

## Preventing harm to children with disability in Queensland – Report 1: Department of Education

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

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

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

This is our first report from the investigation. The Ombudsman will report separately on the findings about other public sector agencies.

### What we investigated

This investigation examined Education's current practices and procedures to consider whether they would prevent the nature and extent of the harm Kaleb and Jonathon experienced from occurring to other children with disability in Queensland.

We found that Education has many practices and procedures to guide staff in student protection reporting, recordkeeping and maintaining professional judgement. It also provides mandatory student protection training.

### Kaleb and Jonathon – what happened?

The Department of Education (Education) engaged with Kaleb, Jonathon and their father, Paul Barrett, from 2001 to 2020. Kaleb and Jonathon attended a special school, which provided specialised educational and disability support.

At times, school staff attended to Kaleb and Jonathon's basic personal hygiene, clothing and school lunches. During Public Hearing 33, Education accepted that this level of care indicated school staff were aware the two students were experiencing neglect at home.

The Royal Commission was concerned that Education made only one student protection report to Child Safety. It also expressed concern about Education's poor recordkeeping and blurred professional boundaries.

Education also identified these issues in the reviews it conducted after Paul Barrett's death in May 2020.

### What needs to be improved

We identified some areas of Education's current practices, procedures and training where improvements could be made to ensure neglect is identified, suspicions of harm are appropriately recorded and cumulative harm is captured.