pp 2, 7–9.

724 Exhibit 33-293, QLD.0002.0027.1327_E, p 9.

725 Agreed Facts, [180(c)]; Exhibit 33-236, QLD.0002.0027.1556_E, p 2.

726 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 2 [7]. The Agreed Facts include four occasions when Department of Education and/or Department of Child Safety employees described Paul Barrett as 'doing his best' in response to concerns raised about his parenting for two children with disability. See Agreed Facts, [94(c)], [183], [243(b)], [245(d)], [272(c)]; Exhibit 33-178, QLD.0002.0027.0094_E, p 1; Exhibit 33-239, QLD.0008.0029.0297_E, p 2; Exhibit 33-276, QLD.0002.0027.1483_E, pp 3–4; Exhibit 33-290, QLD.0008.0029.0630, p 3.

727 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 2 [7].

416. Counsel Assisting submitted it was open to us to make separate recommendations for the Department of Child Safety,[728] Department of Education,[729] Queensland Health,[730] Department of Housing,[731] Department of Disability Services,[732] and SCAN,[733] to implement training on unconscious and conscious bias, and how discrimination occurs, in the context of children and young people with disability experiencing, and being at risk of experiencing, violence, abuse and neglect.

417. Overall Queensland appeared to agree that understanding and addressing unconscious and conscious bias in the context of engaging with young people with disability is important. Although its departments and agencies took different positions as to whether it was open and appropriate for us to make the specific training recommendations for each of them:

a. The Department of Education accepted it was open for the Royal Commission to make the recommendations proposed by Counsel Assisting concerning them.[734]

b. The Department of Child Safety acknowledged the importance of understanding and addressing unconscious and conscious bias.[735] However, it took issue with the training recommendation proposed by Counsel Assisting on the grounds that:

   - it had existing training and practices to address unconscious and conscious bias. Accordingly, the weight of a recommendation would be limited.[736]

   - the Royal Commission did not have evidence of the Department of Child Safety's training on unconscious and conscious bias.[737]

c. The Department of Child Safety accepted, 'with reference to Kaleb and Jonathon's child protection history, and in general, a continued need to address unconscious

728 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 142–143 [437].

729 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 162 [515].

730 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 201 [665].

731 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 210 [706].

732 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 221–222 [755].

733 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 232 [802].

734 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 4 [13].

735 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 39 [188–189], [191].

736 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 39 [188–189], [190].

737 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 39 [190].

bias in practice, to build capacity in risk assessments and cumulative harm, and to continue to be informed by contemporary literature to inform best practice in working with children and young people who experience disability, including the best means of communication with young people.'[738]

d. SCAN did not advance specific submissions about the training recommendation and indicated it would consider any recommendations carefully.[739]

e. Queensland Health, the Department of Disability Services and Department of Housing submitted we should reject training recommendations for them on the grounds that:

   - there was a lack of evidence of the Department of Health's existing training and practices to address unconscious and conscious bias, and discrimination[740]
   - there was no evidence elicited from their witnesses concerning unconscious or conscious bias, nor did their witnesses' statements refer to these matters[741]
   - Counsel Assisting did not make submissions concerning occasions when each of them were affected by unconscious or conscious bias in its conduct to warrant these recommendations.[742]

f. Queensland Health added it was fully prepared to accept the benefit of rolling out unconscious bias training.[743] It recognised additional training on unconscious and conscious bias which is co-designed with people with disability, together with how discrimination occurs, would complement its existing training modules.[744]

418. With respect to Queensland Police, Counsel Assisting submitted it was open for us to recommend that Queensland Police consider their role in child protection matters, and examine how they could improve the manner in which they respond to and investigate

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738 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 40 [193].

739 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 75 [344].

740 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 51 [226]–52 [227], [228(a), (d–h)].

741 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 51 [225], 61 [273], 69 [311].

742 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, pp 51 [224], 61 [274], 69 [310].

743 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 51 [228(a)].

744 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 51 [228(b)].

allegations of child harm.[745] Where allegations involve children with disability, or children who are non-communicative, there should be training for all Queensland Police officers on both unconscious and conscious bias, together with how discrimination occurs. Counsel Assisting also submitted Queensland Police should be committed to considering matters involving harm to children as not solely issues for the Department of Child Safety.[746]

419. Detective Superintendent Clark was put forward by Queensland to assist us to understand the role and responsibilities of Queensland Police relevant to this case study concerning children with disability. We express our concern that he had not followed the hearing (in the two days prior to giving evidence) and he had not followed the work of the Royal Commission over the past 4 years. He had not heard of the *CRPD*.[747] Detective Superintendent Clark told us he had not undertaken any training with respect to people with intellectual disability who are victims of crime.[748] He had not undertaken any training regarding people with disability who are non-verbal and the victims of crime.[749] Detective Superintendent Clark was asked whether police officers in general receive training on interacting with people who have intellectual disability, or who are non-verbal or use different communication styles.[750] Detective Superintendent Clark was not aware of any training of this nature.[751] He was also unaware of the practice kit issued by the Department of Child Safety in relation to children and young people with disability.[752]

420. In response to Questions on Notice, Queensland Police provided information about their collaboration with Women with Intellectual Disability (**WWILD**), an organisation that supports people with intellectual or learning disabilities who have experienced sexual abuse or have been victims of crime.[753] We note the research report by the University of New South Wales commissioned by the Royal Commission on *Police responses to people with disability* also refers to WWILD.[754]

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745 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 188 [603].

746 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 188 [603].

747 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-198 [9–16].

748 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-197 [25–30].

749 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-197 [36–40].

750 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-198 [23–35].

751 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-198 [23–35].

752 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-198 [37–41].

753 Exhibit 33-79, QLD.9999.0074.0001, p 5.

754 Leanne Dowse, Simone Rowe, Eileen Baldry & Michael Baker, *Police responses to people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, October 2021, pp 92, 110.

421. In the submissions Queensland Police agreed it was open for the Royal Commission to make the recommendations proposed by Counsel Assisting concerning them.[755]

422. We consider it appropriate to make a training recommendation generally and accept that the nature and manner of training may differ from department to department or for particular agencies. Obviously, employees who work directly with or have responsibility for decisions or the implementation of policies, practices or undertaking a review should have the opportunity for such training.

423. It is not necessary to have before us evidence of Queensland's departments and agencies existing training on unconscious and conscious bias and discrimination to make this recommendation. We are not making a finding about the existence of such training or the effectiveness of such training. Nor is it necessary for Counsel Assisting to have identified specific incidents of unconscious or conscious bias, or discrimination, against specific departments and agencies for us to make this recommendation.

424. Queensland accepted Kaleb and Jonathon experienced violence, abuse, neglect and a deprivation of their human rights in their father's care, and this was preventable. Prevention requires an awareness and understanding of the particular risks to children and young people with disability. Training and education is key to awareness and developing an understanding.

425. In considering this recommendation, we draw on what we have heard over the life of this Royal Commission. We have heard about the importance of education and training to address ableist attitudes. In April 2020, The Royal Commission released its Issues Paper on *Rights and attitudes*. The responses made it clear few organisations know, understand or enforce disability rights and relevant laws, or appreciate how ableism impacts behaviours and systems. This lack of rights awareness exposes people with disability to increased risk of discrimination, exclusion, isolation and violence, abuse, neglect and exploitation.[756] Responses overwhelmingly pointed to education and increased awareness of rights and obligations as a solution to addressing ableist

755 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 44 [205].

756 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of responses to the Rights and attitudes issues paper*, April 2021, p 3.

attitudes.[757] Some organisations provided examples of training programs that have successfully helped drive behavioural and attitudinal change. [758]

426. Research by the Social Policy Research Centre at the University of New South Wales commissioned by the Royal Commission on *Changing community attitudes to improve inclusion of people with disability* found that specifically education interventions that provide information and opportunities for contact with people with disability generate larger attitude changes.[759] The research found that over time non-disabled people change their expectations of people with disability, reducing their negative attitudes and behaviours.[760]

427. We refer to the more recent Public hearing 31 on a vision for an inclusive Australia, when Mr Dylan Alcott AO, 2022 Australian of the Year told us 'the… lack of negative stigmas, the unconscious bias… that comes down to education and training'.[761]

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757 See for example, The Centre for Inclusive Education, Submission in response to *Rights and attitudes issues paper*, 30 July 2020, ISS.001.00294, p 6; Family Planning NSW, Submission in response to *Rights and attitudes issues paper*, 23 July 2020, ISS.001.00308, pp 2, 8–9; Queenslanders with Disability Network, Submission in response to *Rights and attitudes issues paper*, 5 August 2020, ISS.001.00326, p 6; Uniting Church in Australia, Submission in response to *Rights and attitudes issues paper*, 28 August 2020, ISS.001.00400, pp 4–5; Queenslanders with Disability Network, Submission in response to *Rights and attitudes issues paper*, 5 August 2020, ISS.001.00326, pp 6, 12; Attitude Foundation Limited, Submission in response to *Rights and attitudes issues paper*, 17 August 2020, ISS.001.00371, p 44 (recommendations 5 and 24); Office of the Public Guardian, Submission in response to *rights and attitudes issues paper*, 21 September 2020, ISS.001.00455, pp 4, 6.

758 See for example National Disability Services, Submission in response to *Rights and attitudes issues paper*, 3 August 2020, ISS.001.00321, pp 2–6.

759 Karen Fisher, Sally Robinson, Christiane Purcal, Gianfranco Giuntoli, Jan Idle, Rosemary Kayess, BJ Newton, Christy Newman, Qian Fang, Mitchell Beadman, Yasmin Edwards, Kathleen Reedy & Rosie Pether, *Changing community attitudes to improve inclusion of people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, April 2022, p 105.

760 Karen Fisher, Sally Robinson, Christiane Purcal, Gianfranco Giuntoli, Jan Idle, Rosemary Kayess, BJ Newton, Christy Newman, Qian Fang, Mitchell Beadman, Yasmin Edwards, Kathleen Reedy & Rosie Pether, *Changing community attitudes to improve inclusion of people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, April 2022, p 54.

761 Transcript, Dylan Alcott, Public hearing 31, 13 December 2022, P-65 [27–28].

Recommendation 2: 'Nothing about us, without us'

428. For the reasons set out below we make recommendation 2.

> **Recommendation 2**
>
> The State of Queensland should take active and immediate steps to incorporate the voices and experiences of people with disability, particularly children and young people, and their representative organisations, in the child protection system, with a focus on:
>
> a. representation and/or membership on relevant committees which make decisions concerning children and young people with disability
>
> b. developing and/or reviewing policies and practices concerning children and young people with disability
>
> c. reviewing and/or responding to occurrences and risks of violence, abuse and neglect of children and young people with disability, and
>
> d. developing training materials or delivering training to Queensland public sector employees whose duties, functions and powers concern children with disability in the child protection scheme.

429. During this hearing, Commissioner Mason asked the Queensland department and agency witnesses about their knowledge and understanding of the catchcry *'nothing about us, without us'.* The words emphasise the importance of including people with disability in decisions that affect their lives.[762] Counsel Assisting has recorded the responses in their submissions.[763]

430. We accept Counsel Assisting's submission that the witnesses had varying degrees of understanding of the concept.[764]

431. It was also apparent there was an absence of lived experienced perspectives of disability, particularly intellectual disability and children with disability, in the way the Queensland departments and agencies assessed information and made decisions about Kaleb and Jonathon as two young people living with intellectual disability. For

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762 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, p 98 [392].

763 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 287 [1026]–288 [1030].

764 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 288 [1030].

example, the evidence showed the Department of Child Safety did not communicate or engage directly with Kaleb and Jonathon. It also did not prepare plans to communicate and engage directly with them. There appeared to be an overall view, which was reflected in the Department of Child Safety's records and Dr Crawford's subsequent assessment of these records, that because Kaleb and Jonathon were non-verbal their views and wishes could not be directly ascertained, or that their non-verbal communication complicated the gathering of this information.[765] A further example, there was an absence of a member of SCAN who had relevant lived experience and/or expertise concerning children or young people with disability, when they were coordinating responses to the protection needs of Kaleb and Jonathon.[766]

432. Queensland appeared to be broadly receptive to incorporating and embedding the perspectives of people with disability in their policies and practices. It acknowledged it was on a journey of constantly reviewing and evolving its practices, and reiterated its commitment to achieve equality of opportunity for all Queenslanders.[767]

433. The Department of Child Safety prepared the *Child Safety Practice Manual: Practice Kits: Disability* published on 19 November 2019, to support practice with children and parents with disability.[768] This manual provides practice guidance on a range of matters, such as making reasonable adjustments for children with disability including adapting communication styles to promote effective engagement with them.[769] The Department of Child Safety stated it was preparing to undertake a review of this manual which would include engagement and consultation with children, young people and their families with disability, disability service providers and peak bodies to ensure the lived experiences of people with disability would inform associated guidance.[770] The Department of Child Safety advised it worked collaboratively with people with lived experience in its development of policy, procedures and practice advice wherever possible. It was committed to working alongside people with professional expertise and lived experience to enhance responses to vulnerable children and families.[771]

765 Exhibit 33-60, 'Statement of Dr Meegan Crawford', 5 May 2023, at p 6 [17]; Transcript, Meegan Crawford, Public hearing 33, 10 May 2023, P-141 [25 –P-142 [27]; Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 105 [315]–106 [318], pp 119 [352]–122 [365]. See also Exhibit 33-293, QLD.0002.0027.1327_E, pp 2–4.

766 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, pp 230 [791]–231 [293]; Transcript, Dr Meegan Crawford, Public hearing 33, 10 May 2023, P-152 [43]–P-153 [5].

767 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 81 [359].

768 Exhibit 33-64, DRC.9999.0212.0011. See also Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 83 [368(a–b)].

769 Exhibit 33-64, DRC.9999.0212.0011, p 14.

770 Exhibit 33-79, QLD.9999.0074.0001, p 2 [2].

771 Exhibit 33-79, QLD.9999.0074.0001, p 2 [3].

434. Queensland Health was also receptive to co-designing and incorporating the perspectives of people with disability in its unconscious and conscious bias training. It stated it was committed to building an inclusive and diverse workforce which reflected the community it served.[772] It referred to its roundtable initiative with Queensland Disability Network Inc. stakeholders with diverse disability to share experiences on 'why having a voice in health settings is important'.[773]

435. The Department of Disability echoed the words Commissioner Mason stated to Queensland's witnesses in Public hearing 33 concerning 'Nothing about us, without us'. It added it would continue to ensure decisions made concerning people with disability are made 'for, with and through them'.[774]

436. Counsel Assisting submitted it was open to us to recommend Queensland take active and immediate steps to incorporate the voices and experiences of people with lived experience of disability, particularly children and young people and their representative organisations in the child protection system with respect to:

   a. representation and/or membership of relevant committees or bodies considering the interests and rights of the children and young people with disability in the child protection system,

   b. developing and/or reviewing policies and practices concerning interests and rights of the children and young people with disability, and

   c. developing training materials or delivering training to all Queensland public sector employees whose duties, functions and powers concern children with disability in the child protection scheme.[775]

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772 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 51 [288(b–c)].

773 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 51 [288(g)].

774 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 72 [325–326]. See Transcript, Andrea Mason (Commissioner), Public hearing 33, 10 May 2023, P-161 [28], [42].

775 We refer to the approach taken by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability in Report of Public hearing 10. The issues addressed in that report and the recommendations with respect to embedding an understanding and practices to provide health services for people with cognitive disability, may also be relevant (with the obvious modifications) for engagement with children with disability at risk of entering or in the child protection system.

437. Queensland did not provide detailed responses to this proposed recommendation. Although we note the broad acknowledgments by Queensland outlined above, concerning the importance of including people with disability and their experiences in decisions made about them.

Recommendation 3: Mandatory reporting

438. For the reasons set out below we make recommendation 3.

> **Recommendation 3**
>
> The State of Queensland should review section 13E(1)(d) of the *Child Protection Act 1999* (Qld) to consider:
>
> a. whether it should apply to all Queensland Police officers and
>
> b. if not, why it should not apply to all Queensland Police officers.

439. During the hearing and in the submissions, we heard about the role of reporting suspected and observed violence, abuse and neglect, so that it can be addressed and prevented in the future.

440. Figures 1 and 2 above, show the relational and systems influences in Kaleb and Jonathon's lives, extending from their parents, to community members, service providers and teachers, to Queensland departments and agencies. The Agreed Facts showed various occasions when individuals and professionals had concerns about Kaleb and Jonathon's care and treatment and on some occasions the need to report those concerns to the Department of Child Safety.

441. This hearing highlighted the ongoing importance of reporting concerns of violence, abuse and neglect of children with disability, the reporting of which can be done by community members as well as child safety experts. In Queensland, any person can make a report to the Department of Child Safety if they consider a child is in need of protection.[776]

442. Public hearing 33 was also an opportunity to consider the critical and safeguarding role of 'mandatory reporting' in situations where children with disability suffer harm, are suffering harm, or are at risk of harm.[777] In particular, what role does mandatory reporting serve to prevent children with disability from having experiences of violence, abuse and neglect, like those of Kaleb and Jonathon in their father's care.

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776 *Child Protection Act 1999* (Qld) s 13A(1)(a).

777 *Child Protection Act 1999* (Qld) s 13E(2)(a).

443. In Queensland, ‘mandatory reporting’ is a legal requirement for people working in particular areas to report to the chief executive of the Department of Child Safety their reasonable suspicion of significant harm to a child caused by physical or sexual abuse.[778] This in turn triggers obligations for the chief executive to investigate the report or take other action they consider appropriate.[779]

444. ‘Mandatory reporters’ are people who deal frequently with children in the course of their work.[780] In Queensland, they include:

- doctors[781]
- registered nurses[782]
- teachers[783]
- some police officers,[784] in particular those responsible for child protection investigations[785]
- early childhood education and care professionals[786]
- people performing child advocate functions under the *Public Guardian Act 2014* (Qld).[787]

445. A mandatory reporter’s obligation to make a mandatory report is triggered when they have a reasonable suspicion a child:

- has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse, and
- may not have a parent able and willing to protect the child from the harm.[788]

446. As a mandatory reporter’s obligations are limited to significant harm caused by ‘physical or sexual abuse’, some of Kaleb and Jonathon’s experiences, including

778 *Child Protection Act 1999* (Qld) ss 13E, 13G.
779 *Child Protection Act 1999* (Qld) s 14(1).
780 Australian Government, Australian Institute of Family Studies, Mandatory reporting of child abuse and neglect, June 2020, p 2.
781 *Child Protection Act 1999* (Qld) s 13E(1)(a).
782 *Child Protection Act 1999* (Qld) s 13E(1)(b).
783 *Child Protection Act 1999* (Qld) s 13E(1)(c).
784 *Child Protection Act 1999* (Qld) s 13E(1)(d).
785 Exhibit 33-74, ‘Statement of Denzil Clark’, 8 May 2023, at [15(b)].
786 *Child Protection Act 1999* (Qld) s 13E(1)(f).
787 *Child Protection Act 1999* (Qld) s 13E(1)(e).
788 *Child Protection Act 1999* (Qld) s 13E(2).

instances of serious neglect, would not be subject to mandatory reporting obligations.[789] Although this would not prevent a person from reporting alleged harm or risk of harm to a child to the Department of Child Safety caused by other factors, such as neglect, outside the mandatory reporting scheme.[790]

447. We heard about the Department of Education's policies and practices with respect to the obligations of teachers as mandatory reporters. [791] The Department of Education acknowledged its role as an important protective factor in the lives of children and young people, both for their immediate safety and wellbeing, and long-term life outcomes.[792] Teachers are well placed to identify risks of violence, abuse and neglect of their students. Teachers have access to information not readily available to organised services, including contact with a child's family and the opportunity to observe a child's daily presentation. Ms Stevenson said the Department of Education provides a very protective role and has a unique role given they have eyes on children who are at higher risk of experiencing harm.[793]

448. Since 2003, the Department of Education has maintained a policy requiring its employees to report suspected harm or risk to the Department of Child Safety or Queensland Police.[794] The policy applies to all employees and visitors to state schools.[795]

449. For Kaleb, his teachers were mandatory reporters for the last three years of his education. For Jonathon, his teachers were mandatory reporters for the whole of his high school education. The Agreed Facts described when Department of Education employees were aware of, or should have been aware of, the risks of violence, neglect and abuse to Kaleb and Jonathon, and Paul Barrett's maltreatment of his sons between 2005 and 2020.[796]

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789 *Child Protection Act 1999* (Qld) s 13E(2)(a).

790 See *Child Protection Act 1999* (Qld) ss 149(2–3).

791 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [90].

792 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [89]; Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-176 [29–41].

793 Transcript, Hayley Stevenson, Public hearing 33, 10 May 2023, P-176 [29–40]; Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [89].

794 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [98].

795 Exhibit 33-65, 'Statement of Hayley Stevenson', 4 May 2023, at [104–105].

796 Agreed Facts, [111–112], [123], [146–147], [149], [190–191], [200], [224], [231], [234], [307]; Exhibit 33-185, QLD.0020.0050.1761, pp 1–3; Exhibit 33-196, QLD.0002.0027.0055_E, pp 4–7; Exhibit 33-205, QLD.0002.0027.1643_E, pp 1–5; Exhibit 33-200, QLD.0008.0029.0054, pp 1–4; Exhibit 33-203, QLD.0008.0029.0015_E, p 3; Exhibit 33-201, QLD.0004.0028.0187, pp 1–3; Exhibit 33-204, QLD.0002.0027.1650_E, p 1; Exhibit 33-247, AQS.9999.0003.0001, pp 6, 12, 23, 30–32, 38; Exhibit 33-199, QLD.0005.0028.1360, p 30; Exhibit 33-272, QLD.0005.0028.0352, pp 1–2; Exhibit 33-308, QLD.0005.0028.1056, pp 1–2; Exhibit 33-311, QLD.0005.0028.0154, p 1.

Queensland Police

450. Not all police officers in Queensland are mandatory reporters.[797] Some police officers are mandatory reporters under the *Child Protection Act.*[798] These mandatory reporting requirements are limited to police officers responsible for child protection investigations.[799] This is in contrast to most other Australian jurisdictions where all police officers are subject to mandatory reporting requirements.[800] The only exception being in the Northern Territory where all people are required to report to police or child protection authorities, any reasonable concerns a child has suffered or is likely to suffer harm or exploitation.[801] There are no specified categories of mandatory reporters in the Northern Territory, but where a police officer does receive a report relating to child harm, they are to notify the CEO of the Department of Territory Families, Housing and Communities about the receipt of the report as soon as practicable.[802]

451. We considered the role of police in enforcing Queensland's criminal laws with respect to children with disability and in particular section 364 of the *Criminal Code.* It is an offence for a person who is caring for a child under the age of 16 to cause harm to that child, including by:

> (a) failing to provide the child with adequate food, clothing, medical treatment, accommodation or care when it is available to the person from his or her own resources, or
>
> (b) failing to take all lawful steps to obtain adequate food, clothing, medical treatment, accommodation or care when it is not available to the person from his or her own resources.[803]

452. 'Harm to a child' is defined in section 364 to mean 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing, whether temporary or permanent'.[804] This reflects the definition set out in the *Child Protection Act*, and was amended in 2008 for this purpose [805]

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797 *Child Protection Act 1999* (Qld) s 13E(1)(d).

798 *Child Protection Act 1999* (Qld) s 13E(1)(d).

799 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [15(b)].

800 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 27(1)(a); *Children and Young People Act 2008* (ACT) s 356(3)(i); *Children's Protection Act 1993* (SA) s 11(2)(e); *Children, Young Persons and Their Families Act 1997* (Tas) ss 3, 14(1)(e); *Children, Youth and Families Act 2005* (Vic) s 182(1)(e); *Children and Community Services Act 2004* (WA) s 124B(1)(a).

801 *Care and Protection of Children Act 2007* (NT) s 26.

802 *Care and Protection of Children Act 2007* (NT) s 28.

803 *Criminal Code 1899* (QLD) s 364(2)(a–b).

804 *Criminal Code 1899* (QLD) s 364(2).

805 *Child Protection Act 1999* (QLD) s 9(1).

453. Counsel Assisting referred to the circumstances when Queensland Police are first responders to a range of incidents, and the insight they often obtain about what happens behind closed doors. [806] As first responders, Queensland Police need to have the skills and experience to identify harm to a child and whether certain treatment of a child is an offence.

454. Further the standing and visibility police officers have in a community also means it is likely members of the public will report incidents of suspected harm to a child to police.

455. It is reasonable to expect Queensland Police should also inform the Department of Child Safety of such incidents, not just those police responsible for child protection investigations.

456. Counsel Assisting submitted it was open to the Royal Commission to make a recommendation all Queensland Police officers be mandatory reporters pursuant to the *Child Protection Act.*[807] Such an amendment to the mandatory reporting requirements would also achieve consistency with other jurisdictions across Australia.

457. Queensland submitted this recommendation should not be made[808]. It submitted Queensland Polices' Child Harm Referral Policy, which was introduced on 1 January 2015 in response to recommendations from the 2013 Queensland Child Protection Commission of Enquiry and formulated in consultation with the Department of Child Safety, is contemporary and tailored to local operational requirements. It referred in particular to the Child Protection and Investigation Units (**CPIU**) format, which it submitted is unique to Queensland and to the evidence about these matters in Detective Superintendent Clark's statement, which it submitted were not challenged under cross-examination.

458. Queensland also submitted the proposed recommendation was not made in context. It referred to Detective Superintendent Clark's written evidence which indicated that the Queensland Police had expanded its Vulnerable Person's Unit, initially established in relation to domestic and family violence victims to include the elderly. Queensland also submitted that whilst there is no category yet for disability, a harmonized targeted response consistent with the structure and capacity of the Queensland Police was to be preferred. We note this information was provided at Public hearing 33 in response to Commissioner Mason's questions.

806 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 188 [604].

807 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 188 [604].

808 Submissions by the Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 44 [206].

459. Detective Superintendent Clark's statement sets out details of the 2015 Child Harm referral policy, under which only police responsible for child protection investigations became mandatory reporters under the *Child Protection Act*. It also introduced a Child Welfare Checks policy, which provides a decision-making framework for police in relation to welfare check requests on behalf of another individual or agency.[809] These new arrangements replaced the previous Queensland Police policy to report all instances of exposure of a child to domestic and Family violence to the Department of Child Safety. Detective Superintendent Clark also described the process of reporting and making a Child Harm Report via QPRIME, which is assessed by a senior CPIU or Queensland Police SCAN officer, and depending on the assessment, reported to the Department of Child Safety (in cases of significant harm) or the Family and Child Connect service if it does not amount to significant harm but there are serious concerns for the child's wellbeing.[810]

460. According to Detective Superintendent Clark, the CPIU is staffed by highly trained, skilled and professional investigators who provide a specialist policing response, primarily focussed on the investigation of criminal matters relating to child protection and youth justice issues.[811] He described the role of Queensland Police in the child protection system as principally the investigation of crimes committed against children, and the provision of investigative expertise.[812] He referred to Queensland Police's mandatory reporting obligations as outlined in the *Child Protection Act* and said that members of police at all levels and in every interaction are encouraged to use their experience and understanding to identify concerns for children and to report those concerns as outlined in policy.[813] Notwithstanding this, he asserted that Queensland Police does not have responsibility, nor possess the expertise, to properly assess risk to children to determine if a child has suffered, is suffering, or is at an unacceptable risk of suffering, significant harm.[814]

461. In our view, and contrary to Queensland's submission, these matters were explored in some detail and at times challenged by Counsel Assisting and us when Detective Superintendent Clark gave evidence at Public hearing 33. In particular, Detective Superintendent Clark was asked on a number of occasions about Queensland Police's awareness of and ability to identify neglect and risks of harm to children when investigating allegations of child harm and whether this was a limitation on their

809 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [15].

810 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [16].

811 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [10].

812 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [11].

813 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [14].

814 Exhibit 33-74, 'Statement of Denzil Clark', 8 May 2023, at [17].

capacity to investigate.[815] When asked whether police have the expertise to assess or determine harm, or know whether or not a child is or is not in good health, he did accept that police 'have, as everybody does, the ability to make a general assessment or…form a general view'.[816] He also acknowledged that when undertaking an investigation into neglect a police officer is able to identify neglect. He said this could be done:

> From our observations and evidence that we obtain from others. So, if you're taking about attending a residence, it may be the state of the house. It may be the relationship between the parents and the child. It may be evidence of – that the – lack of food, clothing or other forms of care or medical support…
>
> We rely on their experience as police officers to determine whether they have concerns or serious concerns in relation to that child and then there's a course of action to be taken.[817]

462. Detective Superintendent Clark also gave further evidence at the hearing about the operation of the QPRIME system and several of the occasions where Queensland police investigated notifications or incidents involving Kaleb and Jonathon. He was specifically asked by Counsel Assisting if there was anything that required any improvement by the police. He responded he did not think a change in policy or procedure was required.[818]

463. We do not agree. After considering the evidence from Queensland Police and Detective Superintendent Clark, we are concerned that despite being the first responders to a range of incidents, the Queensland Police do not consider they have responsibility for assessing if a child is suffering or is at a risk of suffering significant harm, and instead, sought to place responsibility with the Department of Child Safety.

464. We also have concerns with Queensland Police's view that the majority of police officers do not have the expertise to assess and identify neglect and risks of harm to children (unless they work in CPIU), despite evidence from Detective Superintendent Clark to the contrary. While we acknowledge that CPIU officers may have specialist skills, we consider it is important for all Queensland Police officers to receive formal training in how to identify risks of harm to children.

465. We also consider it important that there be consistency across Australia in the requirements on police regarding mandatory reporting. For all of these reasons,

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815 See for example Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-200 [40–46], P-201 [9–11], P-216 [24–29].

816 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-216 [30–34].

817 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-199 [25–28], [42–44].

818 Transcript, Denzil Clark, Public hearing 33, 10 May 2023, P-225 [3–9].

we consider it is appropriate for all Queensland Police officers to be mandatory reporters. We recommend that the *Child Protection Act* be amended so that all Queensland Police are mandatory reporters and Queensland Police revise its 2015 policy framework.

466. Alternatively, and at the very least, we recommend Queensland Police should review the 2015 decision that only certain police officers be mandatory reporters and show cause as to why the circumstances in Queensland are sufficiently unique that they should not be mandatory reporters. It would follow Queensland Police officers should be trained to identify child abuse and neglect, particularly those who are first responders.

Recommendation 4: Independent advocacy services

467. For the reasons set out below we make recommendation 4.

> **Recommendation 4**
>
> The State of Queensland should expand the operation of the Child Advocate scheme to provide advocacy services to children and young people with disability who are at risk of entering the child protection scheme.

468. Access to independent advocacy services by people with disability has been a key theme arising from public hearings and in submissions. We heard about the work of disability advocates in many public hearings.[819]

469. In Queensland, a child in the child protection system has access to a Child Advocate through the Office of the Public Guardian. The Child Advocate is responsible for ensuring the child's 'voice is heard'. The Child Advocate may:

- provide information and advice about legal issues
- help resolve disputes and make complaints if the child has been treated unfairly or is unhappy with a decision made about the child's time in the child protection system
- support the child, speak for child in legal meetings with Child Safety (or any other agency) to make sure that child's needs are being met and the child's views and wishes are being heard

819 Transcript, Kevin Stone, Public hearing 3, 4 December 2019, P- 158–170; Transcript, Sarah Forbes, Public hearing 3, 5 December 2019, P- 345–346, P-354–355; Transcript, Jodi Rodgers, Public hearing 20, 8 December 2021, P-137; Transcript, Claire Robbs, Public hearing 20, 14 December 2021, P-567.

- support the child to attend and speak themselves in a court or tribunal
- speak for the child in courts or tribunals if the child wants the Child Advocate to do so.[820]

470. We accept Counsel Assisting's submission that it is possible if Kaleb or Jonathon had been removed from their father's care on a longer-term basis and/or formally in the child protection system, they each may have had access to a Child Advocate. While they remained on the fringes of the child protection system, they did not.

471. We also accept the submission that neither Kaleb or Jonathon had access to an independent advocate to ensure their voices were heard when engaging with government departments and agencies who made decisions about their lives and the absence of access to an independent advocate impaired Kaleb and Jonathon's rights to:

    - be consulted and heard in relation to decisions concerning them, independent of the father's interests
    - reasonable adjustments being considered to enable each of them to participate in accessing services and supports.

472. Queensland did not address this recommendation in its submissions. We proceed on the basis there is no opposition to this recommendation.[821]

473. The Australian Government accepted independent advocacy services may operate as one, among other important safeguards against the risk of violence, abuse, neglect and exploitation of people with disability.[822]

474. We recommend Queensland expand the operation of the Child Advocate scheme to provide advocacy services to children and young people who are at risk of entering the child protection scheme.

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820 'OPG child advocates', *OPG public guardian*, web page. <Office of the Public Guardian : OPG child advocates>.

821 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 4 [13].

822 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0003.0001, p 19 [59]. See also the Australian Government's reliance on its submissions in response to Counsel Assisting's submissions in respect of Public hearing 32 and 26, which sets out the Australian Government's investments in independent advocacy services, and describe its work to improve awareness about and quality of advocacy services.

Recommendation 5: Redress

475. For the reasons set out below we make recommendation 5.

Recommendation 5

5.1 The State of Queensland on behalf of the departments and agencies that engaged with Kaleb and Jonathon should acknowledge and apologise for their omissions in preventing the violence, abuse, neglect and deprivation of their human rights.

5.2 The State of Queensland should conduct an independent review into the powers and responsibilities of all the departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett to examine:

a. the response to the violence, abuse, neglect and deprivation of Kaleb and Jonathon's human rights

b. what each department or agency could and/or should have done to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced

c. whether the current policies and practices are sufficient to prevent the nature and extent of the violence, abuse, neglect and deprivation of human rights occurring to children with disability.

5.3 An independent review should commence at the earliest opportunity.

5.4 The findings and any recommendations of an independent review should be made public and published in an accessible format.

5.5 The State of Queensland should consider making an offer of redress to each of Kaleb and Jonathon, including but not limited to additional supports and assistance each of them may require immediately and on an ongoing basis.

476. Counsel Assisting submitted there was no impediment to Queensland considering and determining to offer Kaleb and Jonathon some form of redress for the violence, abuse, neglect and deprivation of human rights they experienced.[823]

823 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 298 [1068].

477. Article 13(1) of the *CRPD* requires State Parties to ensure ‘effective access to justice for persons with disabilities on an equal basis with others’.[824] Article 16(4) of the *CRPD* requires State Parties to ‘take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services’.[825]

478. The CRPD Committee explained that, in implementing article 5 of the *CRPD* on equality and non-discrimination, State Parties must ‘[e]stablish accessible and effective redress mechanisms and ensure access to justice, on an equal basis with others, for victims of discrimination based on disability’.[826]

479. The CRPD Committee’s guidelines on deinstitutionalisation also state governments:

> should provide individualized, accessible, effective, prompt and participatory pathways to access to justice for persons with disabilities who wish to seek redress, reparations and restorative justice, and other forms of accountability.[827]

480. Redress may take the form of restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition to address either or both individual and systemic issues.

481. Counsel Assisting also referred to the *International Principles and Guidelines on Access to Justice for Persons with Disabilities*,[828] developed by Ms Catalina Devandas Aguilar, the former United Nations Special Rapporteur for Persons with Disabilities. These guidelines provide practical guidance on providing effective remedies for impairing the rights of a person with disability.

482. Queensland rejects the proposed recommendation and it submitted consideration of ‘redress’ was beyond the Royal Commission’s terms of reference.[829] We do not accept this submission. The Royal Commission’s terms of reference expressly recognise:

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824 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), art 13(1).

825 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), art 16(4).

826 Committee on the Rights of Persons with Disabilities, *General comment no. 6 (2018) on equality and non-discrimination*, 19th sess, UN Doc CRPD/C/GC/6 (26 April 2018), [76(h)].

827 Committee on the Rights of Persons with Disabilities, *Guidelines on deinstitutionalization, including in emergencies*, UN Doc CRPD/C/5 (10 October 2022), [117].

828 Submissions of Counsel Assisting the Royal Commission following Public hearing 33, 7 June 2023, p 299 [1073]; Catalina Devandas Aguilar, ‘International Principles and Guidelines on Access to Justice for Persons with Disabilities (Special Rapporteur on the Rights of Persons with Disabilities’, August 2020.

829 Submissions by Queensland in response to Counsel Assisting’s submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 76 [345].

> People with disability are: equal citizens and have the right to the full and equal enjoyment of all human rights and fundamental freedoms, including respect for their inherent dignity and individual autonomy. …
>
> [P]eople with disability have the same rights as other members of Australian society to live and participate in safe environments free from violence, abuse, neglect and exploitation. …
>
> Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities. …
>
> [I]t is important that people with disability are central to processes that inform best practice decision-making on what all Australian Governments and others can do to prevent and respond to violence against, and abuse, neglect and exploitation of, people with disability.[830]

483. Our terms of reference require us to:

- consider 'what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation'[831]
- consider 'what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation'[832]
- have regard to the 'multilayered' experiences of people with disability[833]
- 'make any recommendations' arising out of our inquiry that we 'consider appropriate, including recommendations about any policy, legislative, administrative or structural reforms'.[834]

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830 *Letters Patent* (Cth), 4 April 2019 (as amended), recitals.

831 *Letters Patent* (Cth), 4 April 2019 (as amended), (c).

832 *Letters Patent* (Cth), 4 April 2019 (as amended), (a).

833 Our terms of reference require that we have regard to the fact that 'the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multilayered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability'. *Letters Patent* (Cth), 4 April 2019 (as amended), (g).

834 *Letters Patent* (Cth), 4 April 2019 (as amended), recitals.

484. Redress is a key component of addressing what governments should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation.

485. The development of appropriate systems for remedies for the rights of people with disability is required to meet the *CRPD* obligations.

486. Access to remedies and redress has been a significant part of our work and has been raised at numerous public hearings,[835] including public hearings where Queensland was represented and had the opportunity to make submissions, including on the Royal Commission's approach to redress.

487. In the present matter, a range of forms of redress may be appropriate. From personal remedies, such as apologies, pastoral support, trauma counselling and compensation to addressing systemic issues in the form of conducting a full and comprehensive review of the circumstances that failed to protect Kaleb and Jonathon from violence, abuse, neglect and the deprivation of their human rights.

488. Our recommendation urges Queensland to undertake an independent review into the powers and responsibilities of all of its departments and agencies that engaged with Kaleb, Jonathon and Paul Barrett, to examine:

   a. the response to the violence, abuse, neglect and deprivation of Kaleb and Jonathon's human rights

   b. what each department or agency could and/or should have done to prevent the violence, abuse, neglect and deprivation of human rights Kaleb and Jonathon experienced

835 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 3: The experience of living in a group home for people with disability*, September 2020, [342]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, pp 8, 116, Recommendation 3; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 17: The experience of women and girls with disability with a particular focus on family, domestic and sexual violence: Niky case study*, May 2023, pp 6–7, 32, Finding 6 and Recommendation 1; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, pp 11, 105, Finding 33; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 31, Finding 1. See also the evidence presented to Public hearing 32 *Service providers revisited*. See Transcript, Hayley Dean, Public hearing 32, 13 February 2023, P-87 [8–40]; Transcript, Jennifer Cullen, Public hearing 32, 13 February 2023, P-88 [4–17]; Transcript, Terry Symonds, Public hearing 32, 16 February 2023, P-336 [30]–P-337 [7].

c. whether the current policies and practices are sufficient to prevent the nature and extent of the violence, abuse, neglect and deprivation of human rights occurring to children with disability.

489. Our recommendation is made because of Queensland's submissions 'that the process and procedure used for the hearing did not allow the time and consideration the case study deserved',[836] and its concerns about the need for more notice of issues which were to be addressed in the hearing due to the 'history, complexity, and nature of issues' in this case study.[837]

490. The nature of this public hearing was not intended to examine the circumstances on an incident by incident basis. It was not intended to require the Queensland officers who made decisions, took action or failed to take action to provide their recollections or reasons. The use of the Agreed Facts intentionally confined the scope of the factual inquiry. In this respect, Queensland's submissions rightly identify the limitations of a three-day case study conducted as a public hearing in the Royal Commission. Queensland's submissions highlight why a more detailed inquiry may be warranted and an independent review conducted in a manner that addresses the concerns raised by Queensland in its submissions would be appropriate, following our findings and recommendations. Nothing in this report should prevent Queensland itself conducting a review of the kind it suggests in its submission.

491. An independent review provides a further opportunity to engage in a more detailed review of the circumstances and experiences of Kaleb and Jonathon. It may give rise to broader findings and recommendations directed to what particular Queensland departments and agencies should do to prevent, and better protect, children and young people from experiencing violence, abuse, neglect and a deprivation of their human rights.

836 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 4 [16].

837 Submissions by Queensland in response to Counsel Assisting's submissions in Public hearing 33, 28 June 2023, SUBM.0033.0002.0001, p 6 [22].

Part 8 Concluding comments

492. This was the final substantive public hearing of the Royal Commission and it was an opportunity to reflect on the many themes and issues the Royal Commission addressed in earlier public hearings and in the many submissions and private sessions. This hearing touched on issues concerning:

- domestic and family violence
- child protection
- safe and suitable accommodation and a home
- access to health care at all stages of life
- early childhood education, special schools and post school transitions
- access to supports and services
- communication and behaviour
- attitudes and ableism
- child and adult safeguarding
- transitioning to the NDIS
- the importance of effective reviews and investigations
- guardianship and supported decision-making
- human rights protections
- the impact of COVID-19.

493. This case study demonstrates the harmful impact on children with disability of the persistent gaps and lack of active attention and action on the part of various government departments and agencies. Whilst we heard Kaleb and Jonathon are now receiving support appropriate for their needs, the violence, abuse, neglect and deprivation of human rights that they experienced during their childhood is an indictment on the systemic failures to uphold the rights of people with disability. We hope that these failures are acted on to avoid these things occurring for other children with disability.

Appendices

Appendix A Agreed Facts

[These Agreed Facts are reproduced from Exhibit 33-1, DRC.2000.0014.0118, dated 7 May 2023. We have not altered the details to this Appendix A or Appendix B in this report, except where we note a redaction or alteration using square brackets ('[]').]

Guidance notes

1. Kaleb was born on [redacted].

2. Jonathon was born on [redacted].

3. Titles and job descriptions as set out in this proposed statement of agreed facts reflect an individual's role at the time of the event described.

4. [This paragraph in the Agreed Facts refers to the definitions and terminology used. We reproduce these definitions and terminology in **Appendix B** to this report].

5. [We omit this paragraph in the Agreed Facts, which is unnecessary for the purpose of this report].

6. [We omit this paragraph in the Agreed Facts, which is unnecessary for the purpose of this report].

7. The proposed facts in this document are based on documents produced to the Royal Commission. To the extent any proposed fact is set out in this document, there is a reference to the relevant source document. Those source documents may be included as a part of the proposed hearing bundle.

Early childhood (2000 – 2006)

2000

8. On [redacted], Kaleb was born.[838]

9. On 2 June 2000, a social worker at Hospital 1 notified the Department of Child Safety of concerns with the neglect of Kaleb (**the 2 June 2000 Notification**).[839]

838 QLD.0002.0027.0155_E, p 1; QLD.0002.0027.0751_E, p 1.

839 QLD.0002.0027.2035_E, pp 1-3.

10. On 7 June 2000, a social worker at Hospital 1 referred Kaleb's case to the Suspected Child Abuse and Neglect (**SCAN**) team.[840]

11. On 9 June 2000, the Mother and Child Safety Officer 1 applied for Kaleb to be placed in temporary care from 9 June 2000 until 23 June 2000.[841]

12. On 16 June 2000, Kaleb was placed in Foster Carer 1's care.[842]

13. From 20 to 23 June 2000, Kaleb and his Mother spent time at the Residential Early Parenting Service.[843]

14. By 29 June 2000, in response to the 2 June 2000 Notification, the Department of Child Safety determined there was a risk Kaleb could be 'significantly harmed' if the Parents' parenting capacity was not further assessed.[844] It considered:

    a. the Mother had a history of child protection relating to her other children[845]

    b. the Mother had an intellectual impairment and lived with anxiety and depressive illness[846]

    c. the Parents' intended accommodation for Kaleb was 'questionable and unstable'.[847]

15. Between 24 July to 3 August 2000, Kaleb and his Mother spent time at the Residential Early Parenting Service.[848]

16. On 28 July 2000, the SCAN team held a meeting. The SCAN team members were aware:

    a. Paul Barrett did not attend Family Meetings

    b. the Mother had done little to address accommodation concerns

    c. there were concerns about Paul Barrett's commitment to Kaleb.[849]

840 QLD.0002.0027.0024_E, p 1.

841 QLD.0002.0027.0031_E, pp 2-3.

842 QLD.0002.0027.0419_E, p 1.

843 QLD.0002.0027.0021_E, pp 1-2; QLD.0002.0027.0413_E, p 1; QLD.0002.0027.0016_E, p 1; QLD.0002.0027.0403_E, p 1.

844 QLD.0002.0027.2035_E, p 3.

845 QLD.0002.0027.2035_E, p 3.

846 QLD.0002.0027.2035_E, p 3.

847 QLD.0002.0027.2035_E, p 3.

848 QLD.0002.0027.0021_E, pp 1-2; QLD.0002.0027.0413_E, p 1; QLD.0002.0027.0016_E, p 1; QLD.0002.0027.0403_E, p 1.

849 QLD.0002.0027.0016_E, p 1.

17. The SCAN team recommended a Child Protection Order (**CPO**) should be sought in respect of Kaleb if an assessment of the Mother's care of Kaleb at the Residential Early Parenting Service 'was not favourable'.[850]

18. On 3 August 2000, the Mother discharged herself from the Residential Early Parenting Service. Kaleb remained at the Residential Early Parenting Service.[851]

19. On the same day, Child Safety Officer 1 applied for a Temporary Assessment Order (**TAO**) in respect of Kaleb.[852]

20. On the same day, a Magistrate of the Childrens Court made a TAO in respect of Kaleb.[853] The order:

    a. authorised the Chief Executive[854] to keep custody of Kaleb while the order was in force.[855] The order was in force until 6 August 2000.[856]

    b. directed the Parents not to have contact with Kaleb other than when a Departmental officer or someone deemed appropriate by the Department was present.[857]

21. On 4 August 2000, a Magistrate of the Childrens Court extended the TAO made on 3 August 2000 to expire on 7 August 2000.[858]

22. On the same day, Child Safety Officer 1 applied for a CPO in respect of Kaleb.[859] The matter was listed to be heard on 7 August 2000.[860]

23. On 7 August 2000, a Magistrate of the Childrens Court:

    a. adjourned the proceeding to 4 September 2000[861]

    b. granted the Chief Executive[862] temporary custody of Kaleb until 4 September 2000.[863]

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850 QLD.0002.0027.0016_E, p 1.

851 QLD.0002.0027.0413_E, p 1; QLD.0002.0027.0403_E, p 3; QLD.0002.0027.0017_E, p 2, QLD.0002.0027.0155_E, p 3.

852 QLD.0002.0027.0825_E, p 1; *Child Protection Act 1999* (Qld) (as in force), s 25.

853 QLD.0002.0027.0824_E, p 1.

854 *Child Protection Act 1999* (Qld) (as in force), s 7.

855 QLD.0002.0027.0824_E, p 1.

856 QLD.0002.0027.0824_E, p 1.

857 QLD.0002.0027.0824_E, p 1.

858 QLD.0002.0027.0823_E, p 1.

859 QLD.0002.0027.0769_E, p 1

860 QLD.0002.0027.0769_E, p 2.

861 QLD.0002.0027.0427_E, p 1.

862 *Child Protection Act 1999* (Qld) (as in force), s 7.

863 QLD.0002.0027.0427_E, p 1.

24. On 10 August 2000, Foster Carer 1 was authorised to care for Kaleb until 4 September 2000.[864]

25. On 4 September 2000, a Magistrate of the Childrens Court made a CPO granting the custody of Kaleb to the Chief Executive.[865] The order provided the CPO continued in force until 3 September 2002.[866]

26. By 5 September 2000, the Department of Child Safety and Paul Barrett arranged for Paul Barrett to have unsupervised Family Contact Visits with Kaleb twice a week at an office of the Department of Child Safety.[867]

27. On 14 September 2000, Foster Carer 1 and Child Safety Officer 1 made a placement agreement. Under the agreement:

    a. Kaleb would live with Foster Carer 1[868]

    b. the Mother was to have contact with Kaleb on Mondays, Wednesdays and Thursdays[869]

    c. Paul Barrett was to have contact with Kaleb on Wednesdays and Thursdays.[870]

28. On 18 October 2000, the Parents attended a Family Meeting.[871] As a result of the meeting, the Department of Child Safety were aware the Parents had moved to a caravan park and were unsure of their further accommodation plans.[872] Paul Barrett informed the Department of Child Safety he understood what was required to be the primary parent and was willing to take on this role.[873] The Family's case plan was for Family Contact Visits to remain twice a week with a plan to move towards increased contact with Kaleb.[874]

864 QLD.0002.0027.0800_E, p 1.
865 QLD.0002.0027.0185_E, p 1.
866 QLD.0002.0027.0185_E, p 1.
867 QLD.0002.0027.0762_E, p 1.
868 QLD.0002.0027.0422_E, pp 1-2.
869 QLD.0002.0027.0422_E, p 2.
870 QLD.0002.0027.0422_E, p 2.
871 QLD.0002.0027.0397_E, p 1.
872 QLD.0002.0027.0397_E, pp 1-2.
873 QLD.0002.0027.0397_E, p 3.
874 QLD.0002.0027.0397_E, p 3.

2001

29. On 14 February 2001, the Parents attended a Family Contact Visit.[875]

30. On 28 May 2001, Kaleb was placed in the care of Foster Carer 2.[876]

31. In September 2001, Paul Barrett commenced caring for Kaleb three and a half days per week.[877]

2002

32. On 15 January 2002, there were two Family Meetings:

    a. a Family Meeting with Paul Barrett. Paul Barrett informed the Department of Child Safety he separated from the Mother. A case plan from that time provided Paul Barrett would have contact with Kaleb five days per week.[878]

    b. a separate Family Meeting with the Mother. The Mother informed the Department of Child Safety she separated from Paul Barrett.[879] The case plan provided the Mother would have contact with Kaleb once per week.[880]

33. From this date, Paul Barrett cared for Kaleb five days per week.[881]

34. On 25 February 2002, the Consultant Paediatrician 1 assessed Kaleb. Consultant Paediatrician 1:

    a. diagnosed Kaleb with significant global developmental delay[882]

    b. observed Kaleb was receiving appropriate therapy supports for his global developmental delay[883]

    c. observed he appeared to have a significant degree of intellectual disability[884]

    d. noted there was a plan for a follow up appointment in 6 months.[885]

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875 QLD.0002.0027.0378_E, p 2.

876 QLD.0002.0027.1819_E, p 2.

877 QLD.0002.0027.1819_Ep 2; QLD.0002.0027.0300_E, p 1.

878 QLD.0002.0027.0275_E, p 1.

879 QLD.0002.0027.0277_E, p 1.

880 QLD.0002.0027.0277_E, p 1.

881 QLD.0002.0027.0287_E, p 1; QLD.0002.0027.0294_E, p 1.

882 QLD.0002.0027.0263_E, p 1.

883 QLD.0002.0027.0263_E, p 1.

884 QLD.0002.0027.0263_E, p 1.

885 QLD.0002.0027.0263_E, p 1.

35. On 27 February 2002, the Parents attended a Family Meeting.[886] The Department of Child Safety was informed the Parents were a couple.[887] Paul Barrett informed participants he would ‘cope on his own with [Kaleb] if [the Mother] left’.[888] The Family’s case plan provided the Parents would continue to have contact with Kaleb five days per week.[889]

36. On 25 March 2002, Paul Barrett and the Mother attended a Family Meeting to review Kaleb’s care plan and to discuss his return home.[890] The Department of Child Safety determined to return Kaleb to the full-time care of the Parents from this date.[891]

37. On 17 June 2002, the Parents attended a Family Meeting.[892] The Family’s case plan provided Kaleb would remain living with the Parents.[893]

38. On 18 July 2002, the Parents attended a Family Meeting.[894] Participants discussed the expiration of the CPO in respect of Kaleb and that the Department of Child Safety could apply for a Protective Supervision Order (**PSO**).[895] The Family’s case plan provided Kaleb would remain living with the Parents.[896]

39. On 22 August 2002, Paul Barrett attended a Family Meeting. Paul Barrett informed the Department of Child Safety he was ‘willing to care for [the Mother’s] baby’ and wanted the baby.[897] The Department of Child Safety indicated it would apply for a PSO in respect of Kaleb.[898]

40. On 2 September 2002, Child Safety Officer 2 applied to the Childrens Court to revoke the CPO in respect of Kaleb and to make another CPO in relation to him.[899] The Childrens Court listed the matter to be heard on 3 September 2002.[900]

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886 QLD.0002.0027.0257_E, p 1.

887 QLD.0002.0027.0257_E, p 1.

888 QLD.0002.0027.0257_E, p 1.

889 QLD.0002.0027.0257_E, p 3.

890 QLD.0002.0027.0249_E, p 1.

891 QLD.0002.0027.0249_E, p 3; QLD.0002.0027.0155_E, p 3; QLD.0002.0027.1819_E, p 2.

892 QLD.0002.0027.0232_E, p 1.

893 QLD.0002.0027.0232_E, p 3.

894 QLD.0002.0027.0224_E, p 1.

895 QLD.0002.0027.0224_E, pp 2-3.

896 QLD.0002.0027.0224_E, p 3.

897 QLD.0002.0027.0218_E, p 1.

898 QLD.0002.0027.0218_E, pp 3-4.

899 QLD.0002.0027.0174_E, p 1.

900 QLD.0002.0027.0174_E, p 2

41. On 3 September 2002, a Magistrate of the Childrens Court:

a. revoked the CPO made on 4 September 2000 in respect of Kaleb[901]

b. made an order requiring the Chief Executive to supervise Kaleb's protection in relation to his wellbeing and development. The Order was to continue in force for one year.[902]

42. On 5 September 2002, Child Safety Officer 2 received a call from Paul Barrett asking for them to pick up Kaleb (the **5 September 2002 Incident**).[903] Child Safety Officer 2 visited Paul Barrett and considered he was intoxicated.[904] Paul Barrett told Child Safety Officer 2 the Mother left him.[905] Kaleb was moved to another location.

43. On 13 September 2002, Paul Barrett attended a Family Meeting.[906] Participants discussed the 5 September 2002 Incident[907] and Paul Barrett's consumption of alcohol.[908]

44. On 21 November 2002, the Mother attended Hospital 2 and waited in the maternity outpatients' section with Kaleb for over four hours.[909] At around 3:15 pm Paul Barrett arrived at Hospital 2. Paul Barrett was intoxicated and behaved in 'highly erratic manner'.[910] Hospital 2 'security arrived and tried to contain the situation'.[911] Paul Barrett 'began throwing punches and pushing at security.'[912] Paul Barrett 'began yelling and screaming' (**21 November 2002 Incident**).[913]

45. At 3:50 pm Queensland Police arrived at Hospital 2.[914] Paul Barrett was arrested.[915] Paul Barrett was charged with behaving in a disorderly manner in a public place, namely Hospital 2 (the **Charge**).[916]

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901 QLD.0002.0027.0166_E, p 1; QLD.0002.0027.0185_E, p 1.
902 QLD.0002.0027.0166_E, p 1; *Child Protection Act 1999* (Qld), ss 59, 61, 62, 65 (as in force).
903 QLD.0002.0027.1836_E, p 1.
904 QLD.0002.0027.1836_E, p 1.
905 QLD.0002.0027.1836_E, p 1.
906 QLD.0002.0027.0161_E, p 1; QLD.0002.0027.0152_E, p 1.
907 QLD.0002.0027.0161_E, p 2; QLD.0002.0027.0152_E, pp 1-2.
908 QLD.0002.0027.0161_E, pp 2-3.
909 QLD.0008.0029.0151, p 1.
910 QLD.0008.0029.0512, p 3; QLD.0008.0029.0151, p 1.
911 QLD.0008.0029.0512, p 3.
912 QLD.0008.0029.0512, p 3.
913 QLD.0008.0029.0512, p 3.
914 QLD.0008.0029.0512, p 3.
915 QLD.0008.0029.0512, pp 4-6.
916 QLD.0008.0029.0512, pp 4-6.

46. On 22 November 2002, the Department of Child Safety received a notification relating to the 21 November 2002 Incident from a worker at Hospital 2 (the **22 November 2002 Notification**).[917]

47. On 5 December 2002, Paul Barrett pleaded guilty to the Charge and was convicted.[918]

48. By 9 December 2002, the Department of Child Safety provided protective advice in response to the 22 November 2002 Notification.[919]

2003

49. On 14 February 2003, [redacted] contacted the Department of Child Safety with concerns for the neglect of Kaleb (the **14 February 2003 Notification**).[920] The notification referred to:

    a. Paul Barrett's alleged consumption of alcohol and drugs[921]

    b. the physical presentation and hygiene of Kaleb[922]

    c. the Kaleb's care[923]

    d. the hygiene of the Home 1.[924]

50. In response to the 14 February 2003 Notification, a Child Safety Officer assessed Kaleb was 'not deemed at immediate risk of harm' but was 'at significant risk of future harm.'[925] The Child Safety Officer rated the notification 'Priority Response 1 or 24 Hrs'.[926] The Department of Child Safety approved the Child Safety Officer's assessment on 19 March 2003.[927]

917 QLD.0008.0029.0151, pp 1, 3.

918 QLD.0008.0029.0512, p 2.

919 QLD.0008.0029.0151, pp 3-4.

920 QLD.0008.0029.0169, pp 1, 3.

921 QLD.0008.0029.0169, p 1.

922 QLD.0008.0029.0169, p 1.

923 QLD.0008.0029.0169, pp 1-2.

924 QLD.0008.0029.0169, p 1.

925 QLD.0008.0029.0169, p 3.

926 QLD.0008.0029.0169, p 3.

927 QLD.0008.0029.0169, p 3.

51. On 6 March 2003, the 14 February 2003 Notification was referred to the SCAN team.[928] The SCAN team held a meeting and closed the matter.[929] The SCAN team assessed:

a. the concerns were 'unsubstantiated'[930]

b. Kaleb was 'safe with his parents'[931]

c. Kaleb was subject to a PSO.[932]

52. On [redacted], Jonathon was born.[933]

53. [Redacted], a hospital worker at Hospital 2 notified the Department of Child Safety with concerns for Jonathon (**24 March 2003 Notification**).[934] The notification referred to Jonathon's care when released from Hospital 2 into the care of his Parents.[935] The Child Safety Officer assessed there needed to be an immediate assessment of Jonathon's safety needs. The Department of Child Safety approved the Child Safety Officer's assessment on 23 April 2003.[936]

54. Between 26 and 28 April 2003, among other things, the Parents were assessed for their capacity to care for Jonathon.[937] The Department of Child Safety assessed Paul Barrett was able to care for Jonathon, with follow up support and assistance.[938] As part of that assessment, it was noted Kaleb had scheduled appointments for speech therapy, occupational therapy, paediatrics, geneticist and audiology.[939] Jonathon had scheduled appointments with the Child Health Nurse and doctor.[940]

55. On 28 March 2003, and in response to the 24 March 2003 Notification, Child Safety Officer 3 referred Jonathon's case to SCAN.[941] The referral specified the Department of Child Safety's case plan was to open a Child Protection Follow Up (**CPFU**).[942]

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928 QLD.0002.0027.0001, pp 4-6.

929 QLD.0002.0027.0001, pp 3, 6.

930 QLD.0002.0027.0001, pp 3, 6.

931 QLD.0002.0027.0001, pp 3, 6.

932 QLD.0002.0027.0001, pp 3, 6.

933 QLD.0008.0029.0155, p 1.

934 QLD.0008.0029.0155, pp 1, 3.

935 QLD.0008.0029.0155, pp 1, 3.

936 QLD.0008.0029.0155, p 3.

937 QLD.0002.0027.0706_E, p 2; QLD.0002.0027.0680_E, p 1.

938 QLD.0002.0027.0706_E, p 2; QLD.0002.0027.0680_E, pp 1-4.

939 QLD.0002.0027.0680_E, p 2.

940 QLD.0002.0027.0680_E, p 3.

941 QLD.0002.0027.0706_E, p 1.

942 QLD.0002.0027.0706_E, p 2.

56. On or around 31 March 2003, Jonathon was discharged from Hospital 2.[943]

57. On 31 March 2003, the SCAN team met.[944] The SCAN team was aware:

  a. the Parents were a couple[945]

  b. Kaleb went to child care 2 days per week[946]

  c. there was a verbal agreement between the Mother and Paul Barrett that Paul Barrett would be the primary carer for the two children.[947]

58. The SCAN team had concerns:

  a. Jonathon was at 'risk of neglect and harm'[948]

  b. the 'Mother had no capacity to care for her children'.[949]

59. The SCAN team recommended the Department of Child Safety have a Family Meeting,[950] open the case as a CPFU,[951] and for Child Health to continue visiting.[952]

60. On 1 April 2003, Paul Barrett took Kaleb and Jonathon for an appointment with Consultant Paediatrician 1.[953] Paul Barrett told Consultant Paediatrician 1 he did not currently have a Child Safety Officer involved with him and Kaleb.[954]

61. On 3 April 2003, a nurse from Child Health contacted the Child Advocacy Service, following a visit to Home 1.[955] The nurse made observations to the Child Advocacy Service about:

  a. Paul Barrett's consumption of alcohol[956]

  b. Paul Barrett declining to stay at the Family Centre.[957]

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943 QLD.0010.0033.0013, p 7.

944 QLD.0002.0027.0662_E, p 1.

945 QLD.0002.0027.0662_E, p 1.

946 QLD.0002.0027.0662_E, p 1.

947 QLD.0002.0027.0662_E, p 2.

948 QLD.0002.0027.0662_E, p 2.

949 QLD.0002.0027.0662_E, p 2.

950 QLD.0002.0027.0662_E, p 2.

951 QLD.0002.0027.0662_E, p 2.

952 QLD.0002.0027.0662_E, p 2.

953 QLD.0010.0033.0118_E, p 1.

954 QLD.0010.0033.0118_E, p 1.

955 QLD.0010.0033.0013, p 7.

956 QLD.0010.0033.0013, p 7.

957 QLD.0010.0033.0013, p 7.

62. On 8 April 2003, the Parents attended a Family Meeting.[958] Participants discussed supports for the Mother and Paul Barrett.[959] The Department of Child Safety was aware Paul Barrett declined a referral to stay at the Family Centre, as '[Kaleb] will not settle when out of his own environment'.[960] The Family's case plan provided:

    a. the Department of Child Safety would 'continue working with' the Parents[961]
    b. the Department of Child Safety would make a referral to Family Program 1 for home support for the Parents[962]
    c. a Child Safety Officer would visit the family weekly.[963]

63. On 10 April 2003, Consultant Paediatrician 1 informed Child Safety Officer 3 of an appointment with Kaleb and Jonathon on 1 April 2003.[964] Consultant Paediatrician observed:

> [Paul Barrett] indicates that he is able to manage appropriately, nevertheless he has quite a large task ahead of him. I gather that [the Mother] is in and out of the household and when she is there she is quite unhelpful and he is concerned by her attitude towards the children with yelling and swearing.[965]

64. On 24 April 2003, [redacted] telephoned the National Disability Abuse and Neglect Hotline concerning Kaleb and Jonathon (the **24 April 2003 Notification**).[966] [Redacted] made allegations in respect of:

    a. the care of Kaleb and 'the new born baby boy'[967]
    b. Paul Barrett's 'abusive' treatment of the Mother[968]
    c. the presentation and hygiene of the Home 1[969]
    d. the presentation and hygiene of Kaleb and Jonathon[970]
    e. Paul Barrett's alcohol and drug consumption.[971]

958 QLD.0002.0027.0680_E, p 4.
959 QLD.0002.0027.0680_E, pp 3-4.
960 QLD.0002.0027.0680_E, p 3.
961 QLD.0002.0027.0680_E, p 4.
962 QLD.0002.0027.0680_E, pp 3-4.
963 QLD.0002.0027.0680_E, p 4.
964 QLD.0010.0033.0118_E, p 1.
965 QLD.0010.0033.0118_E, p 1.
966 QLD.0002.0027.0659_E, p 1.
967 QLD.0002.0027.0659_E, pp 1-2.
968 QLD.0002.0027.0659_E, p 1.
969 QLD.0002.0027.0659_E, p 2.
970 QLD.0002.0027.0659_E, p 2.
971 QLD.0002.0027.0659_E, p 2.

65. On 28 April 2003, the SCAN met.[972] The Department of Child Safety's case review for the SCAN team reported:

   a. Paul Barrett performed the role of primary carer for Kaleb and Jonathon[973]
   b. the Mother took a limited role in the parenting of Kaleb and Jonathon.[974]

66. The Department of Child Safety also reported to SCAN:

   a. Paul Barrett was 'child focused' and 'had a good working relationship with Parent Aid'[975]
   b. there were ongoing concerns in respect of the 'mother's lack of medication compliance'[976]
   c. there was a referral to Family Program 1[977]
   d. Paul Barrett 'had a glass of beer when visited but could articulate and not alcohol affected'.[978]

67. The SCAN team closed the matter.[979] The SCAN team considered:

   a. the Department of Child Safety had a PSO for Kaleb[980]
   b. the Department of Child Safety had a CPFU for Jonathon[981]
   c. support services were in place.[982]

68. On 29 April 2003, the Department of Child Safety prepared a referral to Child Safety After Hours (**CSAH**) in relation to concerns the Parents left Kaleb and Jonathon unsupervised.[983] The Department of Child Safety requested CSAH attempt further telephone contact with Paul Barrett and assistance if Paul Barrett requested it.[984]

972 QLD.0002.0027.0949_E, p 1. QLD.0002.0027.0702_E, pp 1-2.
973 QLD.0002.0027.0702_E, p 2.
974 QLD.0002.0027.0702_E, p 2.
975 QLD.0002.0027.0949_E, p 1.
976 QLD.0002.0027.0949_E, p 1.
977 QLD.0002.0027.0949_E, p 1.
978 QLD.0002.0027.0949_E, p 1.
979 QLD.0002.0027.0949_E, p 2.
980 QLD.0002.0027.0949_E, p 2.
981 QLD.0002.0027.0949_E, p 2.
982 QLD.0002.0027.0949_E, p 2.
983 QLD.0002.0027.0678_E, p 1.
984 QLD.0002.0027.0678_E, p 2.

69. On 2 May 2003, the National Disability Abuse and Neglect Hotline notified the Department of Child Safety of the 24 April 2003 Notification.[985] The Department of Child Safety determined it would inform the 'notifier that multiple services were working w[ith] [F]amily' and the allegations in the 24 April 2004 Notification were unsubstantiated.[986]

70. A record of the Department of Child Safety dated 15 March 2003 noted a referral was not made to Family Program 1 'due to family not fitting [with] service.'[987]

71. On 20 May 2003, Paul Barrett attended an outpatient appointment at the Child Advocacy Service with Jonathon.[988]

72. On 24 July 2003, the Parents attended a Family Meeting.[989] Participants discussed Kaleb's and Jonathon's care and health,[990] the supports provided to the Parents by the Parent Aide.[991] Family Meeting notes recorded:

    a. the CPFU in respect of Jonathon was to be closed on this date as Jonathon was 'doing well' and his needs were being met by the Parents.[992]

    b. there were to be further assessments of the Parent's 'ability and willingness to engage Kaleb in appropriate services to meet his developmental needs' in respect of the PSO concerning Kaleb which was due to expire on 3 September 2003.[993]

    c. the Department of Child Safety would remain involved for a further period to assist the Parents to develop their attachment to Kaleb.[994]

73. On 12 August 2003, the Jonathon did not attend an outpatient appointment at the Child Advocacy Service.[995]

74. On 2 September 2003, Jonathon did not attend an outpatient appointment Child Advocacy Service.[996] The Child Advocacy Service contacted the Department of Child Safety and informed them of this.[997]

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985 QLD.0002.0027.0659_E, p 1.

986 QLD.0021.0057.0018, p 1.

987 QLD.0002.0027.0952_E, p 1.

988 QLD.0010.0033.0013, p 6.

989 QLD.0002.0027.0674_E, p 1.

990 QLD.0002.0027.0674_E, p 3.

991 QLD.0002.0027.0674_E, p 1.

992 QLD.0002.0027.0674_E, p 3.

993 QLD.0002.0027.0674_E, p 3.

994 QLD.0002.0027.0674_E, p 3.

995 QLD.0010.0033.0013, 6.

996 QLD.0010.0033.0013, 6.

997 QLD.0010.0033.0013, 6.

75. On 3 September 2003, the PSO in respect of Kaleb expired. [998]

76. On 16 September 2003, the Jonathon attended an outpatient appointment at the Child Advocacy Service with Paul Barrett.[999] Summary notes recorded there was no 'child safety' involvement at that time, and the Family had access to community supports through a Parent Aide, Family and Early Childhood Services (**FECS**) and Child Health.[1000]

2004

77. On 13 January 2004, Kaleb and Jonathon did not attend outpatient appointments at the Child Advocacy Service.[1001] Summary notes recorded the Child Advocacy Service sent letters to the Parents in relation to rebooking appointments.[1002]

78. On or around 26 March 2004, the Family moved into Home 2.[1003]

79. On 7 September 2004, Kaleb and Jonathon attended an outpatient appointment at the Child Advocacy Service with Paul Barrett.[1004] Summary notes recorded:

   a. Kaleb attended Special Education Development Unit (**SEDU**) and FECS[1005]

   b. Jonathon attended FECS for 'developmental delay/ not walking'[1006]

   c. Kaleb remained non-verbal.[1007]

80. On 5 October 2004, Jonathon did not attend an outpatient appointment at the Child Advocacy Service.[1008] Summary notes recorded the Child Advocacy Service was unable to contact the Family as they 'had no phone number'.[1009]

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998 QLD.0002.0027.0166_E, p 1.

999 QLD.0010.0033.0013, p 6.

1000 QLD.0010.0033.0013, p 6.

1001 QLD.0010.0033.0013, p 6, QLD.0010.0033.0002, p 6.

1002 QLD.0010.0033.0013, p 6; QLD.0010.0033.0002, p 6.

1003 QLD.0001.0026.1460, p 2.

1004 QLD.0010.0033.0002, p 6, QLD.0010.0033.0013, p 6.

1005 QLD.0010.0033.0002, p 6.

1006 QLD.0010.0033.0002, p 6.

1007 QLD.0010.0033.0002, p 6.

1008 QLD.0010.0033.0013, p 6.

1009 QLD.0010.0033.0013, p 6.

81. On 26 October 2004, Jonathon did not attend an outpatient appointment at the Child Advocacy Service.[1010] Summary notes recorded the Child Advocacy Service contacted the Department of Child Safety about 'disengagement from service'.[1011]

82. On 11 November 2004, Kaleb did not attend an outpatient appointment at the Child Advocacy Service.[1012]

2005

83. On 4 January 2005, Kaleb did not attend a general paediatrics outpatient appointment with the Child Advocacy Service.[1013]

84. On 15 February 2005, Kaleb did not attend a general paediatrics outpatient appointment with the Child Advocacy Service.[1014] Summary notes recorded the Child Advocacy Service contacted Department of Child Safety to enquire about ongoing involvement.[1015]

85. On 17 February 2005, Consultant Paediatrician 1 notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **17 February 2005 Notification**).[1016] The notification alleged Kaleb and Jonathon did not attend appointments at Hospital 4.[1017]

86. The Child Safety Officer assessed in respect of information in the 17 February 2005 Notification:

> Due to the level of developmental delay for both the children ,their [sic] non attendance at follow up clinic places them at significant risk of further delays. This may be due to neglect on the part of [Paul Barrett.][1018]

87. Department of Child Safety approved the Child Safety Officer's assessment and response on 23 March 2005.[1019]

88. The Department of Child Safety did an initial assessment in response to the 17 February 2005 Notification.[1020]

1010 QLD.0010.0033.0013, p 6

1011 QLD.0010.0033.0013, p 6

1012 QLD.0010.0033.0002, p 6.

1013 QLD.0010.0033.0002, p 6.

1014 QLD.0010.0033.0002, p 6.

1015 QLD.0010.0033.0002, p 6.

1016 QLD.0008.0029.0182, pp 1, 3.

1017 QLD.0008.0029.0182, pp 1-2.

1018 QLD.0008.0029.0182, p 3.

1019 QLD.0008.0029.0182, p 3.

1020 QLD.0021.0058.0001, pp 1-4.

89. On 25 February 2005, Child Safety Officers attended Home 2.[1021] Notes of the visit recorded:

a. in respect of missed appointments, Paul Barrett 'acknowledged he got letter but had lost them. Did not know about eye appt letter'[1022]

b. Paul Barrett did not have contact with the Mother[1023]

c. Child Safety Officers considered Jonathon's 'routine is not too bad'[1024]

d. Child Safety Officers considered Kaleb 'looked OK'.[1025]

89A Records of the Department of Child Safety of a home visit on the same date and in connection with the 17 February 2005 Notification also noted 'the home was very basic with no floor coverings, limited furniture and smelt unclean'.[1026]

89B On 28 February 2005, the Department of Child Safety had a telephone call with Paul Barrett to schedule a home visit for 2 March 2023.[1027] Records of the call stated Paul Barrett 'was abusive and threatening legal action during this phone call'.[1028]

90. A further appointment was arranged for 2 March 2005.[1029]

91. On 2 March 2005, Paul Barrett met with Child Safety Officers.[1030] Notes of the meeting recorded:

a. Paul Barrett thought Kaleb had an eating disorder[1031]

b. Paul Barrett and a DS Worker 1 had concerns Kaleb had autism[1032]

c. Jonathon started walking[1033]

d. Jonathon was not speaking[1034]

1021 QLD.0002.0027.0086_E, p 1; QLD.0021.0058.0001, p 4.

1022 QLD.0002.0027.0086_E, p 1.

1023 QLD.0002.0027.0086_E, p 1.

1024 QLD.0002.0027.0086_E, p 1.

1025 QLD.0002.0027.0086_E, p 1.

1026 QLD.0021.0058.0001, p 4.

1027 QLD.0021.0058.0001, p 4.

1028 QLD.0021.0058.0001, p 4.

1029 QLD.0002.0027.0086_E, p 1.

1030 QLD.0002.0027.0087_E, p 1; QLD.0021.0058.0001, p 4.

1031 QLD.0002.0027.0087_E, p 1.

1032 QLD.0002.0027.0087_E, pp 1, 3.

1033 QLD.0002.0027.0087_E, p 2.

1034 QLD.0002.0027.0087_E, p 2.

e. Paul Barrett was in a relationship with [redacted][1035]

f. Paul Barrett, Kaleb and Jonathon had moved from the Home 1 to Home 2.[1036]

91A Another Department of Child Safety record in relation to the 17 February 2005 Notification noted in relation to a home visit, Paul Barrett apologised for his manner on the telephone previously and was welcoming to his home.[1037] Paul Barrett informed the Department of Child Safety that the Department of Disability Services was still involved with Kaleb and Jonathon, including speech therapy and physiotherapy.[1038] The Department of Child Safety record stated:

> Paul [Barrett] reluctantly agreed to my providing his phone number to the [the child advocacy clinic] to reschedule an appointment. He was very negative about the ability of the paediatrician but agreed to one appointment in the best interests of his children.[1039]

92. On 19 April 2005, Teacher 1 at School 1 informed the Department of Child Safety of concerns for Kaleb's diet, presentation, toileting and hygiene.[1040]

93. On 22 April 2005, Teacher 1 spoke by phone Child Safety Officer 4 about concerns for Kaleb's care, diet, hygiene and physical presentation.[1041]

94. Child Safety Officer 4 informed Teacher 1, the Department of Child Safety:

a. had visited Paul Barrett and seen Kaleb and Jonathon[1042]

b. realised there were some concerns regarding the children[1043]

c. considered '[Paul Barrett] is doing his best and we are working on his communication'.[1044]

94A A Department of Child Safety record relating to the 17 February 2005 Notification noted an 'appointment at a child advocacy clinic was scheduled for late April 2005 that Paul Barrett failed to take the children to.'[1045]

1035 QLD.0002.0027.0087_E, p 3.

1036 QLD.0002.0027.0087_E, p 2.

1037 QLD.0021.0058.0001, p 4.

1038 QLD.0021.0058.0001, pp 4-5.

1039 QLD.0021.0058.0001, p 5.

1040 QLD.0002.0027.0090_E, p 2.

1041 QLD.0002.0027.0094_E, p 1.

1042 QLD.0002.0027.0094_E, p 1.

1043 QLD.0002.0027.0094_E, p 1.

1044 QLD.0002.0027.0094_E, p 1.

1045 QLD.0021.0058.0001, p 5.

95. On 11 May 2005, DS Worker 1 left a telephone message for Child Safety Officer 4 observing when they dropped Kaleb off, Paul Barrett was drinking.[1046]

95A A Department of Child Safety record relating to the 17 February 2005 Notification stated:

> Paul was again abusive and threatening on the telephone when telephoned on [11 May 2005] to confirm the arrangements for the appointment. His threats included dumping the children at the [child safety services centre] and he would return to the country without them. Later Paul [Barrett] reported to me he was happy with the medical appointment, as the doctors are willing to investigate [Kaleb] for Prado-Willi Syndrome that may be causing [Kaleb's] obsession with food. He agreed to attend for a six-month follow up appointment with the [child advocacy clinic].[1047]

95B On 11 May 2005, a program officer at the Department of Disability Services informed the Department of Child Safety:

a. a respite worker took Kaleb out once per week[1048]

b. a social worker was involved with the family[1049]

c. Kaleb and Jonathon attended regular occupational therapy and speech therapy[1050]

d. there was concern 'in relation to stimulation for the children'.[1051]

96C On 12 May 2005, DS Worker 2 informed the Department of Child Safety [they] viewed:

a. Paul Barrett cared for Kaleb and Jonathon adequately with additional support from the Department of Disability Services[1052]

b. Kaleb's 'significant eating disorder' was 'causing some stress for the family'.[1053]

96. On 17 May 2005, Jonathon 'was assessed as having global developmental delay with almost certain intellectual impairment'.[1054]

1046 QLD.0002.0027.0101_E, p 1; QLD.0021.0058.0001, p 5.

1047 QLD.0021.0058.0001, p 5.

1048 QLD.0021.0058.0001, p 5.

1049 QLD.0021.0058.0001, p 5.

1050 QLD.0021.0058.0001, p 5.

1051 QLD.0021.0058.0001, p 5.

1052 QLD.0021.0058.0001, p 6.

1053 QLD.0021.0058.0001, p 6.

1054 QLD.0010.0033.0013, p 5; QLD.0010.0033.0011, p 1; QLD.0021.0058.0001, p 4.

97. On 19 May 2005, [redacted] notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **19 May 2005 Notification**).[1055] The [redacted] referred to:

a. Paul Barrett's care and supervision of Kaleb and Jonathon[1056]

b. Kaleb's and Jonathon's presentation and hygiene[1057]

c. Kaleb's and Jonathon's diet[1058]

d. Paul Barrett's alleged consumption of drugs.[1059]

98. On 15 July 2005, a Child Safety Officer assessed the19 May 2005 Notification and determined to respond by initiating an IA and contact with the Family. The Department of Child Safety approved the assessment and response on 12 September 2005.[1060]

99. On 2 September 2005, [redacted] and a social worker notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **2 September 2005 Notification**).[1061] The notification referred to Kaleb and Jonathon's:

a. care[1062]

b. hygiene.[1063]

100. On around 8 September 2005, a Child Safety Officer assessed the information in the 2 September 2005 Notification indicated Kaleb and Jonathon's 'basic care needs are not being met and they are manifesting behaviours indicative of neglect.' Department of Child Safety approved the Child Safety Officer's assessment on 23 December 2005.[1064]

100A On 12 September 2005, the Department of Child Safety made an assessment in respect of the 17 February 2005 Notification that there was 'Substantiated risk' to Kaleb and Jonathon.[1065] The Department of Child Safety assessed there was:

> Substantiated risk of neglect due to failure to ensure [Kaleb] and [Jonathon's] medical needs were met via paediatric medical assessment, optometry and audiology reviews. After three months of departmental involvement and numerous attempts over the past six months by [the child advocacy clinic] Paul [Barrett] finally

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1055 QLD.0008.0029.0173, pp 1, 3.

1056 QLD.0008.0029.0173, pp 1-2.

1057 QLD.0008.0029.0173, p 2.

1058 QLD.0008.0029.0173, p 2.

1059 QLD.0008.0029.0173, p 2.

1060 QLD.0008.0029.0173, p 4.

1061 QLD.0008.0029.0399_E, p 1.

1062 QLD.0008.0029.0399_E, p 1.

1063 QLD.0008.0029.0399_E, p 1.

1064 QLD.0008.0029.0399_E, p 3.

1065 QLD.0021.0058.0001, p 6.

took the children to their medical review. Paul [Barrett] has a tendency to overreact to departmental involvement and he sees the [child advocacy clinic] as an extension of the department. For this reason there is a risk in the future that Paul [Barrett] will again cease medical treatment for the children. Paul's use of alcohol as a stress release may impair his ability to meet the children's complex needs in the future. Paul [Barrett] also has no involvement or communication with [Kaleb's] school and this has meant [Kaleb's] medical needs have not been communicated effectively to the school.[1066]

101. On 18 October 2005, Child Safety Officers attended Home 2.[1067] The Child Safety Officers observed Kaleb and Jonathon[1068] and the condition and hygiene of the house.[1069] The Child Safety Officers were informed:

  a. Paul Barrett was not working[1070]

  b. [redacted] worked full time[1071]

  c. Paul Barrett spoke to the school on a 'needs basis'[1072]

  d. Paul Barrett felt more organised and did not think Kaleb and Jonathon 'to be a challenge'.[1073]

102. The Child Safety Officers considered Paul Barrett:

  a. '[P]resented to have good insight into child [sic] need and disability'[1074]

  b. to be far more organised as he was not working.[1075]

103. On 27 October 2005, Child Safety Officers attended Home 2.[1076] Child Safety Officers made observations about:

  a. Paul Barrett's behaviour[1077]

  b. the hygiene and condition of Home 2[1078]

  c. Kaleb and Jonathon's behaviours.[1079]

1066 QLD.0021.0058.0001, p 6.

1067 QLD.0002.0027.0966_E, p 1.

1068 QLD.0002.0027.0966_E, pp 1-3.

1069 QLD.0002.0027.0966_E, pp 1-3.

1070 QLD.0002.0027.0966_E, p 2.

1071 QLD.0002.0027.0966_E, p 2.

1072 QLD.0002.0027.0966_E, p 2.

1073 QLD.0002.0027.0966_E, p 3.

1074 QLD.0002.0027.0966_E, p 3.

1075 QLD.0002.0027.0966_E, p 3.

1076 QLD.0002.0027.0964_E, p 1.

1077 QLD.0002.0027.0964_E, p 1.

1078 QLD.0002.0027.0964_E, p 1.

1079 QLD.0002.0027.0964_E, p 1.

2006

104. On 23 January 2006, Kaleb started attending School 2.[1080]

105. On 30 January 2006, the Department of Child Safety conducted a FRE of the Family with respect to the 2 September 2005 Notification. The risk level was 'Very High.' The FRE was approved by a Team Leader on 16 February 2006.[1081] The Department of Child Safety made an assessment about the alleged neglect of Kaleb and Jonathon by Paul Barrett.[1082] It considered:

    a. there were three or more prior notifications of 'neglect' concerning Paul Barrett[1083]

    b. Paul Barrett provided physical care consistent with Kaleb and Jonathon's needs[1084]

    c. Paul Barrett had a drug or alcohol problem in the prior 12 months and prior to that[1085]

    d. children in the household had characteristics of developmental or physical disability.[1086]

106. The Department of Child Safety made an assessment about the alleged abuse of Kaleb and Jonathon by Paul Barrett.[1087] It viewed:

    a. there were no substantiated notifications of physical abuse at the time[1088]

    b. there was one prior abuse notification concerning Paul Barrett[1089]

    c. there were no prior injuries to a child resulting from child abuse and/or neglect[1090]

    d. Paul Barrett had a drug or alcohol problem during the prior 12 months[1091]

    e. there were no characteristics of developmental disability of children in the household.[1092]

1080 QLD.0008.0029.0150, p 1.

1081 QLD.0002.0027.0957_E, pp 1-6.

1082 QLD.0002.0027.0957_E, pp 1-2.

1083 QLD.0002.0027.0957_E, p 1.

1084 QLD.0002.0027.0957_E, p 1.

1085 QLD.0002.0027.0957_E, p 2.

1086 QLD.0002.0027.0957_E, p 2.

1087 QLD.0002.0027.0957_E, pp 3-4.

1088 QLD.0002.0027.0957_E, p 3.

1089 QLD.0002.0027.0957_E, p 3.

1090 QLD.0002.0027.0957_E, p 3.

1091 QLD.0002.0027.0957_E, p 3.

1092 QLD.0002.0027.0957_E, p 4.

107. The Department of Child Safety determined the Family was overall at a 'very high' risk for neglect and/or abuse.[1093] It decided to 'close' the case. The Department of Child Safety considered:

> Of the notifications recorded with this family, [Paul Barrett] has only been identified as the person responsible on one occasion. Prior to this, [Kaleb] was cared for by his [Mother], the person indicated as responsible for all other notifications regarding this family. Furthermore, [Kaleb] was under a custody order, when he was removed from [the Mother's] care. He was later returned to the care of [Paul Barrett]. Given this, a decision has been made not to open the case as a support case, [Intervention with Parental Agreement (**IPA**)] or apply for any orders.[1094]

108. On or around February 2006, Jonathon started attending School 1.[1095]

109. On 3 May 2006, Kaleb's transport service to School 2 was cancelled.[1096] The Department of Disability Services made alternative arrangements to transport Kaleb to School 2 on 4 May 2006.[1097]

110. On 5 May 2006, Principal 1 continued to work on finding a solution to transport Kaleb to School 2.[1098]

111. On the same day, Principal 1 informed the Department of Disability Services of concerns about:

    a. Paul Barrett's behaviour when Principal 1 visited Home 2[1099]

    b. Kaleb and Jonathon being at risk.[1100]

112. The Department of Disability Services advised Principal 1 'if he had specific concerns that he would need to report those to Department of Child Safety'.

113. As at 5 May 2006, the Department of Disability Services were aware of the 'possible risk of neglect towards the children'[1101] DS Worker 2 planned to contact Paul Barrett.[1102]

1093 QLD.0002.0027.0957_E, p 5.

1094 QLD.0002.0027.0957_E, p 5.

1095 QLD.0002.0027.0055_E, p 4.

1096 QLD.0020.0050.1761, p 1.

1097 QLD.0020.0050.1761, p 1.

1098 QLD.0020.0050.1761, p 2.

1099 QLD.0020.0050.1761, p 2.

1100 QLD.0020.0050.1761, p 2.

1101 QLD.0020.0050.1761, p 2.

1102 QLD.0020.0050.1761, p 2.

114. On 9 May 2006, DS Worker 2 visited Paul Barrett.[1103] They discussed arrangements to transport Kaleb to and from School 2.[1104] They also discussed the Family's circumstances.[1105] Paul Barrett told DS Worker 2:

a. '[A]part from the problems with the school transport, things were going all right'[1106]

b. he was content living in Home 2, where there was low rent and the Department of Housing took care of maintenance.[1107]

115. On 10 May 2006, School 2 planned for Kaleb's transport to school by bus, commencing on 22 May 2006.[1108]

Early school years (2007 – 2014)

2007

116. The Department of Housing records stated that on 7 February 2007:

> TENANT [Paul Barrett] CALLED REQUESTING TRANSFER APPLICATION ON G ROUNDS [sic] OF ATTAINING SECOND BEDROOM. [Paul Barrett] HAS 2 BO YS [sic] W HO [sic] HAVE AUTISM AND GLOBAL DELAY DEVELOPMENT DI SORDER [sic] WHICH HE SAYS ANOTHER BEDROOM WOULD BE BENE FICIAL [sic] F OR [sic] WILL SEND OUT TRANSFER FORM AND MEDICAL REPORT.[1109]

117. On 10 September 2007, DS Worker 2 notified the Department of Child Safety of concerns for Kaleb and Jonathon (**the 10 September 2007 Notification**).[1110] The notification referred to:

a. Paul Barrett's alleged consumption of alcohol and drugs[1111]

b. Paul Barrett's interaction with respite services[1112]

1103 QLD.0020.0050.1761, p 3.

1104 QLD.0020.0050.1761, p 3.

1105 QLD.0020.0050.1761, p 3.

1106 QLD.0020.0050.1761, p 3.

1107 QLD.0020.0050.1761, p 3.

1108 QLD.0020.0050.1761, p 4.

1109 QLD.0001.0026.0053, p 20.

1110 QLD.0002.0027.0081_E, p 2. QLD.0002.0027.1684_E, p 1.

1111 QLD.0002.0027.0081_E, p 3; QLD.0002.0027.1684_E, pp 1-2.

1112 QLD.0002.0027.0081_E, p 3; QLD.0002.0027.1684_E, pp 1-2.

118. The notifier informed the Department of Child Safety they had ‘No concerns for neglect of basic care needs. No issues with condition of house - no changes noticed’.[1113]

119. By 10 September 2007, the Department of Child Safety completed assessments of two notifications made to it in mid-2005 concerning Paul Barrett’s care of Kaleb and Jonathon.[1114] In relation to the information in the mid-2005 notifications, the Department of Child Safety determined:

> there was ‘substantiated risk of neglect due to failure to ensure [Kaleb] and [Jonathon’s] medical needs were met via paediatric medical assessment, optometry and audiology reviews.[1115]

120. By the 10 September 2007 Notification, the Department of Child Safety also completed an assessment of a notification made to it in late 2005 concerning the care of Kaleb and Jonathon.[1116] In relation to information in the late 2005 notification, the Department of Child Safety determined there was a substantiated risk of emotional harm to Kaleb and Jonathon.[1117]

121. On 7 October 2007, the Department of Child Safety determined it would record the information in the 10 September 2007 Notification and consider whether it warranted an IA.[1118] On or around the same day, the Department of Child Safety also recorded the 10 September 2007 Notification as a Child Concern Report (**CCR**).[1119]

122. On 12 December 2007, Queensland Police attended Home 2 in relation to alleged domestic violence (**DV**).[1120] Queensland Police spoke with Paul Barrett and Partner separately.[1121] Queensland Police determined there were ‘no allegations or signs of D[V]’.[1122]

1113 QLD.0002.0027.0081_E, p 3; QLD.0002.0027.1684_E, p 2.

1114 QLD.0002.0027.1684_E, p 2.

1115 QLD.0002.0027.1684_E, p 2.

1116 QLD.0002.0027.1684_E, p 2.

1117 QLD.0002.0027.1684_E, p 2.

1118 QLD.0002.0027.1684_E, p 2.

1119 QLD.0002.0027.1679_E, p 1; QLD.0002.0027.1681_E, pp 1-3.

1120 QLD.0008.0029.0050, p 1.

1121 QLD.0008.0029.0050, p 3.

1122 QLD.0008.0029.0050, p 3.

2008

123. On 7 February 2008, Teacher 1 observed Jonathon attended school with a 'full and soiled nappy' on most days of 2008.[1123] Teacher 1 viewed Paul Barrett acted aggressively when Teacher 1 asked him to change Jonathon's nappy prior to sending him to school (the **7 February 2008 Event**).[1124]

124. On 15 February 2008, Teacher 1 observed that after the 7 February 2008 Event, Jonathon arrived at School 1 with a 'fresh nappy, and looking generally clean'.[1125]

125. On 29 April 2008, the Department of Child Safety received a notification of concerns for Kaleb (the **29 April 2008 Notification**).[1126] The Notification referred to:

    a. alleged bruising to Kaleb's eye on 28 and 20 April 2008[1127]

    b. alleged bruising elsewhere on Kaleb's body[1128]

    c. Kaleb's diet[1129]

    d. Kaleb physical presentation and care.[1130]

126. On the same day, the Department of Child Safety did a pre-notification check with Teacher 2 at School 2.[1131] Teacher 2 informed the Department of Child Safety they observed bruising to Kaleb's eye[1132] and, previously, elsewhere on his body.[1133] Teacher 2 also made observations to the Department of Child Safety about:

    a. Kaleb's hygiene and presentation[1134]

    b. Kaleb's diet[1135]

1123 QLD.0002.0027.0055_E, pp 4, 6-7.
1124 QLD.0002.0027.0055_E, pp 4, 7.
1125 QLD.0002.0027.0055_E, pp 4, 7.
1126 QLD.0002.0027.0069_E, p 1.
1127 QLD.0002.0027.0069_E, p 1.
1128 QLD.0002.0027.0069_E, p 1.
1129 QLD.0002.0027.0069_E, p 1.
1130 QLD.0002.0027.0069_E, p 2.
1131 QLD.0002.0027.0069_E, p 3.
1132 QLD.0002.0027.0069_E, p 3.
1133 QLD.0002.0027.0069_E, p 3.
1134 QLD.0002.0027.0069_E, p 3.
1135 QLD.0002.0027.0069_E, p 3.

127. In response to the 29 April 2008 Notification, the Department of Child Safety:

a. recorded a Child Protection Notification with a Response Priority of within 24 hours[1136]

b. opened an IA[1137]

c. referred the matter to Queensland Police.[1138]

128. In response to the 29 April 2008 Notification, the Department of Child Safety and Queensland Police conducted various interviews.[1139]

129. On 15 May 2008, Child Safety Officer 5 and Queensland Police Officers visited Kaleb in relation to the 29 April 2008 Notification.[1140] Child Safety Officer 5 did not see bruises or marks on Kaleb.[1141]

130. On the same day, Child Safety Officer 5 and Queensland Police Officers interviewed Paul Barrett in relation to the 29 April 2008 Notification.[1142] Paul Barrett stated 'he was not home when the incident occurred and [redacted] was looking after the children.'[1143]

131. On 15 May 2008, Child Safety Officer 5 also visited Jonathon in relation to the 29 April 2008 Notification.[1144] Child Safety Officer 5 did not see bruises or marks on Jonathon.[1145]

132. On 18 May 2008, Queensland Police Officers interviewed the [redacted].[1146]

133. On 18 May 2008, the Queensland Police changed the status of the 29 April 2009 Notification matter to 'unfounded'.[1147] A subsequent review of the decision indicated Queensland Police determined the complaint was 'unsubstantiated' and Queensland Police were to take no further action.[1148] Queensland Police viewed the matter should not be referred to CPA SCAN as 'both parents and the school are acting proactively and in the best needs of the child'.[1149]

1136 QLD.0002.0027.1670_E, p 1.

1137 QLD.0002.0027.1670_E, p 1; The Department of Child Safety allocated the IA number: 12207664.

1138 QLD.0002.0027.0073_E, pp 1-3; QLD.0008.0029.0009_E, p 2; *Child Protection Act 1999* (Qld) (as in force) s 14.

1139 QLD.0002.0027.1657_E, pp 1-4; QLD.0008.0029.0009_E, pp 4-6.

1140 QLD.0002.0027.1657_E, p 1.

1141 QLD.0002.0027.1657_E, p 1.

1142 QLD.0002.0027.1657_E, p 2.

1143 QLD.0002.0027.1657_E, p 2.

1144 QLD.0002.0027.1657_E, p 1.

1145 QLD.0002.0027.1657_E, p 1.

1146 QLD.0008.0029.0009_E, pp 4-5.

1147 QLD.0008.0029.0009_E, p 5.

1148 QLD.0008.0029.0009_E, p 6.

1149 QLD.0008.0029.0009_E, p 6.

134. On 22 May 2008, the Department of Child Safety requested School 1 provide information to it concerning Jonathon pursuant to section 159N of the *Child Protection Act 1999* (Qld) (as in force) (the **Information Request 1**).[1150]

135. On 22 May 2008, School 1 prepared a document entitled 'Information Gathering – Confidential' concerning Jonathon's development, behaviour, parental involvement and school concerns (**Information Gathering Document**).[1151] School 1 considered:

    a. there was 'very limited' involvement from Paul Barrett[1152]
    b. Paul Barrett rarely supplied 'nappies to use' for Jonathon[1153]
    c. it had 'no major concerns' about Jonathon[1154]
    d. the teachers and teachers' aides at School 1 were unaware of suspicious marks or bruises on Jonathon.[1155]

136. On 23 May 2008, Teacher 1 saw a bruise on Jonathon's right ear and two thin scratch marks.[1156]

137. On the 28 May 2008, Child Safety Officer 5 interviewed Paul Barrett at Home 2 in relation to the 29 April 2008 Notification.[1157] Child Safety Officer 5 made observations to the Department of Child Safety about Paul Barrett's behaviour and the condition of Home 2 during the interview.[1158]

138. On the same day, Child Safety Officer 5 interviewed the Partner in relation to the 29 April 2008 Notification.[1159] [Redacted] informed Child Safety Officer 5 '[redacted] did not see the incident for [redacted] was downstairs doing the laundry'.[1160]

1150 QLD.0002.0027.0055_E, pp 2-3; *Child Protection Act 1999* (Qld) (as in force) s 159N.

1151 QLD.0002.0027.0055_E, p 1.

1152 QLD.0002.0027.0055_E, p 1.

1153 QLD.0002.0027.0055_E, p 1.

1154 QLD.0002.0027.0055_E, p 1.

1155 QLD.0002.0027.0055_E, p 1.

1156 QLD.0002.0027.0055_E, pp 1, 5.

1157 QLD.0002.0027.1657_E, pp 2-3.

1158 QLD.0002.0027.1657_E, p 3.

1159 QLD.0002.0027.1657_E, p 2.

1160 QLD.0002.0027.1657_E, p 2.

139. On 4 June 2008, the Department of Child Safety received School 1's response to Information Request 1.[1161] The response comprised:

a. the Information Gathering Document[1162]

b. a statement of Teacher 1 dated 11 February 2008 concerning the 7 February Event[1163]

c. a further report from Teacher 1 dated 15 February 2008 concerning Jonathon's hygiene and presentation, and the 7 February Event[1164]

d. a letter to Child Safety Officer 5 dated 29 May 2008 in which Teacher 1 informed them [redacted] saw bruising to Jonathon's right ear.[1165]

140. On 5 June 2008, the Department of Child Safety determined the outcome of its investigation into the information in the 29 April 2008 Notification was:

a. there was a 'very high' level of family risk[1166]

b. the concerns were 'unsubstantiated' and Kaleb and Jonathon were 'not in need of protection'.[1167]

141. The Department of Child Safety viewed:

a. there was insufficient evidence or information to suggest Kaleb had been harmed by [redacted] or Paul Barrett[1168]

b. there was no evidence or information to assess the children experienced significant or unacceptable risk of harm at that point in time.[1169]

142. The Department of Child Safety was aware that risk factors for Kaleb and Jonathon included:

a. Kaleb's disability and Jonathon's disability and their support needs[1170]

b. Paul Barrett's alcohol consumption that might affect his ability to meet the complex needs of the children[1171]

1161 QLD.0002.0027.0055_E, pp 1-7.

1162 QLD.0002.0027.0055_E, p 1.

1163 QLD.0002.0027.0055_E, p 4.

1164 QLD.0002.0027.0055_E, pp 6-7.

1165 QLD.0002.0027.0055_E, p 5.

1166 QLD.0002.0027.1654_E, p 1.

1167 QLD.0002.0027.1654_E, p 1.

1168 QLD.0002.0027.1654_E, p 1.

1169 QLD.0002.0027.1654_E, p 2.

1170 QLD.0002.0027.1654_E, p 2.

1171 QLD.0002.0027.1654_E, p 2.

c. Paul Barrett's rejection of support from government agencies and the Department of Child Safety[1172]

d. the Family's prior child protection history.[1173]

143. The Department of Child Safety considered:

a. there were protective factors that addressed risk factors for Kaleb and Jonathon[1174]

b. Paul Barrett was 'willing and able to protect them at the time.'[1175]

2009

144. On or around 27 January 2009, Jonathon commenced school at School 2.[1176]

145. On 6 April 2009, FECS informed Paul Barrett it would cease providing services and support as Jonathon was over 6 years of age.[1177]

2010

146. On 2 March 2010, Principal 1 notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **2 March 2010 Notification**).[1178] The notification referred to Kaleb's and Jonathon's

a. hygiene attending School 2[1179]

b. diet, including Kaleb allegedly digesting 'foam rubber on a regular basis'[1180]

c. care at home[1181]

d. access to support services.[1182]

1172 QLD.0002.0027.1654_E, p 2.

1173 QLD.0002.0027.1654_E, p 2.

1174 QLD.0002.0027.1654_E, p 2.

1175 QLD.0002.0027.1654_E, p 2.

1176 QLD.0004.0028.3597, 1.

1177 QLD.0020.0050.1728, p 1.

1178 QLD.0002.0027.1643_E, p 1.

1179 QLD.0002.0027.1643_E, p 1.

1180 QLD.0002.0027.1643_E, p 1.

1181 QLD.0002.0027.1643_E, p 1.

1182 QLD.0002.0027.1643_E, p 1.

147. On 2 or 3 March 2010, Queensland Police received a Report of Suspected Harm or Risk of Harm from Principal 1 in respect of Kaleb and Jonathon (**SP-4 Report**).[1183] The SP-4 Report referred to Kaleb's and Jonathon's:

   a. hygiene attending School 2[1184]

   b. diet, including digestion of 'foam rubber on a regular basis'[1185]

   c. care at home[1186]

   d. access to support services.[1187]

148. The SP-4 Report also referred to the hygiene and the condition of Home 2.[1188]

149. On 10 March 2010, a Child Safety Officer spoke with Principal 1 in relation to the 2 March 2010 Notification.[1189] Principal 1 informed the Child Safety Officer of concerns about the hygiene of Kaleb and Jonathon, their diet, access to support services and home environment.[1190]

150. As at 10 March 2010, the Principal 1 viewed:

   a. Paul Barrett struggled caring for Kaleb and Jonathon[1191]

   b. Kaleb and Jonathon were being neglected[1192]

   c. Principal 1 informed the Department of Child Safety of these views.[1193]

151. On 11 March 2020, a Child Safety Officer contacted Principal 1 at School 2 and made a record of the conversation.[1194]

152. On 12 March 2010, the Department of Child Safety determined to respond to the 2 March 2010 Notification by recording a CCR.[1195]

1183 QLD.0008.0029.0054, pp 1-4; QLD.0008.0029.0015_E, p 3; QLD.0004.0028.0187, p 1-3.

1184 QLD.0008.0029.0054, p 4.

1185 QLD.0008.0029.0054, p 4.

1186 QLD.0008.0029.0054, p 4.

1187 QLD.0008.0029.0054, p 4.

1188 QLD.0008.0029.0054, p 4.

1189 QLD.0002.0027.1650_E, p 1.

1190 QLD.0002.0027.1650_E, p 1.

1191 QLD.0002.0027.1650_E, p 1.

1192 QLD.0002.0027.1650_E, p 1.

1193 QLD.0002.0027.1650_E, p 1.

1194 QLD.0008.0029.0069, pp 1-7.

1195 QLD.0002.0027.1649_E, p 1; QLD.0002.0027.1643_E, p 5.

153. On 15 March 2010, the Department of Child Safety determined to also assist School 2 to refer the Family to the Department of Disability Services.[1196]

154. Around 9:30 pm on 28 May 2010, Queensland Police attended Home 2 regarding the 2 March 2010 SP-4 Report. Queensland Police made a record of their observations and discussion with Paul Barrett.[1197] Queensland Police spoke to Paul Barrett about Kaleb's and Jonathon's care, hygiene and presentation when they attended School 2, diet and support services.[1198] Queensland Police entered Home 2.[1199] Queensland Police viewed:

   a. there was a smell of faeces when they entered Home 2[1200]
   b. '[Jonathon] was caged in a room with a wooden child safety gate nailed to the door frame'[1201]
   c. the room Jonathon was in 'was bare with a mattress on the floor and a sheet of plastic "protecting" it. There was no bed-clothing. There was a toy, of sorts, and a lounge against a wall'[1202]
   d. Kaleb with a brown substance on his fingers[1203]
   e. the fridge was bare except for a bag of uncooked chops.[1204]

155. On the same day, Queensland Police contacted Department of Child Safety and made arrangements to attend Home 2 to remove Kaleb and Jonathon from Paul Barrett's care (the **28 May 2010 Notification**).[1205]

156. At 2:50 am on 29 May 2010, the Department of Child Safety was aware of:

   a. Queensland Police's attendance at Home 2[1206]
   b. arrangements to remove Kaleb and Jonathon from Paul Barrett's care.[1207]

1196 QLD.0002.0027.1648_E, p 1.
1197 QLD.0008.0029.0576_E, pp 3-4; QLD.0002.0027.0558_E, pp 1-2; QLD.0002.0027.0563_E, pp 9-23.
1198 QLD.0008.0029.0576_E, p 4.
1199 QLD.0008.0029.0576_E, p 4.
1200 QLD.0008.0029.0576_E, p 4.
1201 QLD.0008.0029.0576_E, p 4.
1202 QLD.0008.0029.0576_E, p 4.
1203 QLD.0008.0029.0576_E, p 4.
1204 QLD.0008.0029.0576_E, p 4.
1205 QLD.0008.0029.0576_E, p 5.
1206 QLD.0002.0027.0047_E, p 1.
1207 QLD.0002.0027.0047_E, p 2.

157. At 10 am on 29 May 2010, the Queensland Police and Child Safety Officers attended Home 2 and made records of their visit. [1208] Queensland Police took photos of Home 2.[1209] The Child Safety Officer viewed:

a. the house was 'unliveable for children'[1210]

b. Paul Barrett 'seriously neglected the children'[1211]

c. Paul Barrett was not likely to ever have the skills or motivation necessary to provide intensive ongoing care to the children[1212]

d. returning the children to Paul Barrett in the future would likely lead to recurring issues due to the complex needs of the children.[1213]

158. In response to the 28 May 2010 Notification, the Department of Child Safety:

a. recorded a Child Protection Notification

b. commenced an IA, and

c. assessed the Response Priority as within 24 hours.[1214]

159. On 29 May 2010, the Department of Child Safety completed a Safety Assessment. The household was assessed as 'unsafe.'[1215]

160. On 29 May 2010, Paul Barrett signed a Care Agreement, pursuant to the *Child Protection Act 1999* (QLD) ss 51Z-51ZI (as in force at the time), consenting to the removal of Kaleb and Jonathon from his care until 4 June 2010.[1216]

161. On the same day, Kaleb and Jonathon were removed from Paul Barrett's care.[1217]

162. On 31 May 2010, Child Safety Officers interviewed Paul Barrett and [redacted].[1218] The interview concerned the condition and hygiene of Home 2,[1219] the use of the child

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1208 QLD.0008.0029.0576_E, pp 5-6; QLD.0002.0027.1621_E, pp 1-2.

1209 QLD.0008.0029.0076, pp 1-9; QLD.0002.0027.1621_E, pp 1-2.

1210 QLD.0002.0027.1621_E, p 1.

1211 QLD.0002.0027.1621_E, p 2.

1212 QLD.0002.0027.1621_E, p 2.

1213 QLD.0002.0027.1621_E, p 2.

1214 QLD.0002.0027.1630_E, p 3; QLD.0002.0027.1633_E, p 4.

1215 QLD.0002.0027.1598_E, p 1; QLD.0002.0027.1624_E, p 2.

1216 QLD.0002.0027.1621_E, p 2; QLD.0002.0027.0581_E, p. 1-4; QLD.0021.0057.0001, p 1-4; *Child Protection Act 1999* (QLD) ss 51Z-51ZI (as in force at time).

1217 QLD.0002.0027.1621_E, p 2.

1218 QLD.0002.0027.1604_E, pp 3-4; QLD.0002.0027.0036_E, pp 1-6.

1219 QLD.0002.0027.0036_E, pp 1-5.

gate,[1220] the hygiene and behaviours of Kaleb and Jonathon, [1221] and supports the family accessed.[1222]

163. On 1 June 2010, Queensland Police referred Kaleb and Jonathon's case to CPA SCAN.[1223]

164. On 4 June 2010, the Department of Child Safety completed a FRE.[1224] It evaluated the Family's risk level was 'very high'.[1225]

165. On 4 June 2010, the Department of Child Safety completed a further Safety Assessment. The household was assessed as 'safe.'[1226]

166. The Department of Child Safety determined:

   a. Kaleb and Jonathon were children 'in need of protection'[1227]

   b. the Department of Child Safety would continue to intervene in the family under an IPA.[1228]

167. The Department of Child Safety viewed:

   a. ongoing intervention with the family was required as without intervention the children would continue to suffer significant harm[1229]

   b. there needed to be supports services arranged to ensure the children's needs were being met.[1230]

168. On 4 June 2010, Kaleb and Jonathon's returned to Paul Barrett's care at Home 2.[1231] On the same day, Child Safety Officers attended Home 2 and observed the Kaleb and Jonathon's arrival at Home 2[1232] and interaction with the Paul Barrett and [redacted]. [1233] Child Safety Officers viewed '[Paul Barrett] had cleaned to an adequate standard'.[1234]

1220 QLD.0002.0027.0036_E, p 3.

1221 QLD.0002.0027.0036_E, pp 2-4.

1222 QLD.0002.0027.0036_E, p 5.

1223 QLD.0008.0029.0069, pp 1-7.

1224 QLD.0002.0027.1598_E, pp 1-6.

1225 QLD.0002.0027.1598_E, pp 1, 4-5; QLD.0002.0027.1610_E, p 3.

1226 QLD.0002.0027.1598_E, p 1; QLD.0002.0027.1614_E, p 2.

1227 QLD.0002.0027.1598_E, pp 1, 5.

1228 QLD.0002.0027.1598_E, p 5.

1229 QLD.0002.0027.1598_E, p 5.

1230 QLD.0002.0027.1598_E, p 5.

1231 QLD.0002.0027.1589_E, p 1; QLD.0002.00027.1604_E, p 5.

1232 QLD.0002.0027.1604_E, p 5.

1233 QLD.0002.0027.1604_E, p 5.

1234 QLD.0002.0027.1604_E, p 5.

169. On 8 June 2010, the Department of Child Safety began to support the Family through an IPA.[1235]

170. On 1 July 2010, the Department of Child Safety met with Paul Barrett. It discussed a case plan, as a part of the Family's IPA, for Kaleb and Jonathon.[1236] The case plan goal was for Kaleb and Jonathon 'to remain safe in the home'.[1237]

171. On 23 July 2010, Child Protection Officers visited Home 2.[1238]

172. On 30 July 2010, Paul Barrett informed the Department of Child Safety, he and [redacted] were no longer a couple.[1239]

173. On 13 August 2010, a Child Safety Officer 6 had a phone conversation with Principal 1 of School 2 and made a record of the conversation.[1240] The Principal informed the Child Safety Officer 6:

   a. the Principal said Paul Barrett had been 'aggressive and abusive' and 'smashed a phone near' Principal 1 and, although there had been times when Paul Barrett had been 'quite receptive', the Principal believed 'that [Paul Barrett] can be quite dangerous'[1241]

   b. last year the Principal had made a notification to the Department of Child Safety after the children ate foam from mattresses at home[1242]

   c. 'If [Paul Barrett] is challenged he is explosive and dangerous'[1243]

   d. School 2 contacted the Department of Disability Services to arrange supports[1244]

   e. when Principal 1 asked Paul Barrett about Department of Disability Services support, Paul Barrett 'became abusive' and said 'don't you ██████ bring anyone in here, I do not need the support'[1245]

1235 QLD.0002.0027.1233_E, p 4; QLD.0002.0027.1553_E, p 1.

1236 QLD.0002.0027.1569_E, p 1; QLD.0002.0027.1780_E, pp 1-4; QLD.0002.0027.0635_E, p 1.

1237 QLD.0002.0027.1569_E, pp 1-4, QLD.0002.0027.1780_E, pp 1-3.

1238 QLD.0002.0027.0607_E, p 1.

1239 QLD.0002.0027.1567_E, p 1.

1240 QLD.0002.0027.1567_E, pp 1-2.

1241 QLD.0002.0027.1567_E, p 1.

1242 QLD.0002.0027.1567_E, p 1.

1243 QLD.0002.0027.1567_E, p 2.

1244 QLD.0002.0027.1567_E, p 1.

1245 QLD.0002.0027.1567_E, p 1.

f. the Principal observed the children were ‘bathed and food supplied’ but did not believe they were ‘eating enough at home’[1246] the Principal did not observe bruising on children, however had observed they had attended School 2 in ‘inappropriate clothing, etc’[1247]

g. the Principal 1 considered it important for Paul Barrett not to remove Kaleb and Jonathon from School 2

h. the Principal 1 ‘had ‘given up’ attempting to meet with Paul Barrett to offer support to the children.’[1248]

174. On 18 August 2010, a Child Safety Officer visited Home 2 unannounced and made a record of their observations.[1249] The Child Safety Officer saw:

a. the home was ‘clean (some clutter)’ [1250]

b. ‘[Paul Barrett] engaged well’[1251]

c. the ‘Freezer [was] defrosted however no food. Box of vegetable in kitchen’.[1252]

175. On 20 August 2010, a Child Safety Officer spoke with Teacher 2 and made a record of the conversation.[1253] Teacher 2 informed the Child Safety Officer, [redacted] considered:

a. prior to the IPA, School 2 bathed Kaleb and Jonathon every day and provided clean clothes. This ‘was not so much now’[1254]

b. School 2 previously supplemented Kaleb and Jonathon’s food. This ‘was not so much now’.[1255]

176. On 3 September 2010, a teacher from School 2 emailed Child Safety Officer 6.[1256] The teacher informed the Child Safety Officer, they viewed:

a. Jonathon attended School 2 ‘clean and dressed appropriately’[1257]

b. Jonathon had a bad nappy rash down the insides of each leg.[1258]

1246 QLD.0002.0027.1567_E, p 1.

1247 QLD.0002.0027.1567_E, p 2.

1248 QLD.0002.0027.1567_E, p 2.

1249 QLD.0002.0027.0605_E, p 1; QLD.0002.0027.1567_E, p 2.

1250 QLD.0002.0027.0605_E, p 1.

1251 QLD.0002.0027.0605_E, p 1.

1252 QLD.0002.0027.0605_E, p 1.

1253 QLD.0002.0027.0603_E, pp 1-2; QLD.0002.0027.1567_E, p 2.

1254 QLD.0002.0027.0603_E, pp 1-2.

1255 QLD.0002.0027.0603_E, pp 1-2.

1256 QLD.0002.0027.0627_E, pp 1-2.

1257 QLD.0002.0027.0627_E, pp 1-2.

1258 QLD.0002.0027.0627_E, p 2.

177. On 24 November 2010, the Department of Disability Services sent a letter to Paul Barrett enclosing an Integrated Support Plan identifying supports for Kaleb.[1259]

178. On 30 November 2010, a Child Safety Officer visited Home 2 unannounced.[1260] Paul Barrett had consumed alcohol.[1261] The Child Safety Officer viewed Paul Barrett became aggressive during the home visit.[1262]

179. On 6 December 2010, the Department of Child Safety met with the Department of Disability Services. Participants discussed the availability of funding for the Family and to support Jonathon and Kaleb's disability needs.[1263]

180. On 6 December 2010, a Child Safety Officer spoke by telephone with Teacher 2 at School 2.[1264] Teacher 2 informed the Child Safety Officer:

a. Kaleb 'passed foam at school' that day[1265]

b. Kaleb had attended speech and language therapy during the year but Kaleb had not displayed 'an interest in talking' and 'simply chooses not to talk.' He was 'mainly interested in food' and he could 'verbalise clearly about food and drink'[1266]

c. [redacted] felt Paul Barrett was doing a 'good job of parenting' but had 'a different standard to others'[1267]

d. [redacted] did not feel that Jonathon and Kaleb's difficulties with toileting were 'as a result of [Paul Barrett] not following through with the strategies in the home' and 'lots of other children [at School 2] present[ed] with similar difficulties'[1268]

e. Kaleb needed 'help with his eating habits' but Teacher 2 was 'not so sure this would have any major effect'[1269]

f. Kaleb and Jonathon needed to be involved in more activities but 'ultimately this is [Paul Barrett's] responsibility'.[1270]

1259 QLD.0020.0050.1776, pp 1-4.

1260 QLD.0002.0027.1556_E, p 1.

1261 QLD.0002.0027.1556_E, pp 1-2.

1262 QLD.0002.0027.1556_E, p 1.

1263 QLD.0002.0027.1556_E, p 2; QLD.0002.0027.1005_E, p 4.

1264 QLD.0002.0027.1556_E, p 2; QLD.0002.0027.1002_E, p 2.

1265 QLD.0002.0027.1556_E, p 2.

1266 QLD.0002.0027.1556_E, p 2.

1267 QLD.0002.0027.1556_E, p 2.

1268 QLD.0002.0027.1556_E, p 2.

1269 QLD.0002.0027.1556_E, p 2.

1270 QLD.0002.0027.1556_E, p 2.

181. On 15 December 2010, [redacted] notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **15 December 2010 Notification**).[1271] The notification referred to:

a. Kaleb and Jonathon's movements in and around Home 2[1272]

b. the presentation of Kaleb and Jonathon[1273]

c. the availability of food in Home 2[1274]

d. Paul Barrett's alleged practices with drugs[1275]

e. Paul Barrett's alleged consumption of alcohol.[1276]

182. On 20 December 2010, the Department of Disability Services emailed a Child Safety Officer regarding support options for the Family and outlining recent interactions with the Family.[1277]

183. On 21 December 2010, the Department of Child Safety determined the information in the **15 December 2010 Notification** did not satisfy the threshold for a Child Protection Notification under section 14 of the *Child Protection Act 1999* (Qld) and it would be screened as a CCR.[1278] At this time, the Department of Child Safety considered:

> 'The information provided indicates the children have not been harmed. The information that has been obtained indicates that both children are severely disabled. The information provided also indicates that [Kaleb] has an eating disorder which would impact the eating behaviours in the household. It was explained that [Kaleb] does not stop eating. This could explain the amount of food/ cooking in the house. [The Department of Child Safety has] been engaging with the family on an [IPA] case. It is believed that due to the children's disabilities, their activities are limited. It is believed that [Paul Barrett] is a willing and able parent who meets both children's care and protection needs. It is believed that [Paul Barrett] is doing his best to meet the high needs of the children. …
>
> It is believed that once the IPA case is closed [Paul Barrett] will be linked in with support services to provide a support network for him and his children. This will act as an additional protective factor for the family.[1279]

1271 QLD.0002.0027.1545_E, pp 1-3; QLD.0008.0029.0297_E, pp 1-3.

1272 QLD.0002.0027.1545_E, p 1; QLD.0008.0029.0297_E, p 2.

1273 QLD.0002.0027.1545_E, p 1.

1274 QLD.0002.0027.1545_E, p 1.

1275 QLD.0002.0027.1545_E, p 1; QLD.0008.0029.0297_E, p 2.

1276 QLD.0002.0027.1545_E, p 1; QLD.0008.0029.0297_E, p 2.

1277 QLD.0002.0027.0587_E, p 1.

1278 QLD.0008.0029.0297_E, p 2.

1279 QLD.0008.0029.0297_E, p 2.

184. On 22 December 2010, the Department of Child Safety performed a further FRE in relation to the IPA.[1280] The Department of Child Safety assessed the Family's risk as 'moderate'.[1281] It determined to close the case.[1282]

185. On 23 December 2010, Paul Barrett met with the Department of Disability Services.[1283] Department of Disability Services informed Paul Barrett it ceased its support linking service and would not be involved in the Family.[1284] The Department of Disability Services viewed Paul Barrett would work with School 2 to arrange supports for Jonathon and Kaleb's therapy needs and would follow up on information under an Integrated Support Plan.[1285]

186. On 23 December 2010, the Department of Child Safety prepared a review report concerning Kaleb and Jonathon's case plan of 1 July 2010.[1286]

187. The Department of Child Services determined Kaleb and Jonathon's 'physical, emotional, developmental and educational needs' were being met under Paul Barrett's care.[1287] It considered:

   a. Paul Barrett worked hard under difficult to provide appropriately for Kaleb and Jonathon[1288]

   b. in conjunction with the services the Kaleb and Jonathon were put in contact with, they 'had every opportunity to be cared for to a high standard in the current living arrangements.'[1289]

188. On 23 December 2010, the Department of Child Safety's IPA concluded.[1290]

2011

189. On 4 January 2011, the Department of Child Safety was informed the Department of Disability Services ceased its support linking service and involvement in relation to Kaleb and Jonathon.[1291]

1280 QLD.0002.0027.1553_E, pp 1-3.

1281 QLD.0002.0027.1553_E, p 2.

1282 QLD.0002.0027.1553_E, p 3.

1283 QLD.0020.0050.1401, p 3; QLD.0020.0050.1791, p 1.

1284 QLD.0020.0050.1791, p 1.

1285 QLD.0020.0050.1791, p 1.

1286 QLD.0002.0027.1549_E, pp 1-2.

1287 QLD.0002.0027.1549_E, p 2.

1288 QLD.0002.0027.1549_E, p 2.

1289 QLD.0002.0027.1549_E, p 2.

1290 QLD.0002.0027.1233_E, p 4.

1291 QLD.0020.0050.1791, p 1.

190. On 16 March 2011, School 2 staff observed Kaleb had diarrhea.[1292] School 2 staff informed Partner and Paul Barrett of Kaleb's diarrhea.[1293]

191. On 18 March 2011, School 2 staff observed Kaleb had diarrhea. School 2 staff also observed 'furniture foam and a fur like substance' in Kaleb's faeces.[1294]

192. The Department of Education has records of photographs of Kaleb's faeces with foreign objects from March 2011.[1295]

193. There were no records the Department of Child Safety received any Child Protection Notifications concerning Kaleb and/or Jonathon between 1 January 2011 to 31 December 2012.[1296]*

2013

194. From in or around October 2013, Autism Queensland and School 2 staff coordinated with the Department of Disability Services for Kaleb to receive funding for disability support services provided by Autism Queensland.[1297] On 4 November 2013, the Department of Disability Service advised Paul Barrett that Kaleb would receive funding for services from Autism Queensland.[1298]

195. There is no record of a separate funding application for Jonathon, although he is referred to in correspondence between Autism Queensland, the Department of Disability Services and School 2.[1299]

196. On 16 December 2013, Autism Queensland contacted Paul Barrett to discuss the funding application.[1300] Autism Queensland record that Paul Barrett 'became very angry and upset about the possible support' and 'made it perfectly clear that he did not want the money or any form of support due to previous experiences.'[1301]

1292 QLD.0004.0028.6708, p 2.

1293 QLD.0004.0028.6708, p 2.

1294 QLD.0004.0028.6708, p 2.

1295 QLD.0004.0028.3558, p 1; QLD.0004.0028.3559, p 1.

1296 *We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

1297 AQS.9999.0003.0001, p 1.

1298 QLD.0020.0050.1360, p 6.

1299 See generally: AQS.9999.0003.0001, pp 1-4.

1300 AQS.9999.0003.0001, p 3.

1301 AQS.9999.0003.0001, p 3.

197. On or around 19 December 2013, Kaleb's funding application was approved. Autism Queensland was funded to provide approximately 50 hours of support to Kaleb.[1302]

198. There are no records the Department of Child Safety received any Child Protection Notifications concerning Kaleb and/or Jonathon between 1 January 2013 to 31 December 2013.[1303]*

2014

199. The Department of Disability Services funded Autism Queensland to provide services to Kaleb between 1 February 2014 to 16 August 2018.[1304] In or around May 2014, an Autism Queensland Occupational Therapist (**OT**) started to attend School 2 to support Kaleb.[1305] An Autism Queensland OT worked with Kaleb at School 2 until the end of 2018, when Kaleb graduated.[1306]

200. On 3 December 2014, a teacher at School 2 told the Autism Queensland OT '[Kaleb] has been having 'tantrums' over the past few days' and there had been 'an increased occurrence of [Kaleb] hitting his head with his hand when asked to do simple things'.[1307] This was the first recorded observation by the OT of Kaleb engaging in self-harming behaviours whilst at School 2, however, this behaviour was recorded by Autism Queensland OTs on a number of occasions.[1308]

201. There are no records the Department of Child Safety received any Child Protection Notifications concerning Kaleb and/or Jonathon between 1 January 2014 to 30 December 2014.[1309]*

202. On 31 December 2014, the Department received a notification concerning Kaleb and Jonathon (the **31 December 2014 Notification**).[1310] The notification referred to:

    a. the supervision of Kaleb and Jonathon at Home 2[1311]

    b. Paul Barrett's alleged consumption of alcohol and drug consumption.[1312]

1302 AQS.9999.0003.0001, p 4.

1303 * We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

1304 QLD.0020.0050.1360, p 1.

1305 AQS.9999.0003.0001, pp 5-6.

1306 AQS.9999.0003.0001, p 41.

1307 AQS.9999.0003.0001, p 12.

1308 AQS.9999.0003.0001, pp 1-41.

1309 * We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

1310 QLD.0002.0027.0110_E, pp 1-3.

1311 QLD.0002.0027.0110_E, p 1.

1312 QLD.0002.0027.0110_E, p 1.

203. In response to the 31 December 2014 Notification, the Department of Child Protection:

a. assessed the Response Priority was within 24 hours[1313]

b. initiated an IA[1314]

c. referred the notification to Police pursuant to section 14(2) of the *Child Protection Act 1999* (Cth).[1315]

204. On the same day, Queensland Police received information relating to the 31 December 2014 Notification.[1316] At 8:45 pm, Queensland Police attended Home 2 and spoke with Paul Barrett.[1317] Police observed:

a. Kaleb and Jonathon, including their physical presentation[1318]

b. the condition and presentation of Home 2.[1319]

205. Queensland Police determined:

a. there was 'insufficient evidence' to suggest a criminal offence was committed based on its investigations[1320]

b. no further action was required by Queensland Police.[1321]

206. Queensland Police informed the Department of Child Safety of its investigation relating to the information in the 31 December 2014 Notification and observations at Home 2 that day.[1322]

207. On 1 January 2015, in response to the 31 December 2014 Notification, the Department of Child Safety did a Safety Assessment and determined Kaleb and Jonathon were 'Safe'.[1323]

1313 QLD.0002.0027.1534_E, p 3.

1314 QLD.0002.0027.1529_E, p 1.

1315 QLD.0002.0027.1538_E, pp 1-2.

1316 QLD.0008.0029.0678, p 1.

1317 QLD.0008.0029.0678, pp 1-2.

1318 QLD.0008.0029.0678, p 2.

1319 QLD.0008.0029.0678, p 5.

1320 QLD.0008.0029.0678, p 5.

1321 QLD.0008.0029.0678, p 5.

1322 QLD.0008.0029.0671, pp 1-2; QLD.0002.0027.1527_E, p 1.

1323 QLD.0002.0027.1525_E, pp 1-2.

Later school years (2015-2019)

2015

208. On 10 January 2015, Queensland Police received a report from a camper at a camping ground concerning the welfare of Kaleb and Jonathon.[1324]

209. At 7:20 pm on 10 January 2015, Queensland Police attended the campsite and saw Kaleb and Jonathon.[1325] Queensland Police determined no ill-treatment discovered.[1326]

210. On 2 February 2015, a Child Safety Officer interviewed Principal 1 in relation to the 31 December 2014 Notification.[1327] Principal 1 informed the Child Safety Officer that Kaleb and Jonathon received a high degree of support from School 2 in and out of school hours. Principal 1 informed the Child Safety Officer Paul Barrett:

    a. clearly loved his children and was protective of them[1328]

    b. 'did well considering the extremely demanding behaviours of [Jonathon] and [Kaleb]'.[1329]

211. On 3 February 2015, Child Safety Officers interviewed Paul Barrett at Home 2 in relation to the 31 December 2014 Notification.[1330] The Child Safety Officers made observations about the condition of Home 2.[1331] Paul Barrett informed Child Safety Officers he received support from School 2, a friend, Autism Australia and Hospital 1.[1332] He told them he thought he managed the children well and did not need further support.[1333]

212. On 9 February 2015, a Child Safety Officer interviewed Teacher 2 in relation to the 31 December 2014 Notification. Teacher 2 informed the Child Safety Officer Kaleb and Jonathon attended school every day, presented well, and their hygiene was good.[1334] Teacher 2 considered Paul Barrett 'loved his children' and was 'managing relatively well with the support from [School 2] and Autism Australia'.[1335]

1324 QLD.0008.0029.0610, p 1; QLD.0008.0029.0027_E, p 1.

1325 QLD.0008.0029.0612, p 1.

1326 QLD.0008.0029.0612, p 1; QLD.0008.0029.0027_E, p 1.

1327 QLD.0002.0027.1508_E, p 4.

1328 QLD.0002.0027.1508_E, p 4.

1329 QLD.0002.0027.1508_E, p 4.

1330 QLD.0002.0027.1508_E, pp 2-3.

1331 QLD.0002.0027.1508_E, p 3.

1332 QLD.0002.0027.1508_E, p 3.

1333 QLD.0002.0027.1508_E, p 3.

1334 QLD.0002.0027.1508_E, p 5.

1335 QLD.0002.0027.1508_E, p 5.

213. By 10 February 2015, the Department of Child Safety completed its IA of the information in the 31 December 2014 Notification.[1336] The Department of Child Safety completed a FRE and assessed the Family's risk level was 'high'.[1337] It determined not to continue intervening with the Family.[1338] The Department of Child Safety considered:

a. Paul Barrett 'worked well' with School 2[1339]

b. Kaleb and Jonathon received supports from Autism Queensland and Hospital 5[1340]

c. concerns about the behaviours of Jonathon and Kaleb outlined in the 31 December 2014 Notification were 'consistent with their severe global development delays and Autism rather than being caused by neglect issues.'[1341]

214. On or around 16 February 2015, a Child Safety Officer contacted Autism Queensland regarding the 31 December 2014 Notification. Autism Queensland reported that 'it did not seem that any red flags had been raised.'[1342]

215. On about 28 August 2015, a Department of Housing Officer inspected Home 2.[1343]* The Department of Housing Officer took photos of Home 2 during the inspection.[1344] Department of Housing records noted:

> *furniture to the property is sparse/no existant [sic] *the main bedroom appears to be fully set up *the second bedroom has nothing in it except an inf lated [sic] double/queen size mattress without any other bedding *Large hole/indent to kitchen wall *glass panel missing and boarded up to rear kitchen/external door *fist size hole, attempted patch, to wall of bed 2 * bathroom in poor condition, in need of upgrade, no survey drawn *kitchen in poor condition, in need of upg rade, [sic] no survey drawn *makeshift sleeping area set up under house *various 'junk' items stored under the h ouse [sic] *large chicken house/aviary [sic] style sheds in rear yard *boat on trailer, motorbike under tarp and mount ain [sic] bike style bicycle stored in yard *other various 'junk' items in yard/under steps at rear [sic] On return t [sic] o [Housing Service Centre (**HSC**)] provided copies of photos taken to tenancy/property manager ... Requested [tenancy/property manager] make contact with

1336 QLD.0002.0027.1516_E, p 1; QLD.0002.0027.1504_E, pp 1-4; QLD.0002.0027.1508_E, pp 1-7; QLD.0002.0027.1515_E, p 1.

1337 QLD.0002.0027.1516_E, p 4.

1338 QLD.0002.0027.1516_E, p 4.

1339 QLD.0002.0027.1516_E, p 4.

1340 QLD.0002.0027.1516_E, p 4.

1341 QLD.0002.0027.1516_E, p 4.

1342 AQS.9999.0003.0001, p 14.

1343 QLD.0001.0026.0053, pp 7-8; QLD.0001.0026.0241_E, pp 1-2; QLD.0001.0026.0245_E, pp 1-13; *Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1344 QLD.0001.0026.0241_E, pp 1-12.

[Paul Barrett], tenant, to advise surveys for kitchen and bathroom upgrades not drawn at time of inspect and still to be completed and also to discuss property condition, who is residing at the property and arrange follow-up access.[1345]

216. A Department of Housing Officer completed an 'Internal Complaint Checklist' form in respect of the 28 August 2015 inspection and recorded in details of their complaint:

> Damage to property
> Undeclared occupants? (female + mattresses under house)
> Poor condition of property
> Child safety concerns?[1346]

217. On 6 November 2015, the Department of Housing issued Paul Barrett a notice to remedy breach concerning alleged 'damaged caused to the premises or inclusions' and a 'Failure to keep the internal and external areas of the premises and inclusions clean' as stated in his tenancy agreement.[1347]*

218. The Department of Housing records in connection with the notice to remedy breach dated 6 November 2015 stated:

> HO [Department of Housing Officer] spoke with TEN [tenant, Paul Barrett] who advised he has two children with ADHD, Autism and other significant health issues including incontenance [sic]. … HO advised it is tenant responsibility to ensure the property is kept in good order and requested TEN call maintenance to have these holes fixed and once property is at an acceptable level the Dept will look at kitchen/ bathroom upgrades. TEN stated when you have Autistic children life is very difficult. HO advised Dept would be breaching TEN for condition of property and to please tidy up by placing things neatly, such as the chairs under the stairs. They can be stacked in a neat pile, ensure the holes are repaired and to please tidy under the house. TEN stated he would try.[1348]

219. On 26 November 2015, the Department of Housing conducted a home visit of Home 2.[1349]* The Department of Housing records noted:

> It was noted TEN [tenant, Paul Barrett] had thrown disinfectant over the vinyl floor in 2nd bedroom (son's [sic] room) It was explained the boys both have severe disabilities and are incontinent and mess themselves and TEN does this to clean

1345 QLD.0001.0026.0053, p 8.

1346 QLD.0001.0026.0241_E, p 1.

1347 QLD.0001.0026.0266_E, p 3; QLD.0001.0026.0053, p 7. *Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1348 QLD.0001.0026.0053, p 7.

1349 QLD.0001.0026.0240_E, p 1; *Refer to the Department of Housing Review at paragraphs 354 to 355 below.

the floor in the bedroom. Due to boys stature and disabilities they both sleep on blow up mattresses as these are easier to clean. TEN said mattresses on the lawn out the back to wash, dry and make up for the night. TEN advised this is a daily occurrence.

> It was noted that property had been tidied up, there was very little furniture in the loungeroom or anywhere in the house except for the main bedroom, which had a TV in it.
>
> Under the house there was a pile of old duna (sic) cover/blankets etc, which TEN advised he will throw away as well as the 2 old mattresses, he has a friend with a ute who will assist.
>
> HO [Department of Housing Officer] requested the pile of winter clothes be folded and neatly placed in a pile on the table, preferably stored in those plastic boxes, TEN advised he could not afford the plastic boxes, so HO requested d some sort of order be made around clothes lying on the table under the house and on the couch. …[1350]

2016

220. There were no records the Department of Child Safety received any Child Protection Notifications concerning Kaleb and/or Jonathon between 1 January 2016 to 31 December 2016.[1351*]

221. On 15 April 2016, the Department of Housing received a call from Paul Barrett enquiring whether the Department of Housing 'would change his front fence to make it safe for his 13 yr old son as he c an [sic] climb current fencing'.[1352]

222. On 20 April 2016, the Department of Housing conducted a home visit of Home 2 in relation to the property's fencing.[1353]

223. The Department of Housing records noted on 17 May 2016:

> TEN [the tenant, Paul Barrett] phoned to discuss OT [occupational therapist] referral for front fence as his 13 yo son climbs and gets out of the property. A dvised [sic] the TEN that an OT referral has been made regarding the fence and he has to wait for the OT to contact him to discuss the fence. The TEN advised

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1350 QLD.0001.0026.0240_E, p 1.

1351 We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

1352 QLD.0001.0026.0053, p 7.

1353 QLD.0001.0026.0278_E, p 1; QLD.0001.0026.0053, p 7.

> that his son is climbing over the fence and that if he gets run over or lost it will be 'Housing Commissions fault'. I advised the tenant that he needs to make sure his children are safe. The tenant advised that if he called child safety they would be disgusted and he would be in trouble for locking his children in doors. I advised the tenant that he is allowed to lock his front and back doors to keep his children safe. The tenant advised that he wanted to put his own fence up - I advised that he is required to wait til [sic] the OT makes that assessment as it is government property. TEnant [sic] says he is not happy that process taking so long - advised I would talk with OT to see when they may be visiting him.[1354*]

224. On 16 June 2016, Autism Queensland staff reported Kaleb showed 'increased behaviours such as grimacing hitting head with palm and spitting' and that his teacher at School 2 'hypothesized [sic] that [Kaleb] may be in pain of some kind due to potential gut issues – bowel motions have been strained and [Kaleb] seems to be passing lots of wind with strong odor [sic].' Autism Queensland's records noted its therapists felt Kaleb needed a medical review.[1355]

225. On 6 July 2016, Autism Queensland contacted the Department of Disability Services to discuss what services could be made available to the Family. Autism Queensland notes recorded a Department of Disability Services representative said that 'the service had had no contact with the [Family] since 2014'.[1356]

226. On 27 July 2016, Autism Queensland staff spoke by phone with Paul Barrett.[1357] Autism Queensland staff thought Paul Barrett 'became hostile' after they asked him about Kaleb's diet at home.[1358]

227. [This paragraph is intentionally blank].

2017

228. On 2 November 2017, the [redacted] Council informed the Department of Housing of a complaint about the potential public health risk at Home 2 (the **2 November 2017 Complaint**).[1359]

1354 QLD.0001.0026.0053, p 6;*Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1355 AQS.9999.0003.0001, p 23

1356 AQS.9999.0003.0001, p 24.

1357 AQS.9999.0003.0001, p 25.

1358 AQS.9999.0003.0001, p 25.

1359 QLD.0001.0026.0232, p 1.

229. On 16 November 2017, the Department of Housing did a home visit of Home 2 in relation to a complaint about a chicken coop and food scraps.[1360] The Department of Housing took photos of Home 2.[1361]

230. On 30 November 2017, the Department of Housing conducted Home 2.[1362]* The Department of Housing records noted:

> the front and backyard has been mowed, the front yard was tidy, but the backyard down the back had a bit of rubbish around, under the house needed a tidy up and the laundry door was rotting and needed replacement, advised [Paul Barrett] to contact maintenance to fix laundry door. [Paul Barrett] has been advised to tidy up under the house and the backyard needs to be cleared of rubbish. follow [sic] up inspection to be completed at the beginning of 2018. Tip vouchers to be sent out to assist [Paul Barrett] to clear out all the rubbish so he can hire a trailer from bunnings and get rid of it all. Referred [Paul Barrett] to … refuse station.[1363]*

2018

231. On 13 February 2018, School 2 staff observed Jonathon attended School 2 with a smell of urine in his hair.[1364] School 2 staff sought to arrange haircuts for Kaleb and Jonathon.[1365]

232. On 8 March 2018, the Department of Housing conducted a home visit of Home 2.[1366]* The Department of Housing records noted:

> HO also noted the back yard was again untidy with the contents of a pillow strewn all through the yard from foster dog playing. TEN [the tenant, Paul Barrett] advised it would take him half an hour to tidy up. HO [Department of Housing Officer] also noted the grass was getting long again, but due to the weather [they] would give TEN 1-month to clean up and mow (due to rain and soggy ground). … Whilst inspecting under the house HO noted dripping from above onto the concrete in the laundry and enquired where the water was coming from. TEN stated when his boys (both Autistic) have a shower there is always water on the floor and it seeps through and drips into the laundry area. The floor was very wet, and the dripping was constant. HO requested TEN contact the Call Centre and report and has also discussed with the Property Team, … who will investigate further.[1367]

1360 QLD.0001.0026.0053, p 4.

1361 QLD.0001.0026.0053, p 4.

1362 QLD.0001.0026.0053, p 4.

1363 QLD.0001.0026.0053, p 4; *Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1364 QLD.0005.0028.1360, p 30.

1365 QLD.0005.0028.1360, p 30.

1366 QLD.0001.0026.0053, pp 3-4; *Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1367 QLD.0001.0026.0053, p 4.

233. On 3 May 2018, the Department of Housing conducted a home visit of Home 2.[1368]* The Department of Housing Records noted:

> It [Home 2] was still in a mess, TEN [the tenant, Paul Barrett] stated he finds it very difficult to maintain with his Autistic children.[1369]

234. On 23 May 2018, School 2 staff observed Jonathon attended School 2:

   a. smelling of strong dog odour[1370]

   b. passing rocks and/or pebbles during bowel movements[1371]

   c. attending school in a shirt and shorts.[1372]

235. School 2 staff also observed Kaleb and Jonathon's attended School 2 with limited lunches on a number of occasions.[1373]

236. As at 23 May 2018, School 2 was aware Teacher 2 considered Paul Barrett was 'not coping' and needed respite.[1374] There are no records of School 2 making a Student Protection Report in respect of Teacher 2's view Paul Barrett was 'not coping' and needed respite.[1375]*

237. Between 24 May 2018 and 25 May 2018, School 2 staff corresponded regarding:

   a. supplementing the food provided to Kaleb and Jonathon[1376]

   b. securing respite and supports to the Family[1377]

   c. other ways to provide support to Kaleb and Jonathon

   d. whether an SP-4 Form should be completed by School 2.[1378]

1368 QLD.0001.0026.0053, p 3; Refer to the Department of Housing Review at paragraphs 354 to 355 below.

1369 QLD.0001.0026.0053, p 3.

1370 QLD.0005.0028.1360, p 30; QLD.0005.0028.0352, pp 1-2.

1371 QLD.0005.0028.1360, p 30.

1372 QLD.0005.0028.1360, p 30; QLD.0005.0028.0352, p 2.

1373 QLD.0005.0028.1360, p 30; QLD.0005.0028.0352, p 2.

1374 QLD.0005.0028.1360, p 30.

1375 QLD.0005.0052.0068, p 6; * We are unaware of any records of the 27 September 2018 incident being reported as a Student Protection Report. Please let us know if this is not the case.

1376 QLD.0004.0028.4429, pp 1-2.

1377 QLD.0005.0028.0352, p 1.

1378 QLD.0005.0028.0359, p 1.

238. On 30 May 2018, School 2 enquired with Service Provider 1 about a one-off short period of centre-based respite in relation to Jonathon and Kaleb.[1379]

239. On 1 June 2018, Kaleb turned 18 years old.

240. On 12 June 2018, School 2 staff contacted Paul Barrett about his respite needs and Kaleb's access to the National Disability Insurance Scheme (**NDIS**).[1380]

241. On 19 June 2018, School 2 staff enquired with Department of Disability Services about Kaleb's and Jonathon's access to the NDIS.[1381] The Department of Disability Services was aware, and informed School 2:

   a. Kaleb's 'access had been met'

   b. the NDIS requested evidence concerning Jonathon's access request.[1382]

242. On 7 August 2018, the Department of Child Safety received a notification of concerns for Jonathon and Kaleb (**7 August 2018 Notification**).[1383] The notification referred to:

   a. the hygiene and condition of Home 2[1384]

   b. Kaleb and Jonathon's movement in and around Home 2[1385]

   c. Kaleb and Jonathon's diet[1386]

   d. Paul Barrett's care and treatment of Kaleb and Jonathon.[1387]

243. On 8 August 2018, the Department of Child Safety did a pre-notification check in respect of the 7 August 2018 Notification with School 2. School 2 informed the Department of Child Safety:

   a. it considered there were 'no issues'[1388]

   b. teachers reported thought Paul Barrett was 'doing his very best'[1389]

1379 QLD.0005.0028.0362, pp 2-3.

1380 QLD.0005.0028.1360, p 29.

1381 QLD.0005.0028.0346, p 2.

1382 QLD.0005.0028.0346, p 1.

1383 QLD.0002.0027.1483_E, p 1.

1384 QLD.0002.0027.1483_E, p 3.

1385 QLD.0002.0027.1483_E, p 3.

1386 QLD.0002.0027.1483_E, p 3.

1387 QLD.0002.0027.1483_E, p 3.

1388 QLD.0002.0027.1483_E, p 3.

1389 QLD.0002.0027.1483_E, p 3.

c. teachers reported 'children do not like wearing shoes but this is due to their disability and dislike for shoes'[1390]

d. 'the children's lunch boxes are good, cannot see neglect or abuse'.[1391]

244. On 9 August 2018, the Department of Child Safety determined:

a. the information in the 7 August 2018 Notification did not meet the threshold for a Child Protection Notification under section 14 of the *Child Protection Act 1999* (Qld) (as in force)

b. recorded a CCR and referred the Family to Family and Child Connect (**FaCC**).[1392]

245. The Department of Child Safety considered:

a. it had conflicting information about Kaleb and Jonathon's diet.[1393]

b. it had conflicting information about Kaleb and Jonathon's movements in and around Home 2.[1394]

c. there was insufficient information about the hygiene and condition of Home 2 'apart from their being holes in the walls, paint coming off the walls and the house smelling of poo, which is likely to be a result of [Jonathon] and [Kaleb] incontinence issues'.[1395]

d. information from School 2 suggested Paul Barrett was 'doing his best' and it had 'no worries' about Paul Barrett's care for Kaleb and Jonathon.[1396]

246. On 28 August 2018, the Department of Child Safety received a notification of concerns for Kaleb and Jonathon (the **28 August 2018 Notification**).[1397] The notification referred to:

a. the conditions and hygiene of Home 2[1398]

b. Kaleb and Jonathon's diet[1399]

c. Paul Barrett's alleged consumption of alcohol.[1400]

1390 QLD.0002.0027.1483_E, p 3.

1391 QLD.0002.0027.1483_E, p 3.

1392 QLD.0002.0027.1483_E, p 4.

1393 QLD.0002.0027.1483_E, p 4.

1394 QLD.0002.0027.1483_E, p 4.

1395 QLD.0002.0027.1483_E, p 4.

1396 QLD.0002.0027.1483_E, p 4.

1397 QLD.0002.0027.1462_E, p 3.

1398 QLD.0002.0027.1462_E, p 3.

1399 QLD.0002.0027.1462_E, p 3.

1400 QLD.0002.0027.1462_E, p 3.

247. The Department of Child Safety recorded the information in the 28 August 2018 Notification in a CCR.[1401] It determined the information in the 28 August 2018 Notification did not warrant recording a Child Protection Notification.[1402]

248. On 30 August 2018, School 2 staff telephoned Paul Barrett and informed him Kaleb suffered a coughing attack on the bus into School 2.[1403] The staff made a file note of the telephone conversation.[1404]

249. On 17 September 2018, School 2 staff observed Kaleb had a lump on his head (**27 September 2018 Incident**).[1405] School 2 contacted Paul Barrett concerning the lump.[1406] School 2's records indicate there were 'no further details regarding the nature of incident'.[1407*]

250. There are no records of School 2 making a Student Protection Report concerning the 27 September 2018 Incident.[1408]

251. On 8 November 2018, [redacted] notified the Department of Child Safety of concerns for Kaleb and Jonathon (the **8 November 2018 Notification**).[1409] The notification referred to:

    a. the movements of Kaleb and Jonathon in and around Home 2[1410]

    b. Kaleb and Jonathon's hygiene[1411]

    c. the hygiene of Home 2[1412]

    d. the supervision of Kaleb and Jonathon in Paul Barrett's care.[1413]

252. On the same day, the Department of Child Safety determined that the Department should record a Child Protection Notification and recommended a Priority Response within 10 days.[1414]

1401 QLD.0002.0027.1462_E, p 4.

1402 QLD.0002.0027.1462_E, p 4.

1403 QLD.0005.0028.1410, p 1.

1404 QLD.0005.0028.1410, p 1.

1405 QLD.0005.0028.1410, p 1.

1406 QLD.0004.0028.0883, p 1.

1407 QLD.0004.0028.0883, p 1.

1408 QLD.0005.0052.0068, p 6; * We are unaware of any records of the 27 September 2018 incident being reported as a Student Protection Report. Please let us know if this is not the case.

1409 QLD.0008.0029.0190, pp 1-6; QLD.0002.0027.1448_E, p 9 – 11.

1410 QLD.0008.0029.0190, p 2.

1411 QLD.0008.0029.0190, p 2.

1412 QLD.0008.0029.0190, p 2.

1413 QLD.0008.0029.0190, p 2. D

1414 QLD.0002.0027.1448_E, p 9 – 11.

253. On the same day, the Department of Child Safety referred the information in the 8 November 2018 Notification to Queensland Police.[1415] Queensland Police determined the matter did not meet the threshold for a criminal investigation.[1416]

254. On the same day, the Department of Child Safety did a pre-notification check in respect of the 8 November 2018 with the deputy principal of School 2.[1417] The deputy principal informed the Department of Child Safety, they considered Kaleb and Jonathon:

    a. occasionally attended school with unwashed clothes or not showered but they were not dirty or unhygienic[1418]

    b. attended school with adequate lunches[1419]

    c. had adequate resources.[1420]

255. The deputy principal informed the Department of Child Safety they were unaware of Kaleb and Jonathon's supervision at home.[1421]

256. The Department of Child Safety conducted various interviews in response to the 8 November 2018 Notification.[1422]

257. On 28 November 2018, in response to the 8 November 2018 Notification, Child Safety Officer 7 interviewed the deputy principal of School 2.[1423] The deputy principal informed Child Safety Officer 7:

    a. Kaleb and Jonathon's attendance at school was very good[1424]

    b. Paul Barrett was 'coping well given the significant disabilities of both children'[1425]

    c. occasionally Kaleb and Jonathon attended school with unwashed clothes or not showered[1426]

    d. Kaleb and Jonathon attended school with lunches.[1427]

1415 QLD.0008.0029.0190, p 5; QLD.0002.0027.1436_E, p 1; QLD.0002.0027.1448_E, p 7. The Department of Child Safety allocated the 8 November Notification the intake number: 13904401, and IA number: 13904761.

1416 QLD.0002.0027.1448_E, p 7.

1417 QLD.0002.0027.1448_E, pp 5-6.

1418 QLD.0002.0027.1448_E, p 5.

1419 QLD.0002.0027.1448_E, p 6.

1420 QLD.0002.0027.1448_E, p 6.

1421 QLD.0002.0027.1448_E, p 6.

1422 QLD.0002.0027.1423_E, pp 1-8.

1423 QLD.0002.0027.1423_E, p 6.

1424 QLD.0002.0027.1423_E, p 6.

1425 QLD.0002.0027.1423_E, p 6.

1426 QLD.0002.0027.1423_E, p 6.

1427 QLD.0002.0027.1423_E, p 6.

258. On 28 November 2018, the Department of Child Safety requested a multi-agency meeting of CPA SCAN to discuss matters concerning Jonathon and relating to the 8 November 2018 Notification.[1428]

259. On 29 November 2018, in response to the 8 November 2018 Notification, Child Safety Officer 7 with another Child Safety Officer observed Jonathon at School 2. He wore a school uniform and they considered he 'looked neat and clean' and appeared 'physically healthy'.[1429]

260. On 30 November 2018, in response to the 8 November 2018 Notification, Child Safety Officers interviewed Paul Barrett at Home 2.[1430] Paul Barrett spoke with the Child Safety Officers about Kaleb and Jonathon's toileting,[1431] behaviours in Home 2,[1432] alcohol consumption,[1433] and his personal physical and mental health.[1434]

261. Paul Barrett informed Child Safety Officers:

   a. he thought he did not need support and was coping fine[1435]

   b. he received support from Teacher 2 and friends[1436]

262. On 30 November 2018, the Department of Child Safety completed a Safety Assessment and assessed that Jonathon was 'Safe.'[1437]

263. On 3 December 2018, CPA SCAN held a meeting relating to Jonathon's care.[1438] At the meeting the Department of Child Safety informed participants:

   a. Paul Barrett informed the Department of Child Safety 'he has just broken up with [redacted] and he believes that [redacted] made a vexatious complaint.'[1439]

   b. Paul Barrett informed the Department of Child Safety he had 'a large network of friends, he has an advocate that used to work at the school, and he also spoke about having a friend that helps him come and clean'.[1440]

1428 QLD.0008.0029.0624, pp 1-6; QLD.0008.0029.0215_E, pp 5-6; QLD.0002.0027.1423_E, p 7.

1429 QLD.0002.0027.1423_E, p 3.

1430 QLD.0002.0027.1423_E, pp 3-4.

1431 QLD.0002.0027.1423_E, pp 3-4.

1432 QLD.0002.0027.1423_E, p 4.

1433 QLD.0002.0027.1423_E, p 4.

1434 QLD.0002.0027.1423_E, pp 4-5.

1435 QLD.0002.0027.1423_E, pp 4-5.

1436 QLD.0002.0027.1423_E, p 4.

1437 QLD.0002.0027.1431_E, p 4.

1438 QLD.0008.0029.0636, pp 1-5.

1439 QLD.0008.0029.0636, p 2.

1440 QLD.0008.0029.0636, p 3.

c. Kaleb and Jonathon's rooms at Home 2 were 'completely bare, [Paul Barrett] had blown up mattresses'[1441]

264. At the CPA SCAN meeting the Department of Education informed participants it considered Paul Barrett may be minimising Jonathon's seizures which may be worth following up.[1442] Queensland Health informed participants Jonathon was 'last seen for seizures in April 2018 however didn't attend in October 2018 and his next appointment is in April 2019.'[1443]

265. CPA SCAN determined to do a further review of the matter on 14 January 2019.[1444]

266. On 10 December 2018, the Department of Child Safety determined Jonathon was 'safe' following a Safety Assessment in connection with the 8 November 2018 Notification.[1445]

267. On 19 December 2018, Child Safety Officer 7 commenced a FRE of the Family in connection with the 8 November 2018 Notification.[1446] They determined:

a. the risk level of the Family was 'high'[1447]

b. it would not intervene on an ongoing basis in the Family.[1448]

268. On 21 December 2018, Child Safety Officer 7 interviewed the General Practitioner in response to the 8 November 2018 Notification.[1449] The General Practitioner informed Child Safety Officer 7:

a. Paul Barrett was 'doing well managing the high needs of [Jonathon] and [Kaleb]'[1450]

b. additional supports for Paul Barrett would be beneficial given the complexity of Kaleb and Jonathon's conditions.[1451]

269. In late-2018, Kaleb finished attending School 2.[1452]

1441 QLD.0008.0029.0636, p 3.

1442 QLD.0008.0029.0636, p 3.

1443 QLD.0008.0029.0636, p 3.

1444 QLD.0008.0029.0636, p 4.

1445 QLD.0002.0027.1431_E, p 4.

1446 QLD.0002.0027.1419_E, pp 1-4.

1447 QLD.0002.0027.1419_E, p 3.

1448 QLD.0002.0027.1419_E, p 4.

1449 QLD.0002.0027.1423_E, p 7.

1450 QLD.0002.0027.1423_E, p 7.

1451 QLD.0002.0027.1423_E, p 7.

1452 QLD.0005.0028.1259, p 2.

2019

270. On 8 January 2019, the Department of Child Safety approved the FRE of the Family it commenced on 19 December 2018.[1453]

271. By 14 January 2019, the Department of Child Safety determined the information in the 8 November 2018 Notification was 'unsubstantiated' and Jonathon was a 'child not in need of protection', and closed the matter.[1454]

272. On 14 January 2019, CPA SCAN held a meeting relating to Jonathon's care.[1455] The Department of Child Safety informed participants it completed its IA of the 8 November 2018 Notification and determined it was unsubstantiated.[1456] The Department of Child Safety informed participants:

    a. the 8 November 2018 Notification 'seemed like quite a malicious notification'[1457]

    b. Paul Barrett managed the care of Kaleb and Jonathon 'quite well'[1458]

    c. a Child Safety Officer 'thought' Paul Barrett was doing his 'absolute best' and 'loved' Kaleb and Jonathon.[1459]

273. At this meeting, CPA SCAN closed the matter.[1460]

274. On 18 January 2019, [redacted] notified the Department of Child Safety of concerns for Jonathon and Kaleb (the **18 January 2019 Notification**).[1461] The notification referred to Kaleb and Jonathon's:

    a. movements in and around Home 2[1462]

    b. behaviours in Home 2[1463]

    c. hygiene[1464]

    d. diet.[1465]

1453 QLD.0002.0027.1419_E, pp 1-4.

1454 QLD.0008.0029.0630, p 2; QLD.0002.0027.1298_E, p 7.

1455 QLD.0008.0029.0630, pp 1-4.

1456 QLD.0008.0029.0630, p 2.

1457 QLD.0008.0029.0630, p 2.

1458 QLD.0008.0029.0630, p 2.

1459 QLD.0008.0029.0630, p 2.

1460 QLD.0008.0029.0630, p 2.

1461 QLD.0002.0027.1401_E, pp 1-9.

1462 QLD.0002.0027.1401_E, p 3.

1463 QLD.0002.0027.1401_E, pp 3, 7.

1464 QLD.0002.0027.1401_E, p 3.

1465 QLD.0002.0027.1401_E, p 3.

275. The notification also referred to the condition and hygiene of Home 2.[1466] [Redacted] informed the Department of Child Services they had not spoken to the Family or been in Home 2 for five months.[1467]

276. The Department of Child Safety did not do pre-notification check in respect of the 18 January 2019 Notification.[1468]

277. On or around 21 January 2019, the Department of Child Safety was aware the Family accepted a FaCC referral.[1469]

278. On 21 January 2019, the Department of Child Safety recorded the 18 January 2019 Notification as a CCR.[1470] It did not refer the Family for other supports.[1471]

279. On 23 January 2019, [redacted] notified the Department of Child Safety of concerns for Kaleb and Jonathon (**23 January 2019 Notification**).[1472] The notification referred to Kaleb and Jonathon's:

    a. toileting[1473]
    b. movements in and around Home 2[1474]
    c. diet[1475]
    d. hygiene.[1476]

280. The notification also referred to Paul Barrett's alleged consumption of alcohol.[1477] [Redacted] informed the Department of Child Services they had not spoken to the Family or been in Home 2 for five or six months.[1478]

281. The Department of Child Safety did not do pre-notification check in respect of the 23 January 2019 Notification.[1479]

1466 QLD.0002.0027.1401_E, p 3.

1467 QLD.0002.0027.1401_E, p 3.

1468 QLD.0002.0027.1401_E, p 4.

1469 QLD.0002.0027.1391_E, p 8.

1470 QLD.0002.0027.1401_E, p 6.

1471 QLD.0002.0027.1401_E, p 6.

1472 QLD.0002.0027.1391_E, pp 1-10.

1473 QLD.0002.0027.1391_E, p 3.

1474 QLD.0002.0027.1391_E, p 3.

1475 QLD.0002.0027.1391_E, p 3.

1476 QLD.0002.0027.1391_E, p 3.

1477 QLD.0002.0027.1391_E, p 3.

1478 QLD.0002.0027.1391_E, p 8.

1479 QLD.0002.0027.1391_E, p 5.

282. On 23 January 2019, the Department of Child Safety determined the 23 January 2019 Notification would be recorded as a CCR.[1480] It considered:

a. there was 'insufficient evidence/ contextual information' to conclude Jonathon did not have a parent who was willing and able to meet his care and protection needs adequately[1481]

b. 'A certain amount of compromised parenting ability/ behaviour is not uncommon in families with single parents having to care for children with significant disabilities. The [Paul Barrett] is being supported by multiple agencies and thus, there is insufficient evidence of the child, [Jonathon] being at an unacceptable risk of experiencing gross abuse/ gross neglect at this time.'[1482]

283. On 9 February 2019, a health professional notified the Department of Child Safety of concerns expressed to them by a community member about Kaleb and Jonathon (the **9 February 2019 Notification**).[1483] The notification referred to Kaleb and Jonathon's

a. movements in and around Home 2[1484]

b. access to food and water[1485]

c. behaviours at Home 2[1486]

d. supervision.[1487]

284. On the same day, the Department of Child Safety provided certain information in the 9 February 2019 Notification to Queensland Police.[1488]

285. In response to the 9 February 2019 Notification, the Department of Child Safety conducted various interviews.[1489]

286. On 10 February 2019, Child Safety Officers attended Home 2 unannounced and did a Safety Assessment in response to the 9 February 2019 Notification.[1490] They

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1480 QLD.0002.0027.1391_E, p 9.

1481 QLD.0002.0027.1391_E, p 9.

1482 QLD.0002.0027.1391_E, p 9

1483 QLD.0002.0027.1370_E, pp 1-12. The Department of Child Safety allocated the IA number: 13945183.

1484 QLD.0002.0027.1370_E, p 3.

1485 QLD.0002.0027.1370_E, p 3.

1486 QLD.0002.0027.1370_E, p 3.

1487 QLD.0002.0027.1370_E, p 3.

1488 QLD.0002.0027.1370_E, pp 3, 5.

1489 QLD.0002.0027.1327_E, pp 1-11.

1490 QLD.0002.0027.1327_E, pp 3-4; QLD.0002.0027.1354_E, pp 1-5.

interviewed Paul Barrett and observed Kaleb and Jonathon.[1491] The Child Safety Officers saw:

a. Kaleb was naked[1492]
b. Jonathon wore 'white medical-type disposable pull-up underpants' They were not soiled and were bright white[1493]
c. no marks on Kaleb or Jonathon's bodies[1494]
d. there was food in the fridges and freezers.[1495]

287. The Child Safety Officers considered Home 2 was 'chaotic and unhygienic.'[1496] They observed:

a. a room with 'one inflatable mattress' and 'several piles of faeces'[1497]
b. one mattress outside Home 2 with 'brown, wet stains'[1498]
c. the home smelled of faeces.[1499]

288. Paul Barrett informed Child Safety Officers he thought he did not require additional support to care for Kaleb or Jonathon.[1500] Child Safety Officers considered he was unwilling to discuss respite, in-home support or other professional assistance.[1501]

289. On 13 February 2019, in connection with the 9 February 2019 Notification, the Department of Child Safety determined Paul Barrett did not meet Jonathon's immediate needs for supervision, clothing, medical or mental health care and as a result his health or wellbeing was serious impaired.[1502] The Department of Child Safety had 'significant concerns for both [Jonathon] and [Kaleb's] emotional wellbeing, given the lack of respect and dignity provided to them'.[1503]

1491 QLD.0002.0027.1327_E, p 3; QLD.0002.0027.1354_E, p 3.

1492 QLD.0002.0027.1327_E, p 3.

1493 QLD.0002.0027.1327_E, p 3.

1494 QLD.0002.0027.1327_E, p 4.

1495 QLD.0002.0027.1327_E, p 4.

1496 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1497 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1498 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1499 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1500 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1501 QLD.0002.0027.1327_E, p 4; QLD.0002.0027.1354_E, p 3.

1502 QLD.0002.0027.1354_E, p 2.

1503 QLD.0002.0027.1354_E, p 3.

290. The Department of Child Safety considered:

a. it was not legally mandated to intervene in relation to Kaleb.[1504]

b. there needed to be ongoing discussions with the NDIS to ensure Kaleb received the level of care he required.[1505]

291. The Department of Child Safety made a safety plan in respect of Jonathon with a review date of 12 February 2019.[1506]

292. On 6 March 2019, Child Safety Officers attended the Home 2 unannounced and interviewed Paul Barrett in relation to the 9 February 2019 Notification. The interview concerned:

a. Kaleb and Jonathon's accommodation[1507]

b. the hygiene and condition of Home 2[1508]

c. supports Paul Barrett had to care for Kaleb and Jonathon[1509]

d. Kaleb and Jonathon's access to the NDIS.[1510]

293. On 7 March 2019, Child Safety Officer 7 attended School 2 and did a Safety Assessment concerning Jonathon in connection with the 9 February 2019 Notification.[1511]

294. On 7 March 2019, the Department of Child Safety received a further notification concerning Kaleb.[1512] It recorded the notification as an additional concern in its IA of the 9 February 2019 Notification (**2019 Additional Concern Notification**).[1513] The notification referred to Kaleb leaving Home 2 and entering a [redacted] property for 1 hour and 15 minutes.[1514] The notifier informed the Department of Child Safety they contacted Queensland Police.[1515]

1504 QLD.0002.0027.1354_E, p 3.

1505 QLD.0002.0027.1354_E, p 3.

1506 QLD.0002.0027.1354_E, pp 4-7.

1507 QLD.0002.0027.1327_E, p 5.

1508 QLD.0002.0027.1327_E, pp 5-6.

1509 QLD.0002.0027.1327_E, pp 5-6.

1510 QLD.0002.0027.1327_E, p 6.

1511 QLD.0002.0027.1344_E, pp 1-5.

1512 QLD.0002.0027.1349_E, pp 1-5.

1513 QLD.0002.0027.1349_E, pp 1, 5.

1514 QLD.0002.0027.1349_E, p 2.

1515 QLD.0002.0027.1349_E, p 2.

295. On the same day, the Department of Child Safety determined to record the 2019 Additional Concern Notification as a Child Concern Report.[1516] It considered Kaleb was over 18 years old and fell outside the Department of Child Safety's jurisdiction.[1517]

296. On 7 March 2019, Queensland Police attended Home 2 and the house of [redacted] where they located Kaleb.[1518] Queensland Police spoke to [redacted] and Paul Barrett. Queensland Police took body camera footage of their attendance.[1519]

297. On 26 March 2019, the Department Child Safety determined in a Safety Assessment of Jonathon done in connection with the 9 February 2019 Notification that he was 'Safe'.[1520]

298. On 3 April 2019, Child Safety Officer 7 interviewed Teacher 2 in response to the 9 February 2019 Notification.[1521] The interview concerned Teacher 2's relationship with the Family, [redacted] attendance at Home 2, [redacted] observations about Home 2's condition and the supports [redacted] thought the Family accessed.[1522]

299. The Department of Child Safety records also specify Child Safety Officer 7 interviewed the Family's General Practitioner on 3 April 2019 in response to the 9 February 2019 Notification.[1523]

300. On 4 April 2019, the Department of Child Safety completed a FRE of the Family in connection with the 9 February 2019 Notification. It assessed the Family's risk was 'high'.[1524] It determined the 9 February 2019 Notification was unsubstantiated and Jonathon was not in need of protection.[1525] It considered:

> [W]hen completing the [Family Risk Evaluation] it was evident that the neglect score was heavily influenced by Mr Barrett's historical alcohol misuse, historical mental health, and the historical child protection history. Mr Barrett over a number of years, with support, has overcome these challenges, and this does not provide a true reflection or Mr Barrett's current capacity to care for the child. The Department have not received information, or gathered information to support that Mr Barrett has a current alcohol addiction, or is currently suffering from mental health

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1516 QLD.0002.0027.1349_E, p 4.

1517 QLD.0002.0027.1349_E, p 4.

1518 QLD.0008.0029.0654, p 1; QLD.0008.0053.0005, p 1.

1519 QLD.0008.0029.0653.

1520 QLD.0002.0027.1344_E, p 4.

1521 QLD.0002.0027.1327_E, p 7.

1522 QLD.0002.0027.1327_E, p 7.

1523 QLD.0002.0027.1327_E, p 9.

1524 QLD.0002.0027.1323_E, p 1.

1525 QLD.0002.0027.1323_E, p 1.

related issues. Further, within this assessment the multitude of supports that Mr Barrett currently has in place demonstrates that Mr Barrett has a healthy support network, which also ensures that [Jonathon] is highly visible in the community. Therefore, although the [Family Risk Evaluation] outcome is returning a HIGH reading, it appears that this is largely based on historical factors that Mr Barrett has overcome, and does not provide a current reflection of Mr Barrett's parenting ability.[1526]

301. There were no records the Department of Child Safety received any Child Protection Notifications concerning Jonathon between 5 April 2019 and 31 December 2019.[1527]

302. On 4 June 2019, contractors attended Home 2 to undertake planned works.[1528] Contractors informed the Department of Housing they placed the works on hold as they considered there were health and safety concerns relating to the condition of the house.[1529] A video was recorded of Home 2.[1530]

303. On 4 June 2019, the Department of Housing wrote to Paul Barrett and referred to its concerns about 'the poor condition of [Home 2], clutter, rubbish and belongings throughout causing a health and safety concern'.[1531]

304. On or around 26 June 2019, the Department of Housing did a home visit of Home 2.[1532] On around 26 June 2019 the Department of Housing had photos of Home 2.[1533]

305. On 28 and 29 October 2019, the Department of Housing received photos of Home 2.[1534]It was aware contractors who attended Home 2 to undertake planned works considered the house was 'in an extremely poor hygienic state'.[1535]

306. On 14 November 2019, a senior housing officer at the Department of Housing instructed that concerns about the hygiene of Home 2 be logged as a complaint into 'Reside', logged 'onto the spreadsheet', and photographs of Home 2 be uploaded to Content Manager.[1536*]

1526 QLD.0002.0027.1323_E, p 2.

1527 We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

1528 QLD.0001.0026.0053, p 1; QLD.0001.0026.0083, p 3; QLD.0001.0026.2539, pp 1-4.

1529 QLD.0001.0026.0053, p 1; QLD.0001.0026.0083, p 3; QLD.0001.0026.2539, pp 1-4.

1530 QLD.0001.0026.2998.

1531 QLD.0001.0026.0083, p 2.

1532 QLD.0001.0026.0053, p 1.

1533 QLD.0001.0026.0053, p 1; QLD.0001.0026.0146, pp 1-10.

1534 QLD.0001.0026.3120, pp 1-7; QLD.0001.0026.2677, p 7.

1535 QLD.0001.0026.2677, p 6.

1536 QLD.0001.0026.0203, p 1; Refer to the Department of Housing Review at paragraphs 354 to 355 below.

From 2020

307. By around 11 February 2020, School 2 was aware:

   a. Jonathon did not have access to the NDIS[1537]

   b. had not regularly brought incontinence products for his personal needs to School 2 for about 6 months[1538]

   c. School 2 provided Jonathon with incontinence products.[1539]

308. By this date, School 2 staff and Paul Barrett had discussed Jonathon's access to the NDIS.[1540]

309. On 25 February 2020, School 2 staff and Paul Barrett had a phone discussion about Jonathon's access to the NDIS and access to incontinence aids.[1541]

310. On 24 March 2020, the Queensland Premier announced Queensland would restrict access at the State boarder from midnight on 25 March 2020 due to COVID-19.[1542]

311. On 26 March 2020, the Queensland Government announced that State schools would be student-free from 30 March 2020 to 3 April 2020. Schools would remain open for children of essential workers.[1543]

312. On 30 March 2020, Jonathon began learning from Home 2 due to COVID-19 restrictions in Queensland.[1544]

1537 QLD.0005.0028.1056, pp 1-2.

1538 QLD.0005.0028.1056, p 1.

1539 QLD.0005.0028.1056, pp 1-2.

1540 QLD.0005.0028.1056, pp 1-2.

1541 QLD.0005.0028.0354, p 2.

1542 'Border Controls Slows Virus Spread', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 24 March 2020. <https://statements.qld.gov.au/statements/89585>; Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>

1543 'Student free days for Queensland state schools next week', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 26 March 2020. <https://statements.qld.gov.au/statements/89596>; Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>

1544 QLD.0004.0028.3597, p 46; QLD.0019.0051.0001, p 6.

313. On 3 April 2020, Term 1 of School 2 concluded and Autumn holidays commenced for Jonathon.[1545]

314. On 13 April 2020, the Queensland Government announced school students would be learning from home for the first five weeks of Term 2 with schools opened to children of essential workers, vulnerable students and students in indigenous communities.[1546] The home-based learning model was scheduled to operate from 20 April to 22 May 2020.[1547]

315. On 20 April 2020, Term 2 of School 2 commenced with home-based learning for Jonathon.[1548]

316. On 30 April 2020, School 2 staff called Paul Barrett concerning Jonathon.[1549] School 2 staff was aware Paul Barrett thought Jonathon was coping well.[1550]

317. On 1 May 2020, School 2 staff delivered school packs to Home 2 due to COVID-19.[1551] The staff offered Paul Barrett help with any of the work.[1552] The staff did not see Jonathon.[1553] The staff considered the outside presentation of the house was 'tidy'.[1554]

1545 QLD.0004.0028.3597, pp 46-47; Department of Education, '2020: School calendar: Queensland state schools', *Department of Education*, web page. <https://education.qld.gov.au/about/Documents/2020-school-calendar.pdf>.

1546 Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>; 'Initial Term 2 school arrangements for Queensland announced', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 13 April 2020. <https://statements.qld.gov.au/statements/89673>; 'Support for every family', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 19 April 2020. <https://statements.qld.gov.au/statements/89701>.

1547 'Initial Term 2 school arrangements for Queensland announced', *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 13 April 2019. <https://statements.qld.gov.au/statements/89673>.

1548 QLD.0004.0028.3597, pp 46-47; Department of Education, '2020: School calendar: Queensland state schools', *Department of Education*, web page. <https://education.qld.gov.au/about/Documents/2020-school-calendar.pdf>.

1549 QLD.0005.0028.0354, p 1.

1550 QLD.0005.0028.0354, p 1.

1551 QLD.0005.0028.1360, p 24.

1552 QLD.0005.0028.1360, p 24.

1553 QLD.0005.0028.1360, p 24.

1554 QLD.0005.0028.1360, p 24.

318. On 1 May 2020, School 2 staff spoke with Paul Barrett about Jonathon and his access to NDIS funding.[1555] School 2 staff was aware of Paul Barrett's worries 'he would lose his carers pension if he accessed NDIS Funding' for Jonathon.[1556]

319. On 4 May 2020, the Queensland Government announced steps for children to return to school for students in kindy, prep, years 1, 11 and 12 to return to school from 11 May 2020.[1557]

320. School 2 records stated on 11 May 2020 '[Paul Barrett] did not realise [Jonathon] was starting back at school today'.[1558]

321. On 19 May 2020, the Teachers' Aide texted Teacher 2 concerning Kaleb and Jonathon.[1559] The Teachers' Aide's text stated:

> I just wanted to see if you could perhaps call [Paul Barrett]. I'm very very [sic] worried about him and the boys…. [sic] I'm not sure if you're aware of [Paul Barrett's] current health situation but it isn't good. [Jonathon] has lost lots of weight and I believe he isn't/hasn't been getting his Epilim medication for his seizures for a many [sic] weeks now… I've tried talking to [Paul Barrett] myself, maybe he needs another perspective from someone who has a good relationship with him. He messaged me early this morning (6am) letting me know that [Jonathon] won't be coming to school today which is very unusual.[1560]

322. On 26 May 2020, School 2 staff attempted to call Paul Barrett to check on Jonathon's welfare.[1561] There was no answer and the staff left a message.[1562]

323. There were no records the Department of Child Safety received any Child Protection Notifications concerning Jonathon between 1 January 2020 to 26 May 2020.[1563]

1555 QLD.0005.0028.0127, p 1.

1556 QLD.0005.0028.0127, P 1.

1557 'Queensland success leads sensible steps back to school' *Queensland Government: The Queensland Cabinet and Ministerial Directory*, media release, 4 May 2020. <https://statements.qld.gov.au/statements/89773>; Rebecca Storen and Nikki Corrigan, 'COVID-19: a chronology of state and territory government announcements (up until 30 June 2020)', *Parliament of Australia*, web page, 22 October 2020. <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements>.

1558 QLD.0004.0028.3597, p 45.

1559 QLD.0005.0028.0154, p 1.

1560 QLD.0005.0028.0154, p 1.

1561 QLD.0005.0028.1360, p 24.

1562 QLD.0005.0028.1360, p 24.

1563 We are unaware of any records of Child Protection Notifications in this period. Please let us know if this is not the case.

After Paul Barrett's death

324. At about 7:19 am on 27 May 2020, a family friend called Queensland Ambulance Service concerning Paul Barrett.[1564]

325. At about 7:20 am, Queensland Ambulance Service attended Home 2.[1565] Queensland Ambulance Service observed:

    a. Paul Barrett had a cardiac arrest[1566]

    b. Kaleb and Jonathon were 'LOCKED IN A ROOM, NAKED AND NO BEDROOM FURNISHINGS'.[1567]

326. Queensland Police also attended Home 2 that day. They observed:

    a. faeces on the floor of the spare bedroom and main bedroom[1568]

    b. Kaleb and Jonathon's bedroom was completely bare with doorhandles removed[1569]

    c. Kaleb and Jonathon were unclothed.[1570]

327. On 27 May 2020, Kaleb and Jonathon were admitted to Hospital 3.[1571] During his admission, Kaleb and Jonathon were each diagnosed with 'severe malnutrition, kwashiorkors'.[1572]

328. On 27 May 2020, the Director-General of the Department of Disability Services sent correspondence to the then Acting Public Guardian, notifying them of Paul Barrett's death, and seeking the Public Guardian assess Kaleb and Jonathon.[1573]

329. On 28 May 2020, media outlets began reporting on the death of Paul Barrett and the conditions Kaleb and Jonathon were found in at Home 2.[1574]

330. On 28 May 2020, the Department of Child Safety referred a matter concerning Jonathon's safety to CPA SCAN (the **28 May 2020 Notification**).[1575]

1564 QLD.0007.0032.0096, p 1.

1565 QLD.0007.0032.0096, p 1.

1566 QLD.0007.0032.0096, p 2.

1567 QLD.0007.0032.0096, p 2.

1568 QLD.0008.0029.0431, p 7.

1569 QLD.0008.0029.0431, p 7.

1570 QLD.0008.0029.0431, p 7.

1571 QPG.9999.0002.1389_E, p 1; QPG.9999.0002.1383_E, p 1; QLD.0008.0029.0431, p 9.

1572 QPG.9999.0002.1389_E, p 1; QPG.9999.0002.1383_E, p 1.

1573 QLD.0020.0050.1616, p 1.

1574 [Redacted]

1575 QLD.0003.0027.6901_E, pp 1-5.

331. On 1 June 2020, CPA SCAN held a meeting in relation to the 28 May 2020 Notification.[1576] CPA SCAN recommendations in respect of Jonathon included:

a. the Department of Education contact School 2 Principal about sourcing a kin carer by 8 June 2020[1577]

b. the Department of Child Safety provide an update on the progress of NDIA planning, provide feedback on the Mother's parenting and capacity assessments, provide an update on placement planning by 8 June 2020.[1578]

332. On 2 June 2020, the Principal 2 informed Queensland Police that School 2 did not have records of notifications made to the Department of Child Safety in the period of 2 June 2018 to 2 June 2020.[1579]

333. On 3 June 2020, QCAT made interim orders:

a. appointing the Public Guardian as guardian for Kaleb for accommodation, health care matters and the provision of services decisions.[1580] The appointment was to remain in force for 3 months.[1581]

b. appointing the Public Trustee as administrator for Kaleb for all financial matters. The appointment was to remain in force for 3 months.[1582]

334. On 4 June 2020, a psychologist prepared a report regarding the parenting capacity of the Mother based on a referral from the Department of Child Safety.[1583] The psychologist determined the Mother did not have capacity to care for Jonathon.[1584]

335. On 4 June 2020, a Child Safety Officer applied for a TAO in respect of Jonathon.[1585]

336. On 4 June 2020, a Magistrate of the Childrens Court made a TAO in respect of Jonathon.[1586] The order:

1576 QLD.0003.0027.6906_E, pp 1-31.

1577 QLD.0003.0027.6906_E, p 6.

1578 QLD.0003.0027.6906_E, p 6.

1579 QLD.0005.0028.1325, pp 1-2.

1580 QPG.9999.0002.1368_E, p 1.

1581 QPG.9999.0002.1368_E, p 1.

1582 QPG.9999.0002.1368_E, p 1.

1583 QLD.0003.0027.6885_E, pp 1-16.

1584 QLD.0003.0027.6885_E, p 2.

1585 QLD.0003.0027.6952_E, pp 1-9.

1586 QLD.0003.0027.6951_E, p 1.

a. authorised a medical examination or treatment of Jonathon[1587]
b. authorised an authorised officer or police officer to take Jonathon into the Chief Executive's custody whilst the order was in force[1588]
c. directed the Mother not to have contact with Jonathon other than when a departmentally approved person was present[1589]
d. was in force until 9 June 2020.[1590]

337. On 9 June 2020, Child Safety Officer 7 applied for a temporary custody order in respect of Jonathon.[1591]

338. On 9 June 2020, a Magistrate of the Childrens Court ordered that:

a. Jonathon may be medically examined or treated[1592]
b. an authorised officer or police officer be authorised to keep Jonathon in the Chief Executive's custody while the order was in force[1593]
c. the Mother was not to have contact with Jonathon other than when a departmentally approved person was present.[1594]

339. The order was in force until 12 May 2020.[1595]

340. On 10 June 2020, the Department of Child Safety approved a FRE in relation to Jonathon.[1596] It viewed:

a. Jonathon needed protection[1597]
b. the Mother was unable to meet Jonathon's ongoing care and protection needs.[1598]

1587 QLD.0003.0027.6951_E, p 1.
1588 QLD.0003.0027.6951_E, p 1.
1589 QLD.0003.0027.6951_E, p 1.
1590 QLD.0003.0027.6951_E, p 1.
1591 QLD.0003.0027.6807_E, pp 1-10.
1592 QLD.0003.0027.6806_E, p 1.
1593 QLD.0003.0027.6806_E, p 1.
1594 QLD.0003.0027.6806_E, p 1.
1595 QLD.0003.0027.6806_E, p 1.
1596 QLD.0002.0027.1233_E, pp 1-11.
1597 QLD.0002.0027.1233_E, p 2.
1598 QLD.0002.0027.1233_E, p 9.

341. The Department of Child Safety determined to apply for a CPO granting guardianship of Jonathon to the Chief Executive until he turned 18 years old.[1599]

342. On 10 June 2020, Kaleb and Jonathon were each discharged from Hospital 3.[1600]

343. On 12 June 2020, the Director of Child Protection of the Department of Child Safety applied for a CPO in respect of Jonathon.[1601]

344. On 17 June 2020, an Area Manager of the Department of Housing informed DS Worker [3] that Home 2 required a full decontamination, and all clothing and toys found at the property had been disposed of.[1602]

345. By 24 June 2020, DS Worker 3 sent an email to Department of Disability Services staff with an update on Kaleb and Jonathon. [Redacted] informed staff there were arrangements for:

    a. long-term housing for Jonathon and Kaleb[1603]
    b. Kaleb and Jonathon and to see a number of medical providers, including, the General Practitioner, an autism specialist and a dentist[1604]
    c. house furniture and clothing for Kaleb and Jonathon[1605]
    d. a visit with the Mother.[1606]

346. On 8 October 2020, a Magistrate of the Childrens Court made a CPO in respect of Jonathon. The order granted long term guardianship of Jonathon to the Chief Executive of the Department of Child Safety pursuant to section 61(f)(iii) of the *Child Protection Act 1999* (Qld). The order was to continue in force until Jonathon turned 18 years old.[1607]

347. On 2 September 2020, the QCAT made orders:

    a. appointing the Public Guardian as Kaleb's guardian for the provision of services, including in relation to the NDIS, decisions. The appointment was to remain in force until further order of QCAT. The appointment was reviewable and was to be reviewed in five years.[1608]

1599 QLD.0002.0027.1233_E, p 9.

1600 QPG.9999.0002.1389_E, p 1; QPG.9999.0002.1383_E, p 1.

1601 CTD.8000.0050.0520, p 1; QLD.0003.0027.6978_E, pp 1-17.

1602 QLD.0020.0050.0098, p 1.

1603 QLD.0020.0050.0020, p 1.

1604 QLD.0020.0050.0020, p 1.

1605 QLD.0020.0050.0020, p 1.

1606 QLD.0020.0050.0020, p 1.

1607 CTD.8000.0050.0520, p 1.

1608 QPG.9999.0002.1524_E, p 1.

b. appointing the Public Trustee as Kaleb's administrator for all financial matters. The appointment was to remain in force until a further order of QCAT.[1609]

348. On 21 March 2021, Jonathon turned 18 years old.

349. On 31 March 2021, QCAT appointed the Public Guardian as Kaleb's guardian for restrictive practices decisions. The appointment was to remain in force for two years unless QCAT ordered otherwise.[1610]

350. On 23 June 2021, QCAT made orders:

a. appointing the Public Guardian as Jonathon's guardian for health care and provision of services, including in relation to the NDIS, decisions. The appointment was to remain in force until further order of QCAT. The appointment was reviewable and was to be reviewed in two years.[1611]

b. appointing the Public Guardian as Jonathon's guardian for restrictive practices. The appointment was to remain in force for two years unless QCAT ordered otherwise.[1612]

c. appointing the Public Trustee as Jonathon's administrator for all financial matters.[1613] The appointment was to remain in force until further order of QCAT.[1614]

Investigations and reviews

Queensland Police

351. On 27 May 2020, the Queensland Police opened an investigation into Paul Barrett's death.[1615]

352. On 11 June 2020, the Queensland Police finalised its investigation into the suspected harm of Kaleb and Jonathon (**Queensland Police Report**).[1616] Queensland Police determined its 'investigation failed to identify a criminal offence of any nature, against any person or entity to cause the continuance of a QPD investigation.'[1617]

1609 QPG.9999.0002.1524_E, p 1.

1610 QPG.9999.0005.1476, p 1.

1611 QPG.9999.0007.0053, p 1.

1612 QPG.9999.0007.0053, p 1.

1613 QPG.9999.0007.0053, p 1.

1614 QPG.9999.0007.0053, p 1.

1615 QLD.0005.0028.1259, p 3.

1616 QLD.0008.0029.0211, pp 1-200.

1617 QLD.0008.0029.0211, pp 1, 16.

Department of Housing

353. On 28 May 2020, the Department of Housing became aware of Paul Barrett's death. Department of Housing contractors attended Home 2 and took photos of Home 2.[1618]

354. On 29 May 2020, a prior area manager engaged by the Department of Housing prepared an internal document for the purposes of discussion with more senior and executive managers. The internal document concerned the Family's tenancy of Home 2 in the period of June 2015 to around 29 May 2020 (**Department of Housing Area Manager Informal Review**).[1619] The Department of Housing Area Manager Informal Review was not a formal review conducted by the Department of Housing but was a document prepared by the area manager for internal discussion with senior and executive managers and set out a summary of the area manager's view as:

- There is a history of the HSC maintaining contact with Mr Barrett regarding the poor condition of his property.
- The HSC appears to be focussed on telling Mr Barrett that the property condition needs to be improved with inspections carried out regularly at times. There is no evidence that the HSC identified that Mr Barrett needed support to maintain his property even though Mr Barrett indicated on many occasions that he was struggling to maintain the property and parent his two disabled children. These are missed opportunities to broker support for Mr Barrett through community or other Government agencies.
- There are no records that the HSC received complaints about how Mr Barrett cared for his children or the internal condition of his house.
- Records indicate that there are at least 12 occasions where staff could have escalated their concerns and/or notified to [the Department of] Child Safety.[1620]

355. The **Department** of Housing Area Manager Informal Review expressed the view there no records Paul Barrett was offered referral to support agencies for assistance or that concerns were escalated to the Department of Child Safety or to a senior officer for consideration on the following occasions where staff could have escalated concerns and/or notified the Department of Child Safety were in connection with:

   a. the 28 August 2015 inspection of Home 2[1621]

1618 QLD.0001.0026.1460, pp 2, 12.

1619 QLD.0001.0026.1460, pp 2-12.

1620 QLD.0001.0026.1460, p 10.

1621 QLD.0001.0026.1460, p 3.

b. the 6 November 2015 notice to remedy breach for Home 2's poor property condition[1622]

c. the 26 November 2015 inspection of Home 2[1623]

d. the 17 May 2016 contact with Paul Barrett concerning Home 2's fence[1624]

e. the 30 November 2017 inspection of Home 2[1625]

f. the 8 March 2018 inspection of Home 2[1626]

g. the 3 May 2018 inspection of Home 2[1627]

h. the Department of Housing's contractor's attendance at Home 2 on 14 November 2019.[1628]

QFCC System Review

356. On 1 June 2020, Queensland Attorney-General 1 requested the Principal Commissioner of the QFCC:

> commence a system review into the policies and practices of relevant agencies who were involved with [Kaleb] and [Jonathon], as well as those agencies that were not involved but perhaps could have played a role in supporting the [F]amily' [**QFCC System Review Request**].[1629]

357. The QFCC System Review Request referred to the proposed commencement of the Child Death Review Board on 1 July 2020.[1630] The Queensland Attorney General 1 informed the Principal Commissioner she would consider whether it would be appropriate for the Child Death Review Board to assume responsibility for the review after this date.[1631]

358. On 4 June 2020, Principal Commissioner of the QFCC, Cheryl Vardon, established the Terms of Reference in respect of the QFCC System Review Request.[1632] The terms of reference specified:

1622 QLD.0001.0026.1460, p 3.

1623 QLD.0001.0026.1460, p 4.

1624 QLD.0001.0026.1460, pp 3-4.

1625 QLD.0001.0026.1460, pp 4-5.

1626 QLD.0001.0026.1460, p 6.

1627 QLD.0001.0026.1460, pp 7-8.

1628 QLD.0001.0026.1460, p 9.

1629 QLD.0019.0051.0001, p 21.

1630 QLD.0019.0051.0001, p 22.

1631 QLD.0019.0051.0001, p 22.

1632 QLD.0019.0051.0001, p 23.

a. The QFCC was to review legislation, policies and practices that supported coordinated responses between agencies to meet the disability support and protection needs of children at risk of harm.[1633]

b. The Child Death Review Board was to establish the system of contact points with the family in the years prior to the younger brother's discovery to examine the effectiveness and appropriateness of responses. This included mapping the interaction of agencies involved with the Family during periods of heightened vulnerability.[1634]

c. The Child Death Review Board was to identify gaps and opportunities for system improvements to legislation, policies and practices and recommend changes to strengthen the child protection system and to promote the safety and wellbeing of children.[1635]

359. On 2 October 2020, the Queensland Attorney General 1 informed the Principal Commissioner she would not refer certain matters outlined in the Terms of Reference for the QFCC System Review Request to the Child Death Review Board.[1636]

360. In about December 2020, the QFCC Principal Commissioner Cheryl Vardon's finalised her review in response to the QFCC System Review Request (**the QFCC December 2020 Report**).[1637]

361. The QFCC Principal Commissioner considered:

> [Kaleb] and [Jonathon] had high support needs and relied entirely on [Paul Barrett] and the system to care for and protect them. However, gaps in system responses meant that at times [Paul Barrett] was responsible for meeting their needs alone.[1638]

362. The QFCC Principal Commissioner viewed in relation to Jonathon's needs during COVID-19, Jonathon 'should have been assessed as a vulnerable child' when he began learning from home during COVID-19.[1639]

> If he had been, school attendance and supports could have been maintained and his safety and wellbeing more closely monitored. This would have also eased demands on his [Paul Barrett].[1640]

1633 QLD.0019.0051.0001, p 23.

1634 QLD.0019.0051.0001, p 23.

1635 QLD.0019.0051.0001, p 23.

1636 QLD.0019.0051.0001, p 9.

1637 QLD.0019.0051.0001, pp 1-26.

1638 QLD.0019.0051.0001, p 6.

1639 QLD.0019.0051.0001, pp 6, 12.

1640 QLD.0019.0051.0001, pp 6, 12.

363. The **QFCC December 2020 Report** set out the QFCC Principal Commissioner's observations that as at early 2020:

a. Paul Barrett struggled with the application process for Jonathon's access to the NDIS[1641]

b. Paul Barrett refused further contact with the NDIA and NDIS services.[1642]

364. The **QFCC** Principal Commissioner found:

a. professionals did not receive enough guidance about how to share information to support NDIS applications for children in the care of parents[1643]

b. there were limited pathways for direct referrals to the NDIS by professionals on the family's behalf.[1644]

365. The QFCC Principal Commissioner considered 'the system did not recognise and respond to the challenges experienced by their [Paul Barrett] in navigating the NDIS access process'.[1645]

366. The QFCC Principal Commission was informed by the NDIA '[Kaleb] was an NDIS participant but had not accessed any of his eligible supports and services'.[1646] The QFCC Principal Commissioner viewed:

> There are no mechanisms for responding when a child's funding package is not being used. If there were, further action could be taken to follow up with the family. In the case of the [Family], [Kaleb] could have been helped to access the available supports. This may also have provided an opportunity to help the brothers' father [Paul Barrett] to prepare [Jonathon's] NDIS application.[1647]

367. On 30 March 2021, the Queensland Attorney-General 1 provided the QFCC December 2020 Report to the Department of Child Safety, the Department of Education, the Department of Disability Services and the Premier of Queensland.[1648]

368. On 20 August 2021, the Queensland Attorney-General 2 tabled a summary report by the QFCC, entitled 'Keeping school-aged children with disability safe' (**Summary Report)**[1649]

1641 QLD.0019.0051.0001, p 7.

1642 QLD.0019.0051.0001, p 7.

1643 QLD.0019.0051.0001, p 7.

1644 QLD.0019.0051.0001, p 7.

1645 QLD.0019.0051.0001, p 7.

1646 QLD.0019.0051.0001, p 7.

1647 QLD.0019.0051.0001, pp 7, 14.

1648 QLD.0020.0050.2574, p 4.

1649 QLD.0020.0050.2209, p 1.

369. On 13 May 2022, Queensland Attorney-General 2 wrote to the Honourable Ronald Sackville AO KC, Chair of the Royal Commission.[1650] The letter enclosed the Summary Report.

370. The letter from Queensland Attorney-General 2 to the Royal Commission dated 13 May 2022 and the Summary Report do not refer to Kaleb and Jonathon.[1651]

371. As at the date of this proposed statement of agreed facts, the Summary Report is available on the QFCC's website.[1652]

Department of Education Review

372. On 3 June 2020, a Department of Education representative completed a Desktop Audit concerning Kaleb, Jonathon and School 2 (**Department of Education Review**).[1653]

373. On 14 June 2020, the Regional Director at the Department of Education informed the Deputy Director-General, State Schools Division at the Department of Education of actions School 2 was taking in connection with its record keeping, Kaleb and Jonathon, and staff training.[1654] The Regional Director informed the Deputy Director-General School 2's actions included:

a. 'Compulsory Training for all staff to be provided by Metro Director Strategy and Performance and Regional Student Protection Advisor beginning immediately - Mandatory Reporting Requirements; OneSchool use; Report writing; Code of Conduct; Child Protection Training; etc.'[1655]

b. 'Regional Additional Allocation will be used to provide a Business Manager Coach to work with [School 2] to improve understanding of responsibilities and review systems and procedures at the school'.[1656]

1650 QLD.9999.0066.0001, p 1.

1651 QLD.9999.0066.0001, p 1; QLD.9999.0066.0003, pp 1-16.

1652 Queensland Family & Child Commission, 'Summary Report', *Queensland Family & Child Commission*, web page. <https://www.qfcc.qld.gov.au/sites/default/files/2022-08/Keeping%20school-aged%20children%20with%20disability%20safe%20-%20Summary%20report.pdf>.

1653 QLD.0004.0028.0614, p 1; QLD.0005.0052.0068, pp 1-8; QLD.0004.0028.0617, pp 1-2.

1654 QLD.0004.0028.0696, pp 1-2.

1655 QLD.0004.0028.0696, p 2.

1656 QLD.0004.0028.0696, p 2.

Appendix B Agreed Facts definitions and terminology

For the purpose of these agreed facts:

'Assistant Regional Director 1' means [redacted], Department of Education

'Bus Service' mean [redacted]

'Care Agreement' means an agreement between the Department of Child Safety and a child's parents to place their child in an approved care arrangement for a short period of time

'CSSC' means a Child Safety Service Centre. These are centres under the control of the Department of Child Safety and provide support and services to children, young people, families and carers to ensure children's safety and wellbeing

'Child Advocacy Service' means a service provided by the [redacted] Hospital

'Child Concern Report' or ***'CCR'*** means a record of child protection concerns received by the Department of Child Safety that does not meet the threshold for a Child Protection Notification. A Child Safety Officer may respond to a Child Concern Report by providing information and advice, making a referral to an appropriate agency, or providing information to the police or another state authority

'Child Death Review Board' or ***'CDRB'*** is the organisation responsible for undertaking systemic reviews following the death of a child connected to the child protection system under Part 3A of the *Family and Child Commission Act 2014* (Qld)

'Child Health' means 'Child Health Services' and 'Children's Health Queensland Hospital and Health Service.' Child Health is a part of the Department of Health and is responsible for some functions related to maternal and child welfare

'Child in need of protection' means a child who:

a. has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm, and
b. does not have a parent able and willing to protect the child from the harm

'Child Protection Case Management' means the overall responsibilities of the Department of Child Safety when managing statutory intervention with a child subject to ongoing intervention

'Child Protection Notification' means the Department of Child Safety has assessed that there is a reasonable suspicion that a child is in need of protection, that is, a child has been significantly harmed, is being significantly harmed, or is at risk of significant harm, and does not

have a parent able and willing to protect them

'Child Safety After Hours' or ***'CSAH'*** is a service provided by the Department of Child Safety which provides after-hours statutory responses to critical and immediate child protection and youth justice matters. It is fully operational from 5pm-9am Monday to Friday and 24/7 on weekends and public holidays

'Child Safety Officer' means staff of the Department of Child Safety, which is an authorised officer under the *Child Protection Act 1999* (Qld)

'Child Safety Officer 1' means [redacted], who was a Child Safety Officer

'Child Safety Officer 2' means [redacted], who was a Child Safety Officer

'***Child Safety Officer 3'*** means [redacted], who was a Child Safety Officer

'Child Safety Officer 4' means [redacted], who was a Child Safety Officer

'Child Safety Officer 5' means [redacted], who was a Child Safety Officer

'Child Safety Officer 6' means [redacted], who was a Child Safety Officer

'Child Safety Officer 7' means [redacted], who was a Child Safety Officer

'Childrens Court' means a specialist magistrates court that deals with proceedings relating to child protection, youth justice and adoptions

'Commissioner of the QFCC' is a statutory role created pursuant to the *Family and Child Commission Act 2014* (Qld)

'Consultant Paediatrician' means [redacted] who was Jonathon and Kaleb's paediatrician [redacted]

'*CPA SCAN'* means Suspected Child Abuse and Neglect (SCAN) Team System. The *Child Protection Act* 1999 (Qld), sections 159I–159L, provides the legislative basis for the establishment and activities undertaken by the SCAN Team System. The Department of Child Safety is the lead agency for the CPA SCAN team system and whole of government response to child protection in Queensland. Provisions establishing the CPA SCAN were introduced into the *Child Protection Act 1999* (Qld) by the *Child Safety Legislation Amendment Act (No. 2) 2004* (Qld)

'CPA SCAN member' means SCAN teams are comprised of core members from:

a. the Department of Child Safety

b. the Queensland Police Service
c. the Department of Education
d. the Department of Health

CPA SCAN teams may also invite and facilitate contributions from other prescribed entities or service providers with knowledge, experience or resources that would help achieve the purpose of the CPA SCAN team system

'CPFU' or ***'Child Protection Follow Up'*** means a response by the Department of Child Safety to provide ongoing departmental intervention with the Family's agreement and consent

'CPIU' means the Child Protection and Investigation Unit of Queensland Police

'CPO' means a Child Protection Order. A Child Protection Order is an order made by the Childrens Court under the Child Protection Act 1999 (Qld), when a child is assessed as needing protection

'Department of Child Safety' means:

a. Department of Children, Youth Justice and Multicultural Affairs from 12 November 2020 to present
b. Department of Child Safety, Youth and Women between 12 December 2017 and 12 November 2020
c. Department of Communities, Child Safety and Disability Services between 3 April 2012 and 12 December 2017, insofar as it had responsibility for child safety matters
d. Department of Communities between 26 March 2009 and 03 April 2012
e. Department of Child Safety between 12 February 2004 and 26 March 2009
f. Department of Families between 22 February 2001 and 12 February 2004
g. Department of Families, Youth and Community Care between 26 February 1996 and 22 February 2001, insofar as it had responsibility for child safety matters

'Department of Disability Services' means:

a. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships from 12 November 2020 to present
b. Department of Communities, Disability Services and Seniors between 12 December 2017 and 12 November 2020
c. Department of Communities, Child Safety and Disability Services Department between 03 April 2012 and 12 December 2017, insofar as it had responsibility for disability services

d. Department of Communities between 12 February 2004 and 03 April 2012
e. Department of Families between 22 February 2001 and 12 February 2004
f. Department of Families, Youth and Community Care between 26 February 1996 and 22 February 2001, insofar as it had responsibility for disability services

'Department of Education' means:

a. Department of Education from 2009 to present
b. Department of Education and Training between 2008 and 2009
c. Department of Education, Training and the Arts between 2006 and 2007
d. Department of Education and the Arts between 2004 and 2006
e. Department of Education between 1957 and 2004

'Department of Health' or means:

a. Queensland Health form 3 April 2012 to present
b. Department of Health between September 1963 and 3 April 2012

'Department of Housing' means:

a. Department of Communities, Housing and Digital Economy from 12 November 2020 to present
b. Department of Housing and Public Works from 3 April 2012 to 12 November 2020
c. Department of Communities 12 February 2004 to 3 April 2012 (noting the Department of Communities became responsible for housing functions from 26 March 2009)
d. Department of Housing from 28 June 1998 to 26 March 2009

'Department of Housing Area Manager Informal Review' means the document entitled '[redacted] Tenancy Management Review' from 29 May 2020 with the document ID, QLD.0001.0026.1460

'Discussion Paper' means the document entitled 'Discussion Paper' with document ID, QLD.0020.0050.2574

'DS Worker 1' means [redacted], who was employed or engaged by the Department of Disability Services

'DS Worker 2' means [redacted], who was employed or engaged by the Department of Disability Services

'DS Worker 3' means [redacted], who was employed or engaged by the Department of Disability Services

'FaCC' means Family and Child Connect. FaCC are a funded non-government community-based intake and referral services that helps families to care for and protect their children at home. Family and Child Connect support vulnerable families by assessing their needs and connecting them with appropriate support services

'Family' means:

a. Paul Barrett, the Mother and Kaleb from [redacted] 2000 to 23 March 2003
b. Paul Barrett, the Mother, Kaleb and Jonathon from [redacted] 2003 to in or around February 2005
c. Paul Barrett, Kaleb and Jonathon from on or around February 2005 to 27 May 2020

'Family Centre' means [redacted], which provided multi-disciplinary specialist child health service for families who require support with building practical skills and confidence in parenting

'Family Contact Visit' means face-to-face contact between a child and their family member/s whilst the child is in care, which is organised or facilitated by the Department of Child Safety

'Family Meeting' means a meeting arranged between officers of the Department of Child Safety and Paul Barrett and/or Mother regarding their child/rens' safety

'Family Program 1' means [redacted]

'Family Risk Evaluation' or ***'FRE'*** means a structured decision-making tool used by the Department of Child Safety to help identify whether Jonathon and Kaleb have a high, moderate or low probability of experiencing abuse or neglect. This differs from a Safety Assessment because a Safety Assessment is concerned with the risk of immediate harm. An FRE estimates the likelihood of future abuse/neglect

'Paul Barrett' means Kaleb and Jonathon's father, whose date of birth is [redacted]

'FECS' means Family and Early Childhood Services, which was a service administered by Department of Disability Services

'Foster Carer 1' means [redacted]

'Foster Carer 2' means [redacted]

'General Practitioner' means [redacted] who was the General Practitioner for Paul Barrett, Kaleb and Jonathon between 2015 and present

'Home 1' means the property at [redacted]

'Home 2' the property at [redacted]

'Hospital 1' means [redacted]

'Hospital 2' means [redacted]

'Hospital 3' means [redacted]

'Hospital 4' means [redacted]

'Hospital 5' means [redacted]

'HSC' *or* ***'Housing Service Centre'*** means [redacted] which is a part of the Department of Housing and provides service including housing assistance

'IA' or '***Investigation and Assessment'*** means an investigation and assessment by the Department of Child Safety in response to all notifications, and is the process of assessing a child's need for protection, when there are allegations of harm or risk of harm to the child (section 14 (1) *Child Protection Act 1999* (Qld))

'ICMS' or ***'Integrated Client Management System'*** means an electronic system for managing information about the children and families who have had contact with the Department of Child Protection

'Integrated Support Plan' means Department of Disability Services tool to guide Paul Barrett to supports and services recommended by the Department of Disability Services, including mainstream, informal services or supports, a specialist disability service, or a combination of these supports

'IPA' means an Intervention with Parental Agreement, which is a time-limited intensive intervention by the Department of Child Safety focusing on the safety, belonging, wellbeing of a child who needs protection, without the need for a court order

'Mother' means [redacted]

'NDIA' means the National Disability Insurance Agency

'NDIS' means the National Disability Insurance Scheme

[Redacted]

[Redacted]

'Office of the Public Guardian' means an Office established pursuant to section 102 of the *Public Guardian Act 2014* (Qld)

'OneSchool' means the Department of Education's operating and information management software, which is used by teachers, administrators and students

'Parent Aide' means the Parent Aide Unit at Hospital 1, which provides home visits by trained volunteers who seek to improve infant-parent relationships

'Parent un/able and un/willing' means a parent is willing to protect a child, but not have capacity to do so, that is, they are 'unable'. This includes situations where the parent's inability is due to factors such as intellectual impairment or ill health. Alternatively, a parent may have the capacity to protect a child, that is they are able, but may choose not to. This includes situations where parents choose an ongoing relationship with a person who is abusing their child and are thus unwilling to protect the child. When child protection assessments are made by the Department of Child Safety both willingness and ability of the parents are considered. If there is at least one parent willing and able to protect the child, the child is not a child in need of protection

'Parents' means the Mother and Paul Barrett

[Redacted]

[Redacted]

[Redacted]

'Premier of Queensland' means the Honourable Annastacia Palaszczuk, who held the office of Premier of Queensland from 7 October 2021 to present

'Principal 1' means [redacted]

'Principal 2' means [redacted]

'PSO' means Protective Supervision Order, which allows the Chief Executive to supervise the child's wellbeing and protection whilst the child remains in a parent's care

'Public Guardian' is a statutory role created pursuant to section 9 of the *Public Guardian Act* 2014 (Qld)

'Public Trustee' is a statutory role created pursuant to section 7 of the *Public Trustee Act* 1978 (Qld)

'QCAT' means Queensland Civil and Administrative Tribunal

'QFCC December 2020 report' means QFCC Principal Commissioner, Cheryl Vardon's, review report published in December 2020

'QFCC System Review 2/2020' means the QFCC review established by way of Terms of Reference developed by the QFCC and endorsed by the Queensland Attorney-General on 3 June 2020

'QFCC System Review Request' means the request at pages 21 to 22 of the document with the document ID, QLD.0019.0051.0001

'QFCC' means the Queensland Family and Child Commission, which was established in 2014

'Queensland Attorney-General 1' means the Honourable Yvette D'Ath, who held the position of Attorney-General and Minister for Justice from 12 December 2017 to 11 November 2020

'Queensland Attorney-General 2' means Honourable Shannon Fentiman, who held the position of Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence from 12 November 2020 to present

'Queensland Police' means the Queensland Police Service

'Report of Suspected Harm or Risk of Harm Report' or '***SP-4 Report'*** is a report to the Department of Child Safety pursuant to section 22 (amended by the *Child Protection Reform Amendment Bill 2014* to section 197A) of the *Child Protection Act 1999* (Qld)

'Residential Early Parenting Service' means the [redacted]

'Response Priority' means a structured decision-making tool used by the Department of Child Safety to guide the timeframe in which an investigation and assessment is to be commenced. There are three response timeframes; immediate or within 24 hours, within five days, or within 10 days

'Royal Commission' means the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

'Safety Assessment' means an assessment by a Department of Child Safety staff member for the purpose of a safety assessment to assess a child's immediate safety and determine what interventions are required to keep them safe in an immediate harm indicator is identified. A safety assessment will always occur at the commencement of an IA and is the focus of the first contact with the child and family. Subsequent safety assessments are completed whenever new information becomes available or circumstances change significantly and/or a threat to a child's safety is indicated, or prior to closure of an ongoing intervention case

'***SCAN***' means Suspected Child Abuse and Neglect

'School 1' means [redacted]

'School 2' means [redacted]

'SEDU' means Special Education Development Unit, which was administered by the Department of Education

'Service Provider 1' means [redacted]

'Supported Independent Living' or '***SIL'*** accommodation means help or supervision with daily tasks to help a person with disability live as independently as possible, while building skills

'TAO' means a Temporary Assessment Order pursuant to the *Child Protection Act* 1999 (Cth). A temporary assessment order authorises actions during the investigation and assessment process when parental consent cannot be obtained. A temporary assessment order can provide the authority to take a child into the custody of the chief executive, but guardianship rights and responsibilities remain with the child's parents. A temporary assessment order may also order specific actions relating to the assessment of a notification, for example, the conduct of a medical assessment in relation to a child. A temporary assessment order can only be granted for a period of 3 business days and can be extended by 1 business day

'Teacher 1' means [redacted]

'Teacher 2' means [redacted]

'Teachers' Aide' means [redacted]

Appendix C Abbreviations and terminology

Term/Acronym	Meaning
ASD	Autism Spectrum Disorder
CEO	Chief Executive Officer
CDRB	Child Death Review Board
Child participants	National Disability Insurance Scheme participants who are under the age of 18
Child safety officer	A person employed by the Department Child Safety, and authorised to carry out certain functions under the *Child Protection Act 1999* (Qld)
Childrens Court	Childrens Court of Queensland established by the *Childrens Court Act 1992* (Qld)
Children Rules	*National Disability Insurance Scheme (Children) Rules 2013* (Cth)
CPO	Child Protection Order, made under Part 4 of the *Child Protection Act 1999* (Qld) when the Childrens Court decides a child is in need of protection
CRM	Customer Relationship Management
CRPD	*Convention on the Rights of Persons with Disabilities,* opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008)
CRC	*Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990)
CRC Committee	Committee on the Rights of the Child, established by Article 43 of the CRC
Department of Child Safety	The Department currently known as the Queensland Department of Children, Youth Justice and Multicultural Affairs. A 'child safety officer' is used to describe
Department of Disability Services	The Department currently known as the Queensland Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

Term/Acronym	Meaning
Department of Education	The Department currently known as the Queensland Department of Education.
Department of Housing	The Department which was known as the Department of Communities, Housing and Digital Economy at the time of the hearing
EAP	Education Adjustment Program
ECDP	Early Childhood Development Program
FCC Act	*Family and Child Commission Act 2014* (Qld)
GP	General Practitioner
ICCPR	*International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976)
ICESCR	*International Covenant on Economic, Social and Cultural Rights*, opened for signature 18 December 1966, 993 UNTS 3 (entered into force 3 January 1976)
Implementation plan	The National Disability Insurance Agency's *Supported Decision Making Policy Implementation Plan*
IPA	Intervention with Parental Agreement, a time-limited intensive intervention by the Department of Child Safety, focusing on the safety, belonging, wellbeing of a child who needs protection, without the need for a court order
Kwashiorkor	Kwashiorkor is a form of severe malnutrition characterised by a severe protein deficiency. It causes fluid retention, a swollen and distended abdomen. Kwashiorkor affects children, particularly in developing countries with high levels of poverty and food insecurity.
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Act	*National Disability Insurance Act 2013* (Cth)
Nominee	A person appointed to be the correspondence nominee of a NDIS participant or the plan nominee of a NDIS participant.

Term/Acronym	Meaning
Nominee Rules	*National Disability Insurance Scheme (Nominee) Rules 2013* (Cth)
Public Guardian of Queensland	An independent statutory officer in Queensland, whose functions may include being the appointed guardian of a person, established under s 9 of the *Public Guardian Act 2014* (Qld)
QCAT	Queensland Civil and Administrative Tribunal
QFCC	Queensland Family and Child Commission
QHRC	Queensland Human Rights Commission
QLD	Queensland
Queensland Police	Queensland Police Service
SCAN	Suspected Child Abuse and Neglect team
SEDU	Special Education Development Unit
SDMF	Structured Decision Making Framework
QFCC Summary Report	Queensland Family and Child Commission's *Summary report: Keeping school-aged children with disability safe*
QPRIME	Queensland Police Records and Information Management Exchange.

Appendix D Witnesses

Witness	Date of appearance
Lisa Hair	8 May 2023
Alexis (a pseudonym), Service Provider A	8 May 2023
Shayna Smith, Public Guardian, Office of the Public Guardian, Queensland	8 May 2023
Scott McDougall, Commissioner, Queensland Human Rights Commission	8 May 2023
Luke Twyford, CEO and Principal Commissioner, Queensland Family and Child Commission, and Chair of Queensland's Child Death Review Board (**CDRB**)	9 May 2023
Dr Sam Bennett, General Manager, Policy, Advice and Research, National Disability Insurance Agency	9 May 2023
Desmond Lee, Acting General Manager, National Delivery, National Disability Insurance Agency	9 May 2023
Dr Meegan Crawford, Regional Executive Director, Brisbane Moreton Region, Department of Children, Youth Justice and Multicultural Affairs, Queensland	10 May 2023
Hayley Stevenson, Acting Assistant Director-General, Department of Education, Queensland	10 May 2023
Denzil Clark, Detective Superintendent, Queensland Police Service	10 May 2023
Francis (Frank) Joseph Eugene Tracey, Health Service Chief Executive, Children's Health Queensland	10 May 2023
Chantal Raine, General Manager, Service Delivery, Housing and Homelessness Services, Department of Communities, Housing and Digital Economy, Queensland	10 May 2023
Michelle Bullen, Executive Director, Inclusion, Programs and Strategy, Department of Seniors, Disability Service and Aboriginal and Torres Strait Islander Partnerships, Queensland	10 May 2023

Appendix E Parties with leave to appear and their legal representatives

Party	Legal representatives
Commonwealth of Australia	Counsel – Mr R Anderson KC and Ms A Munro Solicitors – Mr Andrew Floro, Gilbert + Tobin
State of Queensland	Counsel – Ms K McMillan KC and Ms S Amos Solicitors – Mr Paul Lack, Crown Law Queensland

Royal Commission
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Exploitation of People with Disability