QUEENSLAND OMBUDSMAN

Preventing harm to children with disability in Queensland

Report 3: Queensland Health

An investigation into the effectiveness of current public sector agency practices and procedures – Learning from Kaleb and Jonathon's story.

April 2026

Nathaniel Chapman
***Leaving Our Mark*, (2023).**
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Nathaniel Chapman is a Goenpul/Yagara man from Minjerribah (North Stradbroke Island) and Magandjin (Brisbane) with ancestral ties to the Wambia Tribe in the Northern Territory and Wakka Wakka Country in Eidsvold, Queensland.

We acknowledge the Traditional Owners of the land throughout Queensland and their continuing connection to land, culture and community. We pay our respects to Elders past, present and emerging.

Authority

The Ombudsman has given this report to the Speaker of the Queensland Parliament, the Hon. Pat Weir MP, for tabling in the Legislative Assembly under section 52 of the *Ombudsman Act 2001***.**

Public

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Snapshot

In 2023, Public Hearing 33 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability considered a case study of two children living with disability. They were referred to as Kaleb and Jonathon.

In response to recommendations from the public hearing, the Ombudsman has been investigating some of the public sector agencies that had interactions with Kaleb and Jonathon.

Queensland Health staff had concerns about Kaleb and Jonathon's safety and wellbeing from birth. The boys were diagnosed with disabilities, including significant global developmental delay (delay in reaching milestones in several areas) and intellectual disability. In those early years, Queensland Health staff made several child protection reports to the Department of Families, Seniors, Disability Services and Child Safety (Child Safety).

Kaleb and Jonathon had a range of paediatric and specialist health appointments with Queensland Health services between 2000 and 2020. At times, they did not attend these appointments. Health staff followed up on their non-attendance on some, but not all, of these occasions. In this investigation, we also found there were occasions when Queensland Health did not make bookings for specialist appointments for Jonathon when required.

After their father's death in 2020, Kaleb and Jonathon were admitted to hospital and treated for severe malnutrition.

What we investigated

This investigation examined whether the current practices and procedures of Queensland Health would prevent other children with disability from experiencing the nature and extent of the harm Kaleb and Jonathon suffered. We found that it has developed some practices and procedures to help staff identify and respond to child abuse and neglect, but we also identified opportunities for improvement.

What needs to be improved

Queensland Health needs to provide staff with clear and consistent information about how to identify and respond to child protection concerns. In particular, staff need clearer guidance on:

- concepts like cumulative harm, parent behaviour and neglect of medical care
- resources to use to inform decision-making, such as Child Safety's *Child Protection Guide*
- the importance of consulting with expert staff within hospital and health services' child protection units.

Queensland Health also needs to ensure that:

- staff can recognise that in some circumstances, missed medical appointments may be a sign of potential neglect
- hospital and health services have effective information management systems that support service delivery, including for responding to child protection concerns.

Recommendations

Recommendation 1

Queensland Health amends its current practices and procedures to include more detailed and consistent information about the concept of a parent being able and willing to protect their child from harm.

Recommendation 2

Queensland Health amends its current practices and procedures to include more detailed information about cumulative harm.

Recommendation 3

Queensland Health reviews its current practices and procedures and considers whether to mandate that health staff use Child Safety's *Child Protection Guide* when they are assessing child protection concerns.

Recommendation 4

Queensland Health amends its current practices and procedures so that when staff identify a child protection concern, they consult with their child protection unit if they have queries and it is practical to do so. This should be promoted as best practice.

Recommendation 5

Queensland Health amends its current practices and procedures so they all consistently prompt staff to:

- review a child's health records when responding to a child protection concern
- consider any previous presentations at hospitals or health services, and any previous child protection concerns
- discuss their immediate concerns with colleagues who have had contact with the child and their family.

Recommendation 6

Queensland Health amends its current *Specialist Outpatient Services Implementation Standard* to:

- include information about child protection considerations (for example, neglect of medical care)
- link to Queensland Health's child protection practices and procedures and Child Safety's *Child Protection Guide*.

Queensland Health should also ensure hospital and health services align their practices and procedures with these updates.

Recommendation 7

Queensland Health amends its current *Specialist Outpatient Services Implementation Standard* to include more detailed guidance about what is required in clinical audits, including considering whether the patient lives with disability and has a child protection history.

Recommendation 8

Queensland Health audits, at regular intervals, a sample of outpatient appointments that children fail to attend, and where the children have been subsequently discharged from the outpatient service, across each hospital and health service, to assess:

- whether clinical audits have occurred as required
- the quality of the clinical audits if they have been conducted
- whether the hospital and health service can improve its clinical audit process.

Recommendation 9

Queensland Health reviews its current practices and procedures so they clearly and consistently communicate its expectations about how staff respond to suspicions of harm.

Recommendation 10

Queensland Health amends its current practices and procedures to include information about:

- what staff should do if they have child protection concerns that do not meet the threshold for reporting to Child Safety or the Queensland Police Service
- how and where staff should record these concerns.

Recommendation 11

Queensland Health amends its current practices and procedures so it audits, at regular intervals, a sample of child protection reports made by health staff to Child Safety.

Recommendation 12

Queensland Health amends its current practices and procedures to include information about the obligation of Queensland Health staff to consider human rights when responding to child protection concerns.

Recommendation 13

Queensland Health assists hospital and health services to implement more contemporary information management systems to address the issues identified in this report.

1. Introduction

This report is the third from the Ombudsman's investigation related to recommendation 5.2 of *Public hearing 33 – Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study)*. The hearing was conducted in 2023 by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Kaleb and Jonathon (pseudonyms), two young men with profound disabilities, were found in their home by emergency services on 27 May 2020. The report on Public Hearing 33 stated that they were 'locked in a room, naked and [with] no bedroom furnishings'. Their father and primary carer, Paul Barrett, was found deceased at the property. Kaleb and Jonathon were admitted to hospital that day.

During their admission, they were treated for severe malnutrition. They were discharged two weeks later into the care of state government agencies and with supports funded by the National Disability Insurance Scheme (NDIS).

The Royal Commission examined the experiences of Kaleb and Jonathon across 20 years to determine how and why they experienced violence, abuse, neglect and a deprivation of human rights in their childhood and adolescence.

The Royal Commission recommended that the State of Queensland apologise for the omissions in preventing the harm they experienced. On 12 September 2023, this apology was delivered.

Why we investigated

On his own initiative (see section 18(1)(b) of the *Ombudsman Act 2001*), the Ombudsman commenced an investigation in response to Recommendation 5.2 of Public Hearing 33, which stated:

> 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.

In keeping with this recommendation, the focus of our investigation is on the relevant agencies' current practices and procedures. These agencies include the Department of Education; Queensland Health; the Department of Housing and Public Works; and the Department of Families, Seniors, Disability Services and Child Safety (Child Safety).

We want to know whether they will adequately prevent other children with disability from suffering the harm Kaleb and Jonathon experienced.

However, a Commission of Inquiry into Queensland's Child Safety System (the Inquiry) started on 1 July 2025. The Inquiry's terms of reference include examining the practices and procedures of Child Safety. Considering the scope of the Inquiry's terms of reference, the Ombudsman has decided not to proceed further with the investigation into Child Safety while the Inquiry is underway.

The Ombudsman has previously reported on the practices and procedures of the Department of Education and the Department of Housing and Public Works. This, our third report, focuses on Queensland Health.

On 11 October 2023, the Ombudsman gave a notice under section 27(2) of the Ombudsman Act to the then Director-General of Queensland Health, informing him of the decision to conduct an investigation in accordance with section 18(1)(b) of the Ombudsman Act.

Scope of the investigation

We considered Kaleb and Jonathon's interactions with Queensland Health from 2000 to 2020. (See Appendix A for a timeline of this.) We used this information to:

- identify and assess the current practices and procedures of Queensland Health relevant to ensuring children are safe and protected
- determine whether these practices and procedures are sufficient to prevent the harm that Kaleb and Jonathon experienced
- identify improvements Queensland Health could make to its practices and procedures.

We focused in particular on Queensland Health's current practices and procedures relating to how staff:

- identify and respond to suspicions of child abuse and neglect, including neglect of medical care
- manage health appointments that children do not attend.

We concentrated on these issues because Kaleb and Jonathon missed multiple appointments with Queensland Health paediatric and specialist services between 2000 and 2020. Queensland Health staff did not always follow up on the non-attendance and on some occasions did not make bookings for specialist appointments for Jonathon when required.

We acknowledge the work already done to review specific circumstances of Kaleb and Jonathon's interactions with Queensland public sector agencies, including by the Queensland Family and Child Commission.

What we did not investigate

We have not examined the actions or decisions of the National Disability Insurance Agency (the agency that administers the NDIS) or its engagement with Kaleb and Jonathon. It is a federal agency and therefore outside the Ombudsman's jurisdiction.

We are aware that Queensland public sector agencies interact with the NDIS and provide services to people with disability as part of this scheme. In 2023, a review of the NDIS found that fundamental changes were needed to ensure the scheme was operating as intended.

In July 2024, the Queensland Government released the *Queensland Disability Reform Framework*, in response to recommendations made by both the Royal Commission (in its *Final Report*) and the *NDIS Review*.

In October 2025, the Queensland Government released an updated response to the Royal Commission's recommendations.

The Queensland Government's implementation of the recommendations of both the Royal Commission and *NDIS Review* will take some time. It is not yet clear what these changes will mean in future for children with disability in Queensland and for the agencies that support them. Our investigation is focused on *current* practices and procedures.

We have also not investigated the actions of the Queensland Police Service during its various interactions with the family. Operational actions of police officers are outside the Ombudsman's jurisdiction by virtue of section 7(2) of the Ombudsman Act.

Investigation methodology

We conducted the investigation formally under section 24(1)(b) of the Ombudsman Act. We reviewed material from Public Hearing 33 and accepted the evidence presented to the Royal Commission. It has informed the opinions and recommendations set out in this report.

We also:

- considered relevant legislation
- reviewed and analysed material we obtained from Queensland Health and the Children's Health Queensland Hospital and Health Service (Children's Health Queensland)
- met with representatives from Queensland Health and Children's Health Queensland.

We acknowledge the cooperation of the staff of Queensland Health and Children's Health Queensland.

In the early stages of the investigation, we met with Kaleb and Jonathon. This gave us the opportunity to engage with them directly; observe their current living environment; and learn about their daily routines, likes and dislikes. We also had the chance to see how they communicate and how support staff are working with them to increase their independence.

Ombudsman's jurisdiction

The Ombudsman is an officer of the Parliament empowered by the Ombudsman Act to:

- investigate administrative actions of agencies on reference from the Assembly or a statutory committee of the Assembly; or on complaint; or on the Ombudsman's own initiative
- consider the administrative practices and procedures of an agency whose actions are being investigated
- make recommendations to the agency to improve their practices and procedures
- provide information or other help to the agency about ways of improving the quality of administrative practices and procedures.

Under section 18(1)(b) of the Ombudsman Act, the Ombudsman can investigate administrative actions of agencies if the Ombudsman considers they should be investigated. Queensland Health is an 'agency' for the purposes of section 8 of the Ombudsman Act.

Section 49(2) of the Ombudsman Act outlines the matters about which the Ombudsman may form an opinion before making a recommendation to the principal officer of an agency. These include whether the administrative actions investigated are contrary to law, unreasonable, unjust or otherwise wrong.

Under section 25(2) of the Ombudsman Act, the Ombudsman is not bound by the rules of evidence used in Australian court proceedings.

Instead, the Ombudsman is guided by (although not required to use) the standard of proof used in civil proceedings – the 'balance of probabilities'. A matter will be proven to be true on the balance of probabilities if its existence is more probable than not.

If the Ombudsman investigates administrative action on an own-initiative basis, section 52 of the Ombudsman Act allows a report on the investigation to be given to the Speaker for tabling in the Assembly, if the Ombudsman considers it appropriate.

Procedural fairness

The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

Under section 25(2) of the Ombudsman Act, investigators must comply with these rules when conducting an investigation. If at any time during the course of an investigation it appears that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be given an opportunity to comment on the subject matter of the investigation before the final report is made (section 26(3)).

To satisfy these obligations, we provided a proposed report (which we completed in July 2025) to Dr David Rosengren, Director-General of Queensland Health. The Director-General responded to the proposed report on 24 July 2025. We then requested more detail and clarity from Queensland Health, which it provided on 11 September 2025.

We also provided the proposed report to Mr Frank Tracey, Health Service Chief Executive of Children's Health Queensland, who responded on 22 August 2025.

After considering the responses, we prepared a revised report and amended some of the recommendations. On 18 February 2026, we provided the revised report to Queensland Health and Children's Health Queensland for comment.

Children's Health Queensland responded to the revised report on 10 March 2026. Queensland Health provided a response to the revised report on 20 March 2026. We have included the responses in their entirety in Appendix C and Appendix D.

We will monitor implementation of the recommendations.

The investigation was not undertaken with a view to making findings about any individual; therefore, the Ombudsman has not formed opinions about any individual's decisions or actions. Doing so would not allow proper procedural fairness to be extended to the various people who may have interacted with Kaleb, Jonathon and Paul Barrett between 2000 and 2020.

This report should not be taken as reflecting adversely on the reputation, competency or integrity of any of these people.

Opinions

In this investigation, we focused on Queensland Health's policies, practices, procedures and guidelines for identifying and responding to child protection concerns in a health setting. We refer to these resources collectively as 'practices and procedures'. We also considered the training that health staff receive.

The investigation found that Queensland Health has implemented a range of practices and procedures that have good features. However, there are also some problems. These include that Queensland Health:

- does not promote as best practice that staff consult with their child protection units if they identify a child protection concern
- provides limited guidance and information to staff about
  - determining whether a parent may be able and willing to protect their child from harm
  - identifying cumulative harm
  - recognising that missed health appointments can be a sign of neglect
- does not provide consistent information to staff about what steps they must take when responding to concerns about a child
- does not provide clear or consistent guidance to staff about what they should do if their concerns do not meet the threshold for reporting to external agencies
- allows hospital and health services to store child protection information in paper-based or electronic forms, or a combination of both. This limits a staff member's ability to properly assess a child protection concern or to identify potential patterns of harm or cumulative harm
- does not audit child protection reports that staff send to Child Safety
- has a standard for managing missed health appointments that does not state what to do about children whose failure to attend may raise child protection concerns
- does not provide sufficient information about conducting clinical audits for managing missed health appointments
- does not centrally collect and analyse data about children's attendance at outpatient appointments
- does not ensure staff receive consistent and regular child protection training
- does not provide staff with adequate information about their obligation to consider human rights when responding to child protection concerns.

We explore these issues in the report.

Administrative actions are defined in the Ombudsman Act as including a decision and act, and also a failure to make a decision or do an act. The Ombudsman considers that the above problems are administrative actions that are unreasonable for the purposes of section 49(2)(b) of the Ombudsman Act.

The Ombudsman considers that Queensland Health should take action to rectify these problems, and that some of Queensland Health's current practices and procedures should be changed, as set out in this report.

2. Queensland Health's structure, services and obligations

Most people access health care through primary services, such as general practitioners. However, some people require additional care, including:

- secondary care – specialised care that does not require hospital admission
- tertiary care – highly specialised care requiring hospital admission
- quaternary care – care for complex conditions, which may require emerging or innovative treatment.

At times, Kaleb and Jonathon needed to access secondary and tertiary health care. For example, Kaleb saw an endocrinologist and Jonathon received medical treatment for epilepsy at a hospital.

(See Appendix A for a chronology of Queensland Health's interactions with Kaleb and Jonathon.)

Queensland Health

In Queensland, the public health system is known as Queensland Health. It includes:

- the Department of Health (the department)
- 16 independent hospital and health services located across Queensland.

The department is responsible for governing health services in Queensland and delivering:

- statewide clinical health support services
- health promotion and disease prevention strategies
- urgent patient transport services
- health infrastructure planning and corporate support services.

The department's accountable officer is the Director-General. The person in this position is legislatively responsible for issuing binding directives to hospital and health services and monitoring their performance.

There is considerable legislation governing how health services are delivered and overseen in Queensland. The following Acts are relevant to the responsibilities of Queensland Health staff and the protection of children and young people:

- *Hospital and Health Boards Act 2011*
- *Public Health Act 2005*
- *Child Protection Act 1999*
- *Information Privacy Act 2009*
- *Civil Liability Act 2003*
- *Human Rights Act 2019.*

When we refer to Queensland Health in this report, we mean the department (as distinct from hospital and health services, which we refer to separately).

Hospital and health services

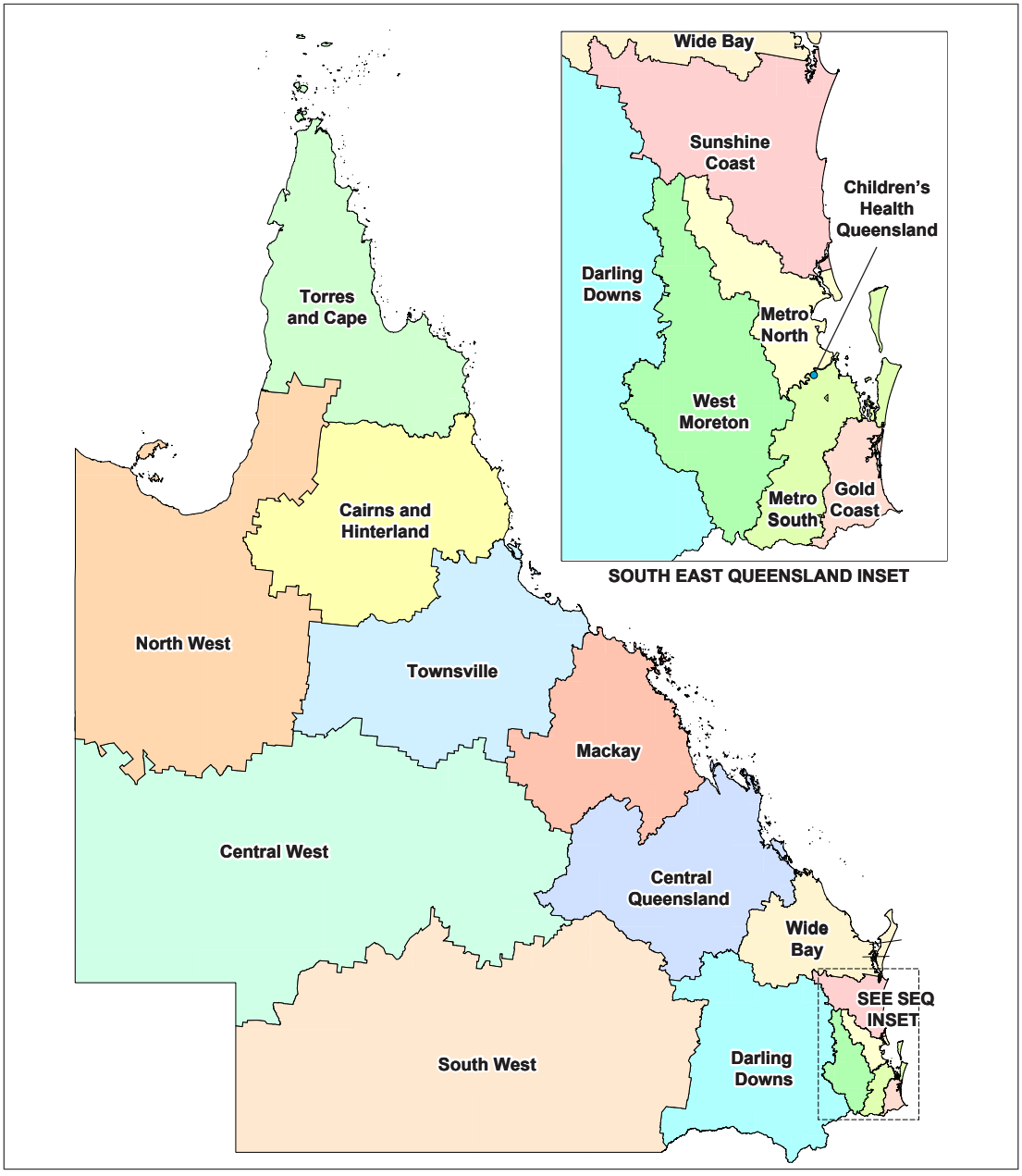
Kaleb and Jonathon had numerous interactions with hospital and health services between 2000 and 2020. During this time, the governance structure of the health system changed.

The most recent and significant change was in 2012, when 16 hospital and health services were established as independent statutory bodies under the Hospital and Health Boards Act.

Each hospital and health service has a chief executive and a board, and a service agreement with Queensland Health. Each agreement details the services provided by the hospital and health service and the level of funding it receives from Queensland Health for those services.

As shown in Figure 1, hospital and health services are divided up by geographical region. They are each responsible for the clinical and operational governance of health services delivered in their region.

Figure 1: Queensland hospital and health services – by region



Source: Queensland Health, *Hospital and Health Service maps*, 2025

Queensland Health told us that while hospital and health services have a degree of autonomy in delivering health services, this is under the 'oversight and strategic direction of the Department'. In this way they ensure a coordinated approach to the delivery of health services, including implementing child protection practices and procedures.

Each hospital and health service has a child protection unit, with staff who are trained in dealing with child protection matters. Usually this includes:

- child protection advisors who provide expert advice to staff within hospital and health services about potential child protection concerns
- child protection liaison officers who act as a point of contact for health staff, as well as staff in Child Safety and the Queensland Police Service. They assist with sharing information about patients and can be from a range of disciplines (for example, nursing, social work, psychology or medicine).

The number of staff in each child protection unit across Queensland varies.

Health services for children and young people

The Children's Health Queensland Hospital and Health Service (Children's Health Queensland) was established under the Hospital and Health Boards Act in July 2012.

Children's Health Queensland is responsible for delivering public paediatric health services. Unlike the 15 other hospital and health services, which provide services within a geographical boundary, it delivers services across the state.

In accordance with the *Hospital and Health Boards Regulation 2023*, it is responsible for:

- providing community-based and secondary health services within the Metro North and Metro South service areas
- coordinating tertiary paediatric services, other than those provided in Townsville
- delivering health care through the Queensland Children's Hospital.

Children's Health Queensland also delivers highly specialised quaternary care for children across all of Queensland and northern New South Wales.

While it provides a large proportion of the paediatric services delivered in Queensland, all hospital and health services need to know about child safety issues because a child could present at any hospital or health service seeking care.

Table 1 details the number of children who required secondary or tertiary intervention at Queensland hospital and health services in the 2022–23 and 2023–24 financial years.

Table 1: Number of children requiring secondary and tertiary intervention

Intervention	2022–23	2023–24
Secondary (non-admitted)	1,251,122	1,340,881
Tertiary (admitted)	176,046	183,529

Source: Office of the Queensland Ombudsman, adapted from information we obtained from Queensland Health.

The Child Protection and Forensic Medical Service

The Child Protection and Forensic Medical Service (CPFMS) is a team within Children's Health Queensland and was established in 2014.

It is described by Children's Health Queensland as:

> … a single point of contact for child protection across [Children's Health Queensland]. Based at the Queensland Children's Hospital … the CPFMS service is comprised of a multidisciplinary team including medical, nursing and allied health staff. CPFMS also manages child protection liaison staff providing child protection liaison at Queen Elizabeth II and Redlands Hospitals and respective Community Health Centres.
>
> CPFMS provides a tertiary referral hospital service for the consultation and management of suspected child abuse and neglect, as part of a state-wide clinical leadership role in education, training and research. This is facilitated through individual case consultation and state-wide education achieved through regular professional development activities, including telehealth, case reviews and professional development activities organised by CPFMS.

Additional functions of the CPFMS, as detailed in *Child Safety's Suspected Child Abuse and Neglect (SCAN) Team System Manual*, include:

- undertaking medical examinations of a child where there are allegations of harm
- providing expert health opinions and forensic medical knowledge when assessing harm to a child
- completing psychiatric or developmental assessments of a child who has been harmed or is at risk of harm
- working with other government, non-government and community agencies to coordinate service responses, including sharing confidential health information where it relates to the welfare and protection of a child
- presenting key health information about a child at SCAN team meetings
- making and/or extending a Care and Treatment Order (a legal directive used when a child is at risk of harm and action is required) when
  - there are significant concerns a child has been harmed or is at risk of harm
  - the child is likely to be taken from the health service facility and suffer harm unless immediate action is taken.

Queensland Health told us that although the CPFMS does not service other hospital or health services, it provides a general supportive advisory role when requested. Staff across all hospital and health services can consult with it (and their own child protection units) to obtain advice about:

- a child's medical condition
- their treatment
- the risks of a child not having treatment.

Queensland Health said that consultation with the CPFMS may lead to a report to Child Safety.

The CPFMS provides education and training to all Queensland Health staff on a range of matters, including sexual assault examinations, injury interpretation, and clinical management of child abuse and neglect.

Mandatory reporting

Since the 1980s, health practitioners have been required, by law, to report suspicions that a child has been (or is likely to be) harmed. Registered nurses have been included in this mandatory reporting scheme since 2004. These obligations were set out in the Public Health Act (formerly the *Health Act 1937*).

In 2013, the Queensland Child Protection Commission of Inquiry (the Carmody Inquiry) recommended amendments to Queensland legislation so that mandatory reporting obligations for certain professionals, including doctors and registered nurses, were consolidated under the Child Protection Act.

Today, if a doctor or registered nurse forms a 'reportable suspicion' about a child during their employment, they *must* make a written report to Child Safety (see section 13E of the Child Protection Act).

A reportable suspicion is defined in section 13E(2) of the Child Protection Act as a reasonable suspicion that a child:

> a) suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and
> b) may not have a parent able and willing to protect them from harm.

There are additional mandatory reporting obligations that apply to *all* Queensland Health staff relating to sexual offences against children. Section 229BC of the *Criminal Code Act 1899* states:

> **229BC Failure to report belief of child sexual offence committed in relation to child**
>
> 1) This section applies to an adult if—
> a) the adult gains information that causes the adult to believe on reasonable grounds, or ought reasonably to cause the adult to believe, that a child sexual offence is being or has been committed against a child by another adult; and
> b) at the relevant time, the child is or was—
> i) under 16 years; or
> ii) a person with an impairment of the mind.
> 2) If, without reasonable excuse, the adult fails to disclose the information to a police officer as soon as reasonably practicable after the belief is, or ought reasonably to have been, formed, the adult commits a misdemeanour.
>
> Maximum penalty—3 years imprisonment.

This obligation is subject to some exceptions, including if the matter has already been reported.

3. Identifying child abuse and neglect

Kaleb and Jonathon were born in Queensland Health hospitals in 2000 and 2003 respectively.

Staff reported their concerns about Kaleb's safety and wellbeing to Child Safety shortly after his birth. He was placed in foster care for significant periods of time during the first 3 years of his life. During this time, Queensland Health provided early childhood and paediatric care to him.

When Jonathon was born, Queensland Health made another report to Child Safety about both children's safety and wellbeing.

As young children, Kaleb and Jonathon were diagnosed with developmental delay and intellectual disability. They had considerable daily care and support needs and sometimes required specialist health care.

In 2005, Queensland Health staff reported to Child Safety again after Kaleb and Jonathon missed several health appointments. Staff were concerned that both children may be experiencing neglect. Child Safety investigated the concerns and found that the concerns of neglect were substantiated.

For the next 10 years, Queensland Health had little interaction with Kaleb and Jonathon.

The boys missed multiple specialist appointments between 2005 and 2020. On a number of occasions, this resulted in them being discharged from these services. Despite this, and their child protection history, Queensland Health did not make any other reports to Child Safety. On other occasions, Queensland Health did not make the required appointments with specialists for them.

At Public Hearing 33, the Royal Commission identified Kaleb and Jonathon's non-attendance at health appointments as an issue. It found that this contributed to the evidence that they experienced chronic neglect in their father's care.

(For more information, see Appendix A.)

In this chapter, we examine the current practices and procedures developed by Queensland Health to help its staff identify child abuse and neglect.

We do this in the context of specific issues that arose in Queensland Health's dealings with Kaleb and Jonathon.

These include:

- reporting requirements
- identifying a child in need of protection
- recognising cumulative harm
- recognising neglect of medical care
- managing health appointments.

In addition to Queensland Health's practices and procedures, hospital and health services may develop their own, more tailored practices and procedures. As such, we have also considered some of the practices and procedures developed by Children's Health Queensland, given its primary role in providing paediatric services throughout Queensland.

Practices and procedures

It was evident when we examined Queensland Health's practices and procedures that child protection is given a high priority. It is referred to in various documented policies, procedures and guidelines.

For example, to help staff identify child protection concerns, Queensland Health has developed a guideline about how and when to report concerns to Child Safety. We refer to this document as the 'reporting guideline'. It applies to all Queensland Health employees, contractors, consultants, students and volunteers providing a service within Queensland Health and its hospital and health services.

The reporting guideline was created in 2021 and was due for review in 2023, which means it is now out of date. We encourage Queensland Health to regularly review this and all of its practices and procedures.

To complement the reporting guideline, Queensland Health has developed an education module about child abuse and neglect. While the module is available to all staff, it is targeted particularly at those who deliver services to children, young people and adults who have parental/carer responsibilities.

The reporting guideline and education module assist health staff to:

- identify a child at risk of harm
- respond to suspicions that a child is at risk of harm, either by reporting to Child Safety or the Queensland Police Service, or by referring the family to support services.

In this chapter, we discuss these resources in more detail, focusing on how effective they are in helping staff to identify harm or concerns.

Reporting requirements

As mentioned earlier, doctors and registered nurses (as mandatory reporters) *must* report a suspicion that:

- a child has suffered significant harm from physical or sexual abuse, and
- may not have a parent able and willing to protect them.

This obligation is set out in the Child Protection Act, and Queensland Health's reporting guideline elaborates on it, stating:

> Mandatory reporters should still report to Child Safety a reasonable suspicion that a child or unborn child may be in need of protection where the harm or risk of harm relates to any other type of abuse, such as emotional abuse and/or neglect under s13A of the [Child Protection] Act.

The reporting guideline also makes it clear that *all* health staff are expected to report all types of suspected harm, including psychological or emotional abuse, neglect and sexual exploitation.

Table 2 summarises the guidance in the reporting guideline about what staff should do if they identify different concerns.

Table 2: Reporting obligations for health staff

Concern	Who	Action	Law or policy
Suspicion that a child has been or is at risk of significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect them	Doctor or registered nurse	Report to Child Safety (in writing)	Child Protection Act
Suspicion that a child has been significantly harmed or is at risk of significant harm and may not have a parent able and willing to protect them	All staff	Report to Child Safety	Queensland Health policy
Suspicion that a sexual offence is being or has been committed against a child by an adult	All staff	Report to Queensland Police Service (QPS)	Criminal Code Act (If reported to Child Safety, staff are not required to report the same offence to the QPS under the Criminal Code Act)
Concerns about a child that do not involve sexual abuse or significant harm, and where there is a parent able and willing to protect them	All staff	Refer to Family and Child Connect (a community-based support service)	Queensland Health policy

Source: Office of the Queensland Ombudsman, adapted from Queensland Health's reporting guideline.

Identifying a child in need of protection

Section 13A of the Child Protection Act states that any person – not just professionals of a certain occupation – can contact Child Safety if they reasonably suspect a child may be in need of protection.

Queensland Health's reporting guideline and education module make it clear that all staff need to know how to identify potential child abuse and neglect. Both resources include the following relevant definitions, which are consistent with the Child Protection Act.

Harm

Any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing. It is immaterial how the harm is caused.

Harm can be caused by:

- physical, psychological or emotional abuse or neglect
- sexual abuse or exploitation
- a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances.

Child in need of protection

A child who:

- has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; and
- does not have a parent able and willing to protect the child from the harm.

While 'significant harm' is not defined, the reporting guideline and education module list the factors a staff member should consider when forming a reasonable suspicion about significant harm to a child. These are consistent with section 13C of the Child Protection Act, and include:

- whether there are detrimental effects on the child's body or the child's psychological or emotional state that are evident to the person (or likely to become evident in the future)
- the nature and severity of the detrimental effects
- the likelihood that the detrimental effects will continue
- the child's age.

The education module includes a list of possible characteristics of child abuse and neglect in a health context. The list prompts staff to consider a broad range of child protection signs, including:

- physical injuries, such as broken bones and unexplained bruising
- poor hygiene and untreated medical problems, which can be indicators of neglect.

The education module also notes that health staff may identify concerns about a parent, such as substance abuse; domestic violence; poor mental health; and intellectual, cognitive or physical disability. Staff are encouraged to consider these factors when assessing a child protection concern and in forming a reasonable suspicion of harm.

Queensland Health's reporting guideline and education module note that a reasonable suspicion can also be informed by:

- relevant knowledge, training or experience
- an observation or other knowledge about the child
- consultation with a colleague (for example, a manager, or staff in a child protection unit).

Determining whether a parent is 'able and willing'

The concept of a parent being able and willing to protect their child from harm comes from the Child Protection Act. It is one of the two factors Child Safety uses to determine whether to investigate a concern.

Queensland Health's reporting guideline provides limited information about how staff should consider a parent's conduct or behaviour when they are assessing concerns about a child. The reporting guideline only states:

> - a parent may be willing to protect a child from harm, but does not have the capacity to do so – that is, they are ***unable*** to protect the child from harm
> - a parent may have the capacity to protect a child from harm but may choose not to do so – that is, they are ***unwilling*** to protect the child from harm.

Queensland Health's education module provides more information for staff to consider. It notes:

> - 'Able and willing' is an important consideration. A parent may be willing to protect a child, but not have capacity to do so, that is they are 'unable'. This includes situations where the parents' 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 do so, that is, they are 'unwilling'. 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.

Queensland Health's practices and procedures should provide detailed and consistent information about this concept. This would give staff greater confidence when assessing a parent's behaviour and determining whether their concerns about a child:

- indicate abuse or neglect that should be reported to Child Safety
- suggest the parent may need support in caring for the child.

It will also ensure consistency in decision-making no matter what resource staff access.

Recommendation 1

Queensland Health amends its current practices and procedures to include more detailed and consistent information about the concept of a parent being able and willing to protect their child from harm.

Recognising cumulative harm

The term 'cumulative harm' refers to a pattern of repeated abuse or neglect that may have a cumulative and significant impact on a child's wellbeing and safety.

Section 9 of the Child Protection Act indirectly refers to cumulative harm by stating that harm can be caused by a series or combination of acts, omissions or circumstances.

It is critical that health staff know how to identify cumulative harm, so they do not miss an opportunity to support a child or their family.

Currently, the only reference to cumulative harm in Queensland Health's resources is contained in its *Child Protection Capability Framework*. This document details the child protection knowledge and skills expected of different Queensland Health staff. It mentions 'missed appointments' as an example of cumulative harm.

We consider Queensland Health's current practices and procedures should provide information about:

- types of cumulative harm
- how cumulative harm (including missed health appointments) can affect a child
- how staff can identify cumulative harm in the health context (for example, in recurring presentations at hospital and health services)
- how staff should respond.

When considered on its own, a concern about a child may not amount to significant harm and not need to be reported to Child Safety. However, when staff members consider their concern in the context of other information, they could identify a pattern of harm.

If this is having a significant impact on a child, it could be considered cumulative harm that should be reported to Child Safety. Kaleb and Jonathon's case was an example of this.

Recommendation 2

Queensland Health amends its current practices and procedures to include more detailed information about cumulative harm.

Recognising neglect of medical care

Queensland Health's current practices and procedures do not provide guidance to staff about how to assess whether a child's medical care has been neglected. They only refer to a parent's failure to access medical care for their child as part of a broader definition of neglect. This is concerning.

If circumstances such as those experienced by Kaleb and Jonathon were to arise today, there is limited information prompting health staff to consider whether repeated non-attendance at medical appointments is a sign of neglect.

There is also no information explaining the circumstances in which a concern about neglect of medical care should be managed by the hospital and health service and when it should be escalated to Child Safety.

However, there is other guidance available to staff about the topic of neglect of medical care in Child Safety's *Child Protection Guide* (the Guide).

Referring to Child Safety's *Child Protection Guide*

The Guide provides information about how to assess a potential child protection concern. Queensland Health refers to the Guide in its reporting guideline as a resource that staff *may* use when assessing a child protection concern.

The Guide is designed to complement, not replace, a staff member's professional judgement. It is not intended to stop a staff member from taking any action they think is appropriate in response to their concerns.

It provides information about how staff can assess concerns about a parent, including a parent neglecting a child's medical care. It refers to this as occurring when a child has an untreated or inappropriately treated medical condition resulting in significant harm. It can occur when a parent:

- does not access the necessary medical treatment for a child's acute condition
- does not follow a medical treatment plan for a child with a chronic condition
- does not meet the medical support needs of a child with disability.

The Guide provides instructions on what health staff should consider when determining whether a child is at risk of harm through neglect of medical care. This includes information about how to determine whether a parent is making reasonable efforts to address their child's medical needs.

We consider that the information in the Guide is thorough and helpful. In addition to information about what may constitute neglect of medical care, it also provides detailed guidance about:

- other forms of neglect (for example, lack of supervision, inadequate housing, poor nutrition)
- other types of harm (for example, physical harm, sexual abuse and emotional/psychological harm)
- parental behaviour that can adversely affect a child.

Information about these concepts is currently lacking in Queensland Health's own guidance material.

Given this, we consider there would be a significant benefit in health staff using the Guide as standard practice to support their decision-making about child protection concerns.

We note that in 2021, the Queensland Family and Child Commission recommended that Queensland Health revise its child protection practices and procedures so that staff are *required* to use the Guide.

In response to our proposed report, Children's Health Queensland submitted:

> … any prescriptive requirement to use the Guide for each and every assessment may become a mere box ticking exercise, especially where experienced CHQ clinicians, who regularly interface with children requiring such assessments, are likely acutely aware of the contents (and high-level nature) of Child Safety's Child Protection Guide (the Guide). CHQ considers that the process of applying relevant considerations contained in the Guide is [a] more important focus, such that a recommendation about promoting the existence of helpful guidance in making assessments, more widely across QH and HHSs, would encourage uptake by any clinicians who may be less regularly required to assess child protection concerns.

We acknowledge these views and accept that there are clinicians who are confident in assessing child protection concerns. However, not all health staff are child protection experts. Unless they are encouraged to consult Child Safety's resource as usual practice, they may be unaware of the detailed information and guidance contained within it.

Recommendation 3

Queensland Health reviews its current practices and procedures and considers whether to mandate that health staff use Child Safety's *Child Protection Guide* when they are assessing child protection concerns.

Consulting about child protection concerns

Queensland Health's reporting guideline does not require health staff to consult with child protection units before submitting a report to Child Safety. It is optional. This differs to Queensland Health's education module which lists consultation with staff in the child protection unit as a step for staff to undertake when assessing a child protection concern.

In our proposed report, we said that staff should be *required* to consult their local child protection unit when they identify a child protection concern.

In response to the proposed report, Queensland Health expressed concern with this proposed change, noting:

- child protection units are not staffed 24 hours per day, 7 days a week
- clinicians may have extensive experience in identifying and responding to child protection concerns and may not need support or advice from the child protection unit.

We acknowledge these points and recognise that there may be occasions when staff cannot consult about a child protection concern or they are sufficiently experienced to not need to. Still, Queensland Health should promote consultation as best practice, because staff within the child protection unit of each hospital and health service:

- are specifically trained in child protection
- have the knowledge and expertise to help health staff assess child protection concerns
- have access to other relevant information such as previous child protection reports. (Which not all staff do.)

If staff do not consult their child protection unit about a concern, they should have a compelling reason for this.

It is important that health staff consider *all* relevant information so they can identify patterns of harm. Consultation with child protection units ensures that critical child protection information (such as previous reports about the child or family) is not overlooked. This is especially important for concerns that may not on their own amount to significant harm, but which could indicate a pattern of harm when considered with other information.

Also, consultation with child protection units is a quality assurance mechanism. It provides expert oversight, which can ensure that health staff make appropriate and consistent decisions.

If consultation is made part of the assessment of a child protection concern, child protection units will be able to:

- identify patterns of concern, as mentioned above
- ensure concerns that meet the threshold are reported in the correct way
- identify children and families who may benefit from a referral to a support service, and assist staff with that process
- provide feedback to health staff about identifying concerns.

As with Child Safety's *Child Protection Guide*, consultation is not intended to stop a staff member from taking any action they think is appropriate in response to their concerns. Consultation is also not intended to delay a staff member from contacting Child Safety if they are concerned a child is at *imminent* risk of significant harm.

Children's Health Queensland told us that it already mandates reporting of child protection concerns. It instructs clinicians to consult with the Child Protection and Forensic Medical Service if they have queries and there is time to do so. This is positive. Queensland Health should ensure that other hospital and health services adopt the same approach in both policy and practice.

Recommendation 4

Queensland Health amends its current practices and procedures so that when staff identify a child protection concern, they consult with their child protection unit if they have queries and it is practical to do so. This should be promoted as best practice.

Queensland Health's education module also provides guidance to staff about consultation on child protection concerns. It instructs staff to:

- review a child's health record to consider previous presentations at hospitals and health services, and any concerns about the child
- discuss the immediate concerns with health colleagues who have had contact with the child and their family.

These steps are important. They recognise that there may be other relevant information about a child that should be considered when responding to a child protection concern.

While following these steps should, again, not prevent health staff from contacting Child Safety in response to imminent safety concerns, they should be consistently promoted as best practice in Queensland's Health's practices and procedures. This should not prevent timely reporting but should occur when possible and practicable.

We note that the current education module describes consultation with colleagues and other experts as 'essential', whereas the reporting guideline only encourages it. Queensland Health should remove this inconsistency so that both documents refer to consultation as an essential part of responding to a child protection concern.

Recommendation 5

Queensland Health amends its current practices and procedures so they all consistently prompt staff to:

- review a child's health records when responding to a child protection concern
- consider any previous presentations at hospitals or health services, and any previous child protection concerns
- discuss their immediate concerns with colleagues who have had contact with the child and their family.

Additional child protection resources

Queensland Health has developed additional resources to help staff assess child protection concerns.

The *Risk vs Protective Factor Assessment Framework* (the assessment framework) sets out many risk factors and protective factors (conditions that can help mitigate risk factors) that staff are required to consider. We have included some of the most relevant in Table 3.

Table 3: Risk factors and protective factors

	Child	Parent/family	Social/environmental
Risk factors	Birth factors (e.g. premature birth, low birth weight)	History of abuse	Lack of access to medical care
	Temperament	High parental conflict	Homelessness
	Disability	Substance abuse	Social isolation
	Illness (chronic or serious)	Single parent with lack of support	Lack of social support
	Age	Domestic and family violence	Community violence
	Trauma	Insecure attachment with own parents	Exposure to racism or discrimination
Protective factors	Good health	Secure attachment	Access to health care and social services
	Secure attachment (a healthy emotional bond with a caregiver)	Supportive family environment	Adequate housing
	Independence of a child	Household rules and structure	Strong positive social networks
	Peer relationships	Positive social behaviour	Mid-to-high socio-economic status
	Positive self-esteem	Stable relationship with parents	Access to well-resourced schools

Source: Office of the Queensland Ombudsman, adapted from Queensland Health's *Risk vs Protective Factors Assessment Framework.*

Based on what we know from Public Hearing 33, some of these risk factors were present in Kaleb and Jonathon's case, as were some of the protective factors.

Queensland Health states that the assessment framework should guide staff towards identifying other information relevant to child protection concerns, such as:

- the type of harm
- the seriousness of the harm
- whether the harm is actual/suspected, or whether the child is at risk
- individuals who may have caused the harm
- family members or others with knowledge of the harm
- health services being provided to the child
- referral pathways for support
- other relevant community and/or government services required.

Queensland Health also has a *High risk population groups* fact sheet. It recognises that certain cohorts of children, including those with disability, are at greater risk of experiencing abuse and neglect. The fact sheet identifies factors that may be observed in high-risk patients and their families.

We consider that these additional resources are helpful for staff members in assessing whether a child may be at risk of significant harm.

Storing child protection information

Queensland Health's practices and procedures require child protection information to be stored in a patient's health file, and it has developed a guideline outlining best practice principles for storing it. This states that:

- all child protection information should be stored in the 'legal' section of a patient's health record
- each hospital and health service is required to consider the most appropriate way to document this information.

Queensland Health told us that the 16 hospital and health services across Queensland use electronic and paper-based files, and a combination of both. This is problematic.

If child protection information is stored in paper-based records, it is confined to one hospital and health service. This means that staff in other hospital and health services will not be able to readily access it. This could limit a staff member's ability to properly assess a child protection concern or to identify potential patterns of harm or cumulative harm.

We acknowledge Queensland Health's efforts to develop guidance for hospital and health services about storing child protection information. While this guidance is helpful, it does not address the limitations and risks in relying on paper-based systems when responding to child protection concerns.

Queensland Health needs to support hospital and health services in ensuring that they have contemporary information systems to support effective and consistent recordkeeping. We discuss this further in Chapter 6.

Accessing child protection history

We asked Queensland Health if it has any mechanisms to help health staff identify whether a child has been the subject of previous child protection concerns. (This could help in determining if a child is at risk of harm or cumulative harm.)

Queensland Health told us that it currently has no automated process to identify a patient's child protection history. It explained that staff are encouraged to consult with their child protection unit if they suspect Child Safety may be involved with a child or their family (or may have been involved in the past).

As detailed in Chapter 2, child protection units have staff who are responsible for helping to share information between hospital and health services and agencies like Child Safety and the Queensland Police Service. They also have access to information, for example, previous reports made about a child.

Queensland Health also told us that in urgent situations, such as when a child may be at immediate risk of harm, health staff can contact Child Safety and obtain information under inter-agency information-sharing arrangements.

Child Safety's new client management system, Unify, is intended to help increase information sharing across Queensland Government departments. During our investigation, Queensland Health told us that components of its system and the Unify system were going to be integrated in 2025.

These changes would have meant that Queensland Health staff had access to:

- what action Child Safety takes in response to a child protection report from Queensland Health
- whether there are court orders relating to a child
- whether a child is known to be at risk of suicide
- whether there are contact details for the child, their parent/carer and an allocated Child Safety officer.

This information would not automatically appear in a child's health record but would be added if a child was 'matched' between systems.

In response to our proposed report (completed in July 2025), Queensland Health told us that while it was originally intended that this information sharing would occur, Child Safety has since transitioned the Unify program initiative with Queensland Health to a 'continuous improvement pipeline'.

As Unify is a program managed by Child Safety, we do not intend to comment further on it in this report.

However, effective information sharing between Child Safety and agencies like Queensland Health is crucial for identifying and supporting children in need of protection. For this reason, Queensland Health should prioritise working with Child Safety to implement a system that supports effective and efficient information sharing between the agencies.

Managing health appointments

In 2014, Jonathon missed multiple appointments with a paediatric service, and as a result, was discharged from the service.

In 2015, and again between 2019 and 2020, Jonathon was referred to a specialist outpatient service. However, Queensland Health failed to book the appointments.

This, along with Jonathon's earlier non-attendance, contributed to gaps in the appropriate healthcare he should have received.

Scheduling health appointments

During the investigation, we asked Queensland Health for information about how it managed Jonathon's health appointments, including an explanation of why some of Jonathon's appointments were not booked. Queensland Health told us this was likely due to 'administrative oversight'.

Children's Health Queensland (as the hospital and health service responsible for paediatric services) told us that it has improved its system for managing outpatient appointments in the years since Kaleb and Jonathon's interactions with its service.

However, we understand that Children's Health Queensland still uses paper slips to record information when managing outpatient appointments. We find this surprising.

As mentioned earlier, there are inherent risks with information management systems and processes that rely on paper records. For example:

- There is a greater likelihood that records will be misplaced.
- The process of entering information from paper records into an electronic system introduces the potential for errors. It is also inefficient.
- The quality of information may be less clear on handwritten, paper records. This makes review and audit processes difficult.

Where possible, information management systems and processes should be contemporary to reduce these risks.

To prevent what happened in Jonathon's case happening to another child, Queensland Health should consider whether hospital and health services have adequate systems to support attendance at health appointments. We discuss this further in Chapter 6.

Managing missed appointments

When we asked Queensland Health about Jonathon's missed appointments in 2014, it told us:

> It appears there [were] no further concerted efforts from the hospital to follow up these non-attendances, such as through registered post for clinic letters.

By not following up these appointments, Queensland Health missed an opportunity to identify reasons why Jonathon did not attend and find out whether his medical care was being neglected.

Queensland Health told us that it does not think Jonathon's missed appointments would have resulted in a report to Child Safety. It said:

> [B]ecause parents can choose to see someone outside of public health to provide care for their child, [Children's Health Queensland] would not be able to assume there are concerns of neglect without any additional information. [Jonathon] may have been seen by a GP or private doctor in the community. Without the hospital seeing the child, it is hard to provide enough information to justify a report of concerns of neglect to Child Safety. Further, it is not clear that Child Safety were involved with the family at that time, so the child would not have come to the attention of [Child Protection and Forensic Medical Service] …

We acknowledge Queensland Health's reasons for not reporting Jonathon's missed appointments on these occasions.

However, from 2005 onwards, each time Kaleb or Jonathon missed a health appointment, there was information available to Queensland Health that these children:

- were siblings with disabilities who had significant care and support needs
- had been known to Child Safety from birth because of reports about their safety and wellbeing from Queensland Health
- had previously been reported to Child Safety by Queensland Health after missing specialist health care appointments
- had not been seen by any Queensland Health service for long periods of time.

This should have indicated that Kaleb and Jonathon were vulnerable children and potentially at a greater risk of harm.

We also note Queensland Health's suggestion that a child needs to be seen to justify a report about neglect to Child Safety. In fact, Child Safety's *Child Protection Guide* recognises that a child's failure to receive health care may be a sign of neglect. It does not require health staff to see a child to assess whether they may be at risk of harm. Staff may have other information about a child and their medical condition to suggest they may be at risk of harm.

It is worth repeating here that that the Royal Commission found that Kaleb and Jonathon's non-attendance at health appointments contributed to the evidence that they experienced chronic neglect in their father's care.

We acknowledge that there are a variety of reasons why parents and children do not attend health appointments. If a child fails to attend appointments, it may not be immediately clear to staff whether the non-attendance represents a risk to the child.

Queensland Health needs to follow up a child's missed appointment so that its staff can assess:

- the potential detriment to the child if they do not attend (for example, the risk that the child will suffer significant harm)
- the behaviour of the child's parent (for example, the ability and willingness of the parent to protect the child) and whether that has contributed to the failure to attend or receive medical treatment.

We have considered this issue in assessing Queensland Health's current practices and procedures for managing missed health appointments.

We have also examined its quality assurance mechanisms relevant to children's non-attendance at health appointments, including data collection and clinical audits.

We want to know whether these mechanisms could prevent what happened in Kaleb and Jonathon's case from occurring to another child.

Queensland Health's Standard

To help hospital and health services manage missed health appointments, Queensland Health has a *Specialist Outpatient Services Implementation Standard* (the standard).

The standard applies to all patients who attend specialist outpatient services, which may involve examination, consultation and/or treatment. It outlines best practice processes for responding to outpatient care, including the follow up of non-attendance at outpatient appointments.

The standard states that hospital and health services should:

- make all reasonable efforts to contact a person if they miss an appointment, to find out why they did not attend and, where appropriate, schedule a new appointment
- document all efforts to contact a person about their appointment
- undertake a clinical audit (a review of a person's care) before removing a person from the patient list (in circumstances where they have failed to attend and cannot be contacted for a new appointment)
- notify the person's treating practitioner if they are removed from the patient list
- record a person's failure to attend multiple appointments on the Queensland Health outpatient appointment management system and the person's health record.

The standard requires staff to prioritise appointments for vulnerable people, including children at risk of entering the child protection system. This is because they are likely to have significant and unmet health needs.

Children's Health Queensland

Queensland Health told us that each hospital and health service is expected to have its own set of practices and procedures for managing outpatient appointments, but they must be based on the standard.

We looked at Children's Health Queensland's practices and procedures regarding missed appointments, given that it is responsible for paediatric health care in Queensland.

In 2023–24, it had more than 304,000 outpatient appointments for children.

Process for no-show appointments

Staff at Children's Health Queensland must follow the *Failure to attend (No show) an outpatient appointment procedure* (no-show procedure) whenever a child fails to attend an outpatient appointment. This requires staff to:

- make reasonable efforts to contact the child/their family and find out the reasons for non-attendance
- contact the child's treating practitioner about the non-attendance
- record all attempts to contact the child/their family and their practitioner
- assess medical records and electronic patient data
- seek clinical guidance to determine whether a further appointment should be offered or if the child should be returned to their practitioner's care.

If the child is to be returned to the care of their treating practitioner, staff must notify the child/their family and their practitioner of the decision within 5 business days.

We consider that the no-show procedure has some effective safeguards for children at risk of harm. The requirement to contact a parent and the child's treating practitioner is especially important. It ensures that:

- efforts must be made to establish *why* a child has not attended a health appointment
- someone outside the family has information about the child's non-attendance and can take further action if necessary.

However, we note that the no-show procedure does not contain a prompt for staff to think about whether a child's failure to attend an appointment raises child protection concerns.

Failure to Attend Guideline

In addition to the no-show procedure, Children's Health Queensland has a *Failure to Attend Guideline* (the guideline). Unlike the no-show procedure, which applies to *every* missed appointment, the guideline only applies if a child's non-attendance at a Children's Health Queensland appointment raises child protection concerns.

It instructs staff to contact a child's family and general practitioner about the child's non-attendance. It also requires staff to identify any barriers to the child's attendance (for example, transport or finances) and refer the family to a health social worker if appropriate.

If staff cannot contact the family, the guideline states they should consider if the non-attendance is an urgent clinical or psychosocial concern for the child. If it is, staff are instructed to contact the Child Protection and Forensic Medical Service at Children's Health Queensland to:

- discuss ways of engaging with the family (such as connecting them to support services)
- determine whether the failure to attend reaches the threshold for reporting to Child Safety.

We note that the guideline does not describe the circumstances in which non-attendance would prompt health staff to consider or recognise it as a child protection concern. Queensland Health advised us that:

> Not every [failure to attend (FTA)] prompts child protection considerations, rather these may be prompted after follow up with a family is unsuccessful, or if there is an indication that they did in fact receive the referral. There may also be numerous other explanations for the non-attendance which cannot be determined without some effort being made to contact the family about the non-attendance. There would also be little justification of a child protection notification to [Child Safety] without effort being made to contact the family to determine why it was missed, and to ensure it was not accidental or the family did not receive notice of the appointment.

> The FTA with child protection response is initiated in cases where there are serious concerns for the medical wellbeing of the child. This is usually in the context of a complex medical condition where specialist care and regular review are needed at [Queensland Children's Hospital (QCH)]. Examples may include malignancy, severe immunological, neurological or respiratory conditions. In these cases, GP care is not specialised enough, and these children usually require a multi-disciplinary team approach to care; without which they may suffer serious consequences such as advanced disease and may even die. These concerns may also arise in the context of an acute severe illness that needs follow up at QCH.

This is practical information. It makes clear that not every missed appointment is a child safety concern. It also refers to some circumstances in which a child's failure to attend a medical appointment may trigger a child protection response.

However, we note that these are not the only situations that may raise child protection concerns. There are also other factors that staff need to consider when a child fails to attend a medical appointment, such as those we refer to in earlier chapters (for example, a child's child protection history or vulnerabilities). These factors were present in Kaleb and Jonathon's case.

To help staff identify when a child's non-attendance may trigger child protection considerations, Queensland Health could include more detailed guidance in its *Specialist Outpatient Services Implementation Standard*.

In response to the proposed report, Queensland Health said that the standard already includes information about prioritising outpatient appointments for children and young people in out-of-home-care.

In our view, this is not enough. The standard should include information relevant to *all* children at-risk of harm, not only those who have been removed from their parent's care by Child Safety.

Recommendation 6

Queensland Health amends its current *Specialist Outpatient Services Implementation Standard* to:

- include information about child protection considerations (for example, neglect of medical care)
- link to Queensland Health's child protection practices and procedures and Child Safety's *Child Protection Guide*.

Queensland Health should also ensure hospital and health services align their practices and procedures with these updates.

Implementing quality assurance processes

Data about missed health appointments

We wanted to know how many children have missed health appointments and been subsequently discharged from a health service (as Kaleb and Jonathon were).

Queensland Health told us that in recent years, almost one child in 10 has not attended an outpatient appointment. It said this is higher than the rate of non-attendance for the general population, regardless of age. We found this concerning.

We asked Queensland Health to tell us:

- which services children failed to attend
- whether those children subsequently attended an appointment
- how many of the children who missed outpatient appointments had a diagnosed disability
- why the current rate of children failing to attend outpatient appointments is higher than the rate for the general population.

Queensland Health told us:

- It does not collect this information centrally and therefore could not provide this detail.
- For outpatient appointments, it does not record whether a child has a diagnosed disability, as this may or may not be relevant to the appointment.

Collecting information

We consider that Queensland Health should have mechanisms in place to identify:

- reasons for a child's non-attendance at an outpatient appointment
- whether the child subsequently attends an appointment after contact from Queensland Health
- whether the child is discharged from the service
- which services have the highest rates of non-attendance.

Collecting this information would allow Queensland Health to understand:

- whether its follow-up practices are effective in ensuring that children are accessing appropriate health care
- whether (and why) there are particular cohorts of children who regularly fail to attend appointments
- whether it can improve the accessibility of its outpatient services.

Recording diagnosed disability

We acknowledge Queensland Health's statement that the presence of a diagnosed disability may not be directly relevant to a child's attendance at an outpatient appointment. However, we consider this information may help a hospital and health service to identify:

- whether the missed appointment results in a care or support need not being met
- whether reasonable adjustments need to be made to support the child.

In our proposed report, we recommended that Queensland Health collect and analyse data about children's outpatient appointments.

In response to the proposed report, Queensland Health said:

> Collecting and analysing all data relating to non-attended children's outpatient appointments would have significant resource and system impacts. Determining the reasons for non-attendance would require individual chart audits and significant staffing resources. Often appointments are missed for legitimate reasons and are re-booked.

Children's Health Queensland said:

> CHQ considers the collection and analysing of data across its services to provide a wealth of opportunity to learn and build upon its existing service provision, as it can create meaningful opportunities to improve upon health and wellbeing outcomes for children.
>
> While the intention of the proposed recommendation 9 aligns with CHQ's views about improving outcomes for children, with a child protection lens, the data that is able to be captured through CHQ's existing systems are constrained in a number of ways – the data included in the recommendation would not simply be able to be extracted, collated and analysed by CHQ's various digital and data teams.
>
> Instead, this would require time intensive, manual audits of individual patient charts, which would be impossible for such teams to achieve and would result in the redirection of finite, frontline resources to achieve this. When you add to this the very large number of outpatient appointments that CHQ undertakes annually (over 350,000 per year), noting there is a consistent non-attendance rate of between 8 and 10%, the actual benefit of redirecting resources to undertake such collection and analysis would be far outweighed by the detriment to actual healthcare service provision.

We acknowledge that intensive, manual audits are not a good use of resources. However, there are benefits in Queensland Health collecting data about children and their attendance at outpatient appointments. Much can be learnt from it, not only in terms of child protection, but potentially in terms of minimising non-attendance and saving Queensland Health's time and resources.

Children are reliant on their parents or primary caregivers to ensure they receive the specialist healthcare to which they have been referred. However, Queensland Health should be doing what it can to help support children's attendance by reducing any barriers to attendance, wherever possible.

By collecting data across hospital and health services, Queensland Health may identify barriers including:

- parents not receiving appointment letters – which suggests improvements can be made to scheduling processes
- parents not understanding the importance of attendance – which suggests improvements can be made to increasing the medical literacy of parents
- parents being unable to attend due to geographical remoteness or financial constraints – which suggests improvements can be made to the accessibility of outpatient services.

This is an area of improvement for Queensland Health.

We discuss this in more detail later in the report, in the context of Queensland Health ensuring hospital and health services have contemporary information systems to support effective administrative practices and service delivery.

Audits of missed health appointments

Queensland Health requires hospital and health services to conduct audits to help manage outpatient services. The *Specialist Outpatient Services Implementation Standard* (the standard) states that audits are intended to identify patients who no longer require care or have received care elsewhere.

We acknowledge that these audits are primarily a mechanism for managing health appointments. However, they also provide a crucial opportunity for health staff to identify children at risk of harm and/or experiencing neglect.

The standard states that when a person fails to attend an appointment and cannot be contacted, the hospital and health service should conduct a clinical audit before removing the person from the service.

We asked Queensland Health whether clinical audits consider factors like the patient living with disability and any child protection history. These were present in Kaleb and Jonathon's case.

Queensland Health told us that a clinical audit involves reviewing all clinical information about a patient, including whether they have a disability or a child protection history. This information is stored on individual files rather than in a way that can be used to extract data about patients and issues.

It would be useful to make it clear to staff conducting audits that they should specifically consider these 2 factors before determining whether a patient should be removed from a service. This should ensure that health staff do not remove children like Kaleb or Jonathon from an outpatient health service without proper regard to their additional vulnerabilities.

Recommendation 7

Queensland Health amends its current *Specialist Outpatient Services Implementation Standard* to include more detailed guidance about what is required in clinical audits, including considering whether the patient lives with disability and has a child protection history.

As referred to earlier, Queensland Health expects each hospital and health service to develop its own practices and procedures for managing appointments, based on the standard. This includes using clinical audits to determine whether a patient is removed from a health service.

We encourage Queensland Health to review how hospital and health services are conducting clinical audits, to ensure that they are not missing opportunities to identify children who may be at greater risk of falling through the cracks.

Where improvements can be made (such as by providing more resources to conduct clinical audits), Queensland Health should support hospital and health services in making them.

Recommendation 8

Queensland Health audits, at regular intervals, a sample of outpatient appointments that children fail to attend and where the children have been subsequently discharged from the outpatient service, across each hospital and health service, to assess:

- whether clinical audits have occurred as required
- the quality of the clinical audits if they have been conducted
- whether the hospital and health service can improve its clinical audit process.

4. Responding to child abuse and neglect

Between 2000 and 2020, Queensland Health submitted several reports to Child Safety about Kaleb and Jonathon.

Queensland Health staff held concerns that:

- Kaleb and Jonathon were at risk of harm as newborns (in 2000 and 2003)
- their medical needs were being neglected, after they failed to attend several health appointments (in 2005).

It is not clear whether Queensland Health referred Kaleb and Jonathon's family to a support service, such as Family and Child Connect, at any time between 2000 and 2020.

If Queensland Health staff members have concerns about a child, they can take various steps. Depending on the seriousness of the issue, they may:

- report their concerns to an external agency like Child Safety or the Queensland Police Service
- refer the child and their family to a support service.

In this chapter, we examine Queensland Health's practices and procedures for responding to child abuse and neglect, again mainly focusing on issues that arose in Kaleb and Jonathon's case. These include:

- reporting suspicions of harm
- referring a family to support services
- responding to concerns that do not meet the threshold for reporting or referring
- implementing quality assurance processes
- considering human rights.

Reporting suspicions of harm

If a staff member forms a reasonable suspicion that a child is at risk of significant harm, Queensland Health's reporting guideline says that they *should*:

- immediately report the concerns in writing to Child Safety using Child Safety's online form
- telephone Child Safety and make a record of the discussion in the child's health record
- print a copy of the report and file it in the child's health record
- forward a copy of the report to the child protection unit *at* the local hospital and health service.

Queensland Health instructs staff to accurately and objectively record actions and conversations associated with a child protection concern in the child's health record. It also tells staff they should record a decision *not* to report to Child Safety or the Queensland Police Service and to include reasons for this.

We consider that Queensland Health's instructions to staff about how to report child protection concerns are generally appropriate. However, we are concerned that the use of the word 'should' in its reporting guideline implies it is not mandatory to follow this process.

We note that Queensland Health's education module is different. It says that if a staff member forms a reasonable or reportable suspicion, they are *required* to undertake the previously mentioned steps in the reporting process.

Noting this inconsistency, there is a risk that health staff might respond differently to child protection concerns based on the practice or procedure they access.

By using more direct and consistent language across its practices and procedures, Queensland Health could improve staff understanding and compliance with the reporting process.

Recommendation 9

Queensland Health reviews its current practices and procedures so they clearly and consistently communicate its expectations about how staff respond to suspicions of harm.

Referring a family to support services

In some cases, concerns about a child's safety can be addressed by offering support to their family. Not all concerns require a report to Child Safety.

The Child Protection Act provides several mechanisms for agencies (including Queensland Health) to refer a child/their family to a support service. For example, Family and Child Connect is a community-based service that helps families by connecting them to appropriate support services. It will accept a referral in circumstances where:

- there is a risk of a child entering or re-entering the child protection system if they do not receive support, and
- the family would benefit from support, and
- the family has multiple and/or complex needs.

Queensland Health's current reporting guideline and education module state that health staff can refer a family to Family and Child Connect if their concern about a child does not meet the threshold for reporting to Child Safety.

The education module provides more detail than the reporting guideline. It states that referral to a support service may be appropriate when:

- concerns do not meet the threshold for reporting to Child Safety, *and*
- the child or family have multiple and/or complex needs that would benefit from ongoing support.

Child Protection Guide

We note that Child Safety's *Child Protection Guide* (the Guide) provides information to staff on determining how to support a family.

For example, if a parent is struggling to support their child's medical needs because of barriers outside their control, the Guide encourages staff to consider whether the family:

- has sufficient supports to respond to the concern
- is actively engaged with a support service to address the concern.

If a family has access to supports, the Guide advises staff that they are not required to make a report to Child Safety or a referral to a support service.

However, if a family does not have supports and has complex or multiple needs, staff are encouraged to refer the family to one of the following:

- Family and Child Connect
- Intensive Family Support
- Aboriginal and Torres Strait Islander Family Wellbeing Services.

The Guide includes information to help staff to decide which service may be most appropriate. (See Appendix B for explanations of the services.)

In circumstances where a family indicates they are not able and willing to promptly engage with a support service, the Guide recommends staff make a report to Child Safety.

As we stated in the previous chapters, Queensland Health's practices and procedures should, as best practice, promote that staff consult the Guide whenever they have concerns about a child or their family. Among other benefits, this would ensure consistency in decision-making.

Responding to concerns that do not meet the threshold for reporting or referring

Sometimes, health staff may determine that their concerns about a child:

- do not meet the threshold for reporting to Child Safety or the Queensland Police Service
- are not appropriate for a referral to a support service.

Queensland Health's practices and procedures provide limited guidance about what staff should do in these circumstances.

We consider that Queensland Health should review its practices and procedures to ensure staff are instructed to record information about these concerns in a consistent and accessible manner. This information could be relevant if new child protection concerns arise in the future.

Recommendation 10

Queensland Health amends its current practices and procedures to include information about:

- what staff should do if they have child protection concerns that do not meet the threshold for reporting to Child Safety or the Queensland Police Service
- how and where staff should record these concerns.

Implementing quality assurance processes

It is not enough to have practices and procedures in place for identifying and responding to suspicions of harm. They must be implemented as required.

This means an agency needs to have mechanisms in place to monitor how staff comply. This allows it to analyse its performance, ensure consistency across decision-making and make improvements where needed.

Reviewing and auditing reports

We asked Queensland Health how it monitors child protection reporting across all hospital and health services. It told us:

- Its child protection practices and procedures require health staff to forward a copy of their Child Safety report to the relevant child protection unit.
- Child protection units can review these reports, which may result in contact with Child Safety about the outcomes.
- Child Safety informs Queensland Health of its response to child protection concerns in a report.
- In certain circumstances, Queensland Health can refer concerns about a child to the Suspected Child Abuse and Neglect (SCAN) team for a multi-agency discussion.
- Queensland Health meets regularly with Child Safety to discuss reporting concerns and strategic issues.

It does not appear that Queensland Health has any centralised review mechanism to audit the reports health staff make to Child Safety. Instead, each hospital and health service is responsible for reviewing reports. We are concerned that this could lead to inconsistent and irregular oversight of hospital and health service reporting practices.

We note that Children's Health Queensland's practices and procedures require an annual audit of reports to Child Safety. Children's Health Queensland is meant to conduct this audit with Child Safety, and the results of the audit are intended to inform staff training. However, during the investigation, Queensland Health advised us that Children's Health Queensland has never conducted these annual audits.

Queensland Health told us that Children's Health Queensland reviews child protection reports in other, ad hoc ways.

We consider that auditing is an effective quality assurance mechanism. In addition to other quality assurance processes, audits would help Queensland Health to:

- confirm compliance with its child protection practices and procedures
- evaluate the quality of reports
- assess the adequacy of recordkeeping
- identify opportunities for staff training.

Recommendation 11

Queensland Health amends its current practices and procedures so it audits, at regular intervals, a sample of child protection reports made by health staff to Child Safety.

Considering human rights

The Queensland Human Rights Act commenced in its entirety in January 2020, so it was not in effect during most of Kaleb and Jonathon's engagement with Queensland Health. However, it is now relevant to the decisions health staff make.

As officers of a public sector agency, Queensland Health staff are required to act and make decisions in a way that is compatible with human rights, and to properly consider human rights when making decisions.

One of these rights relates to the protection of families and children. Section 26(2) of the Human Rights Act states:

> Every child has the right, without discrimination, to the protection that is needed by the child, and is in the child's best interests, because of being a child.

Other human rights may also be affected by child protection decisions, depending on the circumstances.

Queensland Health's practices and procedures

Queensland Health's child protection practices and procedures provide limited information about human rights. They also refer to human rights inconsistently. For example:

- Queensland Health's education module refers to the United Nations Convention on the Rights of the Child but does not refer to Queensland's Human Rights Act.
- The *Child Protection Capability Framework* refers to the Human Rights Act and states that it requires staff to consider the protection of families and children as part of their decision-making. However, it does not explain what this looks like in practice.
- The reporting guideline does not refer to human rights at all.

Children's Health Queensland's training briefly refers to human rights. It mentions the Human Rights Act and notes that it is unlawful for staff to make a decision incompatible with human rights or to make a decision that fails to give proper consideration to human rights. However, it does not explain *how* a staff member considers a child's human rights when responding to a child protection concern, or the process for documenting those considerations.

To ensure compliance with the obligations of the Human Rights Act, Queensland Health should consider including more information about human rights in its child protection practices and procedures. It should also ensure that any training delivered to health staff includes this information.

This information should include scenarios to assist health staff in identifying the human rights relevant to their child protection actions and decisions, considering those rights alongside their decisions, and documenting their assessments of human rights.

In response to the proposed report, Queensland Health told us that human rights are considered generally in Queensland Health decision-making processes.

To ensure this is the case, Queensland Health's practices and procedures should consistently prompt staff to consider human rights, including when responding to child protection concerns.

Recommendation 12

Queensland Health amends its current practices and procedures to include information about the obligation of Queensland Health staff to consider human rights when responding to child protection concerns.

5. Training in child protection

On its website, Queensland Health states that all new health staff should be given introductory information about reporting child protection concerns. It also notes that child protection should be a mandatory component in clinical induction programs.

Queensland Health's *Child Protection Capability Framework* (the capability framework) applies to clinical and non-clinical staff, volunteers and all external contractors working for Queensland Health. Its purpose is to ensure all staff have a common understanding of how to identify and respond to child protection concerns, within the scope of their role.

The capability framework states that *all* Queensland Health staff are expected to:

- have a basic understanding of the legal requirements to report child protection concerns
- take all reasonable steps to prevent child abuse and neglect.

Queensland Health encourages hospital and health services to use the framework to develop the knowledge and skills of their staff, including through training.

We note that Queensland Health (as the overall agency) does not deliver training to staff about child protection. It is at the discretion of each hospital and health service.

In 2023, Children's Health Queensland (the hospital and health service specialising in paediatric care) developed 3 training modules, aligned with the capability framework and staff needs. Concepts in the second and third modules are aimed at staff who have regular interactions with children and greater responsibility for child safety (for example, child protection advisors).

The modules provide helpful guidance about:

- the legislative responsibility for reporting suspicions of harm
- who to consult about a child protection concern
- definitions of harm
- risk factors and protective factors
- whether a parent is able and willing to protect their child from harm
- how to report to Child Safety
- how to refer a family to a support service
- information-sharing powers.

They also provide case examples for staff to test their knowledge.

The majority of the hospital and health services use these modules. However, some use an alternative training program (for example, to address unique social issues in their regions). Queensland Health told us that one hospital and health service does not offer any child protection training.

Clearly, this may mean that health staff are receiving different training on child protection, and in some cases, are not receiving any training at all.

As a result, staff may respond to concerns inconsistently, based on the training arrangements of the hospital and health service they are employed with. We find this concerning.

Queensland Health told us there is also some variation in how hospital and health services monitor staff compliance with child protection training. This makes it more difficult to ensure staff complete the training.

Consistent and regular child protection training is fundamental. It would help staff to:

- identify and respond to child protection concerns
- understand their obligations
- develop their professional judgement
- make consistent decisions.

In our proposed report in July 2025, we recommended Queensland Health require hospital and health services to:

- adopt consistent child protection training for its staff
- conduct child protection training at regular intervals
- implement a process to monitor compliance with attendance at this training.

In response to the proposed report, Queensland Health told us that it is developing a child protection training module that will be mandatory for all Queensland Health staff (departmental and hospital and health staff). This is encouraging.

Queensland Health may benefit from consulting with Children's Health Queensland to ensure that any additional training developed is informed by clinicians who have child protection expertise and experience.

Once the training is implemented, it would also be beneficial for Queensland Health to monitor staff attendance at regular intervals.

6. Improving information management systems

During this investigation, we have identified various issues in Queensland Health's information management systems and practices, specifically:

- the use of paper-based and electronic records to store patient information, including child protection information
- the inability to centrally collect and report on data about children's attendance at outpatient appointments
- the use of paper slips to schedule outpatient appointments by Children's Health Queensland.

These issues (detailed in earlier chapters) appear to stem from outdated information management systems and inefficient practices.

We acknowledge the Queensland health system has its challenges – the geographical coverage of the system, the decentralised nature of hospital and health services, increasing service demands, and financial and resourcing constraints. These challenges all affect the state of the information management systems and practices Queensland Health uses to deliver health services across the state.

However, to improve the ability and capacity of health staff to respond to child protection issues, Queensland Health needs to explore opportunities to improve the limitations of its current information systems.

It must ensure that hospital and health services are equipped with contemporary systems that support the delivery of health services. This will ensure these services can effectively and efficiently support children and their families.

Recommendation 13

Queensland Health assists hospital and health services to implement more contemporary information management systems to address the issues identified in this report.

Appendix A: Queensland Health's interactions with Kaleb and Jonathon

Table 4: History of key interactions with Kaleb and Jonathon

Year	Key interactions
2000–2001	• Kaleb is born. • Queensland Health submits a report to Child Safety with concerns about Kaleb's safety and wellbeing. • The Suspected Child Abuse and Neglect (SCAN) team assesses Kaleb's care and recommends a Child Protection Order be sought for him. • Child Safety places Kaleb with a foster carer until 2002.
2002	• Kaleb attends most of his scheduled appointments with an audiologist and the Child Advocacy Service (a former health service for children experiencing abuse, neglect or violence). • Kaleb is diagnosed with significant global developmental delay. • Kaleb returns to the care of Paul Barrett full time.
2003	• Kaleb misses an appointment at an audiology clinic. He attends a rescheduled appointment. • Jonathon is born. • Queensland Health submits a report to Child Safety about Jonathon's safety and wellbeing as a newborn in his parent's care. • Child Safety assesses the concerns and concludes that Paul Barrett can care for Jonathon 'with follow up support and assistance'. • Kaleb attends an appointment at the Child Advocacy Service. • Jonathon attends 2 appointments at the Child Advocacy Service. • Jonathon misses an appointment at the Child Advocacy Service and does not attend the rescheduled appointment. He attends a further rescheduled appointment.
2004	• Kaleb and Jonathon miss an appointment with the Child Advocacy Service. They attend 8 months later. • Kaleb misses an appointment with an ophthalmologist. He then misses another 2 appointments scheduled in 2005 and does not attend any further appointments with an ophthalmologist. • Jonathon misses 2 more appointments with the Child Advocacy Service.

Year	Key interactions
January – June 2005	• Kaleb misses 3 appointments with the Child Advocacy Service. • A consultant paediatrician (also Queensland Health's SCAN representative) reports concerns about Kaleb and Jonathon's missed appointments to Child Safety. • Child Safety substantiates the reported neglect concerns due to Paul Barrett's failure to ensure the children's medical needs were met through various health care appointments. • Kaleb attends an appointment with the Child Advocacy Service. • Kaleb is referred to an endocrine clinic. • Jonathon is assessed as having global developmental delay. • Kaleb misses 2 appointments at an eye clinic.
July – December 2005	• Kaleb misses appointments at the endocrine clinic 3 times and is discharged from the service. • Paul Barrett advises the Child Advocacy Service that he did not receive the letters from the endocrine clinic. • Paul Barrett cancels Jonathon's attendance at an audiology appointment. • Jonathon does not attend a rescheduled audiology appointment and is discharged from the service. • Child Safety is involved with the family as a result of the Queensland Health consultant paediatrician's report.
2006	• Kaleb is referred to the endocrine clinic again and attends in early 2006. • Kaleb misses 2 follow-up appointments for the endocrine clinic and is again discharged from the service. • Kaleb attends the emergency department. • Jonathon does not have any appointments with a Queensland Health service between 2006 and July 2010.
2007	• Kaleb attends the emergency department on 2 occasions.
July 2010	• Kaleb and Jonathon miss an appointment with the Child Advocacy Service, and Queensland Health is unable to contact Paul Barrett. • Queensland Health emails Child Safety about the missed appointment, aware that Child Safety is involved with the family.
August – November 2010	• Kaleb and Jonathon subsequently miss their rescheduled Child Advocacy Service appointment. • Queensland Health again contacts Child Safety, advising that a further appointment has not been booked; but Queensland Health does not make a report to Child Safety. • Kaleb and Jonathon attend a general paediatrics appointment.
2011	• Jonathon attends an audiology appointment. • Jonathon misses an appointment with the Child Advocacy Service and it is unclear if Queensland Health follows up on this.

Year	Key interactions
2014	• Jonathon presents to an emergency department. Staff note that he has not had a paediatric review for 2 years. • Jonathon is referred to the paediatric outpatient department, to be scheduled within 30 days. • Jonathon does not attend 2 appointments with the paediatric outpatient department. Queensland Health is unable to contact Paul Barrett as his phone is disconnected. • Queensland Health discharges Jonathon from the outpatient program, according to its policy.
January 2015	• Jonathon attends the emergency department for seizure activity and staff note he has been 'lost to follow up'. (We understand this means Queensland Health did not follow the proper process for following up on Jonathon's non-attendance.) • Jonathon is referred to the paediatrics outpatient department for review in 30 days. Queensland Health cannot confirm that the appointment was in fact booked.
May 2015	• Jonathon attends a specialist appointment for his seizure activity.
August 2015	• Jonathon attends the emergency department for seizure activity and has a neurology and social work review. • Staff note there should be a general practitioner (GP) follow up in 2 weeks and 3–6 monthly outpatient department appointments. Queensland Health cannot confirm that the appointments were booked.
2017	• Jonathon attends an appointment with the paediatrics outpatient department.
2018	• Jonathon attends an appointment with the paediatrics outpatient department. • Jonathon attends the emergency department after swallowing a battery.
2019	• Jonathon is due to have an appointment with the paediatrics outpatient department in 2019. Queensland Health cannot confirm that it was in fact booked.
2020	• Kaleb and Jonathon are admitted to hospital after their father's death. • Queensland Health staff treat Kaleb and Jonathon for Kwashiorkor, a severe malnutrition disease. • Queensland Health work with other government departments to create health care plans for Kaleb and Jonathon regarding their nutrition, dental needs and GP visits.

Source: Office of the Queensland Ombudsman, adapted from the Royal Commission's report on Public Hearing 33, Counsel Assisting's submissions, and information we obtained from Queensland Health and Child Safety.

Appendix B: Types of support services

Table 5: Types of support services

	Family and Child Connect	Intensive Family Support	Aboriginal and Torres Strait Islander Family Wellbeing Services
When to use	Use when it is necessary to identify a family's needs, before determining the support required OR when a family may need help deciding what to do about an area of concern.	Use when it appears that a family has multiple complex needs or chronic problems that will benefit from intensive intervention AND the family is committed to the intervention.	Use when the family identifies as Aboriginal people or Torres Strait Islander people who appear to have multiple or complex needs or chronic problems that will benefit from intensive intervention AND the family is committed to the intervention.
What the service provides	• identification of family needs • engagement with the family • referrals to community-based services or other support services • safety or risk assessment.	• case management • holistic supports and services.	• identification of family needs • engagement with the family • case management • holistic supports and services.

Source: Office of the Queensland Ombudsman, adapted from Child Safety's *Child Protection Guide.*

Appendix C: Response from Queensland Health

Queensland Government

Queensland Health

Enquiries to: [redacted]

Telephone:
Our ref: C-ECTF-26/3100
Your ref: 2023/08004

Mr Anthony Reilly
Queensland Ombudsman
GPO Box 3314
BRISBANE QLD 4001

Email: investigations@ombudsman.qld.gov.au

Dear Mr Reilly

Thank you for your letter dated 18 February 2026, regarding the revised proposed report and recommendations (the revised report), following your investigation into Queensland Health's interactions, examined in Public Hearing 33 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and your review of Queensland Health's current practices and procedures.

I understand that the Children's Health Queensland Hospital and Health Service has provided you with a separate response to the original proposed report, and that you have subsequently also provided them with a copy of the revised report.

I note the revised report responds to Queensland Health's feedback provided in July and September 2025 and takes into account changes and improvements made by Queensland Health to date, as well as Queensland Health's ongoing work to strengthen responses to child protection concerns. I am writing to confirm changes already implemented and further proposed changes to Queensland Health's practices and procedures.

Recommendations 1 to 5, 9, 10 and 12 will be considered through Queensland Health's established policy and procedure review cycles.

Recommendations 6 to 8 are being addressed through amendments to the Queensland Health *Specialist Outpatient Services Implementation Standard*. The *Specialist Outpatient Services Implementation Standard* will be updated to include a link to the Department of Families, Seniors, Disability Services and Child Safety's (Child Safety) *Child Protection Guide* and guidance for its use, in relation to child protection considerations, including neglect of medical care. It will also recommend a process for timely clinical audits for all children in child protection who do not attend scheduled outpatient appointments. Hospital and Health Services will need to consider the resources required to audit a sample of outpatient appointments.

Recommendation 11 will be considered through the development of a minimum data set for child protection matters, which will support auditing of a sample of child protection reports made by health staff to Child Safety. This work aligns with Queensland Health's broader implementation of the *Child Safe Organisations Act 2024* to support the safety and wellbeing of children and young people.

Level 37
1 William St Brisbane
GPO Box 48 Brisbane
Queensland 4000 Australia

Website health.qld.gov.au
Email [redacted]
ABN 66 329 169 412

As you acknowledge in the revised report, Queensland Health continues to face challenges associated with information systems across a geographically dispersed and decentralised health system, increasing service demands and resource constraints. Queensland Health will continue efforts to progress the Digital Hospital Program, with the intent of transitioning all Hospital and Health Services to a world-class, digitally enabled health system through the expansion of the ieMR.

I also note that the Queensland Child Safety Commission of Inquiry will provide its final report to Government by 22 May 2026, which may include recommendations relevant to health service delivery and child safety practices. Queensland Health will continue working closely with Child Safety and other partners to strengthen responses to the health needs of vulnerable children, young people and families engaged with Queensland's child protection and public health systems.

Should you require further information, Queensland Health's contact is [redacted], [redacted], on telephone [redacted] or via email at [redacted].

Yours sincerely

Dr David Rosengren
Director-General
19 March 2026

Appendix D: Response from Children's Health Queensland

Queensland Government

Children's Health Queensland Hospital and Health Service

Mr Anthony Reilly
Queensland Ombudsman
GPO Box 3314
BRISBANE QLD 4001

Email: investigations@ombudsman.qld.gov.au

Dear Mr Reilly

Thank you for your letter dated 18 February 2026, regarding the revised proposed report and recommendations (the revised report), following your investigation into Queensland Health's interactions and practices and procedures, as examined at Public Hearing 33 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Children's Health Queensland Hospital and Health Service (CHQ) acknowledges the extent to which your revised report incorporates feedback provided previously by CHQ throughout 2025, and we thank you for the opportunity to again provide feedback in response to the revised report.

Further we acknowledge there are a number of broader systems initiatives being undertaken by Queensland Health, that align with the recommendations, which CHQ along with other Hospital and Health Services (HHSs) will implement as required. Noting the system limitations that public Hospital and Health Services are subject to, we wish to simply acknowledge that the extent to which CHQ will be able to effect any recommendation is constrained by this context. CHQ otherwise commends the intent of the revised report.

Should you require any further information in relation to this matter, I have arranged for [redacted], on telephone [redacted], to be available to assist you.

Yours sincerely

Frank Tracey
Health Service Chief Executive
Children's Health Queensland
Hospital and Health Service
09/03/2026

Queensland Children's Hospital
PO Box 3474
SOUTH BRISBANE Q 4101

QUEENSLAND
OMBUDSMAN