CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of F and M, two parents involved in family law proceedings**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/1132 & 2022/1139
DELIVERED ON:	21 April 2026
DELIVERED AT:	Brisbane
HEARING DATE(s):	21-23 October 2025, 12 November 2025
FINDINGS OF:	Ainslie Kirkegaard, Coroner
CATCHWORDS:	Coroners: inquest, house fire, intimate partner homicide, female intimate partner homicide perpetrator, family law proceedings, parenting proceedings, domestic and family violence, cross-protection orders, Child Safety involvement, systems abuse, misidentification of perpetrator-victim, male victimisation, Independent Children's Lawyer, family law-child protection system interface, independent psychiatric assessment, lethality risk assessment and safety planning, transition of care of children between parents

REPRESENTATION:

Counsel Assisting:	Mr C Forrest SC Ms C Leach
Interested Parties:	Mr B McMillan KC, (Counsel) instructed by the Department of Families, Seniors, Disability Services and Child Safety
	Mr I Neil KC with Ms C Melis (Counsel) instructed by the Australian Government Solicitor for the Federal Circuit and Family Court of Australia

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Introduction

1. F (the father, aged 33) and M (the mother, aged 31) died as a result of a house fire M deliberately ignited at F's home in Southeast Queensland in the early hours of Thursday, 10 March 2022. The three eldest of M's four young children were in the house at the time of the fire. Two of those children were F's biological children, and he was a father figure to the other child. The children survived due to the incredibly brave actions of F's partner who led them from the burning house to safety.

2. M died inside the house before the fire was extinguished. Coronial autopsy determined the cause of her death to be smoke inhalation.

3. F died in hospital late that evening from complications of severe burns sustained after M splashed petrol on him while he was sleeping and then threw a Molotov cocktail, setting him alight from head to toe. Coronial postmortem examination confirmed the clinical finding of extensive burns as the cause of his death.

4. Their deaths occurred during family law proceedings F commenced in July 2021 seeking orders to ensure the three eldest children continued spending time with him. He brought the parenting proceedings because M withheld the children from contact with him and threatened to move away with them after learning he had a new partner. There were no reports of domestic and family violence by either parent or reported concerns for the children's safety made prior to this point. The Department of Children, Youth Justice and Multicultural Affairs as it was then known ('Child Safety') became involved with the family not long after the parenting proceedings commenced. There were current cross domestic violence protection orders in place between F and M. M was being supported by a specialist domestic violence service which was aware of police and Child Safety involvement with the family during the parenting proceedings. She was also seeking advice through and participating in online support groups.

5. A psychologist who prepared a court ordered family report for the parenting proceedings identified concerns about M's mental health. Independent psychiatric assessment ordered by the Federal Circuit Court and Family Court of Australia (FCFCOA) diagnosed M with mental health conditions significantly impacting her capacity to parent all four of her children safely, and identified she posed a serious imminent risk of lethal violence against herself and the children. She did not have a formal mental health diagnosis prior to this assessment. Following an interim FCFCOA hearing on 9 March 2022, all four children were transitioned out of M's care. This was the trigger event for the fatal house fire.

6. F and M's deaths are a devastating loss for the four children and their extended families. What happened following the FCFCOA hearing on 9 March 2022 has also deeply affected the lawyers, the Child Safety officers and FCFCOA decision makers and staff involved with the parenting

proceedings up to and including that day. It has also deeply impacted the specialist domestic violence service workers who were supporting M.

7. M's family remember her as fiercely devoted to her four children and her immediate family. In her mother's words, M was *my everything*. She had brought M up as a single mother and it was just the two of them for a very long time before she met M's stepfather with whom she has two children. M's children were her world.

8. F was a very accomplished university educated young man from overseas who was successfully establishing a life for himself in Australia. He took his responsibilities as a father very seriously, not only to the two biological children he shared with M, but also her eldest child who was born from a previous relationship. Others describe F's relationship with his new partner as loving, respectful and supportive.

9. Notwithstanding the complexities of their relationship and what followed their separation, it is evident F and M each loved their children dearly.

10. The inquest examined:

    (a) The findings required under section 45(2) of the *Coroners Act 2003*.

    (b) The appropriateness and adequacy of any risk assessments conducted, and safety planning enacted by the FCFCOA (Division 2) with respect to the Federal Circuit Court proceedings regarding the children.

    Consideration of this issue did not extend to examining the exercise of federal judicial power by the FCFCOA including in relation to case management and the conduct of the parenting proceedings, and the making and content of the interim consent order on 9 March 2022.

    (c) The appropriateness and adequacy of any risk assessments conducted, and safety planning enacted by the legal practitioners involved in the FCFCOA (Division 2) proceedings regarding the children.

    (d) The appropriateness and adequacy of any risk assessments conducted, and safety planning enacted by Child Safety officers involved in the FCFCOA (Division 2) proceedings regarding the children.

11. The inquest examined these issues with input from an Australian academic, Dr Samara McPhedran, whose primary research focus is violence and violence prevention, particularly lethal violence in a domestic and family violence context, and in the broader context of gender-based violence.

12. Dr McPhedran's examination of what unfolded over June 2021 – March 2022 identified M as the perpetrator of systems abuse (a not uncommon form of coercive control) against F. While multiple agencies recognised M's pattern of mounting unsubstantiated allegations about F, it was not identified as a form of domestic and family violence against him. In Dr McPhedran's

words, what is quite striking about this matter is that despite an independent psychiatrist very clearly identifying M's risk of lethal violence against herself and her children, F was not also identified as potentially being at risk of harm from her. In Dr McPhedran's opinion, at a systems level, the way risk was assessed and identified by multiple agencies involved with the family was very strongly influenced by the gender of the alleged victim and perpetrator, and a limited understanding of male victimisation.

13. The constellation of cross-allegations of domestic and family violence between the parents, multi-agency involvement with the family, M's mounting unsubstantiated allegations of domestic violence and sexual abuse by F once he commenced the parenting proceedings, and emerging concerns about M's mental health and its significant associated risks made this a very complex case. As these findings demonstrate, F and M's behaviours were being assessed through different lenses as the family progressed through the domestic and family violence, child protection and family law systems. In this respect, there are many features common to those examined in the inquest into the deaths of Charmaine McLeod and her four children ('the McLeod inquest').

14. While a person's behaviours may be attributed to a mental health diagnosis, those behaviours and their consequences still need to be risk assessed from a broader domestic and family violence perspective, especially when mental health assessment identifies the risk of lethal violence.

15. Female perpetration of intimate partner homicide is extremely rare. Women and children remain overwhelmingly overrepresented as victims of domestic and family violence perpetrated by men. Nonetheless, the circumstances in which F and M died provide valuable learnings about early and correct perpetrator-victim identification to support effective risk assessment and safety planning and hold perpetrators accountable, and the value of proactive and effective communication between the family law system and child protection agencies regarding families impacted by domestic and family violence in all its forms.

The Coroner's role

16. My role as Coroner is to independently investigate F and M's deaths to make findings as to their respective identity, the medical cause of death and when, where and how they each died. The Coroners Act prevents me from determining criminal or civil liability or regulatory consequences for their deaths.

17. The relevant standard of proof is that of the balance of probabilities, with reference to the Briginshaw[1] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for me to be sufficiently satisfied on the balance of probabilities that the issue has been proven.

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[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.

18. I may, where appropriate, comment on matters connected with F and M's deaths and make preventative recommendations concerning public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

Extent of the FCFCOA's participation in the inquest

19. While not seeking leave to appear as a party to the inquest, the Chief Justice of the FCFCOA instructed Senior and Junior Counsel to adopt a watching brief. They were afforded and took the opportunity to ask questions of witnesses and provide oral and written submissions.

20. Notwithstanding its constitutional primacy, the FCFCOA offered and provided valuable general assistance to help inform my consideration of the issues arising from F and M's participation in the parenting proceedings. It was hoped the inquest would be informed by written and oral evidence from a senior representative of the FCFCOA but this was not forthcoming.

21. The FCFCOA readily acknowledges that parenting proceedings represent a significant source of stress to parties, and a significant proportion of matters before it involve allegations or risks of family violence.

22. I recognise that at the time F initiated the parenting proceedings much had been done, and continues to be done to enhance the FCFCOA's capacity to identify and manage risk to children and vulnerable parties in this context. The FCFCOA assisted the inquest with a helpful information paper explaining its family violence response framework (**Attachment 1**). Of relevance to the issues arising from F and M's deaths are the following elements of that framework:

    (a) **Lighthouse** operates to identify family safety risks and the most appropriate case management pathway early in the proceedings. Parties filing an initiating application or response which includes parenting orders are each invited to complete the online Family DOORS Triage risk screening questionnaire within two business days of filing.

    Family DOORS (Detection of Overall Risk Screen) Triage was developed specifically for early risk screening of litigants in the family law system to help the Courts identify and manage a range of safety risks present in family law matters including family violence, mental health issues, child abuse or neglect and drug or alcohol misuse.

    A specialist team including Triage Counsellors screen the matter to determine a risk screening classification. For matters screened as 'high risk', the Triage Counsellor may, where appropriate, offer a triage interview to conduct further risk assessment with a party, and make service referrals. A high risk classification may result in the matter being allocated to one of three specialist lists including the Evatt List in FCFCOA (Division 2) for serious high risk matters and the Magellan List

in FCFCOA (Division 1) for matters where there are recent notifications or allegations of serious or escalating physical and/or child sexual abuse. Matters allocated to these lists receive intensive case management and parties are supported with tailored safety planning and service referrals.

The Lighthouse Pilot commenced in Brisbane on 11 January 2021, prior to F commencing parenting proceedings, and was expanded in 2022 to become a core component of the FCFCOA's case management pathway for parenting and parenting/property matters in most registries.

Strict confidentiality provisions attach to the family safety risk assessment process. The impact of these provisions on the inquest is discussed in paragraphs 313 - 323 below.

(b) The **National Strategic Framework for Information Sharing between the Family Law and Family Violence and Child Protection Systems** and associated information sharing protocols facilitating the timely two-way flow of information between the FCFCOA and state and territory agencies to inform decision making with a better understanding of any history of violence, abuse or other risk relevant to a matter.

(c) The **Co-location Program** which places state and territory child protection and police officials in or near most of the FCFCOA registries to facilitate information sharing and collaboration between the federal family law, family violence and child protection systems.

(d) The **Court Children's Service**, staffed by psychologists and social workers, supports families and judicial decision making in parenting proceedings. The Service may also assist with facilitating the handover of children from a relinquishing parent to a receiving parent at the Court.

23. As demonstrated by what happened after F commenced parenting proceedings, the FCFCOA is one of multiple agencies responding to risks associated with family and relationship breakdown.

The couple's relationship and separation

24. The couple first met online in late 2017, leading to what F understood to be a casual sexual encounter during January 2018. At this time M had a one year old child (C1) from a previous relationship. Several weeks later M told F she was pregnant. F believed M had lied to him about using contraception, instead hoping to fall pregnant to him, wanting more children but not a man in her life. M's medical records confirm she was actively trying to fall pregnant at this time.

25. The couple's first child (C2) was born in October 2018. F felt strongly about taking responsibility for his child and committed to living with M to try to make something of their relationship and parent both children. Sadly F's decision caused a rift in his family relationships. The couple started living together in a regional town when C2 was several months old. C1's biological father

was not involved at all in the child's life. F developed a close bond with and loved C1, who in turn called him Dad.

26. M wanted more children straight away; F did not because the two children were still so young. F later told a family report writer the couple argued repeatedly about M wanting another baby and then telling him she would get a sperm donor if he did not agree to father another child. M soon fell pregnant again. The couple's second child (C3) was born in October 2019. Paternity testing during the family law proceedings confirmed C3 is F's biological child.

27. F and M were never very compatible and had different approaches to parenting. They separated in early 2020, at which time M and the three young children moved to live with her mother and stepfather in a rural area. F maintained contact with the three children, visiting them at M's family home.

28. M contacted a specialist domestic violence service in July 2020 reporting a range of controlling behaviours by F including him 'snooping' on her when he was at the house visiting the children, previously telling her to wear high heels when she was pregnant, his tendency to 'blow up' when he did not get his own way, making derogatory statements about her appearance and threating suicide when she did not do what he wanted. She told the service she did not feel physically unsafe because F did not have a history of physical abuse.

29. The service provided M with advice about how to apply for a domestic violence protection order. She told the service she was being supported by family counselling, but the counsellor was colluding with F, telling her she just needed to come around to his thinking. She said she had raised concerns with the counselling service which had since changed her support worker. M advised she had completed safety planning with her family counsellor and had an emergency plan. They discussed technology safety as M believed F had access to information about her that she had not shared with him. M declined further follow up by the service as she was going to try mediation.

30. M became pregnant again with her fourth child (C4) who was born in April 2021. C4 is not F's biological child. M told F that after they separated, she found an anonymous sperm donor online and arranged to inseminate herself to fall pregnant again. M had told others in her social network she wanted lots of babies, lined up her Tinder dates when she was ovulating and intentionally chose men from the same specific cultural background so any children conceived would look like their siblings.

31. Following C4's birth, M told F she did not want the child relating to him as a father.

32. M now had four children under the age of five. She and the children moved to a rental house in an outer metropolitan city in Southeast Queensland. F

was living and working in Brisbane. C2 was missing F, so by agreement, he resumed spending time with the three eldest children on a regular basis. M would phone him and ask him to visit the children and help put them to bed.

33. After some family dispute resolution counselling, they entered a parenting plan in early September 2020. F then began spending unsupervised time with the three eldest children each second weekend during the day on Saturday and Sunday, and sometimes for a few hours during the week.

34. The coparenting relationship was amicable and there were no complaints or concerns notified to police or Child Safety regarding the family during this period prior to July 2021.

35. M expressed an intention to have more children by using a sperm donor and raise them alone without the involvement of more stepfathers. Records from her participation in counselling outside the parenting proceedings document her fundamental belief that all men leave relationships. She did not want fathers or stepfathers coming and going from her children's lives. Counsellors variously document her wish for upwards of 8 to 15 to 20 children.

M learns of F's new relationship

36. F met another woman in November 2020. They started living together in February 2021. F had bought a block of land during his relationship with M. He and his new partner were building a house on that land. This is the house destroyed by fire on 10 March 2022.

37. F introduced his new partner to the children for the first time in June 2021, and they spent some more time with her after that.

38. M first became aware of F's new relationship and the children having met his new partner on 18 July 2021. Her attitude to the children spending time with him changed dramatically from this point onwards. Up to this point, their interactions had been amicable.

39. M reacted by immediately threatening to stop F seeing the children without a court order, telling him she and the children were returning to live with her mother and stepfather several hours' drive from Brisbane. She contacted members of his family telling them he was abusive, seeing multiple women and trying to take the children away.

40. While the content of M's communications with F demonstrates a reasonable expectation to feel comfortable about the new adult spending time with her children, they also convey her fear of that woman displacing her role as the children's mother.

41. Within days of learning of F's new relationship, M made the first of multiple and rapidly increasing complaints to police and other agencies alleging F was domestically violent.

42. On 22 July 2021 police responded to an incident when F had a meal with the three eldest children at a restaurant. M alleged F had tried to leave with the three children without her noticing, but she intercepted them, forcing open a car window to unfasten their car seat restraints. While doing so she grabbed Fs car keys and threw them in the bushes. M told police she did not want the children exposed to the multiple women F was seeing. She told them he had never been violent, and she had no concerns about him harming the children. Police obtained a version from F who told them the children had asked for a ride home to M's house in his car, a not unusual occurrence given the parenting arrangements. Police advised both parties to seek legal advice regarding parenting matters and provided them with information regarding private domestic violence applications. Police finalised the complaint as DV – Other Action.

43. That day, M applied for a protection order under the *Domestic and Family Violence Protection Act 2012* citing what she referred to as 'the attempted kidnapping', threats by F she would never see the children again, his unstable behaviour including manipulative suicide attempts, his alleged 'obsession' with the male perpetrator in response to media coverage of domestic and family violence homicides using fire, psychological abuse, and a variety of coercive and controlling behaviours including threats of suicide. She filed a supporting affidavit the following day.[2]

44. F denied all these allegations. His relationship with M was his first real relationship. There is no evidence available to me that he had been identified as a perpetrator of domestic and family violence in previous or subsequent relationships.

45. M's private application led to the making of a temporary protection order on 23 July 2021 naming F as the respondent. All four children were named persons on the order. The order required F to be of good behaviour towards and not commit domestic violence against M, and not expose the children to domestic violence. It also included conditions preventing F from approaching, contacting or attempting to contact M other than in relation to parenting or court matters. The order did <u>not</u> prevent F from having contact with and seeing the children. The matter was adjourned to 3 August 2021.

46. Police served M's application and the temporary protection order on F on 25 July 2021.

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[2] s 159(1) of the *Domestic and Family Violence Protection Act 2012* (DFVPA) prohibits the publication of information that identifies a party to a proceeding under the Act or any evidence given in those proceedings unless the court expressly authorises that the information be published. Publication in these findings of information regarding F and M as parties under the DFVPA and given in those proceedings is expressly authorised under s 159(2)(a) of the Act.

47. M contacted the specialist domestic violence service on 27 July 2021, seeking counselling support for the children 'for record keeping purposes'. She recounted the incident from 22 July 2021 and what happened in court when she applied for the protection order. She was not expecting to have to go before a Magistrate on her own. She said the Magistrate asked what evidence she had to support her application. She was unsure about how much evidence she needed and what evidence to provide at the next mention on 3 August 2021. M told the service nothing was ever reported to police because F would take her phone whenever they argued. She expressed frustration and worry about the invisible nature of his abuse and how this could be evidenced in court.

48. M told the service one of the children was upset about not being able to see F because of the no-contact conditions of the temporary protection order. As noted above, the no-contact conditions did not prevent him from seeing his children. She told the service C1 had told her about F taking the children to see his new house being built, and the child was saying things suggesting F was planning to take the children from her on a full time basis. He was spending longer periods of time with the children. M told the service F had previously threatened to take the children from her and she would never see them again.

49. M was asking for counselling support, particularly for C1, to explore whether the child's stories were true. The domestic and family violence specialist worker explained how the service's family counselling would not extend to establishing the truth or otherwise of her child's stories and told her that given what she wanted to achieve, it was not the appropriate service. She was given advice about how to access private psychology through a GP Mental Health Care Plan.

50. The service's court advocate spoke with M that day, providing her with information about court process and arranged for her to be supported at the next mention date on 3 August 2021. She was also given contact details for Women's Legal Service to discuss what evidence she needed to provide to the court.

F commences family law proceedings

51. F commenced parenting proceedings in the FCFCOA (Division 2) on 29 July 2021 seeking to stop M from moving the children and for orders regulating his time with them. His application related to the three eldest children only. He was legally represented by the same solicitor (S1) throughout the parenting proceedings.

52. The parenting proceedings became the forum through which F and M interacted going forward.

53. Multiple agencies and services received numerous reports of concern about the family as F's parenting application progressed through the family law system over the following nine months. There is a distinct correlation

between the timing, frequency and increasing seriousness of the reported concerns with key milestones in the parenting proceedings. For this reason, it is necessary to detail how the reported concerns were assessed, dealt with and shared across agencies over the course of the parenting proceedings.[3]

54. F filed a Notice of Child Abuse, Family Violence or Risk with his application identifying M as perpetrating domestic violence against and in front of the children. The inquest heard the FCFCOA Registry provides positive notices to Child Safety. That agency's centralised data management service directs the notice to the relevant Regional Intake Service which screens the information to determine whether it reaches the threshold for Child Safety to become involved with the family. The intake outcome is then notified to the FCFCOA registry. In the event Child Safety is or becomes involved with the family, it is the discretion of the Child Safety Officer allocated to the assessment to contact the co-located Family Law Team (FLT) about the assessment.

55. As at July 2021, there were four co-located Child Safety Officers in the FLT for the whole of Queensland, and the Co-Location Pilot was still in development stage. At this time, the FLT periodically intercepted notices of risk and cross-checked with the department whether it was currently involved with the family. The latter did not occur in this matter.

56. Between 28 July 2021 and the first mention of F's parenting application on 16 August 2021:

    (a) Child Safety received the first of multiple reports of concern regarding the family. The initial worries related to M not coping and withholding the children from visitation with F. This was recorded as a Child Concern Report.[4]

    (b) On 2 August 2021 F applied for a protection order naming M as the respondent, seeking no-contact conditions except for matters relating to the children. His application stated he did not feel safe due to recent episodes of harassment by M on social media and her attempts to discredit him in his family, friendship, and work circles. He was worried her behaviours would jeopardise his employment and relationships. F filed a supporting affidavit the following day expressing concern M was causing psychological harm to the children by exposing them to domestic violence as occurred during the incident on 22 July 2021 and exposing them to information about the parenting dispute and associated allegations about him.

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[3] Publication of the account of the family law proceedings between F and M in these findings has been approved under section 114Q(2)(b) of the *Family Law Act 1975* (Cth).

[4] Publication of the account of Child Safety involvement with F, M and the four children in these findings has been approved under section 189(1) of the *Child Protection Act 1999* (Qld).

(c) M's protection order application was mentioned before a Magistrate on 3 August 2021 and adjourned to 10 August 2021.

(d) Police served F's protection order application on M on the morning of 5 August 2021. That same day, M complained to police about F breaching the temporary protection order because she overheard the children speaking with him via Messenger. After taking a version from F, police determined no breach had occurred because the protection order permitted his contact with the children. Police finalised the matter as a No DV event.

(e) The protection order cross-applications came before a Magistrate on 10 August 2021. The parties consented to cross protection orders without admissions in the same terms as the initial temporary protection order. All four children were named persons on the order protecting M. Only the three eldest children were named persons on the order protecting F.

(f) Child Safety received further concerns regarding M's parenting, alleging she had exposed the children to acts of domestic violence and was not coping. These were recorded as a Child Concern Report.

57. F's parenting application came before the FCFCOA on 16 August 2021 at which time M, who was self-representing, sought that all the time the children spent with F be supervised. M was given further time within which to file her material but was restrained from moving with the children away from her current area of residence. The Judge also ordered the three eldest children be independently represented by an Independent Children's Lawyer (ICL).

58. The ICL's role was to independently and impartially represent and promote the children's best interests in the proceedings. ICLs are required to form an independent view, based on evidence, about what is in a child's best interests and ensure all relevant evidence is before the Court.

59. Between the making of these orders and the next FCFCOA hearing on 24 August 2021:

(a) Child Safety received two further reports about the family this time relating to F's unstable mental health, suicidal and homicidal threats and being obsessed with high profile domestic and family violence homicides using fire. These were recorded as Child Concern Reports.

(b) On 19 August 2021, M saw a GP requesting referral for counselling for herself and the children. She told the GP about the parenting proceedings, advising she had stopped the children's contact with F after he tried to kidnap them, reporting C1 had said words to the effect of *dad won't have to kill us anymore*. The GP noted the concerns were *more emotional and psychological abuse by him, no concerns of sexual/physical abuse*. M told the GP the children had been introduced to multiple girlfriends, and that F had completely rejected C3 until starting

a new relationship with a woman M believed wanted children. The GP suggested M approach a counselling service and arranged for M to return for a Mental Health Care Plan for psychology referral.

(c) When followed up by the specialist domestic violence service on 20 August 2021, M explained she had spoken with a duty lawyer at court for the hearing of the protection order applications who spoke to her about consenting without admissions to F's cross-application. She told the service she was so upset she agreed without feeling she had the time to understand what this meant. She wanted to investigate removing the protection order naming her as the respondent while keeping the protection order naming her as the aggrieved in place. The service encouraged her to seek advice from the Women's Legal Service and provided her with information about how to seek a variation.

M told the service she was now living with her family, but F was not aware of her address. She was planning for the children to see a psychologist due to the trauma they had experienced. Her landlord was willing to install security cameras at her rental property. She expressed feeling F was abusing her through legal channels, but she otherwise felt safe from him. She had a safety plan in place. She spoke about the paternity testing, which led to the service providing advice about possible escalation of violence if the testing proved F was not the father. M said she felt safe because F did not know her address.

M told the service F was rushing the parenting proceedings with lies that she was abusing the children. She said she was scared because the ICL had contacted her, putting pressure on her because of the existing parenting plan. She told the service F's mental health was deteriorating and the children were no longer safe under the plan, so she wanted it changed. She was unable to afford a lawyer and felt an imbalance of power between her and F in this regard.

(d) M complained to police that F had stolen her passport and C1's birth certificate. The matter was not further investigated and there is no evidence available to me supporting this allegation.

60. The parenting application came before the FCFCOA again on 24 August 2021, by which time an ICL had been allocated to the matter. The ICL was a very experienced solicitor and longstanding member of the Legal Aid Office's panel of private practitioners who are allocated ICL files. The ICL had conducted hundreds of ICL files over many years. They also performed separate representative work in the Children's Court, so had experience with both the child protection and family law systems.

61. M remained self-represented in the parenting proceedings.

62. The Judge made orders for the three children to spend some limited, unsupervised time with F, continued the restraint on M moving away from the outer metropolitan city and ordered paternity testing for the children.

Arrangements were made for a family report to be done by a report writer nominated by the ICL to inform the parenting proceedings.

63. The specialist domestic violence service court advocate contacted M on 25 August 2021. She was given advice about varying the protection order naming her as the respondent, and the importance of reporting every breach of the protection order to show police and the courts there was an ongoing pattern of abuse.

64. M contacted the specialist domestic violence service on 27 August 2021, initially stating she could not remember whether she had engaged with it previously. She was seeking information about varying the protection order no-contact conditions. She said F had shared the order with other people, one of whom had started harassing her. M was also asking questions about what to do about an affidavit containing false claims, whether the Family Court would be more likely to reduce contact with F if he was breached on the protection order, whether the Family Court would look favourably on her taking herself and the children to counselling and if there was any way to get around sending the children to F as required by the parenting orders.

65. On 30 August 2021 Child Safety received further anonymous concerns that F had been perpetrating ongoing domestic violence against M for several years, including serious threats to kill himself. This was recorded as a Child Concern Report *due to no history or other records of [F] being deliberately or extremely violent towards [M] or in front of the children*.

Mounting reports of concern during September 2021

66. M contacted police three times prior to 18 September 2021 alleging F had breached the protection order. On each occasion, police were satisfied F was either exercising his rights under or complying with the FCFCOA orders. Police determined none of the reported incidents constituted breaches and made two referrals for M to the specialist domestic violence service.

67. M attended a GP on 6 September 2021 to obtain a Mental Health Care Plan. She provided a history of F not having much to do with the children after moving to Brisbane but applying for custody when she told him she wanted to move to be with her family for more support. She was concerned about the children's safety if they ended up in his care. She explained how she was having to travel between her family home and her rental property to facilitate F's contact with the children. She was struggling to cope with this, not sleeping well, having nightmares, losing hair, easily frustrated and panicking about the potential outcome of the family law proceedings. The GP documented a clinical impression of anxiety and stress in the context of multiple family stressors. M was commenced on a Mental Health Care Plan with referral for psychology.

68. On 13 September 2021 M contacted the specialist domestic violence service seeking support with safety upgrades to her home, reporting F had

breached the protection order multiple times. She expressed frustration that police were taking so long to press charges. She described three occasions when F had entered the house, once when the children let him in and twice when he let himself in using a key he had cut before returning his set of house keys. She believed F had entered the house once when she was out, and the children were at home. M felt having security cameras would help her collect evidence.

69. She also spoke with the service's court advocate that day about how she had not understood what she was agreeing to when she consented to the protection order naming her as the respondent. She was again seeking legal advice about varying this order. The service made a warm referral to Women's Legal Service.

70. The specialist domestic violence service waitlisted M for specialist case management.

71. On 18 September 2021 M refused to hand over the children to F, resulting in a police attendance. She told police C2 had told her not to touch her during a nappy change that morning. M had noticed a rash on C2's genitals when F returned the children the previous Wednesday, and assumed it was thrush. C2 did not answer when M asked whether anyone had touched them, so she started listing names. C2 said no to each name apart from that of F's new partner who the child then said gave them lollipops.

72. Police efforts to speak with C2 were hampered by the child's lack of language. C2 was two years old. Police advised M to comply with the FCFCOA order unless she had specific details of the alleged harm. She agreed to hand the children over to F. M phoned police later that afternoon reporting F had not returned the children on time but when police arrived, the children had arrived home albeit a little later than required.

73. Over the following fortnight:

    (a) police investigators from the Child Protection Investigation Unit interviewed C2 who made no disclosures under direct questioning.[5] No further police action was taken.

    (b) M arranged for C2 to be medically examined by a local GP for signs of possible sexual abuse. None were identified.

    (c) M obtained a Mental Health Care Plan for C2.

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[5] The Queensland Child Death Review Board's report *In Plain Sight: Review into System Responses to Child Sexual Abuse* 2025 was delivered in November 2025 (System responses to child sexual abuse | Queensland Family and Child Commission). It examines, among many things, the challenges of reporting and investigating allegations of sexual abuse of young children whose age and developmental stage means they may be unable to recognise or articulate their experience of abuse.

(d) M reported a further alleged breach by F of the no-contact condition of the protection order by sending her a text message. Police initially issued him with a Notice to Appear but on further review determined F had not breached the order because his text message related to parenting matters. M's mother subsequently made a report to police about a verbal altercation she had with F about what the FCFCOA orders meant.

(e) the specialist domestic violence service contacted M on 20 September 2021 in response to the second police referral. She told the service she was struggling to coparent with F, she was worried F might be hurting the children but had no evidence around this and had been told there was not enough evidence for Child Safety to pursue these concerns. She did not disclose any information about the alleged child sexual abuse during this service contact. She felt F had bugged her car or her house as he seemed to know things he shouldn't know. M was open to case management support from the service.

(f) over 21-22 September 2021, Child Safety received multiple concerns about the child sexual abuse allegations. It also received concerns about the children's risk of emotional harm due to M withholding them from F and making false allegations against him for custody reasons. These concerns were recorded as Child Concern Reports noting police had interviewed C2 and no further police action was taken. The Child Safety records document a Family and Children Connect referral was planned.

(g) on 23 September 2021, M presented to the local public hospital emergency department with C2 expressing concern the child had been sexually abused by F. Clinical examination and tests indicated C2 may have a urinary tract infection. Police attended the hospital and spoke with M and the emergency department doctor. Police did not identify additional information to warrant further investigation. No forensic sexual assault examination was performed, and no further police action was taken beyond speaking with F the following day. There is no evidence available to me of M being referred to a sexual assault service.

(h) on 25 September 2021, Child Safety received a further concern alleging F was *working up to kill the children*. This was promptly recorded as a Child Protection Notification and allocated for Investigation & Assessment within ten days. The intake process identified reasonable suspicion the children were in need of protection as they had been or were at risk of physical and emotional harm due to exposure to domestic and family violence perpetrated by both parents.

(i) M took C2 to a local GP requesting examination of possible infection from F on the child's genital and buttock area. There is no evidence of any concerns identified by the doctor.

(j) on 28 September 2021 M saw a GP reporting her mother was worried she might be depressed. She felt irritable all the time, frustrated, was not sleeping well, and was having tummy aches and panic attacks. She was very stressed about the upcoming court date. She told the GP C2 had returned home with bruises after visiting F and when examined by a GP there were suction marks on the child's thighs and genital area. As noted above, this was not the case. M took C2 to hospital and was interviewed by a child safety officer. C2 was diagnosed with a urinary tract infection. M said C1 had returned home from the visit saying F was a bad man and the child would never go back to him.

M denied any suicidal ideation. She was having trouble finding a psychologist with availability for the children, and tried to see a counsellor but they did not see children. She had not yet accessed psychology or counselling for herself. M said F had been abusive to her in the past.

The GP documented a clinical impression of anxiety in the context of complicated family issues. They provided M with contact details for the specialist domestic violence service and Beyondblue and sent a referral to a different psychologist.

74. M was no longer allowing F to have any contact with the children, in contravention of the parenting orders.

F documents being fearful of M

75. On 28 September 2021, F signed an affidavit supporting a contravention application alleging several contraventions by M of the parenting orders.

76. The following day, 29 September 2021, F made an in-person report to police alleging a breach by M of the protection order by entering his car without permission when he was collecting the children. M allegedly thanked his partner for being present because *At least I know he's not going to fucking kill them*. He spoke with police about the way M was using police against him, but she appeared to be getting away with a lot of unacceptable behaviour against him. He was frustrated with 'the system'. Police records document the outcome of this attendance as F retracting his initial wish to have M breached, and police providing advice about settling minor disputes without needing police intervention.

77. In unsworn communication with Counsel Assisting prior to the inquest, F's partner spoke of having accompanied him to a police station several months before the fire because M had contravened so many orders and they wanted to show police they were in danger. She says they were looking for a police presence during handovers. She recalls the police officer said he did not want to get involved in *some petty tit for tat* between F and M, leading to the realisation they would not be getting the help they were seeking, so they withdrew, asking that the police officer not record what they had told him because F did not want police to discuss it with M as the officer suggested

he would do. F's partner remembers the police officer looking a bit worried when they told him they were worried about M using fire because M had been obsessed with high profile domestic and family violence homicides using fire. She recalls they begged the officer not to report their visit or complaint, and they left.

78. The couple had prepared a typed document setting out M's contraventions of the protection order between 28 August 2021 and 18 September 2021 by exposing the children to domestic violence and using domestic violence against F. The document refers to them waiting for S1 to file a contravention application. It describes F's anxiety around handovers, concerns about M's mental health, concern he was not being heard, F feeling unsafe in M's presence and fear she may turn physical against him and his belief she was using domestic violence and family law orders to harass and abuse him. It does not reference concerns about the use of fire by her.

79. Much content of the police record of F's attendance on 29 September 2021 correlates with his partner's recollection of their visit to the police station. The dates of the alleged breaches outlined in the typed document also marry up with the timing of this attendance. However, the police record contains no reference to F's partner's assertion they told police about their fear of M using fire. It was not possible to test her evidence as she was not available for cross-examination at the inquest. Consequently, I cannot make a finding about the accuracy of her recollection on this point.

80. I observe that none of the material filed by S1 on F's behalf in the parenting proceedings alleges actual or threatened physical violence by M, apart from the incident at the restaurant on 22 July 2021 (during which M was banging on the car windows and threw F's car keys in the bushes) and forcing herself into the car to check the children's car seat restraints. His affidavits, including the affidavit dated 28 September 2021 supporting the contravention application, do not articulate concerns or fear M may use fire or another form of physical violence against them. The content of his Parenting Questionnaire responses is discussed below.

81. Similarly, the Child Safety records including the couple's interview with Child Safety on 20 January 2022 do not document reported concerns that M may use physical violence including fire against F or his partner.

The family report writer identifies significant concerns about M

82. The ICL engaged a psychologist and experienced family report writer to prepare the family report.

83. M did not attend her scheduled interview with the family report writer on 30 September 2021, meaning it had to be rescheduled to mid-October 2021.

84. During this interval:

(a) police received unconfirmed information that M had reported an immigration/citizenship offence by F and alleged fraud on a home loan application. Child Safety also received a report regarding the alleged immigration/citizenship offence. There is no evidence available to me supporting these allegations.

(b) Child Safety received further concerns about F perpetrating extreme violence and having threatened to abduct and kill the children.

(c) S1 filed the contravention application and supporting affidavit in the FCFCOA on 6 October 2021 on F's behalf.

85. The family report writer assessed F as an articulate and appropriate man who appeared focused on his children's best interests. They saw no evidence of the alleged sexual abuse by him and observed the children did not appear at all fearful of him. Given the family report writer's assessment of C2's somewhat delayed speech and language, they reported it was difficult to believe M's accounts of the disclosures C2 was said to have made. The family report writer was also concerned about disclosures two of the children had made about what M and her mother had said to them about F taking them away. The family report writer felt M was trying to prevent the children from having a meaningful relationship with F.

86. I note the family report writer's interview with F canvassed domestic violence including M's allegations he was obsessed with high profile domestic and family violence homicides using fire. The family report notes F denied ever having spent time in his room obsessing or researching these deaths and had never taken a full week off work. There is no mention in the report of F or his partner (who was also interviewed) expressing any concern or fear of M using fire or physical violence against them.

87. The family report writer expressed significant concern about M and the stability of her mental health. They felt she may have some personality issues driving her allegations of sexual abuse and inability to adhere to court orders, impacting her capacity to form a positive co-parenting relationship with F and to parent the children. The family report writer considered the FCFCOA would benefit from an independent psychiatric assessment of both parents.

88. The family report writer recommended the children should immediately start spending entire weekends, every second weekend, in F's unsupervised care.

89. The family report became available on 24 October 2021. The ICL was at least aware the family was known to Child Safety because they had subpoenaed the Child Safety records in late September 2021 with a return date of 19 October 2021. The ICL did not provide Child Safety with a copy of the family report. When asked why, the ICL said they took the view:

the report was still couched in a number of possibilities…it was really an evidence gathering exercise at the point in time. And if every report was sent no one would ever prioritise a matter.

90. The value to Child Safety of knowing there was a family report available at this time is discussed in paragraphs 136, 139 and 140 below.

Events between the family report interviews and the report being filed on 2 November 2021

91. Following the family report interviews in mid-October 2021:

(a) M contacted the specialist domestic violence service on 12 October 2021 advising she had recently completed the Wheel of Violence which made her realise the gravity of her situation. She reported concern F was getting into her house and leaving signs he had been there but there was no proof, so he had not been breached.

It was during this contact that M shared information about alleged sexual assault of C2 by one of F's friends. She told the service this was reported to police who investigated but closed the case because they did not believe C2 due to the child's young age. She asked whether there was anything the service could do to get a child safety investigation happening regarding F's care of the children.

M was still on the waitlist for specialist case management support. The service offered her a lock change, but she declined stating she would prefer to be allocated a specialist support worker more quickly.

The support worker with whom M spoke sought internal advice about the service's mandatory reporting obligation regarding the child sexual abuse allegation. They were advised to record it in the service's Failure to Report Register so there was a record of it, but as there was information the matter had already been reported to police, there was no obligation for the service to report it.

(b) on 15 October 2021 M filed an affidavit responding to F's contravention application saying she was withholding the children from their ordered visits with him because she believed he planned to kill them. Much of the evidence adduced by M to support this belief stemmed from F taking legal steps to have contact with the children. She was still self-representing at this time.

(c) the specialist domestic violence service spoke with M that day advising there was unfortunately not much capacity to move her up the waitlist, but it could provide check in calls every three weeks. She accepted this offer. The service encouraged M to continue making Child Safety aware of her concerns as they arose if this was something she felt comfortable doing. M wished to proceed with safety upgrades for her house.

(d) in a follow up call from the specialist domestic violence service on 19 October 2021, M asked whether there was funding to check for bugs in her car and the house as she was concerned F was somehow listening to her conversations. The service advised this was not something it could fund but would look into it for her.

(e) M presented to the local hospital with expressing concern F had poisoned C2. The child was medically examined with no concerns identified.

(f) M had filed a Notice of Child Abuse, Family Violence or Risk on 21 October 2021 alleging the children were at risk of physical, emotional, and sexual abuse by F. She subsequently removed it from the FCFCOA registry portal. She also completed a Parenting Questionnaire in which she said she had consented to mutual protection orders in early August 2021 due to coercion by F who had threatened to kill her and the children.

(g) on 27 October 2021, M contacted the specialist domestic violence service advising she was now staying with her family as she did not feel safe in her rental house. She was optimistic the court ordered restraint on her moving with the children to live with her family might soon be removed. She had been asked to contact the service to complete further safety planning.

M participated in safety planning with the service that day. She continued to express concern about F somehow listening in to her conversations. She was advised to check the children's devices for apps that allowed F to record or listen to conversations. She told the service the children's tablets did not travel between households, but F had access to them previously.

(h) S1 filed an amended contravention application in the FCFCOA on 2 November 2021 on F's behalf.

(i) when followed up by the specialist domestic violence service on 2 November 2021, M advised her Legal Aid application was approved. She was busy preparing for a forthcoming FCFCOA hearing. She was given contact information for RentConnect to assist her future housing needs.

(j) Child Safety received further reports about M's belief someone had been in her home when she was out, her recent hospital presentation with C2, F allegedly threatening the children's lives again and further allegations of abuse by F of C2.

(k) M complained to police that F was seen driving past her home. F provided evidence he was at work that day, so police took no further action.

F's parenting application is listed for an interim hearing

92. On 4 November 2021, the ICL sought to have the matter listed for an interim hearing. They were seeking orders that C2 and C3 each start attending daycare. F wanted orders increasing the time the three children spent with him. The matter was listed for an interim parenting orders hearing before a Senior Judicial Registrar on 8 December 2021.

93. The Legal Aid funded solicitor representing M at this time sought and obtained leave to withdraw from the proceedings.

94. M contacted the specialist domestic violence service in distress after court that day. She told the service her solicitor told her there was nothing they could do if she would not agree to unsupervised visits. She was deeply concerned the FCFCOA would not amend the orders to allow her to relocate. She requested a letter of support from the service explaining her experience of domestic violence. The service subsequently provided a support letter advising:

    A Domestic Violence specialist has undertaken a comprehensive risk and safety assessment with [M] on 27 July 2021.

    This assessment, using evidence based Domestic Violence tools strongly indicate (sic) that [M] is experiencing Domestic Violence. During the assessment a number of risk factors were identified including coercive control, isolation, threats of suicide and threats to kill. [M] has also disclosed that she has concerns for the children's safety in the care of her ex-partner.

95. The service also spoke with M about safety upgrades. She was advised it could not fund security cameras as well as lock changes. The service provided her with information about using no interest loans to purchase security cameras. She also sought advice about how to use certain information from F's family court affidavits as evidence of him breaching the protection order.

96. M complained to police alleging a further contravention by F of the protection order because he attended family dispute resolution counselling. Police reviewed the matter and took no further action. Police made a further referral to the specialist domestic violence service for support for M.

97. When followed up by the specialist domestic violence service on 8 November 2021, M advised she had sought Legal Aid funding for a different solicitor as she was not happy with the service provided by the previous one. She believed F had lost his job and was experiencing financial hardship, meaning he had lost everything, and this increased her risk significantly. There is no evidence F had lost his employment. The service was actioning safety upgrades for M.

98. M contacted the specialist domestic violence service on 11 November 2021 advising she had found a new lawyer and had an initial consultation. She was optimistic she could manage the legal expenses but would end up slightly behind in rent. She was seeking assistance with the cost of a storage unit if the FCFCOA order was amended to allow her to relocate. She was given information about the Escaping Violence Payment.

99. M contacted a psychology practice on 12 November 2021 and made an appointment for 2 December 2021. This was the psychology practice to which she had been referred under the Mental Health Care Plan on 6 September 2021.

100. When followed up by the specialist domestic violence service on 15 November 2021, M advised there had been no incidents since her last contact with them. The service was still waiting for her to provide client consent for the safety upgrades.

101. M contacted the service on 19 November 2021 seeking financial assistance to pay her rent, advising she would be forced to contravene the FCFCOA order if she was evicted from her rental property. She sought advice about the implications for her if she fled with the children in this situation.

102. M spoke with the service again on 30 November 2021, advising she was still spending a lot of time at her family's home. She confirmed the locks at her rental property had been changed. She was still thinking about fleeing. The service recommended she obtain legal advice if she was wanting to flee with the children.

F seeks parenting orders for the children live with him

103. On 1 December 2021, F filed an amended application seeking orders that the children live with him and spend time with M.

104. The ICL subsequently spoke with M. The file note of this discussion documents the ICL's advice to M that given the available material, it could very well be the ICL would have to support F's amended application for the children to be placed in his care. The ICL also documented concerns in the following terms:

> *After my conversation with her, I had a real concern that some of the statements she made showed a real lack of understanding. I pointed out to her there was no evidence for it, but she still believed these things to be true.*
>
> *I am concerned that she may be suffering some form of mental health impact whereby she knows as a matter of intellectual proposition that certain things are not true, but she cannot stop herself from acting as though they are true.*
>
> *Even though I have no evidence for this proposition. I am concerned that if an order is made, or the mother believes an order is likely be made (sic), that the children are to live with the father, the mother may harm the children including*

kill them to prevent them falling into the care of the father which she believes would be a greater harm.

105. The ICL told the inquest M became highly distressed at the idea of the Court ordering that the children spend any time, supervised or otherwise, with F. In the ICL's lay assessment, there were things in M's background that flagged she may have some personality vulnerabilities. The ICL identified M's increasing complaints without any evidence as one of the biggest concerns for them. The phone call with M on 1 December 2021 cemented the ICL's assessment that M was very much aware there was no evidence to support her concerns but nonetheless remained *unshakeable* in her view.

What did the ICL do about their privately held concerns?

106. The ICL did not share their thoughts with any person, including police or Child Safety, at the time because they had no evidence; *it was just a gut feeling and thinking with guts is not very useful to anyone*. They told the inquest they did not raise this with anyone for fear that if their concerns about M were correct, then her belief the children could end up in F's care might be the very tipping point for her. It is difficult to reconcile this justification with the fact the ICL had already squarely flagged with M the possibility they would have to support F's application for the children to move out of her care.

107. In contrast, the FLT CSO told the inquest they would *absolutely* hope and expect an ICL to contact them at the earliest opportunity if they formed a view that a parent potentially posed a significant risk of harm to the children.

108. While the ICL weighed their private concerns in terms of evidentiary value for the Court, those concerns would have still carried weight for Child Safety. The ICL, as an officer of the Court, was a credible independent witness. The FLT CSO told the inquest that while knowledge of the ICL's gut feeling may not have changed the eventual trajectory, it would certainly have formed part of a picture as new information came to light and could have influenced Child Safety's decision making or the nature of the engagement the I&A CSOs had with M at that particular time.

109. M phoned the psychology practice an hour before her scheduled psychology session on 2 December 2021 to cancel because she had sick children. She advised she would rebook when the children were feeling better. She did not.

110. M contacted the specialist domestic violence service in distress on 2 December 2021, saying the ICL had told her if she did not hand the children over for their court-ordered time with F on the coming weekend, there would be changes to the existing custody arrangement at the next hearing. She said she was drowning in debt, could no longer afford her rent and needed to move. She was travelling regularly between her family's home and her

rental property to facilitate the children's visits with F. She was seeking support to move house, specifically storage unit costs, as she had decided to flee. She said she had received legal advice and was aware of the possible consequences if she did.

111. The service recommended M seek financial counselling and develop a plan for how she will leave, where she will go and what she will do once she was there. She was offered contact details for the local domestic violence service of the area she moved to, and accepted further contact to discuss her plan to leave.

112. F completed the FCFCOA Parenting Questionnaire on 5 December 2021. In response to the question *Do you have any concerns about being hurt, threatened or intimidated while you are attending the Court?,* F stated:

> *I get very anxious whenever I have to be in the same place as [M] due to recent malicious and untrue claims that have resulted each time we have been in the same space. I fear for my safety as false allegations of kidnap, threat to kill, sexual and physical abuse of a child are all serious criminal offences which have caused me lost time with my children, significant distress, and if allowed to continue, may put my nursing career and my reputation at risk. Also, due to recent angry outbursts and intimidating behaviour from [M]. If these behaviours stem from intentional malicious motives, then I believe more has to be done to protect myself and the children from the real threat of similar malicious claims and behaviour in the future. However, if they are secondary to [M] suffering from a mental health crisis, then I believe more needs to be done to protect the children from childhood psychological trauma and to provide for the children's physical, emotional, educational and healthcare needs while their mother receives medical help*.

113. F provided a lengthy response to the next question about whether he had any other concerns about his or the children's safety other than while attending court. It starts with:

> *Whenever we do a handover of the kids, [M] comes to my car and starts talking badly about me and trying to argue with me in front of the kids. She also tries to talk to my girlfriend and speaks in a threatening manner. [M] has previously threatened violence against me and I am concerned about what she may do.*

114. It also sets out in detail his concerns about the impact of parental alienation, the potential risk of M fleeing with the children, ongoing psychological harm to the children, C2 being subjected to repeated medical examinations and police intervention flowing from the sexual abuse allegations and M's vexatious use of the protection order. When addressing his concerns about the latter, F stated:

> *..I have not contacted [M] since and prefer to do so through the lawyer because I am afraid for my safety with lies linking me to criminal offences such as kidnap, death threats, physical and sexual abuse of a child may harm me and my livelihood if I continue any attempts at a coparenting contact with [M]*.

115. There is no evidence available to me indicating whether F sought, received or accepted referrals for domestic and family violence supports at any stage prior to his death.

The interim parenting orders hearing

116. M was unrepresented again when the matter came before a Senior Judicial Registrar (SJR) on 8 December 2021. The ICL submitted the greatest risk to the children was M's potential inability to facilitate the children's relationship with F. They urged the Court to take a conservative approach giving M one more opportunity to facilitate the children's time with F but if she did not, the matter should be listed expeditiously with a view to the children living with F. F conceded he had only sought for the children to move into his primary care if M could not facilitate his unsupervised time with them and support their relationship with him.

117. On 9 December 2021, the specialist domestic violence service checked in with M to discuss her plans to flee. She told the service things had been okay since they last spoke. She said she had been told again there would likely be a change in custody if she did not hand over the children for visitation with F. She had asked that F's visits be supervised but this was declined. She said she was trying to negotiate safety provisions in the order for when the children spent time with him, for example, for C1 to always have his safety watch turned on, and that F participate in a perpetrator intervention program and his new partner participate in domestic violence education. She also did not want the children to be given medication without her consent.

118. M told the service she no longer wanted to flee as she was confident she would be found if she did.

119. The SJR delivered judgement orally on 10 December 2021, providing very detailed and considered reasons in which they expressed very serious concerns for the children's wellbeing, particularly considering the mounting allegations M was making against F and the attitude she was displaying to him in her own affidavits. The SJR observed *In the evidence provided by the Mother, events or incidents are described in multiple documents over time; they are described with increasing intensity and with increasing menace, exaggeration as time goes on and, in many instances, significant inconsistences in her evidence*. The SJR placed significant weight on the documented response of medical practitioners, Child Safety, and police to M's allegations of sexual abuse.

120. The SJR made orders for the children to start spending unsupervised time with F as recommended by the family report writer, and for both parents to be independently psychiatrically assessed by a psychiatrist. The SJR cautioned the parties that if M could not move forward and comply with Court's orders, that would be highly persuasive evidence she was unable to facilitate the children's relationship with F, placing them at unacceptable risk of harm and they would need to move into F's care.

121. The matter was set down for hearing in early February 2022, with liberty for the ICL to apply for the matter to be relisted on short notice.

122. M continued to receive support from the specialist domestic violence service and was allocated a case worker on 17 December 2021. During her initial contact with her case manager that day, M advised she was not legally represented because the Legal Aid funded lawyer advised her to agree to all of F's conditions. She was shocked by this and refused, resulting in the lawyer telling her they could not continue representing her if she was not going to listen to their advice.

123. M told her case worker she and the children were all on a waitlist to see a psychologist. She believed her bathroom was bugged but the bug in her car had been removed. She still wanted a security camera. She was apologising repeatedly for being difficult and paranoid. M advised she had a safety plan in place but was hesitant to contact police. She told the case worker the FCFCOA told her she was a good mother, but not a good coparent. She believed that if she contacted police about F contravening the protection order or varying the conditions, it would reflect badly on her ability to co-parent, and she would lose her children.

M's participation in domestic violence counselling

124. M commenced counselling through the specialist domestic violence service in mid-January 2022. She now had a new Legal Aid funded lawyer (S2). She reported her main concern was finding a way to gather evidence that the children were being mistreated while in F's care. She alleged the children had gone a whole day with food, and F and his new partner had a fight about him not feeding them, after which he and the children bought her flowers. She identified this as something he had done in their relationship, which the case worker told her was *love bombing, a form of coercion*. M said the children told her F had spoken negatively about her and prevented them from contacting her via their safety watch.

125. They spoke about whether F's new partner could help M gather evidence of his neglectful parenting, but M did not see this happening. M was hopeful the children might share their experiences with daycare staff so she could argue something was not right while they were in F's care.

126. The case worker documented M's high priority for her children's safety, wellbeing, and happiness. M thanked them for making her feel human and not crazy, as this was the message she was getting from F and the Family Court.

127. The case worker contacted a children's mental health service to arrange referral for the children, but this service has no record of the children accessing its services.

128. S2 told the inquest that when approving funding to represent M, Legal Aid cautioned her firm there had been previous issues with M receiving legal advice in accordance with her grant and that essentially, this would be one of the last times she would be afforded legal aid.

Child Safety commences the first Investigation and Assessment (I&A)

129. It took Child Safety some 15 weeks to commence the I&A allocated to a Child Safety Officer (I&A CSO) on 26 September 2021 with a 10-day prioritisation. The I&A Senior Team Leader (I&A STL) explained this was due to resourcing, case acuity prioritisation and significantly high caseload demands on the team.

130. The I&A CSO interviewed M on 12 January 2022, and again on 17 January 2022 as well as the two eldest children, and then F and his new partner on 20 January 2022. M told Child Safety she was engaged with the specialist domestic violence service.

131. Child Safety was not aware of the family report until F sent a copy to the I&A CSO on 24 January 2022, nearly three months after it was written. This led to the I&A STL informing the FLT an I&A was in progress.

132. The first contact between Child Safety and the ICL occurred on 28 January 2022 when a senior FLT CSO emailed the ICL advising Child Safety was involved with the family via an I&A which was nearing finalisation. The I&A CSO and STL were copied into the email which encouraged the respective recipients to reach out to each other if they held relevant information that may assist their respective roles relating to the family. The FLT CSO was willing to facilitate/coordinate any discussions between them.

133. The FLT CSO's intention in making this link was to facilitate information exchange between the child safety and family law systems at the earliest opportunity so they could get some good decision making happening about the way forward.

134. The ICL did not respond to this email. The FLT CSO told the inquest the ICL was not a regular customer of the FLT. None of the email recipients reached out to each other at this time. With the benefit of hindsight, the FLT CSO acknowledged they could have continued efforts to engage the ICL but in fairness to them, on the information available to them at that time, they did not have reason to believe it was a serious matter. The FLT CSO was not made aware of the contents of the family report including the recommendation both parents be psychiatrically assessed.

135. Notwithstanding the content of the family report, the I&A CSO proposed to conclude the I&A by substantiating the children were at risk of harm from F. The I&A STL provided feedback pointing out the family report writer had done a detailed assessment of the family which did not support this conclusion; rather the report identified concerns about M's mental health and inconsistencies between the children's presentation and her claims

about F. The I&A STL had concerns about how M's interactions during her interview with the I&A CSO may have influenced their conclusion. They observed that seven of the eight additional notified concerns reported since the original Child Protection Notification were in the month preceding the FCFCOA hearing in November 2021, with no further reported concerns since 3 December 2021. No Safety Assessment had been completed. The I&A was well beyond timeframes. In the absence of clear evidence to the contrary, the I&A STL considered there was insufficient evidence to substantiate the investigation.

136. The I&A STL identified the family report as a significant part of the information that held weight in the I&A. It was independent and undertaken by an experienced practitioner with experience in both child safety and family law processes. The I&A STL explained that although the family report recommended psychiatric assessment of the parents, they felt they had sufficient information to *draw the line* without making enquiries about the status/availability of these specialist assessments.

137. When asked about whether the I&A actively considered who was perpetrating the alleged domestic and family violence, the I&A STL explained that while there was an understanding of the behaviours and some of the risk around them, whether they were directly attributable to domestic violence or mental health or other factors was unknown at that time.

138. The I&A was subsequently finalised with the outcome, Unsubstantiated – children not in need of protection, on 31 January 2022.

139. The I&A STL agreed that early awareness by Child Safety of current family law orders and concerns identified in family law proceedings could certainly influence its assessment of information reported about a family.

140. The FLT CSO told the inquest that had Child Safety been aware there was a family report sooner than occurred, it may well have escalated Child Safety's response leading to a timelier I&A. By extrapolation, knowledge of the ICL's privately held concerns about M may have been influential in the I&A process though whether they would have influenced an earlier intervention point is only a matter of speculation.

M's ongoing participation in domestic violence counselling

141. Meanwhile, M had spoken with the specialist domestic violence case worker on 18 January 2022. She said C1 was able to provide the Child Safety officers with examples of neglect the children experienced when they were with F. She said Child Safety told her the FCFCOA would take its input seriously and could be favourable to her case.

142. From the case worker's assessment of what M was telling them about F's behaviours and his *seeming obsession with seeing [M] loose (sic)*, there was a *chance of escalation*. M said Child Safety told her this was their

assessment too. It was recommended M install security cameras as F might retaliate. The case worker documented F was already known to contravene the protection order (by standing around outside or hanging around M's house) but this remained unreported because M was *afraid to argue against the Judge and [F] further*. M accepted domestic violence education commencing on 8 February 2022.

143. M's request for funding for two security cameras through the Safety Upgrade Program was declined because she had already received safety upgrade supports within the past three months. She was given information about accessing financial assistance through a no interest domestic violence loan facility.

144. M contacted the specialist domestic violence service on 31 January 2022 advising she had received notice that her rent was increasing by $80 a week in two months' time. She could not afford the increase and was seeking support to relocate. She was supported to apply for the Escaping Violence Payment as the 12 week timeframe from the most recent incident was almost up. She was also referred for assistance in finding a more affordable rental property.

Independent psychiatric assessment of the parents

145. The ICL had briefed the psychiatrist in late December 2021 to undertake a psychiatric assessment of the parents and provide a psychiatric report for the parenting proceedings. The psychiatrist was briefed with F's parenting application, M's response, their respective affidavits, the family report and the subpoenaed Child Safety, medical and police records. Their parenting questionnaires did not form part of the brief. The ICL's covering letter did not convey the ICL's privately held concerns about M. The psychiatrist confirmed this was entirely appropriate, explaining it was their preference not to have a legal representative's unqualified thoughts or opinion prior to their assessment of the parties because that could create bias.

146. The psychiatrist's role was to independently assess the parties for any mental illness, personality disorder or substance use disorder impacting their parenting capacity.

147. The I&A outcome coincided with the psychiatrist's interview with F. The psychiatrist considered F did not meet diagnostic criteria to be assessed as having any serious mental illness, personality disorder or substance use disorder.

148. The following day Child Safety received a further concern alleging F had previously tried to kidnap the children.

149. The psychiatrist terminated the scheduled online interview with M on 7 February 2022 because they considered it inappropriate to conduct it with the children in and around M that day. The psychiatrist asked M to make

alternative care arrangements for the rescheduled interview on 24 February 2022.

150. That day M contacted the specialist domestic violence service in distress saying she was overwhelmed and not coping due to F's constant messages about the children. She asked if the service could refer her to a psychologist as she believed her mental health was deteriorating due to his contact. She was supported to obtain a telehealth psychology session the following day and referred to another mental health service for longer term free counselling. She said she would contact police about past abuse by F.

151. There is no evidence available to me that M attended the telehealth psychology session arranged for her the following day. The practice where the service documented booking the telehealth session has no record of M ever being a patient.

152. Between then and the psychiatrist's online interview with M on 24 February 2022:

(a) M's first scheduled domestic violence education session on 8 February 2022 was disrupted by her having to leave the phone regularly to attend to the children. She spoke about feeling overwhelmed by the family law proceedings, F getting whatever he wanted and the children possibly experiencing abuse for the rest of their lives.

(b) M participated in a face-to-face domestic violence session at a coffee shop on 17 February 2022. She accepted referral for family counselling. She could not think of any case management support needs at that stage but wished to continue domestic violence education. She mentioned she had her first counselling session with a psychologist scheduled later that day.

Again, there is no evidence available to me that M attended a psychology session that day.

(c) F's contravention application was resolved by agreement between the parties.

(d) M's stepfather told police C2 made a disclosure about F biting them on their genitals.

(e) Child Safety received five further reported concerns over eight days alleging C1 had spoken about watching F chase his partner with a knife, threatening to kill people, F was threatening to kill himself and the children, C1 had witnessed F assault one of the younger children, M was withholding the children from F on advice from police, and C1 disclosed they did not like or want to see F, F had locked C1 in a room and did not give them food.

153. The flurry of reports to Child Safety led to the recording of a Child Protection Notification and allocation for another I&A by the same I&A team on 24 February 2022. The reasons for this determination document a long history of reported concerns demonstrating M was escalating the nature of concerns after the family law proceedings had not steered in her favour. There was now concern that *as part of the machinations of this recent spate of new information, [C1] is being exposed to subject matter relating not only to sexual activity, but also sexual contact that is abusive in nature…The potential for this to have lasting impacts..is unacceptably high*. That same day, the I&A STL received contact from a detective from the police Child Protection Investigation Unit advising M was expected to present the children for interviews on 26 February 2022. A different CSO was allocated to the matter (I&A CSO2). They contacted the FLT CSO about whether there had been any further professional assessment and were advised to contact the ICL.

154. By 23 February 2022, M said she had attended two psychology sessions which she told her domestic violence case worker seemed to be helping her anxiety, and the psychologist had recommended family counselling. M was already waitlisted for this through the specialist domestic violence service.

155. There is no evidence available to me that M attended psychology sessions at this time.

156. The psychiatrist's interview with M on 24 February 2022 was disrupted by interactions with the children, causing the psychiatrist to doubt M's assurances she had arranged for someone else to care for them. Child Safety records show M had in fact arranged for a friend to be there at the time.

157. When asked about her past mental health history, M told the psychiatrist she did not have any mental health diagnosis. She had attempted suicide by prescription medication overdose in her late teens, requiring a one-week mental health inpatient admission after which she attended psychological intervention. This is confirmed by M's past medical records. M told the psychiatrist she had attended two domestic violence counselling sessions. She was not prescribed any psychotropic medications. M spontaneously reported severe anxiety and mild depressive symptoms.

158. The psychiatrist assessed M as meeting diagnostic criteria for borderline personality disorder and a chronic post-traumatic stress disorder secondary to childhood trauma. The psychiatrist considered M's mental health diagnoses posed significant risk to the children.

159. The psychiatrist was so concerned about issues arising from the interview with M, they phoned the ICL immediately seeking advice about how to proceed, particularly considering M had made fresh allegations of sexual abuse by F. The psychiatrist's assessment married with the ICL's observation that M believed her concerns were real. The psychiatrist was particularly concerned that M would act on her beliefs.

160. This discussion with the ICL centred around what the psychiatrist's obligations were in relation to the new sexual abuse allegations.

161. The psychiatrist discussed the situation with their peer supervisor, another psychiatrist, that evening.

162. The ICL and the psychiatrist spoke again the following day, 25 February 2022. The ICL's file note of this conversation documents the psychiatrist's:

(a) opinion that M's allegations were completely false.

(b) concern that M kept talking about the fear that F would kill the children but in their view this was M projecting not what F would do but what the psychiatrist thinks M would do if she became aware the psychiatrist's report recommended the children move into F's care or that he spend unsupervised time with them.

(c) belief that all four children were at immediate risk in M's care if her report was released to M.

163. The psychiatrist explained they were seeking the ICL's advice about how best to expedite the matter given their concerns about the different risks they felt M posed to the children. The psychiatrist was particularly concerned M might hurt herself and the children when M learned of the content the psychiatrist was intending to put in their report. The psychiatrist says they were particularly concerned about M's risk of familicide or kidnapping. The psychiatrist told the inquest they were not focused on M posing a direct risk of harm to F at this time.

164. The psychiatrist explained they wanted to alert the ICL to the imminent risk that M was highly likely to act erratically when she received the psychiatrist's report and believed it may lead the Court to giving F unsupervised time with the children or transition them into his primary care.

165. At the inquest the psychiatrist was asked to explain how they discerned the difference between what M was saying as being symptomatic of mental health as opposed to conscious tactic or strategy to make F look bad and derail the parenting proceedings that might go against her. The psychiatrist explained the intensity and quality of M's thoughts was beyond what would be expected for someone who was vexatious or litigious. While there was a small component of the latter, The psychiatrist explained:

> *the way [M] describes these events in detail that was near delusional, and she believed that – and she – when she talked about events and the fear she had, she became emotionally aroused…it – you – that gives you the impression that she actually believes it, but it was – ah – kind of so far fetched that – and it does not fit in with anything else we saw in the assessment and documentation.*

166. The psychiatrist did not report their concerns to Child Safety as the psychiatrist was aware Child Safety was already involved, and the psychiatrist did not consider the risk of harm to the children was immediate (thereby triggering a mandatory report).

167. Case review by the specialist domestic violence service on 25 February 2022 noted M self-assessed as safe and had a significant protective network.

168. The children were interviewed by police on 26 February 2022 reporting similar but at times contradictory versions of the alleged sexual abuse and threats to C1. Police also interviewed F, concluding there was little prospect of a successful prosecution due to lack of evidence.

The ICL's response to the psychiatrist's concerns and report

169. The psychiatrist told the inquest it was difficult for the ICL to understand their concerns about M projecting onto F what she feared she might do herself. The ICL recalls being a little surprised about the strength of the psychiatrist's concern, but the psychiatrist's assessment that M had a serious mental health issue didn't surprise them. The fact it might represent harm to the children fed into the ICL's earlier gut feeling. The ICL recognised there was now potentially evidence this was a real, immediate risk they had to do something about.

170. The ICL took the psychiatrist's concerns seriously and quickly sought advice from three experienced family law barristers and then phoned the FLT CSO about 'what had gone on'. This was the ICL's first contact with Child Safety. The only documented record of this conversation is the ICL's file note.

171. They spoke about the psychiatrist's concerns. The FLT CSO informed the ICL of Child Safety's decision to commence another I&A as M had been identified as a perpetrator of harm to the children. They spoke about the ICL's intention to have the matter relisted for directions regarding the release of the psychiatrist's report. Conscious of the fact C4 was not a subject child of the parenting proceedings, the ICL was keen to get Child Safety involved to manage risk to that child.

172. The ICL spoke with S2 and their Principal on 27 February 2022 alerting them to concerns about what the ICL understood was going to be a negative report for M. They discussed the ICL's intention not to release the report but relist the matter for in-person attendances. Both S2 and the Principal understood without being told that the ICL was intending to ask the Court to transition the children's care to F and, based on what the psychiatrist was intending to say, expected that might happen. S2's Principal suggested the ICL seek an order requiring M to bring the children to Court to be cared for in the Court Children's Service during the hearing.

173. The ICL had dealt with a similar scenario once before so while unusual, it was not completely new to them.

174. S2 was understandably very concerned for M and how they were going to manage the solicitor-client relationship in these circumstances.

175. The ICL spoke with S1 on 28 February 2022 about their intention to seek directions for the release of the psychiatrist's report and asked about F's capacity to care for the children on a day-to-day basis (flagging their intent to ask the Court to transition the children into F's primary care).

176. The psychiatrist provided their reports to the ICL on 3 March 2022. The psychiatrist's reports included a section on risk. In relation to M, the psychiatrist wrote:

> *Her risk to self and other was assessed as significant and chronically escalated but no imminent risks were identified that required admissions to a mental health inpatient unit or treatment under the requirements of the mental health act. Her risk to the children is assessed as significant in terms of emotional abuse, enmeshment, coercion, emotional instability and incongruency that will impact on her parenting skills and boundary setting.*
>
> *Despite her reported abuse of the children by the father, there was no evidence to suggest that the children were abused, and her reporting appeared to be unsubstantiated. We concluded that the risk to the children did not warrant mandatory reporting.*
>
> *All her mental health diagnoses will negatively affect her ability to care for her children, make decisions in the best interest of the children, and to co-operatively parent with the parties involved.*
>
> *[M's] diagnosed mental health conditions will negatively impact on her sole and co-parenting abilities that is likely to result in significant psychological and emotional harm of the children.*
>
> *Professional supervision arrangements and comprehensive mental health intervention can mitigate risks…*

177. The psychiatrist made recommendations regarding M's mental health care and interventions. She also recommended M would benefit from remaining in contact with her children, with contact being *under constant professional supervision*. The psychiatrist did not expect unsupervised visits to be safe. It flows from these recommendations that the psychiatrist considered the children would be protected from risk of harm by M by no longer being in her primary or unsupervised care. In cross-examination by Senior Counsel for Child Safety, The psychiatrist confirmed they did not have any concerns that F was not able to protect the three eldest children from harm while they were in his care.

178. The ICL spoke with the psychiatrist immediately to clarify what they thought the psychiatrist was saying as the fact the psychiatrist thought the children were at significantly increased risk was unusual. The ICL had

decided to seek an immediate change of residence for the children to be placed with F and did not want the psychiatrist's report left open to question. The ICL's takeaway from this conversation was that M's risk increased significantly when she found out the children were likely to transition out of her primary care, meaning the children weren't necessarily at immediate risk of harm from M just by being in her care without that knowledge.

179. The ICL sought a supplementary report addressing very specific questions about whether the psychiatrist considered all four children were at continued risk in M's care, whether releasing the report to M and F would pose a risk to the children and if so, how to manage risk arising from her reaction to the content of the psychiatrist's report while the children remained in her care.

180. The psychiatrist provided a supplementary report on 4 March 2022 confirming they considered all four children were at risk in M's care and that releasing the report posed a risk to them as it may trigger emotional dysregulation and subsequent risk behaviour by M. The psychiatrist identified *the most imminent risks to all 4 was suicide, familicide, and kidnapping and fleeing with the children*. By *imminent risk*, the psychiatrist meant *worst case scenario* as distinct from immediate risk. The psychiatrist expressed concern that should M become aware of the report she may act out on the thoughts she was projecting onto M in some way. The psychiatrist identified having the children at court when the parties received the report would enable the individuals/professionals present to monitor and manage M's reactivity.

181. The ICL provided all of the psychiatrist's reports to the FLT CSO that day. The ICL provided S1 and S2 with the report relating to F, advising they would only release the report relating to M at the Court's direction. The matter was listed for directions on 9 March 2022, and personal appearances were required. The ICL asked S2 to have M attend in person and bring the children to be supervised by an appropriate adult, nominating M's mother as a potential option.

182. S1 recalls the ICL said they would be recommending orders transitioning the three eldest children to F's care. This is why S1 filed material supporting the ICL's position.

Did the psychiatrist expressly consider risk of harm to F and/or his partner?

183. Dr McPhedran observed the potential for M to perpetrate lethal violence was only clearly identified by the psychiatrist in their reports. Those reports identified a wide range of risks and vulnerabilities in relation to M and connected them with the possibility of suicide, filicide or familicide involving herself and the children only. They did not address risk to F and/or his partner or the risk of intimate partner homicide.

184. Dr McPhedran advised that while there are shared risk factors across intimate partner homicide, filicide, familicide and suicide, lethal violence to a current or former intimate partner also has its own risk factors that may set it apart from lethal violence directed to oneself or children, such as coercive control and sexual jealousy, both of which were present in M's behaviours. She advised a formal domestic and family violence focussed assessment could have identified those additional risk factors.

185. Dr McPhedran identified the psychiatrist's reports as a missed opportunity to recognise potential risk to F.

186. The opening paragraph of the psychiatrist's assessment of risk by M began with the words *<u>Her risk to self and other</u> was assessed as significant and chronically escalated…(*emphasis added). The psychiatrist points to this as evidence of them having expressly considered risk not only to the children but also F and/or his partner if the children were transitioned into their care. The psychiatrist agreed with Counsel Assisting's proposition that this risk was ongoing and significant once the children left the Court with F. When asked specifically about the risk to F and his partner in this situation, the psychiatrist said the risk to them was less but still significantly raised though not imminent and immediate. Anything that threatened M's relationship with the children and made her perceive they were at risk would have the same effect as learning the contents of the psychiatrist's report.

187. The discussions between the psychiatrist and the ICL over 24-25 February 2022 did not canvas risk to the children or others beyond M becoming aware of the contents of the psychiatrist's report while the children continued in her care.

188. At no time did the ICL seek any input from the psychiatrist about managing risk in the event the Court made an order transitioning the children out of M's care. This is because the ICL *just didn't think of it.* Their immediate focus was on how to get the matter before the court in a way that got M and the children to court, so the children were safe when she received the psychiatrist's reports. The ICL did not give any consideration to potential risks <u>after</u> the children left M's primary care.

189. Risk to F and/or his partner and/or the children in his care may well have formed part of the psychiatrist's forensic assessment process, but the psychiatrist did not highlight or articulate it with any clarity in their initial report. Had the psychiatrist done so at this juncture, it may have broadened the ICL's consideration of risk beyond how to manage those attaching to M's reaction to the psychiatrist's report while the children remained in her care.

190. The psychiatrist told the inquest that had they been directly asked they could have provided some clinical advice and guidance about how to mitigate the risk of harm if the Court made an order transitioning out of M's care. I understand the psychiatrist's evidence to be that they had previously

received feedback about not providing recommendations in their reports beyond the scope of their brief.

191. At best, explicit identification of ongoing significant risk to F and/or his partner if children were placed in his care may have given the ICL, S1 and/or Child Safety pause to consider and have a frank discussion with F and his partner about how to manage this risk going forward with the children in their primary care.

M's ongoing engagement with the specialist domestic violence service

192. M's landlord declined her request to extend her lease. She had until 30 March 2022 to relocate before her rent increased. She contacted the specialist domestic violence service on 1 March 2022 seeking assistance. She told the service that she and the children were currently staying at her family's home, where they were all happy and safe. The service supported M to break her current lease and complete a social housing application. M was also receiving support from RentConnect.

193. During this contact, M told the service Child Safety had *closed the case against [F]* but had notified police of their concerns and police had interviewed the children. She told the case worker the police officer had apologised that the police investigation did not yield findings to support an arrest, but he was concerned and would be monitoring the case. There is no evidence available to me to suggest police conveyed this to M.

Planning for the hearing on 9 March 2022

194. On 7 March 2022 the ICL sought direction from the Court that the children be brought to Court on 9 March 2022 and to have an appropriate person supervise them during the hearing. The ICL advised a Child Safety representative would likely be appearing in the matter as well.

195. That afternoon the I&A STL and I&A CSO2 (the I&A Child Safety officers) were copied into an email from the FLT CSO acknowledging the ICL's email attaching the psychiatrist's reports. This led to them speaking with the ICL that evening about the contents of those reports. They discussed the plan to manage the risks the psychiatrist identified around disclosing the report to M. The ICL expressed confidence the Court would transition the three eldest children into F's care. The I&A Child Safety officers were conscious of the need to consider taking action to ensure C4's safety. It was decided the I&A Child Safety officers would both attend Court in person, together with the FLT CSO. This was highly unusual. Neither of the I&A Child Safety officers had previously attended that Court and their experience in the family law jurisdiction was limited.

196. The I&A was prioritised to commence with the Child Safety officers attending at the hearing on 9 March 2022. It was not commenced sooner because the I&A Child Safety officers considered there was no imminent

risk to the children while M remained unaware of the contents of the psychiatrist's reports, and due to the safety planning developed with the ICL.

197. Both the ICL and the I&A Child Safety officers understood the safety plan was to manage risk to the children at the time M received the psychiatrist's reports and understood the children may be placed in F's care. This is what they understood the trigger point for the risk the psychiatrist identified to be.

198. The I&A STL's understanding was that M was not aware of the contents of the report at this time. They told the inquest that if they thought she did, Child Safety may have taken a different action.

199. Over the following two days, the FLT CSO continued to provide the Court with information about Child Safety's involvement with the family and its position in the matter, including that it was not going to formally intervene as a party to the proceedings at that time. Arrangements were being made for the children to be cared for by the Court Children's Service once they presented to Court.

200. The Child Safety officers understood the ICL's intention for the children to be present on 9 March 2022 indicated it was likely all four children would be transitioning out of M's care that day. This meant that all four children were now within the scope of the Child Safety response.

S2 arranges for M to bring the children to Court

201. The ICL told the inquest they assumed neither parent would appreciate the significance of the requirement for them and the children to be at the Court for the hearing because they didn't know the court processes.

202. S2 delayed telling M she was required to bring the children to Court until 7 March 2022 by which time they had received F's amended application. S2 was very worried about how M might react if M believed the children might be placed in his care. S2 recalls that when told she had to bring the children to Court, M quite quickly remarked to the effect this *likely meant the Court would be removing the children from her care*.

203. To their credit, S2 acknowledged that while this might happen, it was necessary to review the psychiatrist's report to assess what direction to take from there. They spoke with M about the likely consequences if she did not attend or bring the children to Court. M was advised to bring a support person if she could. Based on their previous experience with M's mother, S2 suggested this not be her mother, and advised M's two younger siblings should not come either.

204. S2 was privately concerned about what M might do given the intensity of her mounting allegations against F and general narrative of her instructions to date. M did not disclose anything causing S2 concern she would take steps to harm herself, the children or F in the lead up to the hearing; rather it was the nature of the forthcoming proceedings that caused S2 concern.

205. Without knowing the specifics of the psychiatrist's findings, concerns and recommendations, S2 had no basis on which to consider the need for specialist mental health input to support or manage M going into, at or after the hearing on 9 March 2022.

206. M contacted the specialist domestic violence service on 7 March 2022 seeking help as her lawyer had *tipped me off* there would be a change of custody on 9 March 2022. She was extremely distressed, unable to complete sentences. Her stepfather was with her helping her pack up the rental house. She told the case worker the children were being called to appear by phone. She said her lawyer had told her she could not help M argue she needed to relocate due to safety concerns and this would require a further application for legal aid funding. M said S2 told her the case was leaning towards F receiving primary care of the children. She suspected the children would be removed from her care. The case worker offered to speak with S2, but M said she did not know what would help anymore.

207. M contacted the domestic violence support service the following day, 8 March 2022, advising she had a long conversation with her lawyer the night before in which her lawyer told her she suspected M had a poor mental health review coming and wanted to get in early with how M was being supported. She told the case worker she was very confused about what was happening as the ICL required all the children and both her parents to attend Court.

208. The case worker spent time reassuring M that she was not alone or crazy and she had every right to feel afraid and angry with what was happening in the family law proceedings. They told her to contact the police officer who interviewed the children recently if she had any concern or suspicions that F was intending to harm the children or her so there was evidence of her having reported these concerns. M confirmed she would, and mentioned she had contacted that police officer requesting a report that would help her lawyer argue they were concerned that the children were being harmed while in F's care. That police officer was not available. The officer she spoke with told her they were unable to assist.

209. The case worker documented their impression that *it seems like FLC is currently [F's] word against [M's] word and no actual evidence is being presented*. I pause to observe the case worker had not had any contact with or from police or Child Safety or S2 at any stage during their engagement with M.

210. The case worker provided M with a letter of support for her and the children to relocate for their safety.

211. M had a telehealth appointment with a GP that day. The GP documented the consultation as *aspiring a mental health care plan. Multiple stressors in life wants to do debrief and look at coping strategies etc*. The clinical

impression was of adjustment disorder and the plan was for M to attend a face-to-face consultation.

The hearing on 9 March 2022

212. M attended Court on 9 March 2022 accompanied by all four children, her mother, her stepfather and her two younger siblings. They arrived at the Court a little bit late at around 9:30am.

213. M's mother told the inquest that M had led her to believe the whole family was required to attend Court on 9 March 2022 to assess the closeness of their family bond. M's stepfather told the inquest as far as he was aware, there was no requirement for him to be there. He attended Court that day purely for moral support, and it was possible the children might not be coming home, so it was a chance for M's mother and two younger siblings to say goodbye to them. He believed he was going to help look after the children and M's stepsiblings during the hearing.

214. The four children were taken to the Court Children's Services room to be cared for by Court Children's Service staff. The children's transition from M and her parents was prolonged and traumatic, exacerbated by the heightened emotional response of M's mother. S2 agreed the level of upset they observed in M was consistent with her understanding she might not be getting them back.

215. The SJR gave leave for the ICL to file and rely on the psychiatrist's reports, directed the reports be released to the parties and stood the matter down to allow the parties and their legal representatives time to read and consider the reports before responding to them in Court. The SJR made it clear the matter was the Court's ultimate priority that day, and there was no limitation on the submissions parties may make or the time required to come to terms with the evidence as it currently stood. The matter was adjourned at 10:13am.

216. F, his partner and S1 went to their conferencing room with the reports. They did not have a lot of time. S1 gave the reports to F who sat with his partner on the other side of the table and let them read through the material. The ICL had alerted both S1 and S2 to the significance of the paragraph in the psychiatrist's supplementary report expressing her opinion about the risk of *suicide, familicide and kidnapping and fleeing with the children*.

217. F's partner has no recollection of having read or having had her or F's attention drawn to that critical paragraph in the supplementary report. When given the opportunity to respond to this, S1 said they would have given the couple everything to read but did not say they had expressly drawn the couple's attention to those words in that part of the material. S1 recalls they and the couple were all shocked by the contents of the reports about M, saying *..it was a feeling of knowing there was something wrong but not – it was beyond belief what was in the report, and they were shocked as well*. Given S1's recollection of sitting opposite the couple while they were all

reading the reports at the same time, I find it likely the couple did see and react to the contents of the psychiatrist's reports about M.

218. M, her mother and S2 went back to their conferencing room to read and consider the psychiatrist's reports. S2 told the inquest she knew the reports were going to be concerning but *I wasn't prepared for how bad the report was*. S2 provided M with advice about her options noting the likely outcome of a contested interim hearing was an order transitioning the three eldest children into F's care and Child Safety placing C4 in care. S2 was not surprised by M consenting to orders and engaging with Child Safety given an order would likely be made regardless. They spoke about steps M could take after the orders were made to get her back to a position where she was spending time with the children.

219. A little later in the morning, after further discussions between the ICL and the parties through their lawyers and the Child Safety officers, the parties agreed the three eldest children would go home with F and his partner that day and remain in his primary care on an interim basis with limited supervised time with M at her expense.

220. The Child Safety officers spoke with F and his partner that morning before orders were made. The discussion was part of their Safety Assessment regarding the three children going into F's care. It is not clear whether S1 was present during these discussions. The Child Safety officers were satisfied F was able to protect the children and did not oppose the parenting arrangements being discussed between the parties.

221. The I&A STL told the inquest the following factors weighed positively in their assessment that F had capacity to protect the children from harm in his care:

(a) the fact that the Court was making orders in his favour.
(b) the police information seemed to indicate they weren't taking further action in relation to the sexual abuse allegations.
(c) the psychiatrist's report identified no concerns about F.
(d) F had suitable accommodation for the children and was maintaining employment.
(e) there was no information indicating F did not have a protective manner around the children.
(f) F's partner presented well and had capacity to make good decisions.

222. The matter went back on at the SJR's prompt shortly after midday. The ICL advised progress was being made that would potentially avoid a contested hearing, but they were still working through a few minor points. The FLT CSO advised Child Safety was very keen to speak with M about a voluntary arrangement for C4. The matter was adjourned to facilitate ongoing discussions. The parties returned before the Court at 1:48pm with signed consent interim orders for the three eldest children. None of the parties made submissions that the making or content of the consent interim orders entailed or should address any risk to F or the children in his care.

Interim consent orders were made, and the matter was adjourned at 2:01pm for further mention on 4 May 2022.

223. I acknowledge the SJR's sensitive recognition of the enormous disruption to the children, the need for M to properly digest and respond to the psychiatrist's reports with therapeutic support, and the importance of sensitivity to the grief M and her family were no doubt experiencing at that time.

224. Once the parties had reached agreement in relation to the three eldest children, the focus of the immediate safety planning by the I&A CSO and I&A STL was C4. The FLT CSO was not involved in these discussions. S2 recalls these discussions occupied most of the day. M ultimately entered a voluntary immediate safety plan with Child Safety to place C4 with a friend pending ongoing Child Safety investigation and assessment.

225. The FLT CSO described the hours spent at the Court that day as *hectic*.

226. Court Children's Service staff facilitated the handover of the children.

227. The Child Safety officers left with C4 after giving M an opportunity to say goodbye.

228. It was the ICL's intention to ensure M's supervised time with the children after they transitioned to F commenced straight away. M had asked about what might ultimately happen to C4. The ICL told her they did not know but that one scenario might possibly be the child was placed with the three other children with F. M became extremely distressed on hearing this, sobbing loudly and hitting herself repeatedly for about ten seconds. She settled down and apologised to the ICL who reassured her but said they could not speak for what Child Safety might do.

229. The ICL's file note describes what happened next. Having regard to M's high level of distress when she handed the children over to the Court Children's Service staff, and concern about the impact on the children seeing her upset again, the ICL decided they could not support M's request to say goodbye to the three other children. As a result, M and the three children were not given the opportunity to say goodbye to each other before the children left with F and his partner.

230. Court security officers escorted the couple and the three children from the Court building out a back door and saw them safely away from the Court.

Observations of M's demeanour and behaviour at Court

231. Responsibility for monitoring and managing M's reaction to the psychiatrist's report fell largely to S2 that day, with assistance from the I&A Child Safety officers.

232. The psychiatrist was not told the matter was being listed that day. This is despite them telling the ICL they would make themself available to attend the hearing to give evidence or answer any questions about their opinions. No one contacted the psychiatrist about the matter at any stage that day.

233. The FLT CSO told the inquest there was no impediment to the I&A Child Safety officers contacting the psychiatrist as part of their safety assessment process, but this is not something they would have had done in their FLT capacity.

234. Dr McPhedran made it very clear in her oral evidence she was not in any way criticising the actions of the lawyers or the Child Safety officers that day. She rightly observes that the psychiatrist's report highlighted the importance of monitoring M's reactivity. This is a mental health issue and none of those present that day were mental health professionals. The psychiatrist agreed none of the lawyers or Child Safety officers present that day could have been expected to assess risk accurately or adequately in someone with a presentation as *exceptionally complex* as M.

235. M was understandably upset, particularly after she and her mother were able to read and consider the psychiatrist's report. While M understood the psychiatrist's report was not likely to be favourable, she cannot possibly have contemplated the assessment that her children were at such significant risk of harm from her. They were her everything. Her worst fear was realised with the three eldest children going into the care of the person she believed would harm them. While M appears to have contemplated the possibility the three eldest children might be removed from her care that day, she was not expecting to lose primary care of her baby. She needed time not only to come to terms with this new reality but to identify and make practical arrangements for someone to take C4 into their care that day, rather than going into departmental care. She had to work through the practicalities of what can only be described as monumental disruption to her world over a matter of about five hours.

236. M's mother told the inquest she believed M was having a breakdown that day because the children were *taken off her*, and she could not say goodbye to them. She didn't think M had any mental health concerns *until she lost her kids*.

237. S2 describes the response of M's mother who stayed with them for most of the day as unhelpful. The I&A STL told the inquest they held very serious concerns about the role M's mother was playing, describing her as unhelpful and more concerned about her own needs than those of her daughter. At one point the I&A STL asked M's mother to leave the conference room so Child Safety could progress matters regarding C4 with M and S2 in a less emotionally charged way.

238. At one stage in the day, S2 observed M's demeanour change from being upset to more defiant, with her mannerisms appearing cold and different and her thoughts elsewhere. It was shortly after this change that M gave

instructions consenting to the three eldest children transitioning to F and C4 being placed with a friend under a voluntary immediate safety plan.

239. While M did not say anything expressly or make any threats that alarmed S2, they held significant concerns M would harm herself after leaving Court that day. S2 spoke with M and her mother to ensure M would not be going home to an empty house alone that night. S2 had to stress this point several times to M's mother who would not accept M needed significant mental health support.

240. The I&A STL recalls having a clear discussion with M in the conference room about her plans for the evening. They specifically asked what M was planning to do that night, and if she would be with someone as it would be hard for her to be alone. They recall M saying she might stay with her mother. M declined their offer to speak with her mother about this.

241. The I&A STL recalls clearly asking M if she had any thoughts or plans of self-harm, suicide or of hurting the children. They recall being direct in their questioning, referring to the specific risks the psychiatrist identified. M denied having any such thoughts or plans. The I&A STL was confident they actively turned their mind to what the combination of learning the contents of the psychiatrist's reports and having all four children immediately removed from her care might mean in terms of the risks the psychiatrist identified when assessing M's mental state.

242. The I&A STL told the inquest there were no indicators at all to suggest M had thoughts or plans to hurt or kill herself or others. She presented as future focussed, asking about when she could see C4. At no point did the I&A STL see or hear anything from M that raised concerns for them. They assessed her response as reasonable and proportionate to what was happening that day.

243. The FLT CSO was not involved in the I&A CSOs discussions with M. They observed her to be teary but not escalated at times through the day but there was nothing about the behaviour or interactions with the I&A CSOs the FLT CSO observed suggesting she posed an immediate risk to the children or F at that time. In the FLT's experience, M's presentation that day was not unreasonable or worrying in the circumstances. Had M's behaviour been more escalated, or had she made threats, the FLT CSO's practice response would have immediately triggered an escalation point and a different response.

244. S1 told the court they and their clients all observed M to be calm and non-reactive during the time they saw her in the courtroom. In retrospect, S1 did not consider this to be a natural reaction to the psychiatrist's report and the change of care that was happening.

245. S2 walked M and her mother to the carpark where M became upset because she could not afford the parking. It is a testament to S2's compassion that they paid M's parking ticket.

Was there any consideration of risk to F and/or his partner with the children in their care, and safety planning with them before they left Court with the children?

246. In oral evidence the psychiatrist agreed there was a two-stage consideration of risk in what happened at Court on 9 March 2022 - the risk attaching to M's reaction to the contents of her report, and an elevation of risk when all four children were removed from her care.

247. M knew where the couple were living and where they would likely be taking the children home that day. F had bought the property when they were together, and numerous documents filed in the proceedings from the outset disclosed his home address.

248. No one spoke to the couple about taking precautions for the children's safety or their own from M once the children were in their care.

249. The ICL had not turned their mind to this. The ICL was working on an assumption M did not know where F lived.

250. The I&A STL told the inquest that the psychiatrist's reports were considered as part of the safety assessment of risk to the children in both F and M's care, particularly in relation to M. They acknowledged the risks identified by the psychiatrist, but to their knowledge at the time, there was no previous pattern of behaviour by M to indicate violence or the behaviours the psychiatrist identified.

251. This was not unreasonable. There were points leading up the hearing on 9 March 2022 at which M actively contemplated the Court may be asked to order a change of residency for the three eldest children, namely:

(a) the ICL's discussion with her on 1 December 2021;

(b) discussions had at the interim hearing on 8 December 2021; and

(c) S2's discussion with her on 7 March 2022 about the ICL's requirement that M bring the children to Court with her on 9 March 2022.

None triggered the serious risks identified by the psychiatrist beyond M giving serious thought to fleeing with the children, thoughts she did not act on at those times.

252. In cross-examination by Counsel for the FCFCOA, the I&A STL agreed they did not see any reference in the psychiatrist's reports to an ongoing risk to anyone including F, after the children were removed from M and transitioned to F. When pressed about the extent to which they actively turned their mind to the children's risk of harm from M while they were in F's care, the I&A STL recalled they did *to a point*. They said their exploration of M's intentions to harm herself or others did not elicit any indicators at that

time to consider in relation to F's ability to protect the children from harm in his care.

253. The Child Safety officers told the inquest that they asked F and his partner if they had any worries. They say the couple did not raise any concerns requiring Child Safety planning. They did not ask the couple whether they had any specific concerns in relation to M.

254. While the FLT CSO has no recollection of the specifics of her interactions with F and his partner that day, they told the inquest that had the couple told her they were fearful of M, that would have been an *automatic red flag for me. There's no two ways about it*. They would have talked to F about relocating for a time to a location not known to M out of an abundance of caution, just to let things settle. This is something the FLT CSO had done previously in different settings over the years. They could have potentially made referrals for F to domestic violence support services, as well as ensuring the I&A CSOs alerted police to the heightened risk.

255. With the benefit of hindsight, the FLT CSO would certainly have initiated a discussion with F and his partner about their safety even had they not raised any concerns.

256. The focus of the Child Safety officers was the safety of the children as required by the *Child Protection Act 1999,* but as subsequent events bear out, the children's safety was inextricably linked to F's safety once they were in his care.

257. The ICL did not speak with the couple that morning nor did they speak with S1 about the issue of F and the children's prospective safety once they left Court. The ICL agreed they did not suggest to S1 that she counsel the couple to take any additional precautions for their and the children's safety such as arranging alternative accommodation for a few days somewhere unknown to M. The ICL has since changed their practice in this regard.

258. S1 did not speak with the couple about their prospective safety after leaving the Court with the children. S1 told the inquest that while the risk was *written in words*, M had not threatened F, so it was difficult to know what they were meant to do with the psychiatrist's reports in terms of safety.

Expert commentary on the impact of the hearing outcome on M

259. When asked about the impact on M of none of the children going home with her on 9 March 2022, the psychiatrist told the inquest:

> *Oh it would have been massive. As I said, her thought processes were not normal. She was enmeshed with those children. She lived for those children. That was part of her life. And she thoroughly believed that she needed to protect them, regardless of any law, any – uh – paper, any guidance and her belief was that they were abused. And so if you have, kind of, that near delusional belief that the court has now just go and gave all four of these*

children – all three of the children to the father that's going to abuse them, that – uh- she needs to rescue them, she needs to get them back, regardless of what anyone else say – um – and that would have been her thought process.

260. With reference to what the research says about the impact of acute trigger events on women with risk factors for violence, Dr McPhedran suggests the prospect that C4 might be placed with F and his partner going forward was a key event in M's pathway to perpetrating homicide.

What happened after the parties left Court

261. M's stepfather drove her home to the rental property, leaving the city carpark at around 3:15pm. She was devastated by what had happened, so they stopped at a local pharmacy to buy some over-the-counter sleeping pills. Her mother arrived with her younger siblings not long after M and her stepfather arrived home at around 4:30pm.

262. M had contacted the specialist domestic violence service from her mother's phone at around 3:00pm. She told the case worker she had lost custody to F because she had been assessed as having severe trauma and was at risk of suicide and possibly harming the children. She said F's mental health assessment stated there was nothing wrong with him and he was the *healthier parent* to care for the children. She said the ICL told her the best case scenario would be 50/50 custody.

263. She was extremely distressed but surrounded by her family for at least that night. She wanted to keep her scheduled session the following morning. M told the case worker she was using her mother's phone because she had broken hers and asked if the service could help her with a new phone.

264. M's parents later told police M soon went out again saying she was collecting a new mobile phone from the domestic violence service which closed at 6:00pm. M did not attend the service that evening.

265. The police investigation determined that M entered a local Bunnings at 5:42pm. There she purchased an axe, a large cooking knife and microfibre cleaning cloths. She left the store at 6:00pm. She entered a local Kmart store at 6:22pm where she purchased a black zip up hoodie, a black T-shirt, black leggings and black safety boots. She then entered Woolworths in the same shopping centre at 6:37pm where she purchased Vaseline petroleum jelly. She left but re-entered the store at 6:46pm and purchased cigarettes and a mobile phone.

266. M's mother and stepfather both told police that after M arrived home, the family ate dinner together before putting the two younger girls to bed in M's room. They sat up with M talking until around 8:30pm when her stepfather made everyone a cup of tea. He says he took a sleeping tablet and gave one to M but was not sure if she swallowed it. At around 9:00pm they had a group hug and went to bed.

267. M went to C2's bedroom. Her stepfather went to C1's room. Her mother joined the younger siblings in M's room. M's stepfather recalls seeing the time on his mobile phone when he put it down to go to sleep at 9:38pm.

268. Triangulation of the mobile phone number M was using that night shows the phone left home at 9:50pm and travelled east through three suburbs to a suburb neighbouring where F lived, arriving there at 10:06pm. The phone remained in that neighbouring for about 10 minutes before moving west back through two suburbs at 10:23pm.

269. At that time, the phone is recorded to have turned around and travelled back east through four suburbs at 10:27pm. It is then recorded as travelling west again to the suburb neighbouring where F lived, where it remained for several hours.

270. In the meantime, F and his partner had started putting the children to bed from around 7:30pm, reading them stories as they did. The children were all sleeping in the same room. The couple decided to go to bed at around 9:00pm. F's partner had a work event the following day. F told her he wanted to check all the doors were locked before he went to bed so they both checked the locks.

M enters F's home and starts the fire

271. F's partner was woken at around 1:00am on 10 March 2022 by the sound of C2 crying. F went to the children's room and brought C2 back to bed with the couple in their room. F was on the side of the bed closest to the window. His partner was on the side closest to the ensuite. C2 was between them. They all went back to sleep.

272. F's partner was then woken by feeling a splash on her body. She initially thought C2 had wet herself, but she was confused because her face was wet.

273. F jumped out of bed and shouted *What the fuck. What are you doing?* His partner could see a silhouette of a person standing in front of the window. She saw F push the person to the end of the bed. When she turned on the bedside light, she saw M. F pushed past M and stood in the middle of the room. His partner got out of bed and stood beside the bedside table. C2 ran out of the room. F and his partner were both screaming at M but M said nothing.

274. M was holding a brown beer bottle in her right hand. There was a light coloured rag that looked torn coming out of the top of the bottle. M held both hands out in front of her. F's partner could see something else in M's left had but could not identify what. She picked up the bedside lamp and threw it at M. The lamp hit M in the face. M did not say anything but lit the rag and threw the bottle at F, who lit up with flames from head to toe.

275. F fell to the floor. His partner ran straight into the ensuite and turned on the shower, intending for F to get in to douse the flames. When she went back into the bedroom F was gone. M started approaching her. M was wearing black three quarter length pants and her leg was on fire. F's partner punched M in the middle of the face as M got closer to her. M did not react or say anything, just pushed past her and entered the shower. F's partner followed her into the ensuite, and when M turned to face her, she punched M in the face again. M just sat down in the shower which extinguished the flames on her leg.

276. F's partner told M *we didn't want this* to which M replied *I didn't want this either*.

277. The smoke in the room was intensifying, so F's partner turned and left to go to the children. M remained sitting in the shower.

278. As she made her way to the children's room, F's partner saw the canvas cover of the dog crate was on fire. She retrieved the dog and ran to the children's room. C1 and C2 were standing beside the bed. C3 was still asleep. C1 asked *where's Mummy?* indicating the child knew M was there. F's partner told C1 to take C2 to the lounge room and out the back door. She picked up C3 and left the room, meeting the two other children at the baby gate in the hallway. Together they made their way into the loungeroom. The back door was already open. F's partner observed a small fire on the cement. She looked back at the house to see the parent retreat part of the house was totally on fire.

279. Fs partner took the children to safety of the neighbour's house where she found F in the backyard. He had rolled on the grass to extinguish the flames. Other neighbours came to their aid, one of whom was a nurse who started treating F. Emergency first responders including police, paramedics and firefighters attended to manage the scene.

280. The couple were both transported to the Royal Brisbane & Women's Hospital, and the children were taken to the Queensland Children's Hospital.

281. When police arrived at 3:16am, the house was completely engulfed in flames. At around 4:00am, firefighters located M in the ensuite. She was deceased.

282. F succumbed to his severe burn injuries at 11:10pm that evening.

Police and fire investigation

283. F's vehicle was found parked just off the road at the end of the cul-de-sac street. There was a red plastic fuel can with a yellow lid in the front passenger side footwell which later tested positive for petrol. M's stepfather later told police he had seen a red jerry can with a yellow cap at M's home before and had used it to fill the lawnmower. He last saw it on the mudguard of his trailer at M's rental property.

284. Police located a black hoodie and black boots at the southeastern end of the house where the fly screen had been removed and part of the screen cut. The keys to M's car were in the hoodie pocket. The sliding glass door was open, and the lock was in an unlocked position.

285. C1 later told police they were woken by M coming into the children's room. C2 told police they saw M pouring a liquid and lighting the fire.

286. Fire investigators confirmed the fire started on the western side of the master bedroom where F's partner observed M light and throw the Molotov cocktail at F.

What was M's intention in going to F's house that night?

287. M's mother told the inquest they were a very close family and did everything together. She spoke of her grandchildren as *our babies*. She found it *..very, very hard to even fathom that [M] would hurt the children because she loved those children. I cannot see her hurting the children.*

288. The psychiatrist told the inquest:

> *these children were [M's] world. That was what she lived for. That is what she – um- she was so enmeshed and so focussed on these children.*

289. The psychiatrist did not think M intended to kill herself that night; rather M was trying to get the children out of the house, perhaps to kidnap them to escape and prevent F from having them. The psychiatrist speculated M did not really intend to kill F because the repercussions of that would prevent her from seeing the children anyway.

290. M's mother and stepfather said nothing in their statements to police of any prior knowledge of her plan to go to F's home that night or to do him harm. They both made a point of telling police they were very concerned about F and his attitude to M. They each vehemently denied the suggestion put to them at the inquest they knew what M intended to do that night, portraying overt shock and distress at the details presented to them about that night's events. The degree to which both parents actively participated in M's efforts to discredit F and the extremely close bond M shared with them, particularly her mother, support the possibility the family discussed M's intention to go to F's house that night. However, there is insufficient evidence to make a positive finding either or both did.

291. M had actively contemplated fleeing with the children before she received the psychiatrist's report. Having regard to the psychiatrist's clinical assessment that M genuinely believed F was abusing the children, I find M most likely went to the house that night intending to protect the children by removing them from his care. That she equipped herself with petrol and the makings of a Molotov cocktail supports a finding she intended to set fire to the house with F and his partner inside. Her plan was disrupted finding C2

in bed with the couple when she threw petrol on them while they were sleeping. M was the victim-survivor of childhood abuse. She believed F had sexually abused C2. She disabled F by setting him alight, but his partner put up a fight at which point M walked herself into the ensuite, making no attempt to save herself or the children from the fire.

292. Regardless of M's intent, her use of fire as a weapon to harm F and his partner could have cost the children their lives. The actions of F's partner prevented this from being an even greater tragedy.

Could what happened have been anticipated?

293. Dr McPhedran's analysis of lethality risk factors in this matter recognises statistically there are relatively few female intimate partner homicide offenders, and not much research on this homicide perpetrator cohort. Consequently the available research has its limitations.

294. She identified M as having many of the known lethality risk factors shared with male perpetrators of intimate partner homicide – socioeconomic disadvantage, exposure to adverse childhood circumstances including childhood abuse, low education, unemployment, mental illness, and personality disorder. However she stressed that the mere presence of these risk factors does not *necessarily offer meaningful information about who is most likely to be at 'high risk' of perpetrating intimate partner homicide*.

295. The inquest heard how M's diagnosis of borderline personality disorder is highly relevant, making her especially susceptible to emotional instability and reactivity, intense and disproportionate emotions, insecurity and fear of losing control, impulsivity and antagonism. As such, Dr McPhedran suggested M may have been *especially susceptible to feelings of losing or having lost control of her circumstances as a result of the Court involvement*.

296. M's choice of arson is consistent with research suggesting female intimate partner homicide offenders are more likely to use indirect methods of homicide requiring some degree of premeditation.

297. Dr McPhedran told the inquest that while there is a reasonable body of research looking at family law involvement in non-lethal domestic and family violence, there is very limited research into family law involvement as a distinct risk factor in lethal violence. There are some studies suggesting it can be a contributing factor. A study Dr McPhedran conducted jointly with others using Australian data found that just under 7% of homicide-only offenders and 3.3% of homicide-suicide cases *were known to have experienced child custody issues around the time of the incident*. Dr McPhedran readily acknowledged that of the huge number of cases in the family law system where systems abuse may occur and domestic and family violence is alleged or actually occurring, *very, very, very few of those end in lethal violence*. Nevertheless, rarity does not make the outcome any less devastating.

298. Stressful life events have been clearly associated with lethal violence including between intimate partners. Court involvement is inherently stressful and can impact a person emotionally, psychologically, and financially. Family law involvement can trigger strong negative emotions including grief, betrayal, and a sense of grievance which have been associated with intimate partner homicide. For people who may have underlying personality vulnerabilities, the family law process can lead to a feeling of loss of control of their life circumstances.

299. Research has identified that coercive control may indicate a high risk of future severe/lethal violence even in the absence of physical violence. Dr McPhedran identified the pattern of M's unsubstantiated reports about F across multiple systems as systems abuse as a form of coercive control. While multiple agencies identified the allegations were unsubstantiated, they were not linked to potential abuse of F. F's partner felt any mention to police or Child Safety about the possibility of M being the perpetrator of domestic and family violence was not taken seriously. Dr McPhedran observed there has been relatively little research into coercive control used by women against men, or in non-heteronormative relationships.

300. Dr McPhedran explained the research recognises escalation as a well-established dynamic risk factor for intimate partner homicide, typically characterised by an increase in the severity and/or frequency of abusive behaviours. M's unfounded allegations and use of her network to report them increased in frequency and seriousness as the parenting proceedings progressed other than in her favour. This was apparent across multiple agencies but framed by them as M's reaction or vexatious response to the parenting proceedings. Similarly, F's reported concerns were regarded as vexatious in this context.

301. Dr McPhedran identified multiple points when F was expressing concern for his and the children's safety, concern that M's multiple unsubstantiated allegations would affect his reputation, career, wellbeing and relationships, he did not want her knowing where he worked in case she came to his workplace, and he had expressed concern she might turn physical against him. Dr McPhedran felt there were points when people could have turned their minds to whether F was a victim. Instead, because this was occurring within the context of parenting proceedings with child safety involvement, the focus was on risk to the children. F's reported concerns lost visibility particularly once the psychiatrist's reports became available and the acute concern was how to get the children out of M's care when she received the psychiatrist's reports.

302. Dr McPhedran told the inquest:

What is really striking about this is the risk that [M] posed to herself was identified, to her children was identified, but no one stopped to consider that perhaps there was also a risk to [F]…I am simply highlighting that it is very striking that when risk of lethal violence had been identified, that an ex-partner wasn't conceived of as potentially being at risk.

303. In Dr McPhedran's opinion, the way risk was assessed and identified was very strongly influenced by the gender of the alleged victim and perpetrator and *…to make assumptions about who is the victim and who is the perpetrator based on gender is fundamentally problematic*. Dr McPhedran observed there is relatively little known about male victimisation and a lack of understanding about differences in how victimisation can look between men and women, because it hasn't been well studied.

304. What flows from not correctly identifying the victim and the perpetrator is that any risk assessment will be inherently flawed. In Dr McPhedran's words *if you're risk-assessing the wrong person, it doesn't matter what tool you're using. And that is the absolutely crucial feature of this particular matter, that the wrong person was being risk assessed as the victim*. Identifying F as a potential victim of domestic and family violence and applying risk assessment tools from that perspective may have better identified his support needs.

305. On the material available to the inquest, Dr McPhedran could not say how people were assessing risk in this matter. She observed that different agencies and services all have their own risk assessment tools and *no one really knows quite who's doing what with risk assessment is the reality..there's a lot of misconceptions about it. There's an idea that it's a very clean, neat, organised thing that people do; it's not*.

306. Dr McPhedran was very clear in her evidence that the various tools used in domestic and family violence focussed risk assessment across the world have been found to have relatively limited <u>predictive</u> capability. She explained:

> *…the value of risk assessment is more in helping to identify what is going on in people's lives – um – and what their – their support needs and vulnerabilities may be and then, ideally, using that to – um – to – to try to devise ways to better respond to them and better support them. So I absolutely accept that there is a – a big leap from saying, you know, "There are – there are risk factors present" to "Someone is going to kill someone", because we don't who, with these risk factors, will go on to kill.*

307. She is not critical of the actions of anyone at the Court on 9 March 2022. Rather she is highlighting at a systemic level there were opportunities to do things differently and to look at risk differently. She is not saying that anyone on the day failed.

308. Dr McPhedran considered that in a context where lethality risk is identified, and noting the significance of trigger events and dynamic factors in pathways to lethal violence (homicide and suicide), it may have been appropriate for a suitably qualified professional to assess M's psychological and emotional state. She acknowledged that while those present properly recognised M's distress and endeavoured to ensure she would not be alone that night, none had the requisite clinical skills to undertake a comprehensive assessment of M's mental state. That said, Dr McPhedran

acknowledged lethality is extremely difficult if not impossible to predict even for highly skilled professionals with advanced mental health training and experience, and there is no way of knowing whether specialist mental health assessment of M on that day would have changed the outcome.

Findings required by s. 45

Identity of the deceased – [deidentified for publication]

How he died – F died from burns sustained after his former partner, M , deliberately splashed petrol on him while he was sleeping and then threw a Molotov cocktail, setting him alight. M had broken into his house during the night to remove her three eldest children from his care. The children had been placed in his primary care by an interim consent order made by the Federal Circuit & Family Court of Australia (Division 2) the previous day due to concerns about M's mental health and its impact on her ability to parent her children safely.

Place of death – Royal Brisbane & Women's Hospital HERSTON QLD 4006 AUSTRALIA

Date of death– 10/03/2022

Cause of death – 1(a) Burns

Identity of the deceased – [deidentified for publication]

How she died – M died from smoke inhalation after she made no effort to save herself from the house fire she ignited by throwing a Molotov cocktail at her former partner, F. She had broken into his home in the early hours of 10 March 2022 to remove three of her children from his care. The children had been placed in F's primary care by an interim consent order made by the Federal Circuit & Family Court of Australia (Division 2) the previous day due to concerns about M's mental health and its impact on her ability to parent her children safely.

Place of death – [deidentified for publication]

Date of death– 10/03/2022

Cause of death – 1(a) Smoke inhalation

Comments and recommendations

The adequacy and appropriateness of any risk assessments conducted, and safety planning enacted by the FCFCOA (Division 2) with respect to the Federal Circuit Court proceedings regarding the children.

309. I acknowledge the FCFCOA's powers in relation to parenting proceedings are limited to the exercise of the Commonwealth's judicial powers by making interim and final parenting orders under Part VII of the *Family Law Act 1975* (Cth). The objects of Part VII are to *ensure the best interests of the children are met, including by ensuring their safety*.[6] The children's best interests must be the Court's paramount consideration when deciding what parenting orders should be made.[7]

310. As at 9 March 2022, one of the mandatory primary considerations the Court had to consider when making a parenting order was *the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence*.[8] At that time, the Family Law Act did not confer a statutory power or duty on the FCFCOA to consider the interests or safety of anyone other than the children in the making of a parenting order.

311. Amendments to 60CC(2) of the Family Law Act which took effect from 6 May 2024 require the FCFCOA to consider the impact of parenting arrangements on the health of a parent or carer.[9] Once it makes an order, the Court does not have any ongoing supervisory powers in relation to post-order outcomes or to the design or implementation of risk management plans including making orders concerning the health or wellbeing of a parent unless it directly affects the child's best interests in the context of a parenting order.

312. The FCFCOA's information paper provides a very helpful explanation of its family safety risk screening process in Lighthouse. The paper references the *Family Violence Triage in Family Courts: Safety, Efficacy and Benefit* research project and its findings reported in the paper [Family Violence Risk on Entry to the Family Courts of Australia: Profiles and Predictive Validity of the DOORS Triage Process - PubMed]. The FCFCOA points to this paper's findings as suggesting the Family DOORS Triage Tool is a reliable and useful initial screen for high risk in the FCFCOA.

313. However, strict confidentiality provisions attaching to the FCFCOA's family safety risk screening process prevent me from examining this aspect of its family violence framework as it may or may not have applied to F and M. This is because the Family Law Act operates to prevent the admission

[6] s.60B, *Family Law Act 1975*
[7] s.60C
[8] s.60CC(2)(b)
[9] s.60CC(2)(a)(ii)

into evidence of information connected with a family safety risk screening process, including information identifying that a person participated in that process. This statutory prohibition applies irrespective of the source from which the information is obtained.[10]

314. This means as far as I can take this aspect of F and M's participation in the parenting proceedings is to note that upon F filing his Notice of Risk in late July 2021, both he and M would have been invited to complete the online Family DOORS Triage risk screening questionnaire. I cannot know whether one or both did, and if so, what happened next in terms of risk identification, case management, support and referral for F and/or M and whether the FCFCOA's family safety risk screening process correctly identified who was the victim and who was the perpetrator in this matter.

315. There is very sound policy rationale for making this information impenetrable to encourage parties to participate in the FCFCOA's family safety risk screening process without fear the information they provide may be used against them in other contexts while they are alive. However, it is perhaps an unintended consequence of the confidentiality provisions to frustrate the power of a Coroner to inquire into a deceased person's participation in this aspect of the FCFCOA family violence prevention framework when the issue of family violence risk identification and management in the context of ongoing family law proceedings is highly relevant to the Coroner's statutory duty to make a finding about how a person died.

316. The FCFCOA confirmed that Court Children's Service staff conducted a risk assessment for the handover of all four children at the Court on 9 March 2022. No documentation regarding this risk assessment was made available to the inquest nor was a Court Children's Service representative offered to speak to it or the handover process generally at the inquest. The then current protocol focussed the risk assessment entirely on the process and logistics by which the children were physically handed over from the relinquishing parent to the receiving parent/carer in the Court premises. At that time, risk assessments were prepared informally and, in some instances, not documented. Court Children's Service staff generally considered issues including the children's age, gender, medical conditions and likely reaction, any history of violence, the length of time since the children had spent time with the receiving parent, who would be participating in the handover and the exposure of Court Children's Service staff to any safety risks during the process.

317. This changed from 1 April 2024 with the introduction of a formal planning and risk assessment tool to support Court Children's Service staff when assessing risk for a Court Children's Service facilitated handover process. The tool is used to guide risk assessment and safety planning to support physical and psychological safety and minimise trauma for all participants including Court Children's Service staff. The tool is structured as a

[10] Sections10V, read together with ss 10S & 10T, *Family Law Act 1975* (Cth)

branching Microsoft Form where certain responses trigger follow up questions or require escalation to the Service's Executive Director. It collects a range of information including risk factors and is dynamic and updated regularly based on feedback from senior staff and emerging risks before the FCFCOA. Neither the tool itself nor a Court Children's Service representative to speak to it were made available to the inquest.

318. FCFCOA advises that Court Children's Service staff may seek information from an appointed ICL, and judicial officers may decide to involve an ICL and legal representatives for the parents/carers in the Court Children's Service Handover Process when considered appropriate, for example to explain the orders to the children. However, the FCFCOA advises ICLs and lawyers for the respective parties have never participated in the preparation of a risk assessment for a Court Children's Service Handover Process.

319. As before, the risk assessment is confined to the process and logistics of the Handover Process as it occurs in the Court premises. It does not consider what might occur after the Handover Process is completed. This reflects the fact the FCFCOA's powers and duties do not expend to what happens after the children and the parties leave the Court premises.

320. The FCFCOA's submissions point to recognition in its *Family Violence Best Practice Principles* that *[u]nderstanding the gendered nature of family violence is crucial to developing effective responses within the legal system*. Its information paper and submissions detail elements of its ongoing education and training of its judicial officers and staff on this topic, highlighting the FCFCOA's substantial investment in ensuring this education and training represents best practice in identifying and responding appropriately to risk.

321. The FCFCOA's information paper indicates it is currently exploring additional areas for professional development, including risk factors associated with domestic and family violence homicide, infanticide and filicide, and the intersection of family violence with mental health issues and substance misuse. No further information about this body of work or a FCFCOA administration representative were made available to the inquest.

322. Dr McPhedran's review and oral evidence highlights a gap in knowledge about family law involvement as a distinct risk factor in lethal violence. Existing Australian domestic and family violence death review mechanisms are well placed to identify systemic learnings from the deaths of parties and/or children known to the family law system at the time of or within proximity to their death with a view to preventing similar deaths in future. However, the capacity of these mechanisms to properly examine these deaths is limited in the same way as this inquest by not only the strict confidentiality provisions of the Family Law Act but also the FCFCOA's constitutional primacy.

323. For this reason, **I recommend that** the Commonwealth Attorney-General, as Minister with portfolio responsibility for the Family Law Act, consider amendments to the confidentiality provisions of that Act to facilitate the provision by the FCFCOA of information regarding a person's participation in a family safety risk screening or other risk assessment/safety planning process undertaken by FCFCOA staff for the purpose of proceedings relating to the domestic and family violence related death of that person or another person, or to a body with the statutory function of reviewing domestic and family violence related deaths.

The appropriateness and adequacy of any risk assessments conducted, and safety planning enacted by the legal practitioners involved in the FCFCOA (Division 2) proceedings regarding the children.

324. The FCFCOA's *Family Violence Best Practice Principles* clearly articulate the expectation that all professionals working in or appearing before the Courts are expected to undertake ongoing training to assist in understanding family violence in all its forms. Lawyers are expected to understand *the multifaceted layers to family violence, to work carefully and respectfully with their clients, and to ensure that the Courts are provided with documents that articulate the violence, coercive control, and other cross-cultural or religious matters that may alter the nature and dynamics of the abuse*.[11]

325. Information provided by the FCFCOA, the Queensland Law Society, Legal Aid Queensland, and the Queensland Family Law Practitioners Association shows an array of best practice frameworks and guidelines, case management standards and continuing professional development to guide and support lawyers to understand, identify and manage concerns about risk and impact of domestic and family violence present or alleged in family law proceedings.

326. Each of the lawyers were asked about the extent to which they considered M's behaviours as domestic violence.

327. S1 told the inquest that both F and his partner had previously told them they were very worried about M. F felt there was *something that wasn't right* with M. When asked by Senior Counsel Assisting whether S1 had considered M's behaviours towards F as domestic and family violence (as distinct from a vexatious response to the parenting proceedings), S1 said that apart from the incident at the restaurant, M's behaviours were *subtle* and *all very strange.* S1 agreed with Senior Counsel for Child Safety that from F's perspective, M's false accusations were part of a strategy to damage his reputation and influence the parenting proceedings to sever his relationship with the children. None of the material filed by or on F's behalf in the proceedings expressly referenced him being concerned that M posed an imminent risk of serious physical harm to him or the children. S1 did not

[11] Family violence best practice principles - Fifth Edition, p.11

consider there was a lethality risk in M's behaviours before the psychiatrist's reports become available.

328. S2 was only involved in the parenting proceedings for a short time. Nonetheless, they and their Principal were aware there was something driving M's mounting unsubstantiated allegations against F and her overall objective of severing his relationship with the children, but they were not quite sure what it was. They had *pretty big concerns* M's allegations were untrue. S2 told the inquest they were trying to connect the dots, identify the risk issues and work out how to give M the advice she needed.

329. ICLs are guided and supported by specific guidelines issued by National Legal Aid and endorsed by the FCFCOA[12], supplemented by Legal Aid Queensland's family law case management standards relating specifically to the ICL role. In combination, these guide ICLs to proactively assess and respond to the risk of harm arising from children's exposure to domestic and family violence. The National Legal Aid guidelines highlight the utility of engaging experts such as mental health professionals and family violence specialists to assist the ICL to determine how issues of risk and harm should be assessed and managed.

330. The ICL did consider domestic violence as a driver for M's mounting unsubstantiated allegations but only from the perspective of F possibly being *very good at perpetrating subtle domestic violence* against her that she couldn't prove to the satisfaction of police or other agencies. However, the ICL's consideration of the reverse possibility is couched in terms of M perhaps still having romantic feelings for F and doing what she could to get a response from him. This does not reflect consideration of M's behaviours as potentially a form of systems abuse to ..*gain an advantage over or to harass, intimidate, discredit or otherwise control F.*[13]

331. Nonetheless it is evident the ICL responded proactively to the allegations of domestic and family violence and sexual abuse, by engaging independent assessment through a family report followed by independent psychiatric assessment of both parents.

332. Once informed of the psychiatrist's concerns of M's significant risk of lethal violence, the ICL acted swiftly to engage the FCFCOA and Child Safety in developing a plan to manage disclosure of the psychiatrist's report to M and the associated risk of serious harm to the children once she learned of its contents.

333. Dr McPhedran acknowledged that once the psychiatrist's concerns became known, there was a coordinated mechanism to share and discuss that information and responses to it.

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[12] Guidelines for Independent Children's Lawyers | Federal Circuit and Family Court of Australia

[13] As described by the FCFCOA *Family Violence Best Practice Principles*, p2.

334. As discussed in paragraphs 183-191 above, the way in which the psychiatrist communicated their assessment of M's risk of lethal violence and recommendations to manage it, narrowed the focus of what followed on managing risk of harm to M and the children.

335. The SJR very clearly articulated the impact on the children, M, and her family of what was occurring by consent that day.

336. None of the lawyers present at Court on 9 March 2022 observed disproportionate or threatening behaviour by M to prompt concern she posed an immediate risk of harm to the children or anyone else. None of them appreciated there was significant risk of harm to F with the children now in his care.

337. S2 responded appropriately with professional maturity and compassion in a very challenging solicitor-client situation, made more difficult by M's mother's reaction to what unfolded at Court that day. S2 was carefully monitoring her client's reaction in a very dynamic situation and doing their best to ensure M did not go home to an empty house. S2 could not have predicted or prevented what M did next.

338. There are valuable learnings for family law practitioners managing parenting proceedings in which a radical change of residence based on risk is expected to occur. Mental illness and perpetrating domestic and family violence are not mutually exclusive. A radical change in residence is an acute trigger event for a parent/carer whose mental illness is driving persecutory beliefs about the receiving parent/carer. Children remain at risk of harm if the relinquishing parent/carer poses a risk of harm to the receiving parent/carer. What happened in this case demonstrates the importance of bringing and maintaining an expansive consideration of risk of harm, particularly lethal violence, to others in the children's support network in circumstances where:

(a) the relinquishing parent/carer has identified personality vulnerabilities that predispose them to acute reactions in crisis situations;

(b) the relinquishing parent/carer is identified as having unsubstantiated persecutory beliefs about the receiving parent/carer harming the children; and/or

(c) the receiving parent/carer has alleged domestic and family violence by and/or expressed fear of the relinquishing parent/carer.

339. ICLs are very well placed to seek specialist assessment and clarification of this broader risk. Supplementing the clinical opinion of a mental health professional with input from a family violence specialist may better inform risk assessment and safety planning towards handover and beyond. I acknowledge this comes at a cost to an already under-resourced system, but the potential cost of one or more lives must surely outweigh it. It is vital that lawyers representing the receiving parent/carer have a frank discussion

with their client about what the identified risk of harm might mean for their safety with the children in their care, escalate any safety concerns or fears their client may have and develop a safety plan with their client for handover and beyond.

340. The McLeod inquest identified opportunity *to provide additional training and support for legal practitioners when dealing with clients experiencing crisis or with complex mental health needs*. The presiding Coroner directed a recommendation to the Queensland Law Society regarding the provision of a mental health specialist consultant service for solicitors seeking advice about how to assist clients with complex vulnerabilities.

341. The Queensland Law Society advised this is not possible given the number of specialist consultants needed to provide a comprehensive service, and the difficulty of engaging consultants with the expertise required for different mental health conditions. However it points to existing and planned (though unspecified) support services including its Ethics and Practice Centre, Senior Counsellors, Mental Health first aid training and the Domestic and Family Violence portal.

342. The Queensland Law Society and Legal Aid Queensland are working collaboratively to provide further continuing professional development opportunities in domestic and family violence and the coercive impact of family law proceedings on clients. Following consultation with National Legal Aid and the FCFCOA, Legal Aid Queensland has identified additional education and training areas for consideration as future training options.

343. The unexpected, highly emotional and dynamic situation S2 was required to manage at Court on 9 March 2022 causes me to question whether the psychologists and/or social workers employed by the FCFCOA Court Children's Service might be a resource that could be extended to support a relinquishing parent/carer in circumstances where a suppressed adverse report is being released to them in the Court precinct with the likely outcome that the children will be transitioned out of their care on the same day. It seems to me a logical extension of the Court Children's Service role and function in assessing risk, safety planning and facilitating anticipated handovers in the Court precinct, particularly for a party who is not already engaged with mental health supports.

344. However, without the benefit of evidence from FCFCOA witnesses as to how the Court Children's Service Handover Process works in practice or the Service's current and future capability and resourcing it would be inappropriate to make a recommendation in this regard. That said, I respectfully suggest there is merit in the Chief Justice exploring this concept with the FCFCOA administration in furthering the FCFCOA's commitment to the safety and support of its users.

345. This matter also offers an important learning for ICLs about the importance and mutual benefit of proactive engagement and information sharing with the co-located Child Safety officers from the outset of their ICL

appointment in parenting proceedings where there is concurrent Child Safety involvement with the family.

346. Having regard to Child Safety's significant investment in improving departmental capability and practice in domestic and family violence (summarised in paragraph 354 below), proactive engagement by ICLs with Child Safety may offer a conduit by which Child Safety Officers can work collaboratively with ICLs to identify when specialist family violence input to parenting proceedings may be needed to properly understand and assess risk.

347. I acknowledge the ongoing efforts of Child Safety Court Services to educate ICLs and family law practitioners about the role of the co-located Child Safety Officers.

The appropriateness and adequacy of any risk assessments conducted, and safety planning enacted by the Department of Families, Disability Services and Child Safety officers involved in the FCFCOA (Division 2) proceedings regarding the children.

348. Child Safety's statutory remit in relation to this family was focused on assessing risk and protecting the children from harm. Senior Counsel for Child Safety quite rightly submits Child Safety had no statutory power or authority to take action to protect F and/or his partner from violent harm by M other than for the purpose of protecting the children from harm.

349. Child Safety's direct involvement in the parenting proceedings was limited in duration and because Child Safety was never a party to the proceedings. Prior to the hearing on 9 March 2022, Child Safety first became indirectly involved on 28 January 2022, when the FLT CSO reached out to the ICL advising the first I&A was in progress, offering to facilitate/coordinate discussions that may assist the ICL or Child Safety in their respective roles. Child Safety did not become actively involved in the parenting proceedings until the ICL contacted the FLT CSO on 26 February 2022 regarding the psychiatrist's concerns, seeking to involve Child Safety in managing the release of the psychiatrist's reports to the parties because C4 was not subject to the parenting proceedings. By this time, steps were being taken to get the second I&A underway.

350. Senior Counsel for Child Safety acknowledges that part of Child Safety's functions in assessing risk to children and protecting them from harm is recognising and assessing harm that may arise from children being exposed to domestic and family violence between adults in their family, noting this exposure has potential to cause physical and emotional harm. A parent's ability and willingness to protect their children from this form of harm is relevant to the assessment of whether a child is 'in need of protection'.

351. It is evident that once informed of the psychiatrist's concerns, Child Safety escalated its risk assessment and immediate safety planning for all four children while they continued in M's care leading up to her receiving the

psychiatrist's reports on 9 March 2022, and in the event the Court made orders transitioning the children out of her care at the interim hearing. Child Safety acted quickly to assist the Court and make arrangements for the children's safety in very challenging circumstances on 9 March 2022.

352. The assessment of F as a person willing and able to protect the three eldest children from harm once they were in his care was entirely reasonable on all the information available to Child Safety, including the family report and the psychiatrist's independent clinical assessment and recommendations. No one present at Court that day observed anything disproportionate or overtly concerning about M's demeanour or conduct at the Court on 9 March 2022 to have warranted a different response by Child Safety. No one heard her or anyone else make any threats towards F and/or his partner. M expressly denied thoughts or plans to harm the children. There was no explicit identification of risk to F and/or his partner from M to prompt Child Safety to expressly consider the children might be at immediate or imminent risk of harm arising from domestic and family violence perpetrated by M towards their father.

353. I acknowledge that working with M to achieve her agreement to an immediate voluntary safety plan for C4 took skill given the heightened emotions and time pressures, particularly for Child Safety making appropriate arrangements for C4 following the hearing.

354. As acknowledged by the psychiatrist and Dr McPhedran, it would have been extremely difficult for anyone without specialist mental health expertise to identify the risk M posed to F given the complexity of her mental health diagnoses, let alone predict the likelihood she would imminently cause his death.

355. Child Safety's Chief Practitioner provided a statement outlining significant system improvements to departmental practice and capability in domestic and family violence since March 2022 including through:

(a) its Enhanced Intake and Assessment Approach, aligned with a new information and record keeping system Unify[14]. The enhanced approach is supported by new and revised operational policies, procedures and practice guidance, and training. Of relevance to this matter are changes that record all new concerns as an intake; where there have been two or more previous intakes for a child in the preceding 12 month period, prompts to consider cumulative harm; and introducing exposure to domestic and family violence as a distinct abuse type.

(b) introduction of domestic violence as a distinct abuse type to support staff to consider the impact of exposure to domestic and family violence.

[14] In December 2025, the Department of Families, Seniors, Disability Services and Child Safety published the independent Unify Review Report which identified a range of issues and challenges with the Unify System design, functionality and performance, data and reporting (Department of Families, Seniors, Disability Services and Child Safety Unify Review Report December 2025).

(c) changes to definitions of household, household member and harm household to recognise a violence perpetrator may not reside in the child's primary household but can still expose the child to domestic and family violence.

(d) the role of the Domestic and Family Violence Practice Leader within the Office of the Chief Practitioner.

(e) revisions to the Domestic and Family Violence practice kit to provide contemporary practice guidance and incorporate the Safe and Together model and the Common Risk and Safety Framework (CRASF).

(f) training and resources including Safe and Together, mandatory domestic and violence e-learning module, mandatory full day training on domestic and family violence informed practice as part of face-to-face training for new Child Safety Officers – current training includes courses regarding assessment when domestic and family violence is present, the impact of violent and coercive behaviours on children, working with families when violence and coercive behaviours are causing harm and working with survivors and perpetrators.

(g) Domestic and Family Violence Child Protection Practitioners in High Risk Teams across Queensland.

356. The inquest identified opportunities for Child Safety to have become engaged with the parenting proceedings sooner than occurred. I accept this may in part have reflected the relative infancy of the Co-Location Pilot at the time of the parenting proceedings. The FLT CSO told the inquest as at early 2022, the Pilot was still in development stage and there had been some ICL turnover meaning it took time to develop relationships with new ICLs, though it had very good working relationships with some who understood the mutual benefit in terms of outcomes for children and their families. The Co-location Pilot became more commonly understood over time, with ICLs beginning to understand its purpose and function and a lot more ICL engagement.

357. The National Strategic Framework for Information Sharing between the Family Law and Family Violence and Child Protection Systems was embedded by changes to the Family Law Act in May 2024. Child Safety witnesses were enthusiastically positive about the significant impact of the Co-Location Program and the Framework as a *gamechanger* for closing gaps in the child protection/family law/domestic and family violence system interface in Queensland.

358. Child Safety's Director of Court Services told the inquest the Co-Location Program will be expanding over the next three years with additional roles to free up its professional FLT officers to focus on 'the really complex cases consults and case management'.

359. The FLT CSO identified the following opportunities for improvement in facilitating early information gathering and faster information exchange between the child protection and family law systems:

(a) an operational requirement for Child Safety Officers allocated to an Assessment where Child Safety knows children are the subject of family law proceedings to notify the FLT that an assessment is underway would be an *ideal scenario*.

(b) for Child Safety to receive copies of FCFCOA orders as they are made.

(c) The FLT CSO agreed *emphatically, absolutely* that routinely linking Child Safety Officers involved in an assessment with an appointed ICL would be ideal. They told the inquest the FLT have a *tremendous amount of liaison with ICLs. No two ways about it. Some more than others*.

(d) in their experience some ICLs willingly hand over documentation such as family reports but others will not without a court order, which triggers a court event which can take time. The FLT CSO identified an opportunity for improvement in facilitating a faster exchange of information without requiring a court event or something to fast track that process:

> *At least that provides..early information to the departmental officers as soon as possible, and it will obviously invariably support them in terms of deciding which pathway next*.

360. The FCFCOA acknowledges:

> *improved information sharing between agencies is critical in supporting informed and timely decision making and enabling a robust system response through a better understanding of any history of violence, abuse or other risks relevant to a matter. Improved information-sharing will also continue to support the FCFCOA's ability to assess risk in the context of its powers, to triage and prioritise cases, and to make orders which, to the greatest extent possible, protect children and adults who have experienced family violence or abuse*.

361. I acknowledge the Child Safety and family law system interface is complex and subject to legislative and resource limitations. Nonetheless, it is incumbent on the FCFCOA and the Department of Families, Seniors, Disability and Child Safety to continue working collaboratively to examine opportunities to enhance the current information sharing protocol and Program resourcing to achieve earlier and faster exchange of information about active Child Safety involvement with a family whose children are the subject of parenting proceedings.

I close the inquest.

Ainslie Kirkegaard
Coroner
BRISBANE

21 April 2026

FEDERAL CIRCUIT AND FAMILY COURT OF AUSTRALIA

Attachment 1

INFORMATION PAPER

Coroners Court of Queensland inquest into the deaths of [redacted] and [redacted]

EXECUTIVE SUMMARY

1. This paper has been prepared by the Federal Circuit and Family Court of Australia (**FCFCOA**) to assist Coroner Kirkegaard (**Coroner**) in her examination of issues arising in the Inquest into the deaths of [redacted] and [redacted]. It outlines the FCFCOA's role, statutory powers, and relevant initiatives within the broader family law system, and provides context for the Coroner's consideration of systemic issues and risk factors.
2. Key areas addressed include:
   a. *FCFCOA's Participation in the Inquest*: An overview of the FCFCOA's involvement in the inquest concerning the death of [redacted] and [redacted].
   b. *How the FCFCOA considers and manages risk:* The FCFCOA deals with many forms of risk to children and vulnerable parties in the context of parenting proceedings. The FCFCOA's capacity to respond to those risks is determined by the context in which it arises.
   c. *Role in the Broader System*: The FCFCOA's position within a multi-agency framework that responds to risks associated with family and relationship breakdown, including collaboration with other courts, government agencies and support organisations.
   d. *Statutory Powers and Confidentiality*: A summary of the FCFCOA's statutory powers in family law proceedings, particularly in relation to parenting orders and child-related matters, alongside provisions governing confidentiality and publication restrictions.
   e. *Operational Context*: Data on the volume of family law applications, with an emphasis on parenting matters and associated risk factors.
   f. *Risk Assessment and Safety Planning*: An outline of initiatives such as the Lighthouse Programme, which supports early risk identification and safety planning.
   g. *Co-located Services*: Information on integrated support services including Family Advocacy and Support Services.
   h. *Information Sharing*: The FCFCOA's approach to sharing relevant information with stakeholders to enhance safety and coordination.

3. **Index**

   a. **Section A** – Purpose of the Information Paper
   b. **Section B** – Preliminary Issues
   c. **Section C** – FCFCOA's Statutory Remit
   d. **Section D** – The Context in which the FCFCOA Exercises its Statutory Powers
   e. **Section E** – Risk Assessment and Safety Planning (outside the exercise of statutory powers)
   f. **Section F** – How the FCFCOA Considers and Manages Threats

g. **Section G** – Specialist Roles and Training
h. **Section H** – Co-Located Services and Information Sharing

4. **Dictionary of Defined Terms**
   a. **2024 Amendments** means amendments made under the *Family Law Amendment Act 2023* (Cth);
   b. **CCS** means Court Children's Service;
   c. **CIR** means Child Impact Report;
   d. **Coroner** means Coroner Kirkegaard;
   e. **Coroners Act** means the *Coroners Act 2003* (Qld);
   f. **Department** means the Department of Families, Seniors, Disability Services and Child Safety;
   g. **FASS** means Family Advocacy and Support Services;
   h. **FCFCOA** means the Federal Circuit and Family Court of Australia;
   i. **FCFCOA Act** means the *Federal Circuit and Family Court of Australia Act 2021* (Cth);
   j. **FLA** means the *Family Law Act 1975* (Cth);
   k. **Information Sharing Act** means the *Family Law Amendment (Information-Sharing) Act 2023* (Cth);
   l. **Lighthouse** means the Lighthouse Programme discussed at paragraph [70];
   m. **Lighthouse Expansion** means that expansion of the FCFCOA Lighthouse Programme in 2022 – see: Update to the profession: Expansion of the Lighthouse Model | Federal Circuit and Family Court of Australia;
   n. **Marshal** means the person who is responsible for the security of the FCFCOA and the personal security of Judges, officers and staff of the Court: ss 104(2) and 262(2) of the FCFCOA Act;
   o. **National Framework** means the National Strategic Framework for Information-sharing between the Family Law and Family Violence and Child Protection Systems;
   p. **PIC** means the Pre-Inquest Conference on 26 August 2025;
   q. **Plan** means the Family Violence Plan discussed at paragraph [83];
   r. **Principles** means the Family Violence Best Practice Principles discussed at paragraph [85];
   s. **Relevant Family Law Proceedings** means ;
   t. **Safety Planning** means a plan setting out specific safety measures if a litigant is concerned about their safety when attending the premises of the FCFCOA – discussed at paragraph [94] below;
   u. **SIR** means Security Incident Report.

5. **Attachments**
   a. **Attachment 1** – A non-comprehensive list of federal and state and territory services that respond to risks and issues arising from relationship and family breakdown.
   b. **Attachment 2** - A non-comprehensive list of non-governmental organisations in Australia that provide services in the context of relationship and family breakdown.

c. **Attachment 3** - A non-comprehensive list of Australian courts that issue domestic violence protection orders, intervention orders or similar protective orders, along with the legislation under which these orders are made in each jurisdiction.
d. **Attachment 4** - A non-comprehensive list of Children's Courts in Australia organised by jurisdiction.
e. **Attachment 5** – Court Children's Service – a description
f. **Attachment 6** – Objectives and Principles of the FLA
g. **Attachment 7** – Table: Comparison of FLA Provisions: Pre- and Post-2024 Amendment
h. **Attachment 8** – Table: Areas of Focus against each goal and actions required.

6. For completeness, Attachments 1–4 have been prepared for the purposes of this Information Paper only.

SECTION A - PURPOSE OF THE INFORMATION PAPER

7. The FCFCOA seeks to provide preliminary assistance[1] to the Coroner in her examination of the issues outlined in paragraph [9] below by outlining the matters listed at paragraph [2] above.[2]

Issues for Examination

8. A Coroner has powers under the Coroners Act.
9. The Coroner advised[3] at the PIC that she will examine the circumstances of [redacted] deaths and further:

> "*I see this inquest as an important forward-looking opportunity to examine how the family law system can identify and manage dynamic risk of harm to children and their carers during family law processes and to develop the capacity of those working within the system to identify and respond to domestic and family violence.*
>
> With reference to the *Domestic and Family Violence Death Review and Advisory Board Annual Report 2018-19*, Her Honour went on to say:
>
> *Risk is dynamic and matters that may screen as low or medium risk can quickly escalate to high risk if there is a change in circumstances in the family.*
>
> *Her Honour continued – "I will be assisted by information about existing specialist resources within the federal family courts:*

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1 This paper provides *preliminary* assistance because consistent with Ian Neil SC's submissions at the Pre-Inquest Conference (see paragraph [10] of this paper), the Chief Justice instructed Mr Neil to adopt a 'watching brief' and provide assistance to the Coroner in relation to key issues as they were defined by the Coroner – this means this paper does not purport to provide a comprehensive position at this stage, and it may be supplemented according to the outcomes of the watching brief.

2 To minimise the length of this paper, links are provided to material on the FCFCOA website where available. If the Coroner or Counsel Assisting would prefer us to extract material, please do not hesitate to let us know.

3 Email dated 26 August 2025 from the Coroner to the solicitors that appeared for various persons at the Pre-Inquest Conference on the same day.

*a) FCFCOA Family Violence Plan & Family Violence Best Practice Principles (**Best Practice Principles)***

*b) Lighthouse – screen and case manage new family law matters for DFV, child abuse and family safety risks (**Lighthouse Program**)*

*c) Family Advocacy and Support Services (**Court Services)**, and*

d) Co-located officials[4]".

SECTION B - PRELIMINARY ISSUES

Basis upon which the FCFCOA is participating in the Inquest

10. At the PIC, Ian Neil SC, representing the interests of the FCFCOA, advised the Coroner that:
    a. the FCFCOA would not seek leave to appear as a party in the Inquest; and
    b. the FCFCOA would adopt a 'watching brief' in relation to the Inquest and voluntarily provide assistance to the Coroner in relation to key issues as they are defined by the Coroner, noting that the Coroners' compulsive powers are not operative in relation to the FCFCOA, its judicial officers or its staff.

How the FCFCOA considers and manages risk

11. The FCFCOA deals with many forms of risk to children and vulnerable parties in the context of parenting proceedings including physical abuse, alcohol and drug abuse, sexual abuse, family violence, psychological and emotional abuse, financial abuse, social isolation, homelessness/ transience and poor mental health/ poorly managed mental health.
12. The FCFCOA's capacity to respond to those risks depends on the context in which it arises:
    a. where the FCFCOA has statutory power to make orders in relation to the risk (**Context 1**);
    b. where the FCFCOA does not have statutory power to make orders in relation to the risk, but it is a permissible incident of the exercise of judicial power[5] to take action in relation to the risk (**Context 2**); and
    c. where the FCFCOA does not have any power itself to do anything in relation to the risk other than to refer the risk to a person or agency that does have power to deal with it (**Context 3**).
13. Risks in Context 1 are considered by a judicial officer of the FCFCOA to decide a parenting application in the best interests of the child. Context 1 is discussed in paragraphs [48]-[52], [71], and [129]-[135] below, and in the AGS letter to Counsel Assisting dated 7 October 2025.
14. Risks in Context 2 are assessed and managed by the FCFCOA's non-judicial staff (save for allocation to a special hearing list[6] such as Evatt, Magellan and

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[4] Email dated 26 August 2025 from the Coroner to the solicitors that appeared for various persons at the Pre-Inquest Conference on the same day.

[5] *The Queen v Davison* (1954) 90 CLR 353 at 367.

[6] Allocating a case to a specialist hearing list is considered an exercise of judicial power, though the actual "hands-on" work is performed by FCFCOA staff.

the Critical Incident List). Context 2 is discussed in paragraphs [26]-[29], [68]-[69], [70], and [72]-[97] and [101]-[128].

15. Risks in Context 3 are notified to the FCFCOA or identified in the course of the work of the FCFCOA by its judicial officers or non-judicial staff or other persons. Context 3 is discussed in paragraphs [98]-[100].

Role of the FCFCOA (family law jurisdiction) in the broader system

16. The FCFCOA plays a central role in resolving legal disputes arising from relationship and family breakdown, including matters relating to parenting, finance and property, and divorce. This Information Paper is focused on parenting orders.
17. A significant proportion of matters before the FCFCOA involve allegations or risks of family violence. In the financial year 2024-25[7]:
    a. 86% of parenting matters alleged that a party had experienced family violence; and
    b. 81% of parenting matters alleged that a child had experienced family violence.
18. The FCFCOA operates within a broader multi-jurisdictional and multi-agency system that responds to the complex issues associated with relationship and family breakdown - particularly where family violence is present or alleged. This broader system includes:
    a. state and territory courts;
    b. police;
    c. child welfare agencies;
    d. domestic, family and sexual violence services;
    e. health and mental health services;
    f. housing services;
    g. community and specialist services;
    h. legal assistance and advocacy organisations; and
    i. federal and state government agencies.
19. **Attachment 1** is a non-comprehensive list of federal and state and territory services that respond to risks and issues arising from relationship and family breakdown.
20. **Attachment 2** is a non-comprehensive list of non-governmental organisations in Australia that provide services in the context of relationship and family breakdown, along with a summary of the services each offers.
21. **Attachment 3** is a non-comprehensive list of Australian courts that issue domestic violence orders, intervention orders or similar protective orders, along with the legislation under which these orders are made in each jurisdiction.
22. **Attachment 4** is a non-comprehensive list of Children's Courts in Australia organised by jurisdiction.
23. The services and institutions referenced above are each a plank in the system that responds to the risks and consequences of family breakdown. Different elements of this multi-jurisdictional and multi-agency system may be accessed

[7] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 11 (scheduled for publication on 17 October 2025).

by participants at different times, depending on their specific needs. It is an obvious opening statement, but not all family relationship breakdowns require any intervention or support by an agency within the multi-jurisdictional and multi-agency system, whereas some require a significant degree of support and some participants are required to access a wider range of services.

24. The FCFCOA is focused on resolving legal disputes – that is, justiciable controversies between parents that are within the FCFCOA's power to determine in accordance with the law. The involvement or intervention of the FCFCOA is triggered when an application is filed, thereby committing the dispute to the powers of the FCFCOA.
25. The FCFCOA's involvement:
    a. tends to be at a later stage in the process (i.e. than the involvement of other participants in the broader family law system);
    b. is generally sought by parties who have not been able to resolve a dispute without any form of assistance or who have accessed other forms of assistance to resolve their disputes, but those mechanisms/forms were partially or wholly unsuccessful; and
    c. operates alongside other services that address safety, wellbeing, and recovery.

Risk assessment processes and safety planning in the Relevant Family Law Proceedings that was undertaken by FCFCOA staff (not including judicial officers)

26. Risk assessment and safety planning processes are discussed in Section E. However, due to the confidentiality provisions addressed in Section C, the FCFCOA is prohibited from discussing the engagement or non-engagement of any party with Lighthouse, including the Family DOORS Triage risk screen (including the parties to the Relevant Family Law Proceeding).
27. The FCFCOA does not have any record suggesting that the parties to the Relevant Family Law Proceeding requested a safety plan (as that term is defined in paragraph [94] below).
28. CCS facilitated the handover of three children to [redacted] and one child to the Department of Families, Seniors, Disability Services and Child Safety (**Department**) on 9 March 2022. Security escorted [redacted], his partner and the children as they exited the FCFCOA building.[8] [redacted] was not present at the handover.
29. CCS and its remit are discussed at **Attachment 5**. At the time when the FCFCOA was dealing with the Relevant Family Law Proceeding, CCS did **not** conduct a formal risk assessment process when it was preparing to facilitate the physical transfer (i.e. referred to as a "*handover*") of the children from the relinquishing parent ([redacted]) to the receiving parent [redacted]) and the Department. Since April 2024, CCS has conducted a formal risk assessment in relation to all proposed handovers before its staff (generally psychologists and social scientists – see **Attachment 5**) facilitate the physical transfer of a child or

[8] B.52, paragraph [21].

children from one parent or guardian to another (see **Attachment 5** below). This assessment is focused on risks occasioned by the handover.

SECTION C - STATUTORY REMIT OF THE FCFCOA

Constitutional basis for the FCFCOA's jurisdiction

30. The judicial power of the Commonwealth is vested in, relevantly, the High Court of Australia and other federal courts as are created by the Parliament.[9]
31. The jurisdiction to be exercised by a federal court, including the FCFCOA, must be conferred and defined by federal legislation.[10]
32. It is settled doctrine that Parliament may not confer jurisdiction on a federal court except in relation to a "matter".[11] A "matter" is a justiciable controversy.[12] This requires "some concrete, or real-world, application of rights, duties or liabilities about which opposing parties disagree".[13]
33. There are some non-controversial matters that may appropriately be dealt with by a federal court.[14] A federal court has power that is "expressly or impliedly conferred by the legislation governing the court and 'such powers as are incidental and necessary to the exercise of the jurisdiction or the powers so conferred'".[15]

The Establishment of the FCFCOA

34. The FCFCOA was established by the FCFCOA Act.
35. Under the FCFCOA Act, two separate courts, the FCFCOA (Division 1) and the FCFCOA (Division 2), exist with a complementary and efficient administrative structure.
36. The FCFCOA (Division 1), a specialist family law court, is a continuation of the Family Court of Australia and is a superior court of record and a court of law and equity established by Parliament in 1975 under Chapter III of the Constitution. It hears the most complex family law trials and appeals.
37. The jurisdiction of FCFCOA (Division 1) is set out in s 25(1) of the FCFCOA Act. The section provides, in substance, that FCFCOA (Division 1) judges can deal with:
    a. family law or child support proceedings transferred to the FCFCOA (Division 1) under s 51 or s 149; and
    b. matters as conferred by any other act.
38. The FCFCOA (Division 2) (a continuation of the Federal Circuit Court of Australia) deals with family law, migration and general federal law matters. It is a court of record, and a court of law and equity.[16] It is 'the only inferior court at

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9 *Australian Constitution* s 71.
10 *Australian Constitution* ss 75, 76 and 77.
11 See *In re Judiciary and Navigation Acts* (1921) 29 CLR 257 at 264–267 (*the Boilermakers' case*).
12 Re *Wakim; Ex parte McNally (1999) 198 CLR 511* at 585–586. See also *Scott v Handley* (1997) 79 FCR 236 at 239.
13 *AZC20 v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs* (2023) 278 CLR 512 at [72] (Edelman J).
14 *Re Hedge, as Administrator of Goldfields Medical Fund Inc (No 2)* (2002) 196 ALR 557 at [41]-[46].

[15] *Minister for Immigration and Multicultural Affairs v MZAPC* (2025) 99 ALJR 486 at [58] and the cases cited therein.

[16] FCFCOA Act, ss 8, 10.

federal level.'[17] The FCFCOA (Division 2) operates under the leadership of the Chief Judge and two Deputy Chief Judges – a Deputy Chief Judge for family law, and a Deputy Chief Judge for general and fair work which includes all general federal law and migration.[18] It is constituted by judges who are assigned to Division 2.[19]

39. The jurisdiction of the FCFCOA (Division 2) is set out in ss 131, 132 and 133 of the FCFCOA Act. This includes original jurisdiction:
    a. conferred by federal laws or legislative instruments including appeals from non-court bodies (s 131);
    b. in relation to family law and child support matters, including matters in respect of which proceedings may be instituted under the FLA (s 132); and
    c. in relation to Commonwealth tenancy disputes (s 133).
40. Relevant to this Information Paper, the FLA confers jurisdiction on the FCFCOA to deal with a range of matters including parenting orders, property settlements, divorce, and child support.
41. In the exercise of that jurisdiction the FCFCOA has no ability to deal with issues that:
    a. do not involve a justiciable controversy;
    b. are not an exercise of judicial power, or an incident, or derivative, of the exercise of judicial power;[20]
    c. require investigative or supervisory functions not authorised by statute; or
    d. fall within the remit of other agencies (e.g. child protection, law enforcement, or health services).
42. Further, the Parliament cannot confer jurisdiction in relation to any of the above actions as they do not form part of the judicial power of the Commonwealth or are not incidental to the exercise of that power.
43. In addition to the passage of the FCFCOA Act, the FCFCOA has implemented significant internal reforms to family law case management practice and procedure including, where appropriate, harmonising processes across both courts. The focus is on innovation and fair and efficient processes that centre on risk, responsiveness and resolution.
44. The FCFCOA prioritises minimising risk and harm to children and vulnerable parties. Further, parties are given ongoing opportunities for dispute resolution where it is safe to do so. For those cases that do need to proceed to contested litigation, the FCFCOA provides a modern, transparent and efficient system of justice which is aimed at getting parties through the process as safely, quickly and fairly as possible without undue delay.
45. In the general federal law and migration jurisdictions, the FCFCOA (Division 2) ensure that justice is delivered effectively and efficiently through the enhanced use of technology and centralised case management processes. Migration is the biggest area of the FCFCOA (Division 2) workload after family law.

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17 Second Reading Speech, *Federal Courts Legislation Amendment (Judicial Immunity) Bill 2023*, Hansard, House of Representatives, 15 November 2023, p 8166.

18 FCFCOA Act, s 10(2).

19 FCFCOA Act, ss 10(1)(a), (2); s 111(1); 112.

20 *Queen Victoria Memorial Hospital v Thornton* (1953) 87 CLR 144, 151; *R v Davidson* (1954) 90 CLR 353, 369-370.

46. **Attachment 6** summarises the objects and principles of the FLA (current version) particularly in relation to children under s 60B.
47. **Attachment 7** is a comparison table of key provisions of the FLA provisions in relation to the framework for making parenting orders before and after the 2024 Amendments; noting that the Relevant Family Law Proceedings were conducted before the 2024 Amendments.

Part VII – Children

48. Part VII of the FLA gives the FCFCOA the power to make orders for the care and welfare of children in Australia (except in Western Australia) and sets out the considerations guiding the FCFCOA's decision-making in matters involving children. Section 60B provides that the objects of Part VII are 'to ensure the best interests of the children are met, including by ensuring their safety'.
49. Under s 60CA, the FCFCOA is required to regard the best interests of the child as the paramount consideration when making a parenting order. Section 60CC outlines how the FCFCOA determines what is in a child's best interests. As at 9 March 2022, s 60CC(2)(b) identified one of the mandatory primary considerations as 'the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence.'[21]
50. At the time of the Relevant Family Law Proceedings, the legislation did not explicitly require the FCFCOA to consider the impact of parenting arrangements on the health of a parent or carer. However, amendments introduced by the 2024 Amendments (which were not in force at the relevant time) require the FCFCOA to consider such impacts under s 60CC(2)(a)(ii).

Allegations of Child Abuse and Family Violence

51. Under s 67ZBB of the FLA, the FCFCOA is required to take prompt action in relation to allegations of child abuse or family violence by considering:
    a. what interim or procedural orders (if any) should be made:
        i. to enable appropriate evidence about the allegation to be obtained as expeditiously as possible; and
        ii. to protect the child or any of the parties to the proceedings; and
    b. make such orders of that kind as the court considers appropriate; and
    c. deal with the issues raised by the allegation as expeditiously as possible.
52. In doing so, the FCFCOA must also consider whether to make orders under ss 67ZBD or 67ZBE to obtain information from relevant agencies, and whether

to make orders or grant injunctions under s 68B to ensure the safety of the child or parties.

[21] Subsection 60CC(2) was amended by the 2024 Amendment with effect from 6 May 2024.

Confidentiality Provisions in the FLA (Part IIA)

53. Part IIA of the FLA prevents the disclosure and admission into evidence of information that is in connection with a family safety risk screening process carried out by the FCFCOA in relation to a party to proceedings under the FLA.[22]
54. A family safety risk screening process is carried out by a ‘family safety risk screening person’, being an officer or staff member of the FCFCOA, a family counsellor, a contractor engaged on behalf of the FCFCOA, or an officer, employee or subcontractor of the contractor.[23] Risk screening is discussed in paragraph [72] below.
55. A screening person has, in performing that person’s functions, the same protection and immunity as a Judge of the FCFCOA (Division 1) has in performing the functions of a Judge.[24]
56. Subject to certain exceptions[25], a screening person must not disclose information obtained in connection with a family safety risk screening process or about whether a party participated in the screening process.[26]
57. However, a screening person must disclose such information if the person reasonably believes the disclosure is necessary for the purpose of complying with a Commonwealth, State or Territory law: s 10U(2). Further, a screening person may disclose such information in circumstances including:
    a. where the screening person reasonably believes that the disclosure is necessary for certain purposes that are generally concerned with preventing or lessening risk of harm or threat to the life, health or property of a person (s 10U(6)); or
    b. in order to provide non-personal information for research relevant to families (s 10U(7)).
58. Such information, or things said in the presence of a professional to whom the party was referred, is generally not admissible in any court or proceedings before a person authorised to hear evidence: ss 10V(1) and (3). However, where it is indicated that a child under 18 has been abused or is at risk of abuse, and there is insufficient evidence available from other sources, the information or thing said may be admissible: ss 10V(2) and (4).

Non-publication provisions within the FLA (Part XIVB)

59. The policy of 'open justice' is reflected in s 97 of the FLA. However, the special nature of family law proceedings, which often involve children, requires that a balance be struck between the need for open justice and a family’s right to privacy.
60. Part XIVB of the FLA is titled ‘Restrictions on Communications of Accounts and Lists of Proceedings’. Part XIVB was introduced by the 2024 Amendments. In simplified terms, under Part XIVB:[27]

22 FLA, s 10Q.
23 FLA, ss 10R and 10T.
24 FLA, s 10W.
25 Exceptions to disclosure are contained in s 10U(6) FLA.
26 FLA, ss 10U(1), 10S
27 FLA, s 114N (‘Simplified Outline’).

a. It is an offence to communicate to the public an account of proceedings under the FLA, if the account identifies certain people involved in the proceedings.
b. It is an offence to communicate to the public a list of proceedings that are to be dealt with under the FLA, and that are identified by reference to the names of the parties to those proceedings.
c. A communication is not made to the public if the communication is made to a person with a significant and legitimate interest in the subject matter of the communication and that interest is greater than the interest of members of the public generally.

61. Sections 114Q and 114R of the FLA create indictable offences when a person communicates information that identifies persons or witnesses involved in family law proceedings unless:
    a. otherwise directed by a court (as defined in s 4 of the FLA) under s 114Q(2)(a); or
    b. otherwise approved by a 'court' under s 114Q(2)(b).
62. Section 114S provides for when a communication is not a 'communication to the public' (and so not captured by ss 114Q and 114R of the FLA).

SECTION D - THE CONTEXT IN WHICH THE FCFCOA EXERCISES ITS STATUTORY REMIT

63. In 2024-25, there were 101,693 first instance family law applications filed across both Division 1 and 2 of the FCFCOA, representing a 4% increase in total filings compared to 2023-24.[28] In Division 1, there were 2,555 family law filings[29] and in Division 2, there were 99,138 family law filings.[30]
64. A major complexity of the family law jurisdiction is responding to the types of risk discussed in this and the next paragraph. In 2024-25, 82% of parenting matters were referred on a mandatory basis to the relevant child welfare agency because of allegations that:
    a. a child to whom the proceedings relate has been abused or is at risk of abuse; or
    b. there has been family violence, or there is a risk of family violence, that amounts to abuse of a child.[31]
65. In 2024-25, the risk factors listed below were alleged by one or more parties to a parenting and property matter:[32]
    a. matters alleging a child has been abused or was at risk of child abuse: 77%;
    b. matters alleging a party has experienced family violence: 86%;

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[28] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 11 (scheduled for publication on 17 October 2025).
[29] Federal Circuit and Family Court of Australia Annual Reports 2024-25, table 3.3.1(a) (scheduled for publication on 17 October 2025).
[30] Federal Circuit and Family Court of Australia Annual Reports 2024-25, table 4.3.1(a) (scheduled for publication on 17 October 2025).
[31] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 32 (scheduled for publication on 17 October 2025).
[32] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 34 table 2.5(a) (scheduled for publication on 17 October 2025).

c. matters alleging a child has experienced family violence: 81%;
d. matters alleging drug, alcohol or substance misuse by a party had caused harm to a child or poses a risk of harm to a child: 56%;
e. matters alleging mental health issues of a party have caused harm to a child or pose a risk of harm to a child: 63%;
f. matters alleging a child is at risk of being abducted: 48%; and
g. matters alleging recent threats made to harm a child or other person relevant to the proceedings: 23%

66. 73% of matters involved allegations by either party of four or more risk factors.[33]
67. The allegations of risk factors increased from 2023-24 and indicate a growing level of risk in the FCFCOA's caseload. This confirms the complexity of FCFCOA matters and the necessity for the FCFCOAs' tailored case management approaches and strong focus on responding to risk.[34]

SECTION E - RISK ASSESSMENT & SAFETY PLANNING IN FAMILY LAW PROCEEDINGS (conducted outside the exercise of a judicial officer's powers)[35]

Allegations of Child Abuse and Family Violence

68. The Notice of child abuse, family violence or risk is a mandatory form for any person who files an Initiating Application, Application for Consent

Orders or Response in the FCFCOA seeking parenting orders. This notice enables the FCFCOA to assess potential safety concerns and risks to the child or parties. Under s 67Z of the FLA, where an 'interested person' (i.e. party to the proceedings, an independent children's lawyer, or any other person prescribed by the regulations) alleges that a child has been abused or is at risk of abuse and has filed a Notice of risk notifying this, the Registry Manager must notify a prescribed child welfare authority as soon as practicable.

69. Under s 67ZA, individuals involved in family law proceedings – including registrars, family consultants, family counsellors, Court Children Services' practitioners, family dispute resolution practitioners, arbitrators, and independent children's lawyers and family report writers – are subject to discretionary reporting obligations. If such a person, in the course of their duties, has reasonable grounds to suspect that a child has been abused or is at risk of abuse, they must notify a prescribed child welfare authority as soon as practicable and provide the basis for their suspicion.

The Lighthouse Programme

70. Lighthouse plays a central role in the FCFCOA's response to cases which may involve risk relating to family violence, mental health, drug and alcohol misuse and child abuse and neglect, by shaping the allocation of resources and urgency given to such cases. By providing tailored support, service referrals, a

[33] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 35 (table 2.5(b)) (scheduled for publication on 17 October 2025).

[34] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 34 (scheduled for publication on 17 October 2025).

[35] In parenting proceedings, the statutory tests require judicial officers to assess the facts to determine what is in the best interests of the child – the central risk assessment process in a family law matter.

specialist Court List known as the Evatt List (see paragraph [75]) and identification of the most appropriate case management pathway, Lighthouse aims to screen and manage risk with a primary focus on improving outcomes for families as they navigate the family law system.

71. Importantly, Lighthouse is not the only method for assessing and managing risk at the FCFCOA, and so risk assessment does not 'stop', or fail to be contemplated, if a party chooses not to complete a Lighthouse risk screen. Lighthouse allows for early identification of risks but is not the sole point of risk assessment. Judicial officers and registrars continue to assess and respond to emerging risks throughout the life of a matter. For example, judicial officers engage in ongoing risk assessment in response to information received through urgent applications, information provided by state and territory police and child protection agencies (under ss 67ZBD and 67ZBE of the FLA),[36] and reports prepared by family consultants.[37] This continuous approach ensures that the FCFCOA remains responsive to evolving circumstances and maintains a protective focus on children and vulnerable parties.

72. Lighthouse involves:
    a. ***Risk screening via the Family DOORS Triage questionnaire*** – Early risk screening through a secure online platform (sometimes referred to as "Family DOORS Triage") – parties are invited, not required, to participate and this is a first step in identifying risk issues. All information in connection to the risk screening process is confidential[38], protected and unable to be disclosed or used in court under Part IIA of the FLA.
    b. The confidentiality provisions mean that:
        i. parties can freely and confidently participate in the family safety risk screening process, without fear that the information they provide may be used against them in other contexts;
        ii. parties cannot be asked to disclose whether they undertook risk screening;
        iii. the risk screen answers, classification and referrals made because of the screening process cannot be used as evidence in a proceeding; and
        iv. information shared or provided by a party to a Triage Counsellor (acting in the role of family counsellor) in the course of conducting risk screening cannot be disclosed or used as evidence.
    c. ***Triage and assessment of cases*** – This is conducted by a specialised team consisting of Lighthouse Support Officers and Triage Counsellors (acting in the role of Family Counsellor) who direct cases into the most appropriate case management pathway based on the level of risk. They also identify parties who may require additional support and safety measures. This may include online referrals or interviews with those most at risk, provide support and refer the party to appropriate services, and

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36 Discussed further at paragraphs [129] to [135] below.
37 Discussed at Attachment 5 below.
38 Exceptions to disclosure are contained in s 10U(6) FLA.

make recommendations on the most appropriate case management pathway based on the level of risk.

d. ***Case Management and the Evatt List*** – Those matters with the highest levels of risk will be referred to be placed on the Evatt List. An Evatt Judicial Registrar will review the referral and determine whether it is appropriate for the Evatt List (discussed at paragraph [75] onwards).

e. ***More about the Family DOORS Triage*** – Family DOORS Triage is a risk screening tool developed for use in the FCFCOA, based on the DOORS framework established by Professor Jennifer McIntosh and Dr Claire Ralfs[39] in 2012.The screening tool asks a series of questions to identify multiple risk factors in a short amount of time. All of the questions seek a yes or no answer and do not require any specific detail or examples. The questionnaire takes approximately 15 minutes to complete. As noted above, the answers are confidential and inadmissible in proceedings. Sections 10Q-10W of the FLA protect the confidentiality and inadmissibility of the screen. Please see: Lighthouse information sheet for parties - risk screening | Federal Circuit and Family Court of Australia for further information. Importantly, in November 2023 changes were implemented to the FCFCOA's first version of the Family DOORS Triage risk screen and these have been closely monitored and analysed with positive observations into 2024. The changes include:
    i. amendments to the questions to better capture coercive control through expanding the types of questions asked about family violence to better identify concerning behaviours;
    ii. amendments to the questions to better capture risks to children, expanding the questions to ask about specific risk types (physical, sexual, emotional/psychological safety), identifying whether the current parenting arrangements are working and asking about areas of increased vulnerability and risk, such as serious health or developmental problems; and
    iii. the introduction of a new non-parent Family DOORS Triage risk screen for non -parent parties such as grandparents, aunts, uncles or kinship carers.

f. ***Research paper on the Family DOORS Triage –*** In 2021 Professor McIntosh approached the FCFOCA to become a partner organisation for an Australian Research Council Linkage Grant application to conduct research on the validity of Family DOORS Triage as a risk screening tool, long-term benefits of early risk screening of litigants within the family law system and on children's development, and the cost benefits to services and society. The application was successful and since 2022 the FCFCOA has been the partner organisation for the research project Family Violence Triage in Family Courts: Safety, Efficacy and Benefit. A paper stemming from the research project was published in the Journal of interpersonal

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39 See familydoors.com/about-us/ for more about Professor McIntosh and Dr Claire Ralfs. A full copy of the original FamilyDoors risk screen (c.f the FamilyDOORSTriage) is available at this website familydoors.com/about-us/

violence in August 2025. The paper "*Family Violence Risk on Entry to the Family Courts of Australia: Profiles and Predictive Validity of the DOORS Triage Process*" found that self-reported risk was consistent with subsequent independent assessment for 87% of parties who completed the Family DOORS Triage Risk Screen. In this light, the Family DOORS Triage Tool demonstrated utility and validity across the FCFCOAs' population in differentiating high-risk cases from low-risk cases. In all, findings suggest the Family DOORS Triage Tool is a reliable and useful initial screen for high risk in the FCFCOA. The findings show there are critical links between ancillary risks for families, which can be reliably self-reported and which may enhance rapid targeting of support to families on entry to court. A copy of this paper is available here: https://pubmed.ncbi.nlm.nih.gov/40844847/

73. The Lighthouse Pilot commenced in Brisbane on 11 January 2021. The Relevant Family Law Proceedings were initiated on 29 July 2021.
74. The Lighthouse Pilot was expanded in 2022 from a pilot to a core component of the FCFCOA's case management pathway for parenting and parenting/property matters and covers all registries other than Dubbo, Lismore and Albury (**Lighthouse Expansion**).

Evatt List

75. The Evatt List is the FCFCOA's specialist list developed and designed to assist those families that have been identified as being at high risk of family violence and other safety concerns. The Evatt List focuses on active information gathering and intervention from the commencement of proceedings.
76. Lower risk cases will be considered for a range of case management pathways, including dispute resolution, in accordance with the level of risk and the Central Practice Direction – Family Law Case Management - see Central Practice Direction: Family Law Case Management | Federal Circuit and Family Court of Australia.
77. Dedicated Judges, Senior Judicial Registrars, Judicial Registrars, Court Child Experts and Court staff assist with the intensive case management of high-risk cases in the Evatt List.
78. The Evatt List aims to provide support, resources and safeguards against high risk factors present in family law matters, for example:
    a. serious abuse or risk of serious abuse of a child of the proceedings whether it be physical, psychological or neglect;
    b. serious family violence or risk of serious family violence by a party to the proceedings, whether this is physical, emotional/psychological or financial;
    c. exposure or risk of exposure to serious family violence by a party or a child;
    d. serious drug, alcohol or substance misuse which has caused harm or poses a serious risk of harm to a child or party;
    e. a party's mental health issues which has caused harm or poses a serious risk of harm to themselves or others, including a child;
    f. a party who poses a potential risk of self-harm;
    g. recent threats or attempts to abduct a child; or

h. recent threats to harm a child or another person relevant to the proceedings, such as a new partner.[40].

79. Importantly, matters are included in the Evatt List if:
    a. the matter is for either parenting orders only or parenting and financial orders;
    b. a party/parties are eligible for and have competed the Family DOORS Triage Risk screening and returned a 'high risk' screening classification; and
    c. the party has had a case file review by a Triage Counsellor to confirm the high-risk classification.

80. The focus of the Evatt List on close and careful case management and early information gathering from the moment the matter is placed on the Evatt List has continued since Lighthouse Expansion. This ensures the FCFCOA is informed about the prevalence and types of risk to assist with the making of safe and appropriate orders which cater to the needs and circumstance of each individual family.

81. Since Lighthouse Expansion, 2,373 Evatt matters have been finalised.[41] Of the Evatt matters that have finalised, 56 per cent finalised within 12 months of filing, and only 18 per cent proceeded to final hearing before a Judge. Positive feedback has been received by the FCFCOA in relation to the expansion and management of matters on the Evatt List.

82. Importantly, matters not allocated to the Evatt List nonetheless receive equivalent levels of resourcing and case management where risk indicators are present – for example, priority hearing dates, multiple interim hearings, orders for expedition and preparation of psychiatric assessments or interim reports, and leave to issue subpoenas to external agencies. Judicial officers determine the appropriate level of case management based on the issues raised, not the formal designation of the matter.

Family Violence Plan – see Family Violence Plan | Federal Circuit and Family Court of Australia

83. In summary:
    a. The FCFCOA's vision under the Family Violence Plan (**Plan**) is to be responsive to allegations of family violence, to effectively address family violence in all matters coming before the FCFCOA, to enhance the safety of children and their families, and to provide a safe environment for all court users, judges and staff. The Plan is updated on a four yearly cycle. The current plan covers 2023-2026.
    b. The Family Violence Committee of the FCFCOA (a judicial committee established by the Chief Justice) oversees compliance with the Plan.
    c. The Family Violence Committee's principal responsibility is to provide advice to the Chief Justice, the Chief Judge and the CEO and Principal Registrar on the issue of family violence. In discharging this responsibility,

[40] See Family Law Practice Direction: Evatt list at [2.4], https://www.fcfcoa.gov.au/fl/pd/fam-evatt

[41] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 45 (scheduled for publication on 17 October 2025).

the Committee reviews and updates the FCFCOA's Family Violence Plan and Family Violence Best Practice Principles, as well as undertaking discrete projects.

d. The Plan is an overarching document that contains goals and actions for the operation and administration of the FCFCOA in order to protect and support those experiencing, or at risk of, family violence and to ensure all court users are safe. The Plan's actions are specific and targeted across three areas of focus: A) protection from violence B) safety at court and C) information and communication.
e. Measures include:
    i. regular review of the Family Violence Best Practice Principles (see below), which provide guidance to judges, registrars, lawyers and litigants about the conduct of matters in which family violence or child abuse is alleged;
    ii. regular review of the operational and administrative processes and the case management pathway of the FCFCOA in relation to family violence;
    iii. ongoing training and development for decision makers and staff to enhance awareness and capability in addressing family violence issues; and
    iv. improved communication of the FCFCOA's responses to family violence.

84. For more detail: **Attachment 8** is a table that sets out the Plan's three areas of focus against their corresponding goals and required actions.

Family Violence Best Practice Principles (Principles)

85. The current edition is at Family Violence Best Practice Principles | Federal Circuit and Family Court of Australia. The first edition was published in March 2009.
86. The Principles set out seven overarching principles, and detail about how each principle is given effect by the FCFCOA, as well as the expectations for court users, legal practitioners and litigants. The overarching principles are as follows:
    a. Family violence is not acceptable.
    b. Safety is a right and a priority for all court users.
    c. Parenting matters involving family violence will be identified early and appropriately managed.
    d. All professionals working in or appearing before the FCFCOA are expected to undertake ongoing training and professional development to ensure that they have a sound and contemporary knowledge of family violence.
    e. Litigants must have access to specialist and support services, and clear information to assist their full participation in all court processes.
    f. The FCFCOA must have access to information relevant to safety and risks.
    g. All litigants have an equal right to access justice, and those experiencing family violence are not to be disadvantaged in the court system.

Critical Incident List

87. The Critical Incident List is for family law applications where no parent is available to care for a child due to death (including homicide), critical injury, or incarceration arising from family violence, and orders are sought for parental responsibility to enable appropriate arrangements to be made.

Magellan List

88. The Magellan List is a specialised case management pathway in the FCFCOA (Division 1), designed for complex and high-risk parenting matters involving serious allegations of child abuse. It ensures these cases are managed efficiently by a dedicated team of Judges, Registrars, and Court Child Experts.

CCS

89. The role of CCS is described at **Attachment 5.**

Triage Counsellors

90. In the context of Lighthouse, Triage Counsellors assist parties in family law matters by conducting confidential risk assessments to identify appropriate support services, safety planning and case management. This assistance targets families who are at high risk because of family violence, mental health, drug and alcohol misuse, and child abuse and neglect. See paragraph [72.c] for discussion of Triage Counsellor involvement with the Lighthouse. Triage Counsellors must hold:
    a. a recognised degree in a relevant social science area (e.g. social work, psychology, counselling, human services);
    b. a minimum three (3) years relevant clinical experience working with children and families, such as in child protection, family support, family and domestic violence; and
    c. a clearance for working with children as required within the relevant State/Territory scheme.
91. Triage Counsellors assist with the risk screening, risk assessment and triage functions within Lighthouse. Importantly, for the 61% of parties returning a high-risk classification, Triage Counsellors firstly conduct a Case File Review and then, if considered appropriate, a Triage Interview is offered. The Triage Interview involves a 30-to-45-minute interview with a Triage Counsellor who conducts a further risk assessment with the party.[42]
92. Triage Counsellors undertake more than 6,000 file reviews and more than 3,000 interviews per annum and play an integral role in supporting parties and children at increased risk and working with them to strengthen their support networks as well as find ways to improve safety around family violence and family safety risks. Data reveals that Triage Counsellors are providing information on more than 18 different categories of support services with the most common referrals being to:[43]

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[42] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 45 (scheduled for publication on 17 October 2025).

[43] Federal Circuit and Family Court of Australia Annual Reports 2024-25, page 45 (scheduled for publication on 17 October 2025).

   a. Family Advocacy and Support Services (**FASS**), which is an integrated duty lawyer and social work service for those affected by family violence, delivered by the Legal Aid Commissions (discussed further below);
   b. other domestic and family violence services; and
   c. post-separation and parenting courses and services.

Safety Planning for Family Law Proceedings (i.e. Safety at Court)

93. Please see Safety at court | Federal Circuit and Family Court of Australia
94. Safety planning involves developing a plan setting out specific safety measures if any litigant is concerned about their safety when attending the premises of the FCFCOA. This is to support the safety and wellbeing of court users.
95. Safety plans can be requested by a variety of stakeholders, for example:
   a. parties or their representatives can request a safety plan if they have any fears about attending a court event;
   b. third parties or external agencies such as a domestic violence agency may request a safety plan; or
   c. FCFCOA staff may request a safety plan where safety concerns have been identified; and
   d. FCFCOA staff may contact parties to offer a safety plan based on the Notice of child abuse, family violence or risk that must be filed with any Initiating Application, Response to Initiating Application or Application for Consent Orders.
96. Safety measures include:
   a. Support person to attend – Parties may have a friend or support person attend a court conference or other court appointment with them.
   b. Staggered arrival and departure times.
   c. Alternate waiting areas.
   d. Secure / Safe Rooms - Many court locations offer access to safe rooms i.e. private, secure spaces where vulnerable parties can wait before and after their court appearance (or appear remotely from). These rooms are typically located away from public areas and are monitored by security staff.
   e. Security accompaniment - The FCFCOA can arrange for security escorts to accompany parties to and from the courtroom or building, further reducing the risk of confrontation or harassment arising in the use of the FCFCOA's premises.
   f. Electronic attendance - Parties may be permitted to attend court remotely via telephone or video link. This mechanism is particularly valuable for individuals who may be at risk of harm or intimidation if required to attend in person.
97. The FCFCOA is currently trialling a Proactive Safety at Court Pilot program, which aims to proactively identify and engage with parties affected by family violence to reduce reliance on court users to initiate safety arrangements associated with the use of the FCFCOA's premises, and ensure court users have access to legal and social support as early as possible in their engagement with the family courts. This initiative involves early engagement with parties to assess potential risks and implement tailored safety measures,

such as FASS referral, staggered arrival times, separate waiting areas, use of secure rooms, security escorts, support person attendance, virtual attendance, or attendance by audio only.

SECTION F: HOW THE FCFCOA CONSIDERS AND MANAGES THREATS (Context 3)

98. This section deals with risks (including threats) that are notified to the FCFCOA or identified by judicial officers or non-judicial staff or other persons, however the FCFCOA does not have any power to take action in relation to the risks, other than to notify those who do have power (e.g. law enforcement).
99. The FCFCOA has a three-level system to assess and respond to threats notified through its Security Incident Report (**SIR**) system. SIRS are submitted by FCFCOA judges and staff (including judicial registrars) to the Marshal[44]. The SIR form is used to report security related incidents that come to the attention of judges and staff of the FCFCOA, including, but not limited to:
    a. threats to self-harm;
    b. threats to harm parties to a matter, including witnesses;
    c. threats to harm judges, staff (including judicial registrars), and members of the public (including the legal profession);
    d. disruption to proceedings or disorderly conduct;
    e. damage to Commonwealth property; or
    f. the death of a party, witness or in the case of family law matters, a child involved in a matter.
100. This system has a process for each level:
    a. **Level A: Work Health and Safety Compliance** - manage safety in accordance with the *Work Health and Safety Act 2011* (Cth) (physical and psychosocial risks). Under this process, the SIR is assessed by the Marshal who assesses credibility and determines immediate action, including referral to police, or other agencies that have power to deal with risk.
    b. **Level B: Judicial Considerations** - determine if knowledge of the threat or the risk is relevant to the exercise of judicial powers (e.g. conduct of proceedings or judicial decision-making) and direct accordingly.
    c. **Level C: Court Children's Service Considerations** - determine if knowledge of the threat or the risk is relevant to the performance of family consultant functions (e.g. family reports) and direct accordingly.

SECTION G: SPECIALIST ROLES and TRAINING

Director of Family Violence

101. The Director – Family Violence & Director - Access, Equity and Inclusion plays a strategic leadership role in enhancing the FCFCOA's ability to respond to family violence within the limits of its jurisdiction, and improving access to justice for priority population groups such as Aboriginal and Torres Strait Islander people,

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[44] The Marshal is responsible for the security of the FCFCOA and the personal security of Judges, officers and staff: FCFCOA Act ss 104(2) and 262(2).

culturally and linguistically diverse communities, people from migrant and refugee backgrounds, people with disability, women, children and young people, people from the LGBTIQA+ community, and people in regional, rural and remote geographical locations. The role was created in 2023 and the incumbent has been in place since July 2023.

102. The Director provides policy and strategic advice and support, leads consultation and design initiatives, and delivers trauma-informed, culturally responsive training to judicial officers and staff – training, projects and systems introduced include:

a. Establishment of a Cross-Agency Working Group on Safety and Accessibility. The Working Group's focus areas for improvement and innovation, include:
    i. Improved forms, workflows, and data collection to identify safety and accessibility needs, and appropriate adjustments for individuals with disabilities, neurodiversity, or limited English proficiency.
    ii. Enhanced proactive referral processes to connect parties with essential legal and social support services such as the Family Advocacy Support Service and our internal Indigenous Family Liaison Officers.
    iii. Strengthened evidence-based risk screening and response mechanisms to address the physical and psychological safety concerns of court users dynamically.
    iv. Enhancements to safe rooms and court facilities, as part of the FCFCOA's property improvement plan.
    v. Improvements to website, resources, and communications to ensure these are accessible, trauma informed, and family violence informed.
    vi. Assessment of procedures and practices to ensure they are trauma-informed, family-violence informed and promote accessibility.
    vii. Strengthened consultation and feedback mechanisms from court user groups to inform continuous improvement.
    viii. Updated digital systems to ensure inclusive, trauma-informed, family violence informed data collection and better evaluate initiatives aimed at improving responses to family violence.

b. Improved Safety at Court Reports:
    i. Safety at Court Reports have been developed to improve the FCFCOA's ability to identify, manage, and monitor safety concerns for parties attending court. The report provides data on all upcoming court events within the next two weeks where one or more of the following risk indicators are present:
        1. A party has advised they have safety concerns.
        2. The matter is an Evatt List matter.
        3. A family violence order is attached to the matter.
        4. A security flag exists on the court file.

5. A previous Safety at Court Plan has been recorded for the matter.

c. Proactive Safety at Court Pilot program – see paragraph [97] above.
d. Safety Room Improvement Project: safe room improvement in relation to:
    i. Security: Pin/swipe locks, frosted glass for privacy, pin holes for visibility, duress alarms, and external CCTV coverage.
    ii. Accessibility: Safe room access for both in-court and CCS events.
    iii. Functionality: Power outlets, data points for remote witness connections, and drinking water dispensers.
    iv. Wellbeing: Warmer, more inviting furnishings, quality prints of the Reconciliation Action Plan artwork, hot water made available for cups of tea and coffee, information on available about Family Advocacy and Support Services and Indigenous Family Liaison Officer support services.

103. The Director also provides strategic support to programs such as the Indigenous Family Liaison and Cultural Liaison Programs, and engages with internal and external stakeholders (including government agencies, the legal profession, and community organisations) on key issues relating to:
    a. Aboriginal and Torres Strait Islander peoples and communities;
    b. migrant, refugee and culturally and racially marginalised peoples and communities;
    c. people with limited English and legal literacy;
    d. people with disability or neurodiversity;
    e. victim-survivors of family or sexual violence;
    f. children and young people;
    g. people experiencing socioeconomic disadvantage;
    h. people from the LGBTIQA+ community; and
    i. people from regional, rural and remote areas.

Training and Education (Family and Relationship Violence)

104. The FCFCOA has implemented a comprehensive and evolving training and education framework that reflects its commitment to trauma-informed practice, expertise in family violence, cultural responsiveness, and inclusive service delivery. This framework encompasses judges, registrars, Court Child Experts, Triage Counsellors, Indigenous Family Liaison Officers, and other staff. This is consistent with the FCFCOA's commitment to ongoing family violence training as part of the Plan.

105. The FCFCOA has invested substantial time and effort to ensure that the training undertaken by judges and staff, and court procedures and processes, represent best practice in identifying and appropriately responding to risk, including family violence and child abuse.

106. Training related to family violence is delivered regularly and in a range of modalities across the FCFCOA including during intensive induction programs, plenaries, regular Continuing Legal Education sessions, interactive sessions in-person or by livestream, pre-recorded sessions, small group sessions with an expert facilitator, and online learning modules.

107. Due to the high prevalence of allegations of family violence experienced by litigants who attend the FCFCOA, family violence is also often covered in the wider context of other training topics, such as training around case management and dispute resolution.
108. Safe & Together Training - Since 2021, the FCFCOA has maintained a strong educational partnership with David Mandel and the Safe & Together Institute. This collaboration has led to the adoption of a whole-of-system, perpetrator pattern-based approach to family violence. The Safe & Together Institute, in consultation with senior management of the FCFCOA, has also developed individually tailored training streams for judges, registrars and social scientists at the FCFCOA.
109. Internal Family Violence Modules - The FCFCOA has developed internal family violence training modules that are mandatory for all frontline staff, including registrars, Court Child Experts, Triage Counsellors, Indigenous Family Liaison Officers, Associates, Legal Case Managers, and Child and Family Services staff. These modules were significantly updated in 2024-25 and have now been extended to include judges. The development and enhancement of this training was led by the Executive Director – CCS and the Director – Family Violence / Director – Access, Equity and Inclusion.
110. Training on Sexual Violence and its intersection with Family Violence - In 2024–25, the FCFCOA collaborated with Griffith University, ANROWS, and leading experts to develop comprehensive training modules addressing sexual violence. These modules cover adult and child victimisation, coercive control, disclosure and reporting, impacts on litigation, and risk mitigation in family law cases. The training also addresses family perpetrators of child sexual exploitation material and the effects of sexual abuse on both adults and children. These modules will be delivered to all judges, registrars, and staff in late 2025.
111. Training on Collusion and Perpetrator Engagement - The FCFCOA has provided training on recognising and resisting collusion with people who use family violence. This training was delivered by No to Violence to registrars, Court Child Experts, and staff. Judicial training on this topic is scheduled for late 2025.
112. Judicial Workshops on Family Violence - In partnership with the National Judicial College of Australia, the FCFCOA has delivered full-day, in-person workshops on family violence to judges as part of the 2025 Judicial Plenary. These workshops build on a pilot program conducted in late 2024 involving 25 judges and 7 senior judicial registrars. The sessions cover the use of the National Domestic and Family Violence Bench Book, understanding coercive control and strangulation, applying the Safe & Together model, and using respectful language and judicial courtroom craft skills (i.e. the method by which judicial officers manage and maintain the courtroom) to prevent systems abuse.
113. Trauma-Informed Practice and Vicarious Trauma Training - Training in trauma-informed practice and vicarious trauma awareness, mitigation and management has been delivered to all staff and judges through online modules, interactive workshops, and leadership sessions.
114. Future Areas of Training and Development - The FCFCOA is currently exploring additional areas for professional development, including:
    a. risk factors associated with domestic homicide, infanticide, and filicide;

b. the prevalence and impact of child maltreatment and recovery pathways;
c. the intersection of family violence with mental health issues and substance misuse;
d. economic and financial abuse and its impact on victim-survivor economic security;
e. evidence on the effectiveness of men's behaviour change programs;
f. child and adolescent use of violence; and
g. consolidation and leadership workshops focused on working with First Nations families, neurodiverse individuals, and the LGBTIQA+ community.

115. For court users and practitioners
   a. Family violence: Overview | Federal Circuit and Family Court of Australia
   b. Family Violence Orders (made by State and Territory Tribunals) https://www.fcfcoa.gov.au/fl/fv/orders
   c. Family violence and children and child protection laws - Family violence and children | Federal Circuit and Family Court of Australia (i.e. relevant state and territory laws)
   d. The impact of family violence on children | Federal Circuit and Family Court of Australia

Professional and community education

116. Judges, registrars, court child experts and senior members of the FCFCOA's national operations team regularly participate in professional and community education events across Australia and internationally. These include keynote presentations, panel discussions, conference workshops, webinars and guest lectures, with a strong focus on family violence, child safety, and accessibility in family law proceedings.

Family Violence Symposium – April 2024

117. In April 2024, Chief Justice Alstergren convened the inaugural Family Violence Symposium to strengthen collaboration between the FCFCOA and the family, domestic and sexual violence sector. The Symposium aimed to:
   a. build stronger connections with the sector;
   b. educate stakeholders on the FCFCOA's operations and initiatives relevant to family violence;
   c. invite feedback and ideas for improvement; and
   d. establish a framework for ongoing engagement within an integrated service system.

118. The event brought together 80 key stakeholders from across Australia, including representatives from frontline services, government, academia, legal and victim support sectors.

Family Violence Reference Group – 2024–25

119. Following the Family Violence Symposium, the Family Violence Reference Group was established to formalise ongoing consultation with key national networks and peak bodies. The Group provides a platform for:
   a. sharing sector updates and trends;
   b. consulting on FCFCOA initiatives and reforms;

c. educating the sector about the FCFCOA's work and responses to family violence;
d. advising on service system integration and referral pathways; and
e. offering advice and support in relation to improving service system integration.

120. The Family Violence Reference Group comprises representatives from key national networks and peak bodies that work within the family law system with people who have experienced family violence and people who have used family violence.

121. The Family Violence Reference Group met several times in 2024–25 and continues to play a vital role in shaping the FCFCOA's approach to family violence through sustained, collaborative engagement.

SECTION H - CO-LOCATED SERVICES & INFORMATION SHARING

Co-location Program

122. The Co-location Program commenced as a pilot in 2020 with state and territory child protection and police officials being located across most of the FCFCOA's registries. As at 30 June 2025, child welfare and police officials are currently co-located in, or near, all registries across jurisdictions.

123. The Co-location Program is intended to facilitate a cohesive response to identifying and managing family safety and child protection issues across the family law, family violence and child welfare systems. Co-located state and territory child protection and police officials perform a range of functions within their respective powers, which enhance information-sharing and collaboration between federal family law and state and territory child protection and family violence systems.

124. Improved information sharing between agencies is critical in supporting informed and timely decision-making and a robust system response by providing a better understanding of any history of violence, abuse or other risks relevant to a matter. Improved information-sharing will also continue to support the FCFCOA's ability to assess risk in the context of its powers, triage and prioritise cases, and make orders which protect children and adults who have experienced family violence or abuse to the greatest extent possible.

125. The Co-location Program has provided additional benefits including:
a. a reduction in the number of subpoenas to state and territory child protection agencies and police.
b. the two-way flow of information between the FCFCOA and state and territory agencies, which promotes a more coordinated response to safety and enhances possible system responses of all entities; and improved inter-jurisdictional understanding and cooperation.

FASS

126. FASS provides support to parties affected by family violence by bridging the gap to legal and social services. FASS ensures that individuals impacted by family violence can understand the court process, prepare for their cases, receive safety planning assistance, and connect with critical support services. FASS is funded by the Australian Government through the Attorney-General's

Department and delivered by Legal Aid Commissions in each state and territory. For example, in Queensland, FASS is run by Legal Aid Queensland.

127. FASS helps:
    a. Individuals experiencing family violence, those involved in family law court proceedings.
    b. Grandparents and other family members impacted by family violence.
    c. Men who are perpetrators of violence and wish to change their behaviour.
128. FASS helps with:
    a. *Family Law Issues*: Arrangements for children, divorce and child support and property matters after separation.
    b. *Family Violence Issues*: Getting Apprehended Violence Orders (or other state/territory equivalent), help with Department of Community Services (or equivalent) issues and victim support.
    c. *Support Services*: Providing duty lawyers at court, referrals to mental health services, offering social support and assistance navigating the court system and arranging interpreters if needed.

Information Sharing

129. The National Strategic Framework for Information-sharing between the Family Law and Family Violence and Child Protection Systems (**National Framework**) was endorsed by the Meeting of Attorneys-General on 12 November 2021.
130. The objective of the National Framework is to promote the safety and wellbeing of adults and children affected by family violence and child abuse, and support informed and appropriate decision making in circumstances where there is, or may be, a risk of family violence or child abuse.
131. The National Framework represents a high-level commitment to a nationally consistent process for information-sharing between the family law courts and these state and territory bodies, to support the safety of vulnerable families and children across all jurisdictions. The National Framework is facilitated by reform to legislation, court rules and regulations, and an Information-sharing Protocol.
132. In May 2024, the Information Sharing Act commenced. These amendments broadened the scope of information that can be shared from information sharing agencies to the family law courts, in recognition of the complex nature of family violence, child abuse and neglect risk.
133. Throughout 2024–25, the FCFCOA has engaged with the Federal Government and state and territory agencies to effectively operationalise the legislative amendments and the National Framework more broadly. This includes working with the Federal Government as part of the statutory review of the Information Sharing Act, which commenced in May 2025.
134. Relevant FLA Provisions:
    a. Under ss 67ZBD and 67ZBE of the FLA, the FCFCOA can make an order requesting particulars, information and documents from State and Territory police and child protection agencies which relates to abuse, neglect, family violence or risk.
    b. This information supports the FCFCOA in the exercise of its powers to make parenting orders.

c. Upon receipt of the documents or information provided under a ss 67ZBD or 67ZBE order, the presiding judicial officer will determine whether the information is to be released to parties and legal representatives, and the conditions of that release. The FCFCOA must admit into evidence any particulars, documents or information on which the FCFCOA intends to rely, except if it is only being relied on to assist in case management.
d. If an order has been made to an agency under s 67ZBE, a party must not request the issue of a subpoena to that agency without leave of the FCFCOA. For more information, see the Leave requirements for subpoenas in family law proceedings flowchart.

135. While judicial officers consider risks arising from allegations based on what parties set out in their material, more substantive or dynamic risks are frequently identified through information provided by external agencies such as police and child protection departments under the above information-sharing arrangements. These sources often provide a more complete picture of the risk environment, particularly where parties may underreport or fail to recognise concerning behaviours. As discussed at paragraph [72.f], self-reported risk can align with independent assessments – but a more complete understanding of risk indicators, or risks that have arisen later in time, often emerge only after information is obtained under the above arrangements.

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ATTACHMENT 1

A non-comprehensive list of federal and state and territory services that respond to risks and issues arising from relationship and family breakdown.

NATIONAL (FEDERAL SERVICES AVAILABLE IN ALL STATES)

Services Australia – Child Support

- Services: Child support assessments, payments, enforcement, and information for separated parents.

Family Relationship Centres

- Services: Free or low-cost family dispute resolution (mediation), parenting plans, referrals to counselling and legal services.

Family Advocacy and Support Services (FASS)

- Services: Legal and social support for families affected by family violence.

NEW SOUTH WALES (NSW)

Legal Aid NSW

- Services: Legal advice and representation in family law, family dispute resolution, domestic violence support, FASS.

NSW Department of Communities and Justice

- Services: Child protection, domestic violence services, housing support, parenting programs.

NSW Police

- Services: Respond to domestic violence incidents, issue and apply for Apprehended Domestic Violence Orders (ADVOs).

Community Legal Centres NSW

- Services: Free legal advice and support in family law, domestic violence, and child protection.

VICTORIA (VIC)

Victoria Legal Aid

- Services: Legal advice and representation in family law, dispute resolution, child protection, FASS.

Department of Families, Fairness and Housing (DFFH)

- Services: Child protection, family violence services, housing and support programs.

Victoria Police

- Services: Domestic violence response, intervention orders.

Community Legal Centres VIC

- Services: Free legal help in family law, family violence, and related areas.

QUEENSLAND (QLD)

Legal Aid Queensland

- Services: Family law advice, representation, dispute resolution, FASS, domestic violence support.

Department of Families, Seniors, Disability Services and Child Safety

- Services: Child protection, family support, domestic violence services.

Queensland Police Service

- Services: Domestic violence response, protection orders.

Community Legal Centres QLD

- Services: Free legal assistance in family law and domestic violence matters.

WESTERN AUSTRALIA (WA)

Legal Aid WA

- Services: Family law advice, dispute resolution, representation, FASS.

Department of Communities

- Services: Child protection, family and domestic violence services.

WA Police

- Services: Domestic violence response, restraining orders.

Community Legal Centres WA

- Services: Free legal support in family law and related areas.

SOUTH AUSTRALIA (SA)

Legal Services Commission of SA

- Services: Family law advice, representation, dispute resolution.

Department for Child Protection

- Services: Child protection and family support.

SA Police

- Services: Domestic violence response, intervention orders.

Community Legal Centres SA

- Services: Free legal help in family law and domestic violence.

TASMANIA (TAS)

Legal Aid Tasmania

- Services: Family law advice, representation, dispute resolution, FASS.

Department for Education, Children and Young People

- Services: Child protection and family support.

Tasmania Police

- Services: Domestic violence response, family violence orders.

Community Legal Centres TAS

- Services: Free legal support in family law and related areas.

AUSTRALIAN CAPITAL TERRITORY (ACT)

Legal Aid ACT

- Services: Family law advice, representation, dispute resolution, FASS.

Child, Youth and Families

- Services: Child protection and family support.

ACT Policing

- Services: Domestic violence response, family violence orders.

Community Legal Centres ACT

- Services: Free legal help in family law and domestic violence.

NORTHERN TERRITORY (NT)

Legal Aid NT

- Services: Family law advice, representation, dispute resolution, FASS.

Department of Children and Families

- Services: Child protection, family support, domestic violence services.

NT Police

- Services: Domestic violence response, protection orders.

Community Legal Centres NT

- Services: Free legal support in family law and related areas.

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ATTACHMENT 2

A non-comprehensive list of non-governmental organisations in Australia that provide services in the context of relationship and family breakdown.

Relationships Australia

- **Services**: Counselling for individuals, couples, and families; family dispute resolution (mediation); parenting education; support for family violence and separation.
- **Availability**: Nationwide, with state-based branches.

Anglicare

- **Services**: Family and relationship counselling; parenting programs; financial counselling; emergency relief; support for domestic violence and homelessness.
- **Availability**: Operates in most states and territories.

CatholicCare

- **Services**: Relationship counselling; family dispute resolution; parenting support; domestic violence services; mental health and housing support.
- **Availability**: State-based branches (e.g., CatholicCare Sydney, CatholicCare Victoria).

UnitingCare

- **Services**: Family support services; counselling; mediation; domestic violence support; emergency housing; financial assistance.
- **Availability**: Operates across multiple states under different Uniting Church agencies.

Centacare Catholic Community Services

- **Services**: Family and relationship counselling; mediation; parenting education; domestic violence support; mental health services.
- **Availability**: State-based branches (e.g., Centacare Brisbane, Centacare Adelaide).

The Salvation Army

- **Services**: Crisis accommodation; family and domestic violence support; financial counselling; case management for families in crisis.
- **Availability**: Nationwide.

Interrelate

- **Services**: Family dispute resolution; relationship and parenting education; counselling; support for children experiencing separation.

- **Availability**: Primarily NSW, with some services in other states.

Women's Legal Services (state-based)

- **Services**: Free legal advice and representation for women in family law, domestic violence, and child protection matters; community legal education.
- **Availability**: State-based (e.g., WLS NSW, WLS QLD, WLS Victoria).

Men's Referral Service (Operated by No to Violence)

- **Services**: Telephone counselling and referral for men concerned about their use of family violence; support for behaviour change.
- **Availability**: Nationwide.

MensLine Australia

- **Services**: Telephone counselling and referral service for men.
- **Availability**: Nationwide.

Kids Helpline

- **Services**: Telephone, online and mobile counselling service for young people, including assistance with family and relationship problems.
- **Availability**: Nationwide.

Family Law Pathways Networks

- **Services**: Coordination and referral networks that connect professionals working with families post-separation; not direct service providers but enhance access to services.
- **Availability**: Regional networks across Australia.

Frontline state-based domestic, family and sexual violence services e.g. Domestic Violence Crisis Services (DVCS)

- **Services**: Crisis support, safety planning, legal advocacy, and referrals for people experiencing domestic and family violence.
- **Availability**: ACT-based, with similar services in other states under different names.
- **Family Violence Prevention & Legal Services:** Family Violence Prevention & Legal Services are Aboriginal and Torres Strait Islander community-controlled organisations that deliver culturally safe legal and non-legal services.

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ATTACHMENT 3

A non-comprehensive list of Australian courts that issue domestic violence protection orders, intervention orders or similar protective orders, along with the legislation under which these orders are made in each jurisdiction.

Jurisdiction	Court	Order Type	Legislation
Federal	Federal Circuit and Family Court of Australia	Injunctions for personal protection	Family Law Act 1975 (Cth), ss 68B & 114
NSW	Local Court / Children's Court	Apprehended violence order (which includes an apprehended domestic violence order, apprehended person violence order or injunction)	• Crimes (Domestic and Personal Violence) Act 2007 (NSW) s 3(1) • Crimes (Domestic and Personal Violence) Regulation 2019 • Property (Relationships) Act 1984 (NSW) s 53)
VIC	Magistrates' Court / Children's Court	Family violence intervention order	Family Violence Protection Act 2008 (VIC) s 8
QLD	Magistrates Court	Domestic violence order (which includes either a protection order or temporary protection order)	• Domestic and Family Violence Protection Act 2012 (QLD) s 23(2) • Domestic and Family Violence Protection Regulation 2012 (QLD) • Domestic and Family Violence Protection Rules 2014 (QLD)
WA	Magistrates Court / Children's Court	Family violence restraining order	• Restraining Orders Act 1997 (WA) s 3 • Restraining Orders Regulations 1997
SA	Magistrates Court	Intervention order	• Intervention Orders (Prevention of

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Jurisdiction	Court	Order Type	Legislation
			Abuse) Act 2009 (SA) s 36 • Intervention Orders (Prevention of Abuse) Regulations 2011 (SA)
TAS	Magistrates Court	Family violence order	Family Violence Act 2004 (TAS) s 4
ACT	Magistrates Court	Family violence order	• Family Violence Act 2016 (ACT) Pt 3, Dictionary • Family Violence Regulation 2017 (ACT) reg 5
NT	Local Court	Domestic violence order	• Domestic and Family Violence Act 2007 (NT) ss s 3(2)(a) and 4 • Domestic and Family Violence Regulations 2008 (ACT)

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ATTACHMENT 4

A non-comprehensive list of Children's Courts in Australia organised by jurisdiction.

Jurisdiction	Court	Jurisdiction Details	Key Legislation
New South Wales (NSW)	Children's Court of New South Wales	Care and protection, criminal matters involving children (under 18), compulsory schooling orders, and applications under the Children and Young Persons (Care and Protection) Act 1998.	• Children's Court Act 1987 (NSW) s 4 • Children and Young Persons (Care and Protection) Act 1998 (NSW) • Children (Criminal Proceedings) Act 1987 (NSW)
Victoria (VIC)	Children's Court of Victoria	Criminal cases involving children (10–17 years), child protection matters, and intervention orders.	Children, Youth and Families Act 2005 (VIC) ss 3 and 504
Queensland (QLD)	Children's Court of Queensland	Serious criminal offences by children, child protection matters under the Child Protection Act 1999.	• Children's Court Act 1992 (QLD) s 4 • Youth Justice Act 1992 (QLD) • Child Protection Act 1999 (QLD)
Western Australia (WA)	Children's Court of Western Australia	Criminal matters involving children, protection and care matters under the Children and	• Children's Court of Western Australia Act 1988 (WA) s 5

Jurisdiction	Court	Jurisdiction Details	Key Legislation
		Community Services Act 2004.	• Young Offenders Act 1994 (WA) • Children and Community Services Act 2004 (WA)
South Australia (SA)	Youth Court of South Australia	Criminal matters involving young people, child protection, adoption, and family matters.	• Youth Court Act 1993 (SA) s 4 • Young Offenders Act 1993 (SA) • Children and Young People (Safety) Act 2017 (SA)
Tasmania (TAS)	Magistrates Court (Youth Justice Division)	Criminal matters involving children, care and protection matters under the Children, Young Persons and Their Families Act 1997.	• Youth Justice Act 1997 (TAS) s 159 • Children, Young Persons and Their Families Act 1997 (TAS)
Australian Capital Territory (ACT)	The Children's Court	Criminal matters involving children, care and protection matters under the Children and Young People Act 2008.	• Magistrates Court Act 1930 (ACT) s 287 • Children and Young People Act 2008 (ACT)

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Northern Territory (NT)	Youth Justice Court / Family Matters Division of the Local Court	Youth Justice Court: Criminal matters involving young people who are under 18 years old when	• Youth Justice Act 2005 (NT) s 45 • Care and Protection of

Jurisdiction	Court	Jurisdiction Details	Key Legislation
		they are charged or appear in court. Family Matters Division of the Local Court: Child protection and welfare matters under the Care and Protection of Children Act 2007.	Children Act 2007 (NT)

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ATTACHMENT 5

COURT CHILDREN'S SERVICE

1. CCS operates under the authority of the CEO/PR, who supports the Chief Justice in business and operations of the FCFCOA's functions.
2. CCS is staffed by psychologists and social workers who have specialist expertise in the needs of children in families that are separated. The role of the service is to assist parents and assist registrars and judges make decisions in parenting proceedings about parenting arrangements that are in the best interests of the children. For example, with whom a child should live and/or spend time, who should make decisions about a child, and matters like where child should go to school. CCS can assist families and the FCFCOA by:
    a. helping parents understand the needs of their children after separation;
    b. identifying risk factors that impact children. For example family violence, child abuse, drug, alcohol or substance misuse and mental health concerns;
    c. identifying family strengths and protective factors;
    d. providing assessments and advice to the Court as an expert witness;
    e. providing information about resources and support services; and
    f. assisting in the resolution of disputes.
3. The different types of services provided by CCS include:
    a. undertaking preliminary assessments early in proceeding (see paragraphs [10] to [11] below);
    b. undertaking comprehensive assessments for final hearings (see paragraphs [12] to [31] below);
    c. assisting registrars in the delivery of dispute resolution conferences; and
    d. undertaking confidential assessment interviews as part of Lighthouse.

Family Consultants

4. The work of CCS is undertaken by family consultants. There are two types of family consultants who perform work for the FCFCOA:
    a. Child Court Experts, who are employees appointed under s 18ZH of the *Federal Court of Australia Act 1976* (Cth); and
    b. private practitioners who are appointed under the *Family Law Regulations 2024* (Cth) and referred to as Panel Family Consultants, who undertake comprehensive assessments for final hearings.
5. Family Consultants are appointed under s 11B of the FLA. They assist the FCFCOA by providing services in relation to proceedings under the FLA, including:
    a. assisting and advising people involved in the proceedings with regards to what may be in the best interests of the children; and
    b. assisting and advising courts, and giving evidence, in relation to the proceedings; and
    c. helping people involved in the proceedings to resolve disputes that are the subject of the proceedings; and
    d. reporting to the FCFCOA under ss 55A and 62G; and

e. advising the FCFCOA about appropriate family counsellors, family dispute resolution practitioners and courses, programs and services to which the FCFCOA can refer the parties to the proceedings.

6. Family consultants have legal immunity equivalent to that of a Judge (s 11D), subject to compliance with regulations applicable to family report writers if the family consultant is also a family report writer.

Family Report Writers

7. The 2024 Amendments inserted a new Part IIIAA into the FLA in relation to family report writers. Family report writers are individuals who prepare designated family reports i.e. expert assessments of the child's care, welfare and development (and, if appropriate, advising of the child's views) for the purposes of informing parenting orders being made by the FCFCOA in relation to the child: ss 11H and 11J.
8. Section 11K sets out the power to make regulations that set standards and requirements, including recognition, monitoring and enforcement of compliance with the set standards and requirements for family report writers.

CCS Involvement

9. CCS is only involved in a case if a Registrar or Judge has made an order that this is to occur. For example, participants in family law proceedings may be ordered to attend for the reports listed below if further evidence is required to enable judicial officer to make an interim or final parenting order.

Child Impact Report

10. A CIR is prepared by a Court Child Expert who works in CCS. The purpose of a CIR is to provide the relevant judicial officer information early in proceedings about the experiences and needs of children, for the purposes of informing the making and content of parenting orders. In preparing the report, the Court Child Expert will consider a range of issues such as children's development, children's relationships and the presence of risk factors (such as family violence). CIRs focus on the impact these types of issues have upon children and parenting.
11. A CIR is an assessment that generally occurs in two parts:
    a. Part 1 (adult interview), and
    b. Part 2 (child assessment).

Child Impact Addendum Report

12. The Child Impact Addendum Report is a child-focused report which builds upon a previous CIR and is undertaken by the same Court Child Expert (who prepared the CIR) within six months of the CIR's release. A Child Impact Addendum Report offers an analysis and evaluation of the issues and needs identified for the children/family in the context of the proposals before the Court, and provides recommendations (wherever possible) to support Final Hearings. The purpose of the Child Impact Addendum Report is to inform the making and content of parenting orders.
13. The Child Impact Addendum Report involves a Court Child Expert undertaking limited and targeted enquiries to build upon the information they gathered in the

CIR. The nature and scope of the additional enquiries undertaken will be determined by the Court Child Expert on a case-by-case basis.

14. The Child Impact Addendum Report cannot provide a comprehensive assessment of risk or other complex issues and is best suited to matters that involve disputes about children's relationships and/or development, rather than issues of disputed risk.

Specific Issues Report

15. The Specific Issues Report is a limited report which targets a particular issue or specific event (such as obtaining children's views or conducting a parent/child observational assessment) identified by the FCFCOA. It offers a limited assessment and a concise report about the issue that has been specifically stipulated in the order and provides (wherever possible) social science opinion and conclusions related to the specific issue for the purpose of assisting a Final Hearing. The purpose of the Specific Issues Report is to inform the making and content of parenting orders.
16. The process of a Specific Issues Report is structured to obtain information relevant to the limited issues being assessed. As such, the process will vary on a case-by-case basis to meet the specifications of the FCFCOA.
17. The Specific Issues Report cannot provide a comprehensive assessment of relationships, risk and/or child wellbeing or recommendations that extend beyond the scope of the specific issue being assessed.
18. The Specific Issues Report is best suited to matters where the scope of information sought is restricted to one or two narrow issues, or a limited assessment event.

Family Report

19. A Family Report is ordered by a registrar or a judge under s 62G of the FLA. A Family Report is prepared by a family consultant. This could either be a Court Child Expert, practicing under their appointment as a family consultant, or a Panel Family Consultant. The purpose of the Family Report is to inform the making and content of parenting orders.
20. If participants have any concerns about their safety, they are asked to let the CCS know before attending the interview with the family consultant and appropriate arrangements are put in place.
21. When preparing a Family Report, the family consultant will conduct a series of interviews in one day or over a few days. They will have individual interviews with both parties. They may also interview other significant people, such as adult siblings, step or half siblings, partners or grandparents.
    a. Children will be seen separately from any adults (except in special circumstances). The children will be given an opportunity to express their views and wishes, but no child will be expected to do so. The family consultant may also observe the interaction between the children and each parent (and other significant people) in separate observation sessions.
22. Generally, the family consultant will gather information about:
    a. the issues in dispute

  b. past and present parenting arrangements
  c. the parenting capacity of each party
  d. children's relationships with significant people
  e. children's wishes and views, and
  f. any risks to the children.

23. The family consultant may request the parties' permission to contact teachers, doctors or other relevant professionals for more information about their children. The FCFCOA may also direct that the family consultant have access to material which has been subpoenaed.
24. Any information provided to the family consultant is admissible in court and can become evidence in the case. The family consultant is required to include relevant information in the report and may also provide this information in FCFCOA if they are called to appear for cross-examination.
25. A family consultant must notify a child welfare authority if:
    a. they reasonably suspect that a child has been, or is at risk of being, abused, and/or
    b. they reasonably suspect that:
        i. a child is being ill-treated, or is at risk of being ill-treated, or
        ii. a child has been exposed or subjected, or is at risk of being exposed or subjected, to psychological harm.
26. The family consultant may also need to contact police if they reasonably believe that a person is at imminent risk of being harmed or seriously injured.
27. After the Family Report is completed, the family consultant provides it to the ordering judge or registrar who will then formally release the report for use in the proceedings. The parties' lawyer (or the party if they are not represented), will receive a copy of the report when it is released or it will be made available on the Commonwealth Courts Portal. A copy will also be given to the Independent Children's Lawyer if one has been appointed.
28. The Family Report will be released prior to the final hearing. It is possible (and not uncommon) for matters to settle based on what is contained in the Family Report.

An Update Family Report

29. This is an adjunct report undertaken by the author of a Family Report and involves a limited re-assessment, focused on changes that have occurred in the family since the initial assessment was conducted. It offers a consideration of whether the changed circumstances of the family alter the evaluation and/or recommendations made in the initial Family Report, and provides updated recommendations, where appropriate, to support Final Hearings. The purpose of the Update Family Report is to inform the making and content of parenting orders.
30. The Update Family Report involves targeted additional enquiries focused on gathering information about the changed circumstances of the family. As such, the process of the Update Family Report will vary on a case-by-case basis.
31. The Update Family Report cannot provide a comprehensive re-examination or re-assessment of all issues. It is best suited to matters where a family's changed

circumstances are such that they cannot be adequately canvassed with the author of the initial Family Report during cross-examination.

Handover

32. CCS staff may also assist with facilitating the handover of children from a relinquishing parent to a receiving parent.
33. From time to time, the FCFCOA may order or direct that a child/children be delivered to CCS. This is usually because a change of primary care is being considered, with CCS being required to facilitate the handover of the child/children. If such an order is made, then the child/children will be collected by a different person than brought the child/children to CCS.

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ATTACHMENT 6

OBJECTS AND PRINCIPLES OF THE FLA

The below is a summary of the objects and principles of the FLA as amended by the 2024 Amendments, effective 6 May 2024.

Section 60B – Object of Part VII (Children)

The objects of Part VII is to ensure that the best interests of children are met, ensuring their safety; and to give effect to the Convention on the Rights of the Child.

Section 60CC – Determining Best Interests of the Child

The best interests of the child are the paramount consideration (s 60CA) and are assessed using the following factors:

- safety of the child and each person who has care of the child (including exposure to violence, abuse, neglect, or other harm);
- the child's views;
- the developmental, psychological, emotional and cultural needs of the child;
- capacity of each person to provide for those needs;
- benefit to the child of having relationships with parents and other significant people; and
- any other relevant circumstances.

In considering the above matters, the FCFCOA must consider any history of family violence, abuse or neglect involving the child or a person caring for the child; and any family violence order that applies.

Section 60CA – Paramount Consideration

In deciding parenting matters, the FCFCOA must regard the best interests of the child as the paramount consideration.

Section 61DAA – Joint Decision-Making

Replaces the presumption of equal shared parental responsibility with a focus on joint decision-making about major long-term issues, where safe and appropriate.

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ATTACHMENT 7

This table compares key provisions of the FLA before and after the 2024 Amendments in relation to the framework for making parenting orders, which came into effect on 6 May 2024.

Section	Pre-2024 Amendments Summary	Post-2024 Amendments Summary
s 60B	Outlined multiple objects including ensuring children benefit from meaningful relationships with both parents, protection from harm, and proper parenting. Included principles such as shared parental responsibility and cultural rights.	Simplified to provide that the objects of Part VII (Children) are to ensure that the best interests of children are met, and to give effect to the Convention on the Rights of the Child.
s 60CA	Established that the best interests of the child are the paramount consideration in making parenting orders.	Remains unchanged: best interests of the child continue to be the paramount consideration.
s 60CC	Contained a list of primary and additional considerations for determining best interests, including benefit of meaningful relationships, need to protect from harm, views of the child, and family violence history.	Revised to a streamlined list of factors to determine best interests including safety, child's views, developmental and cultural needs, caregiver capacity, benefit of relationships, and history of violence or abuse.
s 61CA	Did not exist.	If it is safe to do so, and subject to court orders, parents are encouraged to consult each other about major long-term issues in relation to the child, having regard to the best interests of the child as the paramount consideration.
s 61DAA	Did not exist. Section 61DA presumed equal shared parental responsibility unless rebutted.	Introduced to replace s 61DA. Focuses on joint decision-making about major long-term issues where safe and appropriate, without presumption of equal shared parental responsibility.
s 65DAA	Required courts to consider making an order that the child spend equal time, or substantial and significant time, with each parent, if an	Removed. It remains open to the court to consider equal time arrangements, or arrangements that give substantial or significant time with each parent, in

Section	Pre-2024 Amendments Summary	Post-2024 Amendments Summary
	order for equal shared parental responsibility was made.	accordance with the child's best interests.

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ATTACHMENT 8

Areas of Focus against each goal and actions required

	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
	AREA A PROTECTION FROM FAMILY VIOLENCE		
1		**Goal 1:** All staff and judges are aware of and apply the Family Violence Best Practice Principles for the effective, timely and safe disposal of all matters coming before the Courts in which family violence or risk of family violence is an issue.	1.1 The Family Violence Committee will review and update the *Family Violence Best Practice Principles* triennially in 2026 and as needed, particularly following any significant legislative change. 1.2 The Chief Executive Officer and Family Violence Committee will implement and annually review screening processes for all families in both Courts to ensure early identification of risks including family violence and child abuse.
2		**Goal 2:** The Courts collaborate and share information with state and territory courts, police and child protection agencies to enhance the safety of families involved in more than one jurisdiction.	2.1 The Executive Director – Court Children's Services (Executive Director – CCS), Coordinating Registrars and Directors and Managers of Court Operations will, on a regional and ongoing basis, develop relationships with other courts, child protection agencies and police to ensure timely exchange of information including through the co-located officers. Compliance will be reviewed annually. 2.2 The National Operations Team, Executive Director – CCS, Directors and Managers of Court Operations will collaborate with state and

	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
			territory courts, police and child protection agencies to improve information sharing, coordination and better service delivery. Compliance will be reviewed annually.
3		**Goal 3:** All staff and judges are aware of and apply the *Family Violence Best Practice Principles*[45] for the effective, timely and safe disposal of all matters coming before the Courts in which family violence or risk of family violence is an issue.	**3.1** The Chief Justice/Chief Judge will ensure that all judges undertake the Safe and Together family violence training (or other nominated training) within the first year of appointment and some form of family violence training annually thereafter. **3.2** The Chief Executive Officer will ensure that all registrars undertake the Safe and Together family violence training (or other nominated training) as part of their induction program and some form of family violence training annually thereafter. **3.3** The Directors and Managers of Court Operations will ensure that all staff working in family law complete the eLearning course on family violence as part of the induction process. **3.4** The Executive Director – CCS will annually review and update the family violence training package for all Family Consultants, including Regulation 7 Family Consultants. **3.5** The Executive Director, Strategy and Corporate Services, and Directors and Managers of Court Operations will implement training to ensure all relevant staff are

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	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
			skilled in creating and implementing safety plans for litigants experiencing, or at risk of, family violence. Compliance will be reviewed annually. **3.6** The Directors and Managers of Court Operations will ensure that all staff are aware of and make appropriate referrals to the Family Advocacy Support Service (FASS). Compliance will be reviewed annually. **3.7** The Executive Director, Strategy and Corporate Services, Marshal and contracted security management (currently MSS Security) will ensure that contracted security staff undertake family violence training tailored for their role. Compliance will be reviewed annually.
4		**Goal 4:** The Courts have an understanding of the unique issues for particular communities in relation to family violence and use this information to inform practice and procedures.	**4.1** The National Operations Team, Executive Director – CCS and Directors and Managers of Court Operations will collaborate with other justice sector and social and community services dealing with family violence and child protection matters to inform and improve practice and procedures. Compliance will be reviewed annually.
	AREA B SAFETY AT COURT		
5		**Goal 5:** The Courts' processes and practices comply with best practice for	**5.1** Coordinating Registrars, Directors – CCS and Directors and Managers of Court Operations will monitor the

	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
		accessibility and safety of all court users.	current practices of Courts' event listing and their impact on safety of all court users. Compliance will be reviewed annually. **5.2** The Chief Executive Officer will ensure, so far as practicable, that the Courts' procedures to enable safe access to the Courts are available and made known to culturally and linguistically diverse communities. Compliance will be reviewed annually. **5.3** The National Executive Group and Chief Information Officer will develop nationally consistent descriptors for matters in which there is a safety plan or there are special risk factors. Compliance will be reviewed annually.
6		**Goal 6:** The physical layout of courtrooms and court buildings complies with the best practice principles for accessibility and safety of all court users.	**6.1** The Chief Executive Officer and Director Security will ensure, so far as is practicable, that all Court premises and circuit locations meet minimum safety standards. Compliance will be reviewed annually.
	AREA C INFORMATION AND COMMUNICATION		
7		**Goal 7:** Court users have ready access to relevant information about how the Courts can assist them if they	**7.1** The National Communications Manager will annually review and update family violence specific publications to ensure they are

	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
		have experienced, or are at risk of experiencing, family violence.	current, accessible and relevant. **7.2** The National Communications Manager will annually review general publications and web content to ensure relevant family violence and/or safety information is included. **7.3** The National Communications Manager will ensure that information in relation to the Courts' operations concerning family violence is up-to-date and coherent across the Courts. Compliance will be reviewed annually. **7.4** The Chief Executive Officer and National Communications Manager will explore the development of family violence specific information and referral advice for: **7.4.1** Aboriginal and Torres Strait Islander communities **7.4.2** Culturally and linguistically diverse communities **7.4.3** Individuals with a disability **7.4.4** LGBTQIA+ community Compliance will be reviewed annually. **7.5** The National Communications Manager will annually review the metadata in family violence sections of the websites to maximise the search results. The Directors and Managers of Court Operations will ensure that all staff are aware of where and

	AREA OF FOCUS	GOALS	ACTIONS REQUIRED
			how to access information about family violence and the Courts. Compliance will be reviewed annually. **7.6** Directors of Court Operations and National Communications Manager will annually review safety at court information provided in appointment emails for clarity and appropriateness. **7.7** National Communications Manager, Executive Director – CCS, Executive Director – National Registrar Operations and Practice and Directors and Managers of Court Operations will biennially review and update all information about referrals to external agencies currently available to those experiencing, or at risk of, family violence. **7.8** Executive Director – CCS, Executive Director – National Registrar Operations and Practice, and Directors and Managers of Court Operations will annually review, update and strengthen processes followed by client service staff, family consultants and registrars in making referrals to other organisations, including ensuring the information about the organisations is up to date, on an ongoing basis. **7.9** The Directors and Managers of Court Operations will meet regularly with FASS to ensure effective referrals, information exchange and safety planning. Compliance will be reviewed annually.