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# Submission on **Complaints and Incident Systems**

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# Introduction

Few powers held by the state are more profound, more intimate, or more morally weighty than the power to intervene in the life of a family and remove a child. Child protection agencies are entrusted not merely with services—they are entrusted with childhoods, identities, futures. The lives they intervene in are not files or caseloads; they are stories in motion, each with the potential for healing or further harm. That is why the systems that surround and oversee child protection must be infused with integrity, transparency, justice, and care.

Child protection is the sharpest edge of government authority, it is a power that enters the private sphere, crosses the threshold of the home, and declares that the fundamental bond between parent and child must be broken. This power, unique in its gravity and consequence, reflects the state's role not merely as protector but as substitute parent, guardian, and moral custodian. This reflects the ethical complexity of statutory child protection: it rescues, but it also disrupts; it safeguards, but it also harms. Child protection powers must consequently be exercised with care, balance, transparency and reflection.

> *"When the state acts in loco parentis, it takes on a sacred responsibility—no less weighty than that of the biological parent, and arguably more fraught, for it does so by force of law rather than force of love".*
>
> – attributed to former High Court Justice Michael Kirby

Indeed, the removal of a child from their family is not just a social intervention, it is a momentous constitutional act. The UN Convention on the Rights of the Child, to which Australia is a signatory, enshrines the right of the child to know and be cared for by their parents, and insists that removal can only occur as a last resort, in accordance with law, and subject to review. Likewise, the *Queensland Child Protection Act 2024*—in section 5(B), in the paramount principle and at Schedule 1—outlines onerous tests and obligations on the State who proposes to enact child protection powers, however these principles, obligations and rights, are not important if there is no complaint, appeal or oversight mechanism to detect and resolve the breach.

The principle of parens patriae, that the state acts as the parent of last resort, is one that should be exercised with profound humility, however, the history of child welfare teaches us that unchecked authority in the name of child protection can become a tool of oppression rather than liberation. Australia's own history, the Stolen Generations, institutionalisation, and past forced removals, warns us that decisions made "in the best interests of the child" can cause intergenerational trauma when made without accountability, without cultural understanding, or without the voice of the child.

It is precisely because the state has this immense power that robust complaints systems, appeals processes, and independent oversight must not be seen as bureaucratic mechanisms but as moral and democratic necessities. These safeguards ensure that the machinery of child protection does not operate in darkness or with impunity. As philosopher Jeremy Bentham famously wrote, *"The more closely we are watched, the better we behave."*

Recognising this history and the potential for harm when power is exercised without scrutiny demands that we build systems that prioritise transparency, accountability, that empower the active participation and leadership by children and families. Independent complaints and appeal mechanisms give voice to those who might otherwise be silenced - parents who believe they were wrongly treated, children who feel unheard, carers who witness injustice. They allow the system to self-correct, to learn, and to remain responsive. Without them, errors are repeated, biases remain hidden, and the harm intended to be prevented may instead be perpetuated by the very system designed to protect.

A good complaints process with oversight is what distinguishes a just child protection system from a coercive one. It reassures the public that state intervention is not arbitrary, but lawful, accountable, and transparent. It ensures that power is wielded with compassion, not convenience, with discernment, not dominance. In the words of Justice James Wood, who led an inquiry into child protection in New South Wales: *"There can be no higher obligation than the protection of vulnerable children - but the pursuit of that duty must always be accompanied by the light of scrutiny, the voice of the marginalised, and the humility to acknowledge error".*

# Child Safety complaint mechanisms in Queensland

Complaints are a fundamental component of an accountable child safety system. They serve not only as mechanisms for resolving individual concerns but as critical indicators of where the system is falling short in meeting the needs of children, young people, and families. However, complaints (and the complaint system) cannot be considered on their own, or in the absence of the surrounding system architecture.

Public administration and service delivery increasingly recognise that isolated mechanisms of quality assurance and accountability fail to address the complexity of modern systems. Mechanisms such as complaints, legal appeals, or evaluation may function in silos, with limited feedback loops and failures to flag or identify systemic learnings. This fragmentation risks missed insights, duplication, and an undue focus on procedural case compliance over broader systemic outcome improvement. Within our child protection system we must have an integrated accountability and oversight mechanism that includes complaints systems, advocacy roles, evaluation, oversight, incident response, performance monitoring, legal appeals, and administrative reviews. Each mechanism performs a distinct function; however, their true value lies in their capacity to interact and contribute to an integrated system of accountability and learning.

The Commission of Inquiry gives us the opportunity to look at the whole system within which the Queensland Family and Child Commission (QFCC) will argue for a deliberately integrated model of accountability and responsiveness that acknowledges both the discrete and overlapping purposes of various mechanisms.

Within Queensland's child protection system there are many moving parts and bodies. These are organised below against key accountability and oversight mechanisms:

- **Complaints:** Complaints are expressions of dissatisfaction by service users or third parties, typically regarding decisions, conduct, or quality of services (McKenna, 2019). They are often the first and most direct signal of system failure or injustice. Since the Carmody Inquiry (2013), child protection complaints have largely been seen as the internal ownership of Department of Families, Seniors, Disability Services and Child Safety (the Department), however complaints can be made to the Queensland Ombudsman (Ombudsman), Queensland Human Rights Commission (QHRC), Office of Public Guardian (OPG), peak bodies including Queensland Foster and Kinship Care (QFKC), Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), the Family Inclusion Network and PeakCare Queensland (PeakCare), and members of Parliament including the Minister. The QFCC is prohibited by section 9(2) of the *Queensland Family and Child Commission Act 2014* (Qld) from investigating "the circumstances of a particular child, young person or family or to advocate on their behalf". Other entities also exist within the system for specific complaints. For example, the frontline workforce can make complaints to and through their Unions and the Public Service Commission. Employment and misconduct complaints may also go to entities such as the Crime and Corruption Commission (CCC) or Fair Work Commission.
- **Advocacy:** Advocacy involves promoting and protecting individual or group rights, often focusing on those who are vulnerable or marginalised. Advocacy may be systemic (seeking policy change) or individual (case support), acting both as a voice and a conduit for unaddressed concerns (Beresford, 2002). In Queensland the OPG, the QHRC and the legal service providers that represent children and families conduct individual advocacy. Peak bodies and other non-government organisations (including funded service providers, but also entities such as the Youth Advocacy Centre and CREATE Foundation) can also deliver individual and systemic advocacy.
- **Evaluation:** Evaluation is a structured, methodical inquiry into the effectiveness, efficiency, and relevance of programs or policies. Drawing from the fields of public management and program theory, evaluations aim to generate evidence for decision-making (Scriven, 1991; Weiss, 1998). In Queensland the Child Safety leads an internal evaluation function and commissions its own evaluations. Externally the Queensland Auditor General's Office, the Ombudsman, and the QFCC conduct evaluations of child protection the Department's services.
- **Oversight and Inquiries:** Oversight refers to audit and review functions, internal and external, designed to ensure legal compliance, ethical conduct, and effective use of public resources (Behn, 2001). In Queensland

the QFCC is considered one of the main oversight bodies of the child protection system. Other bodies include the Queensland Audit Office, Ombudsmen, State Coroner, Child Death Review Board, CCC, and other integrity commissions, or regulatory authorities.

- **Incident response:** Incident response encompasses the reactive measures taken by an organisation when a critical or adverse event occurs. It often involves triage, investigation, mitigation, and prevention strategies, with a strong focus on risk management (Reason, 1997). In Queensland Child Safety manages incident responses internally.
- **Performance monitoring:** Performance monitoring involves continuous collection and analysis of data to assess whether a system or service is meeting its goals. It serves managerial, policy, and public accountability functions and provides early warning signals of decline or success (Hatry, 2006). In Queensland the Department manages system performance monitoring internally. The QFCC monitors system performance and is required to produce a public assessment in its annual report each year. Other entities that produce performance monitoring for Queensland's child safety system include the Australian Institute of Health and Welfare and Productivity Commission. Other entities such as the Director of Child Protection Litigation, Treasury, and peak bodies produce data and assessments of system performance. **Legal appeals and administrative review:** Legal appeals involve the formal challenge of decisions through tribunals or courts. Appeals provide a rule-of-law safeguard, particularly when administrative or quasi-judicial decisions affect individual rights or entitlements (Mashaw, 1985). Legal challenge and review of decisions in the child safety system are limited to a few clear points within the system. The courts, Queensland Civil and Administrative Tribunal (QCAT)and Ombudsman perform roles in this area of oversight and accountability.

While each of these above mechanism operate at different levels and with different orientations, they can contribute to mutual reinforcement when deliberately linked. For example:

- Patterns in complaints may inform systemic evaluation.
- Individual advocacy may identify systemic themes that warrant oversight inquiry.
- Incident response data may trigger administrative review or signal a need for policy evaluation.
- Performance monitoring may expose trends that warrant targeted evaluation or oversight.

These mechanisms also operate in different time spans (retrospective vs future); with different focus (individual vs systemic) and with different lenses (micro, meso and macro). This is outlined in the table below:

**Table 1: Distinct but interacting accountability and oversight mechanisms**

| Mechanism | Primary role | Feedback focus | Time orientation | Level |
|---|---|---|---|---|
| **Complaints** | Voice, grievance resolution | Individual/episodic | Retrospective | Micro |
| **Evaluation** | Evidence, decision support | Programmatic/system | Retrospective | Meso |
| **Incident response** | Risk mitigation, safety | Event/episodic | Immediate/future | Micro |
| **Legal appeals** | Justice, legal integrity | Individual | Retrospective | Micro |

This framework conceptualises the mechanisms as nodes within an interconnected web. In a successful system information should flow bi-directionally, and each mechanism should contribute to an overall cycle of feedback, correction, learning, and system improvement. In order for this integrated system to operate there are four key pillars:

1. **Data interoperability**: The system must enable performance, complaint, monitoring, and evaluation data to speak to each other.
2. **Clear roles and escalation pathways**: The system must define when and how issues move between mechanisms and trusted partnerships between key players must enable intelligence sharing.
3. **Established governance structures**: The system must ensure mechanisms are independent where necessary (e.g. oversight evaluation and monitoring) and collaborative where useful (e.g. advocacy and evaluation).
4. **Engaged users and stakeholders**: The system must empower and include lived experience in designing and evaluating the system.

Public systems that aspire to accountability and excellence cannot rely solely on compliance-based or siloed mechanisms. A holistic model that integrates complaints, advocacy, evaluation, oversight, incident response, performance monitoring, legal appeals, and administrative review is required to enable Queensland to not only to detect failure but to learn, improve, and transform the child protection system. An integrated accountability framework as outlined above would provide a conceptual foundation for designing such a system, recognising the necessity of individual fairness, systemic justice, and continuous organisational learning.

> *Special note: One remaining element of an integrated complaints system would include the ability of Departmental staff to raise concerns and challenge decisions internally. This internal management process sits well outside the common understanding of a complaints system, however through my work it is clear that there are significant and longstanding tensions between staff in functions such as case management, placement services, commissioning, and the Office of the Principal Practitioner. The internal systems within a Department to aerate and resolve concerns about practice and performance are critical to the overall health of the system.*

# Understanding the key individuals that might make a complaint

In Queensland's child protection system, complaints are raised by a diverse range of individuals and organisations, each situated differently within the system's power structure, and each bringing distinct perspectives on the adequacy of the system. Understanding who complains, and the nature of their concerns, is critical to evaluating the effectiveness and inclusivity of current complaints systems and identifying opportunities for systemic improvement.

The Queensland child protection system comprises six distinct stages. It is important to note that children and families may be engaged in multiple stages simultaneously, particularly in cases involving intergenerational involvement or families with multiple siblings.

1. Intake and Assessment;
2. Intensive Family Support and Intervention with Parental Agreement (i.e. services provided to families with children at risk of entering the child protection system, or to assist in the facilitation of reunification of the child with their family of origin where separation has already occurred);
3. Investigation;
4. Court activities;
5. Out-of-home care – Home based care (foster and kinship care)
6. Out-of-home care – Residential and institutional care

Across the following table I have outlined the key players for each of these six stages and the likely complaints.

**Table 2: People likely to make complaints and common topics during Intake and Assessment**

| **Intake and Assessment** | | | |
|---|---|---|---|
| Group Cohort | Notifiers | Intake staff | Frontline Department Staff |
| Individuals | Mandatory Reporters<br>Public Reporters | Intake officers<br>Managers<br>Cultural advisors | CSO: Child Safety Officers<br>Managers |
| Likely complaint topics | Call wait times<br>Failure to respond<br>Lack of action<br>Lack of feedback<br>Disagreement with decisions | Availability of information<br>Accessibility of intelligence and support services<br>Vexatious notifiers | Intake decision-making including thresholds |

**Table 3: People likely to make complaints and common topics during Intensive Family Support and Intervention with Parental Agreement**

| Intensive Family Support and Intervention with Parental Agreement | | | | |
|---|---|---|---|---|
| **Group Cohort** | Subject family | Non-government service providers | Frontline Department Staff | Peak bodies and |
| Individuals | | | | PeakCare |
| Likely complaint topics | Communication<br>Clarity<br>Balance of support and compliance | Level of funding<br>Reporting requirements | Availability/accessibility of support services<br>Caseload<br>Risk thresholds | |

**Table 4: People likely to make complaints and common topics during investigation**

| Investigation | | | | | |
|---|---|---|---|---|---|
| **Group Cohort** | Subject family | Frontline Department Staff | Government services | service providers | |
| Individuals | Partners of parents | Case Manager<br>Team leader | General | Family support<br>Domestic and Family services | |
| Likely complaint topics | Communication<br>Clarity of process<br>Rights and fairness<br>Behaviour and conduct | Caseload<br>Risk thresholds | Role creep<br>Information request requirements | Rights and fairness<br>Behaviour and | Rights and fairness<br>Behaviour and |

**Table 5: People likely to make complaints and common topics during court activities**

| Investigation | | | | | |
|---|---|---|---|---|---|
| **Group Cohort** | Subject family | Frontline Department Staff | Legal service providers | | |
| Individuals | | | | | |
| Likely complaint topics | Communication<br>Clarity of process<br>Rights and fairness<br>Behaviour and conduct | Paperwork requirements | Rights and fairness<br>Behaviour and conduct<br>Paperwork requirements | | |

**Table 6: People likely to make complaints and common topics during home-based care**

| Out of home care | Home based care (foster and kinship care) | | | | | |
|---|---|---|---|---|---|---|
| **Group Cohort** | Family | Subject child | Child's case manager | | | |
| Individuals | | Subject child | Support staff | support staff | | Executive Board |
| Likely complaint topics | Contact arrangements<br>Lack of Information<br>Contradictory standards | Disempowerment<br>Lack of information<br>Loss of autonomy<br>Unmet needs | Caseload<br>System fragmentation<br>Information gaps | Information gaps<br>Timeliness and pre-planning | Lack of Information<br>Unmet needs<br>Timeliness of response | Funding and reporting requirements |

**Table 7: People likely to make complaints and common topics during residential care**

| Out of home care | Home based care (foster and kinship care) | | | | | |
|---|---|---|---|---|---|---|
| **Group Cohort** | Family | Subject child | Child's case manager | Placement team | Care household | Care provider |
| Individuals | | | | Placement support staff | Youth worker<br>House coordinator<br>Other children | CEO<br>Executive Board |
| Likely complaint topics | Contact arrangements<br>Lack of Information<br>Contradictory standards | Disempowerment<br>Lack of information<br>Loss of autonomy<br>Unmet needs | Caseload<br>System fragmentation<br>Information gaps | Information gaps<br>Timeliness and pre-planning | Information gaps<br>Timeliness and pre-planning | Funding and reporting requirements |

Parent concerns typically arise from experiences of disempowerment, lack of transparency, limited or inconsistent contact with their children, and insufficient support to keep families safely together or achieve reunification. For many parents, particularly Aboriginal and Torres Strait Islander parents who are significantly overrepresented in the system, the complaints process can feel inaccessible or adversarial. These parents often experience the system as one that imposes decisions upon them rather than working in partnership. As a result, complaints are often raised only after multiple failed attempts at informal resolution. Many parents are unaware of formal pathways, lack trust in internal complaint mechanisms, or fear negative repercussions, including reduced access to their children. Their complaints often reflect both individual procedural concerns and deeper systemic issues around cultural safety, power imbalances, and unequal treatment.

Children and young people in care also raise complaints, although far less frequently than might be expected given the complexity and risks inherent in their placements. **The underrepresentation of child-initiated complaints is a significant system failure.** When children speak out, their concerns often relate to their immediate safety, a lack of stability, being ignored, or having their daily needs go unmet. Many children report that they are unsure of how or where to raise concerns, that they fear not being believed or facing retribution, or that past complaints were ignored. These experiences severely undermine trust and discourage future concerns from being raised. Children

most commonly express complaints through trusted adults, rather than formal channels, demonstrating the need for relationally based and child-friendly mechanisms that provide genuine safety and responsiveness.

Foster and kinship carers are also key participants in the complaints landscape. Foster carers frequently report concerns related to inadequate support, lack of consultation, poor communication, and insufficient information about the children in their care. Many feel sidelined from key decision-making processes, despite playing a central caregiving role. Fear of losing placements or being deregistered can deter carers from speaking up, resulting in underreporting of significant concerns. Kinship carers face unique challenges. Many report frustrations are over insufficient financial and practical support, complex administrative processes, and limited recognition of their contributions. For Aboriginal and Torres Strait Islander kinship carers, additional concerns around cultural safety and the failure to honour kinship ties are frequently raised, but not always formally documented due to cultural obligations, systemic mistrust, or lack of access to advocacy.

As can be seen from the above the Queensland child protection system is complex with divers players subject to inter-related decision making, funding dependencies and power imbalances. Complaints by parents and carers subject to investigation or monitoring are perceived as negatively affecting the outcome of their matter and similarly, service providers are hesitant to jeopardise funding arrangements if complaints are levelled at their funding agency. Children and young people are the most at risk when complaining about the adults responsible for their wellbeing and care. A fundamental challenge within Queensland's child protection complaints framework lies in the disconnect between the needs of vulnerable children and families and the design of formal government complaint mechanisms.

*Given the vast array of people who may need to make a complaint, and the obvious diversity of needs and maturity of these individuals, the Department will be the only entity that benefits from a centralised and consistent complaints system.*

# Understanding the key individuals that might receive a complaint

In Queensland, formal complaints about the child safety system can be lodged through multiple avenues, including directly with the Department, the Queensland Ombudsman, the Queensland Human Rights Commission, the OPG, QCAT, the QFCC, as well as peaks and unions. These multiple avenues should not, however, be misconstrued as an open and easy to access system with "no wrong door". In practice, the complexity of multiple complaint agencies with differing thresholds, jurisdictions, roles and response times creates a landscape that is fragmented and confusing for those attempting to navigate it. Too often in my role I respond to people in the child protection system with deep and legitimate concerns that my legislation means I cannot legally help.

Often those involved in the child protection system are experiencing significant stress, trauma and struggling to navigate an overwhelming bureaucratic complaints system. It is unreasonable to expect those in this system to understand which body is responsible for which type of complaint, and what outcomes they can reasonably expect. This fragmented system erodes the public's confidence, delays resolution, and ultimately disempowers and discourages individuals from seeking help.

The Department holds the central operational responsibility for children under the care of the state. It acts as the primary decision-maker in matters involving statutory intervention, placement, case management, and ongoing support. The internal complaints process generally involves an escalation from local offices to the Complaints Unit and potentially to internal review. A significant proportion of concerns are managed at what is known as the First Attempt at Resolution (FAAR) stage, handled at the level of a Child Safety Officer (CSO), Child Safety Service Centre, or team manager within the department. It is estimated that up to 80 per cent of complaints never escalate beyond this FAAR stage, however this information is not captured in the department's complaint management system. The 2020 review of Child Safety's complaint management process by the Queensland Ombudsman found that very few frontline officers were able to recognise that clients expressing dissatisfaction with the actions or decisions of the department were complaints if they were not referred to them by the Central Complaints Unit or regional office. This insight into frontline practice demonstrates that the data available to oversight bodies and the public is not capturing the full picture of complaints within the system.

The **Ombudsman** holds an oversight role in reviewing the administrative actions of public sector agencies, including Child Safety. It investigates complaints about unfair or unreasonable departmental decisions and has powers to make recommendations for rectification. However, the Ombudsman does not investigate all complaints and requires resolution to be attempted with the agency before accepting a complaint. The Ombudsman is also the oversight body for the Child Safety complaints management system and has produced two reports in 2016 and 2020 on the management of Child Safety complaints.

**OPG** provides individual advocacy for children in the child protection system, particularly those under guardianship orders. Community Visitors from the OPG conduct regular visits to children in care and are often the first to hear concerns directly from children. However, the OPG's advocacy role is constrained by resourcing pressures and jurisdictional limits, and there is variation in how actively concerns raised through this channel are escalated or resolved.

The **QHRC** also plays a role in receiving complaints about human rights breaches under the *Human Rights Act 2019* (Qld), but its role in child protection-specific complaints is relatively limited in practice with a requirement that any complaint must be directed to the public entity first and allowing 45 business days for response before accepting a complaint.

**QCAT** serves as the principal forum for the review of many child protection decisions, including those related to child protection orders, guardianship, and long-term care arrangements. While QCAT provides a legal avenue for challenging departmental decisions, its role is limited to matters that meet specific thresholds for review. Importantly, QCAT is not a general complaints body. It does not respond to complaints about poor service delivery, breaches of rights, or unsafe placements unless those matters are legally actionable. Furthermore, the formality and complexity of QCAT proceedings may deter children and families from pursuing this pathway, particularly without legal representation or advocacy support.

The **QFCC** provides systemic oversight of the child protection system. Although the QFCC does not handle individual complaints, it monitors trends, investigates systemic issues, and advises government on improvements to legislation, policies, procedures and practice. The QFCC also plays a critical role in elevating children's voices and providing policy advice grounded in the lived experience of children and families.

**Peak bodies** such as the CREATE Foundation, QFKC, PeakCare and QATSICPP play a role in collecting, analysing, and advocating based on trends and concerns raised by their members. These bodies amplify concerns that often do not make their way into formal complaints systems. Peak organisations can often serve as intermediaries, translating on-the-ground concerns into systemic policy dialogue and reform recommendations. This role for peak bodies is opaque, and at times the relationships between peaks, the Department and the sector is tested as issues of concern are triangulated within or outside of the established processes.

# Queensland's incident system

Concerns about individuals in the child safety system do not always need to be formally raised as a complaint to be seen. All modern child protection systems operate a critical incident, or reportable incident, system to identify worrying client outcomes or practice concerns. In Queensland these incidents (termed in this paper as negative events) can include:

- Events that raise concerns about compliance with the statement of standards listed in section 122 of the Child Protection Act 1999 (Qld) and/or that a child in care has been harmed as defined by the Act;
- Events that raise concerns about conformance with the Queensland Government Human Services Quality Framework (HSQF) which provides indicators for assessment of the quality of human services being provided and requires determination of conformance or non-conformance;
- Events that raise concerns about compliance with care service licences; and
- Events that are critical incidents as defined and established by the Department.

**Table 7: Types of negative events in out-of-home care**

| Event | Definition |
|---|---|
| **Standards of Care events** | A Standard of Care event response includes:<br>• conducting a standard of care review where a reasonable suspicion is held that the child's carer may not have met, or be meeting, one or more of the standards of care outlined in section 122 of the Child Protection Act. This is also completed when concerns are historical and the staff member is employed by a non-family-based care service provider;<br>• recording a harm report where a reasonable suspicion is held that the child may have experienced harm due to the actions or inactions of their carer, or a staff member in a non-family-based care arrangement. This is also completed for harm concerns that are historical regardless of whether the staff member is a current or former employee of that or any other non-family-based care service provider; or<br>• deciding that the threshold for a standard of care review or a harm report is not met and determining what steps need to be taken to make sure the identified issue does not continue or escalate.[1] |
| **HSQF non-conformance** | There are six standards in the HSQF, including governance and management; service access; responding to individual need; safety, wellbeing and rights; feedback, complaints and appeals; and human resources.[2] Each standard has indicators of compliance (known as conformance) including common mandatory evidence requirements and/or relevant service specific requirements that organisations must demonstrate.[3]<br>If a requirement of a standard, or an element associated with a standard are not met, either an observation, a non-conformity, or a major non-conformity is recorded.[4] |

[1] Department of Families, Seniors, Disability Services and Child Safety. (n.d.). *Support a care arrangement*. Child Safety Practice Manual. Accessed November 25, 2024, from **https://cspm.csyw.qld.gov.au/procedures/provide-and-review-care/support-a-care-arrangement#Respond_proactively_to_emerging_issues.**
[2] Queensland Government, February 2024 *Human Services Quality Framework: User Guide – Certification, Quality guidelines and evidence requirements for organizations required to achieve HSQF certification* (v9) **HSQF User Guide - Certification Version 9.0 (dcssds.qld.gov.au).**
[3] Queensland Government. (n.d.). *Human Services Quality Framework: User guide – Certification, Quality guidelines and evidence requirements for organizations required to achieve HSQF certification (v9)*. Department of Families, Seniors, Disability Services and Child Safety. Accessed November 25, 2024, from **https://www.dcssds.qld.gov.au/_media/documents/hsqf/certification/user-guide-certification.pdf**.
[4] Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS) (July 2024). *Human Services Quality Framework: Certification – Quality requirements and resources* (Accessed November 2024) **Certification - Quality requirements and resources | Department of Child Safety, Seniors and Disability Services (dcssds.qld.gov.au).**

| | |
|---|---|
| | Where serious concerns are held in relation to an organisation's compliance with the six standards they are known as notifiable issues. Serious concerns which meet the threshold for referral as a notifiable issue include an issue that meets the definition of 'serious concern' in Section 16 of the *Community Services Act 2007*; professional misconduct; failure to report a death in care as defined in section 7 of the *Coroner's Act 2003*; non-conformance with criminal history screening requirements; non-conformance with harm reporting requirements; and non-conformance with key legislative safeguards.[5] |
| **Licensing non-compliance** | Under section 144 of the Child Protection Act, a licensee must not contravene a condition of the licence. If a licensee contravenes a condition of the licence, the maximum penalty is 50 penalty units under the Child Protection Act. |
| **Critical incidents** | A critical incident involves an incident of a critical or sensitive nature involving children, young people, the department staff and services. Critical Incidents are categorised based on the severity and impact and comprise 2 levels of management.[6]<br>Level 1 Critical Incidents are the most serious incidents that pose an immediate risk to the health, safety or well-being of the child or young person. The response required is:<br>• immediate verbal advice to the Regional Director or Director (or similar level officer); and<br>• completion of a critical incident report to the department within four business hours of being aware of or notified of the incident.<br>Level 2 Critical Incidents are major incidents that have significant impact but do not pose an immediate or life-threatening risk, or are minor incidents or incidents of significant concern and are less severe incidents that involve manageable safety and behavioural concerns, or where a child or young person may not require medical intervention however still needs documentation and attention. The response required is:<br>• immediate verbal advice to the Manager (or similar level officer); and<br>• completion of a critical incident report by 5pm the next business day of being aware of or notified of the incident.[7]<br>Under section 14(2) of the Child Protection Act, critical incidents that result in harm to a child in care (for example, assault) should be reported to the police. |

Management of negative events is primarily overseen by the Department as the involved child or young person's custodian or guardian and the residential care service provider's funding body. Extensive documentation exists in legislation, regulations, policies and procedures to direct and guide staff on the management of negative events in residential care. There are requirements for all negative events to be reported and responded to on an individual child or service provider basis. Documentation is provided to staff of the Department at a statewide level to support consistency in the management of negative events.

In contrast, it is the responsibility of each residential care organisation, whether licensed or unlicensed, to develop their own operational policies, procedures and processes for managing negative events and ensure they meet legislative requirements and those set by Child Safety.[8] The Department has created resources to help support residential care service providers in drafting their policies, procedures, and processes. This appears to be aimed at balancing autonomy and flexibility in governance decision-making to support organisational independence. However, this approach may lead to inconsistencies in interpretation, expectations and practices across non-government organisations if left unchecked.

[5] Department of Families, Seniors, Disability Servies and Child Safety (DFSDSCS), (Feb 2024) *HSQF Audits and Notifiable Issues - Frequently Asked Questions* (Accessed November 2024). **HSQF Audits and Notifiable Issues factsheet.**
[6] Department of Children, Seniors, Disability Services and Child Safety (2018). *Critical Incident Reporting*, *Circulation Policy*. Accessed November 25, 2024, from **https://www.dcssds.qld.gov.au/__data/assets/pdf_file/0026/3986/cir-policy.pdf.**
[7] Department of Children, Seniors, Disability Services and Child Safety (2018). *Critical Incident Reporting*, *Circulation Policy*. Accessed November 25, 2024, from **https://www.dcssds.qld.gov.au/__data/assets/pdf_file/0026/3986/cir-policy.pdf.**
[8] Department of Child Safety, Youth and Women. (2019). *Incident management for residential care services* (Version 2). Accessed November 25, 2024, from **https://www.dcssds.qld.gov.au/_media/documents/about-us/partners/licensing/incident-management-residential-care.pdf**.

While extensive data on individual negative events is captured in the Department information and communication technology (ICT) systems, reporting on negative events at the system level is extremely limited. The Department is unable to provide the numbers of, or details for negative events involving children and young people placed in residential care, or whether a negative event involved a licensed or unlicensed residential care service provider, or information describing how negative events were resolved, and the extent to which associated risks were adequately addressed.

Concerns about inadequate data reporting and low visibility of residential care are not new. The *QFCC's Oversight of Child Safety's Review of Residential Care Monthly Report - October 2023* report noted concerns about data held regarding residential care.

> During the process of the regional forums, the Commission noted significant sensitivity about data held regarding residential care. We also noted a clear gap between the data held by providers and Child Safety, and the opportunity for all parties to be more transparent about the current outcomes being achieved across the system.
>
> The QFCC will be recommending a public performance framework for non-family-based care (including residential care) as part of the roadmap – including better measurement and monitoring of life domain outcomes for children, and greater information sharing and linkage to drive system improvement.[9]

The Royal Commission into Institutional Responses to Child Sexual Abuse also emphasised the importance of high-quality reporting and record keeping:

> Inadequate records and recordkeeping have contributed to delays in or failures to identify and respond to risks and incidents of child sexual abuse and have exacerbated distress and trauma for many survivors… During our inquiry we heard about poor records and recordkeeping practices by contemporary institutions such as non-government schools and agencies providing out-of-home care, as well as by historical institutions… it is clear that institutional practices require further change.[10]

Improving transparency around negative events will help ensure issues are identified and understood promptly and that data is available to identify risks early and take corrective actions before they escalate into systemic problems.

[9] Queensland Family and Child Commission. (October 2023). *Residential care review*. Queensland Government. Accessed November 25, 2024, from **https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/residential-care-review.**
[10] Royal Commission into Institutional Responses to Child Sexual Abuse. (2017). *Volume 8, Recordkeeping and information sharing* (p. 9). Accessed November 25, 2024, from **https://www.childabuseroyalcommission.gov.au/recordkeeping-and-information-sharing.**

# Key issues in Queensland's complaint system

Once we understand the identity and needs of who is likely to make a complaint and the identity and roles of the people likely to receive a complaint we can start to asses the design of Queensland's child protection complaint and incident system. While the QFCC has had a lot to say in this area throughout our public reporting over the last three years, the three key points that we raise in this submission are:

1) A child-friendly complaints system for children in care is not the same as parenting.
2) Any complaints system must acknowledge and resolve the power dynamics present in the system.
3) The fragmented service provider system makes complaints resolution more difficult than it should be.

We deal with each of these in the following sections and conclude with suggestions for the Commission of Inquiry to further consider.

## Shouldn't a 'child-friendly complaint system' for children in care be 'parenting'?

A fundamental challenge within Queensland's child protection complaints framework lies in the disconnect between the needs of vulnerable children and families and the design of formal government complaint mechanisms. In any household with children, complaints are constant, colourful, and chaotic:

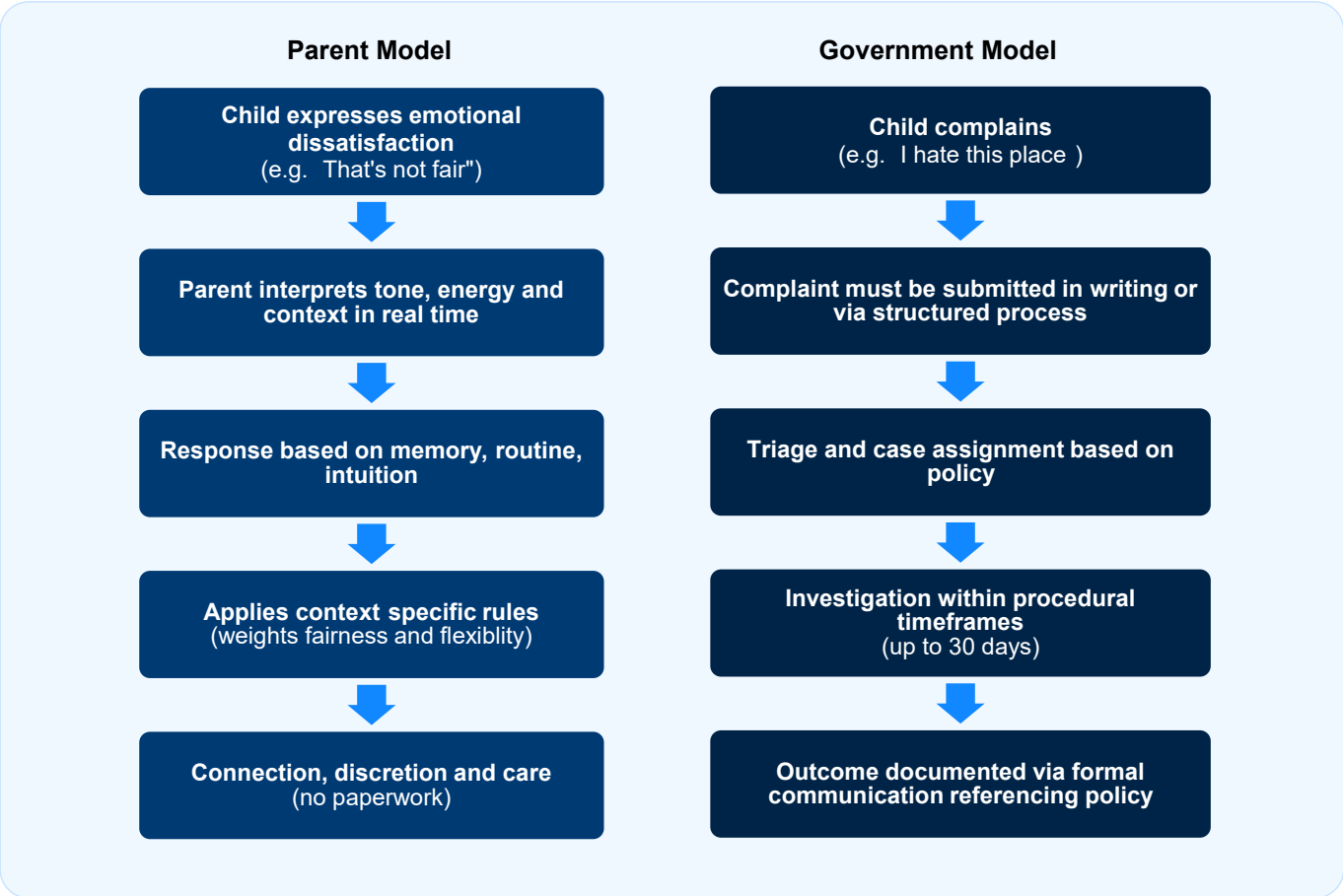
> *"You said I could have two biscuits."*
>
> *"She looked at me funny."*
>
> *"Why do I always have to sit in the middle?"*
>
> *"This isn't how you cut the toast."*
>
> *"it's my turn."*

Despite the volume and variety, most parents would not say they run a complaints management system. Yet in practice, parenting may be the most immediate, high-frequency, high-stakes form of complaints handling there is. It is human, dynamic, irrational, responsive—and nothing like government.

A traditional complaints system is not, and cannot be, a substitute for parenting. However, for many children in out-of-home care, it is presented as the primary avenue through which distress, dissatisfaction, or even crisis needs to be expressed. This reflects a system that interprets the act of complaining as a transactional issue to be resolved, rather than recognising it as a deeper expression of a child's need to be seen, heard, respected, and emotionally responded to.

In family environments, children express dissatisfaction frequently and often in emotionally charged ways—statements such as "That's not fair" or "You love them more than me" are rarely about the specific incident at hand. Parents instinctively respond not through formal mechanisms but through presence, relational awareness, and emotional connection. This "parent model" of complaint response draws on memory, routine, and intuitive understanding of the child's individual temperament and circumstances. A parent assesses not only what is said, but how it is said, interpreting tone, energy, and context in the moment. They respond in real time, weighing fairness against flexibility, and often apply context-specific rules that feel just, if not consistent. There are no forms, case numbers, or structured review periods, only connection, discretion, and care.

**Figure 1: Comparison of child complaint response models**




By contrast, government complaints systems are inherently procedural. They are designed to manage risk, uphold policy, and document defensible decision-making. Processes are typically standardised across contexts, relying on written complaints, triaged workflows, statutory timeframes, case management systems, and structured correspondence. These models are suitable for transactional grievances regarding government service delivery (such as delays or administrative errors), but they are not built to engage with the emotional, relational, and existential needs that often underpin complaints from children in care.

When a young person says “I hate this place,” it is rarely a literal policy critique; it is more often a plea for belonging, safety, or connection. Responding with a templated letter or internal policy reference, while procedurally sound, risks missing the point entirely, and can, in fact, deepen a child’s sense of abandonment or invisibility. When a child says, “That’s not fair”, a parent does not:

- log a reference number;
- ask the child to submit their grievance in writing;
- route it through a triage team;
- investigate within 30 business days;
- provide a written outcome letter explaining the policy basis.

Instead, the parent:

- weighs up past behaviour, fatigue, fairness, and chaos levels;
- applies rules they made up on the spot but somehow feel just;

- balances consistency with mercy;
- tries to avoid a meltdown during dinner preparation.

This kind of complaints management is emotional and intimate, non-linear, and deeply attuned to the power dynamics at play. Parents can sense when a complaint is really about hunger, tiredness, sibling rivalry, or existential despair about life's injustices.

**A traditional government complaints system is unfit for children in care.** This structural mismatch is exacerbated by the separation between those who hold legal authority and those who hold daily presence. See Appendix One.

This structural mismatch is exacerbated by the separation between those who hold legal authority and those who hold daily presence. Children in care are often expected to raise complaints with departmental officers or community visitors they may rarely see or trust. Caseworkers, the designated guardians in law, are frequently overextended and organisationally removed from a child's daily life. Carers and youth workers, who are physically present and most likely to observe distress or receive disclosures, may lack both the authority and support to act. They may also fear professional repercussions or be unclear on appropriate escalation pathways. As a result, concerns raised by children in care may be muted, delayed, dismissed, or distorted by the time they reach someone with the power to intervene. The emotional urgency of the child's experience is often lost within procedural filters.

This dynamic is particularly harmful when children voice what may appear to be minor or irrational grievances, such as how meals are served, what chores they are assigned, or how household rules are applied. To an institutional complaints system, these concerns may seem insignificant or outside scope. Yet to a child, they are their very life. They can be expressions of fairness, autonomy, cultural identity, or psychological safety. Failing to engage meaningfully with these complaints risks reinforcing precisely the types of harm that the child protection system is meant to address, including emotional neglect, exclusion, and relational disconnection.

To respond more effectively, complaints systems must embrace a dual mandate: procedural rigour alongside relational responsiveness. While legal compliance, transparency, and defensibility are critical, the system must also empower frontline workers, and specifically the carers and youth workers, to engage immediately and empathetically when concerns arise. Children should be able to express dissatisfaction in the moment, not weeks later via formal portals. Emotional expressions should be treated not as incidental noise, but as legitimate data about wellbeing. Critically, children must be active participants in the design of complaints systems, shaping not only how complaints are made and resolved, but how the system feels and functions in real time.

Ultimately, children do not complain because they want an investigation. They complain because they want to be noticed, soothed, and taken seriously. A procedurally robust complaints system is essential, but it must operate in tandem with a child protection culture grounded in care, presence, and relational accountability. A strong system is one where complaints are commonly expressed between the child and their carer. True safety is not only physical and procedural, it is emotional, cultural, and deeply human.

In the residential care review and roadmap the Government committed to "Co-design a child friendly complaints process to empower children and young people to give feedback and raise their concerns" this was (in-part) based on the QFCC noting "many of the young people were disempowered and disconnected. Young people spoke about the fear of speaking up about their workers and providers, and held cynicism that their worries would be acted on". When I reviewed the roadmap and the implementation plan I advised government that:

> *""Based on the above and our observations, it is our view that this action is an important reform, but that it will not be achieved via a process to update or introduce an administrative complaints process. Instead, this action should deliver change that creates a culture of empowerment – where residential care providers and staff proactively seek and act on the feedback of young people in residential care as a matter of practice".* – A System that Cares,
>
> *"While a new complaints mechanism may form part of this work, the goal is to change the control dynamics that exist within residential care households and across the funding and contracting relationships to ensure young people's views and feedback is the critical determinant of system performance – and that it is not*

*only sought but is also acted on. This requires sector leadership, with residential care providers demonstrating how youth participation and youth-empowerment feature in their operations".* – A System that Cares.

Instead of action 1.3, in "A System that Cares" I recommended that "the Department and sector implement the new complaints process by incorporating system-wide changes that empower young people in alignment with their rights under existing legislation – this practice and system improvement will reach further than re-establishing new formal complaints mechanics". In September 2024 I received the Department's project plan for this action showing that it was narrowly focused on updating processes and complaints procedures. This included "identify gaps/opportunities for improvement, e.g. from the Coaldrake Report, from feedback from children and young people, and subject matter experts including operational staff and parties responsible for reporting mechanisms" by July 2024 and "implement process improvements, if required" by June 2025. In Too Little Too Late I said, "This narrow approach to "the complaints process" has not given true regard to the other half of the action, to: "empower children and young people to give feedback and raise concerns"."

## Understanding and clarifying power dynamics to reform the complaints system

One of the most significant barriers to an effective child protection complaints framework in Queensland lies in the uneven and often opaque distribution of power within the system. Children and families involved in the child protection system frequently operate within a structure where decision-making authority is concentrated among adults who may be distant from their lived experience. The Carmody Inquiry (2013) highlighted that this imbalance contributes directly to children's disempowerment, silencing, and systemic neglect.[11] For any reform to succeed, these entrenched power dynamics must be acknowledged, understood, and recalibrated.

### *Knowledge is a pre-requisite for complaints*

For children and families involved in the child protection system the knowledge of the system, the process, and their rights is especially critical. Information is not always delivered in culturally or age-appropriate, accessible formats or reinforced in meaningful, relational ways that support understanding over time. While the *Charter of Rights for a Child in Care* is a legislated safeguard, the extent to which children are aware of these rights varies significantly. For parents, particularly those experiencing disadvantage, trauma, or systemic bias, often lack clear, consistent information about their rights in the child protection process. Complex terminology, inconsistent communication from the department, and fear of retaliation, all contribute to a culture where concerns are not raised. This is especially true for Aboriginal and Torres Strait Islander families, where mistrust in statutory systems, rooted in historical and ongoing removal practices, further suppresses complaints. In some cases, parents and kinship carers do not understand that they are entitled to be consulted about decisions, to access support services, or to challenge case planning outcomes. Without clear articulation of these rights at every stage, the complaints system risks becoming redundant.

The current architecture of complaint handling in the child protection system reveals a deep and consequential divide—one that separates those with legal authority from those with relational proximity. At the heart of this divide is the mismatch between decision-making power and daily caregiving presence. This misalignment creates barriers

[11] Queensland Parliament (2021). Independent Review of the performance of the Queensland Family and Child Commission of its functions. https://www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/docs/5722t18/5722t18.pdf

to listening, validating, and responding effectively to the concerns of children and families engaged with the child protection system.

On one side are departmental caseworkers who, by law and policy, possess substantial authority. They make critical decisions about a child's placement, contact with family, educational access, and health treatment. They are the ones who receive and respond to formal complaints. However, these caseworkers are frequently overextended, holding responsibility for large caseloads, and may go weeks or even months without direct contact with a child. For many children, the individual who holds the power to shape their daily life is practically invisible.

"The person who decides what happens to me doesn't know me."

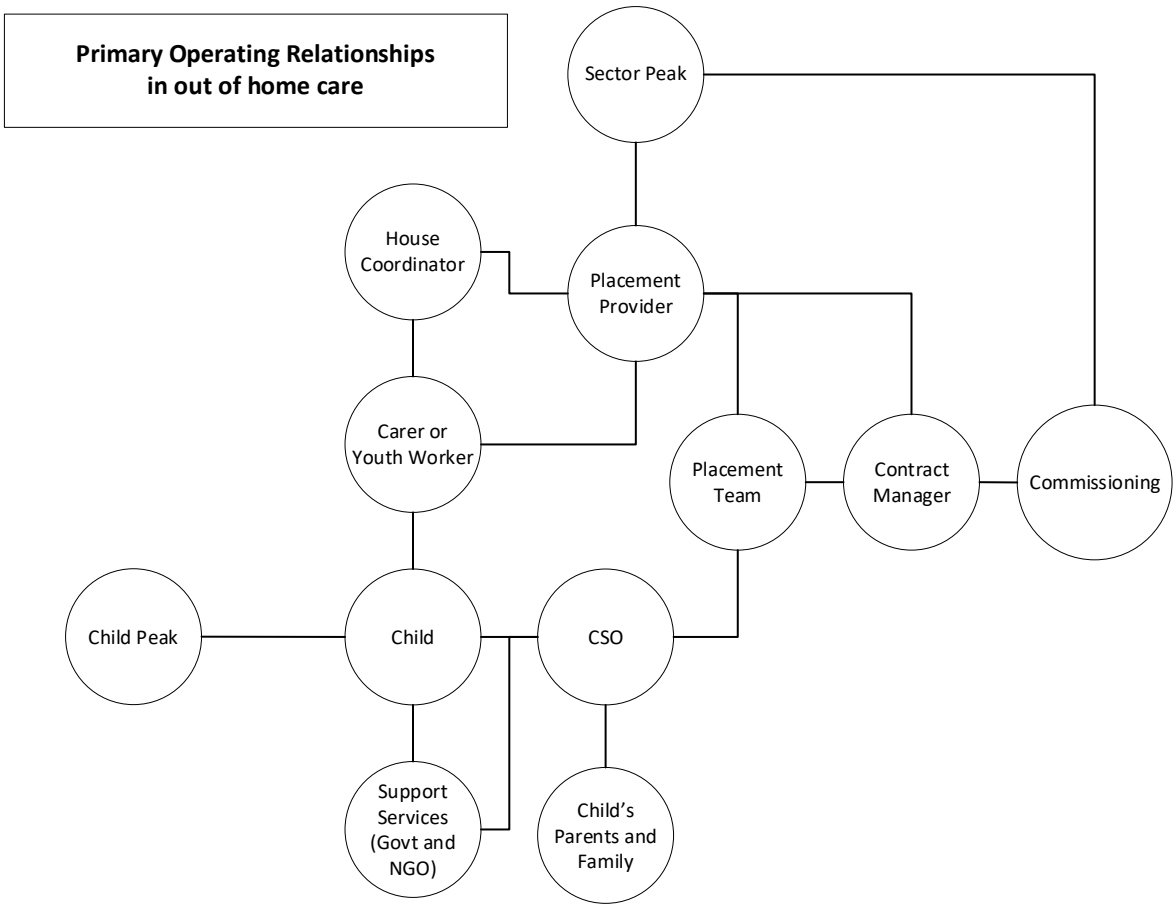
On the other side are the carers, support workers, and frontline staff—those who see the child every day, who prepare meals, help with school routines, respond to distress, and become trusted adults in a child's life. These individuals are often the first to hear a child's worries, fears, and complaints. Yet, their ability to act is tightly constrained by policy, contract terms, and role definitions. They hold presence but not power.

"I can listen, but I can't change anything."

This structural separation creates more than inconvenience. It generates a breakdown in the feedback loop that is essential to a responsive and child-centred complaints system. When children and families speak, they speak to those they trust. But those individuals frequently lack the authority or clear pathways to act. The result is a system where client voices are heard but not heeded.

In the below figure I have attempted to emphasise who is connected to who in the system. This highlights primary operating relationships through which decisions and complaints will be made and resolved. What is significant is the absence of clear relationships and connections between functions that clearly impact on system performance and child outcomes.

**Figure 2: Conceptual schema of primary relationships and connections**



The consequences of this division are visible across multiple dimensions of the system. The first is a breakdown in the feedback loop. When a child discloses a concern to a carer or youth worker, it must often be relayed through a convoluted chain of command before reaching the person empowered to respond. Many complaints are diluted, delayed, or lost entirely in this process.

The second challenge is the gatekeeping and minimisation of concerns. Frontline workers, unsure of their authority or wary of escalation, may filter complaints based on their own assessment of seriousness or systemic tolerance. Emotional neglect, cultural disrespect, or exclusion are too often dismissed as “not reportable” or “not serious enough.”

There are also significant gaps in cultural and psychological safety. Many children—especially those from Aboriginal and Torres Strait Islander backgrounds, LGBTQ+ children, and those with disabilities—experience harm not through overt abuse, but through subtle daily interactions: microaggressions, stereotyping, or being misunderstood. These issues rarely register in formal complaint systems. The environment is further undermined by fear. Children fear being moved, punished, or losing connection with trusted adults if they complain. Carers and youth workers fear jeopardising their employment or damaging relationships with departmental officers. Silence becomes the safest option.

When complaints are finally raised, delays and dismissals often follow. Without timely acknowledgment or action, children internalise the message that their experiences are unimportant. Carers and workers become disillusioned, contributing to burnout and disengagement.

The outcomes of these systemic challenges are deeply harmful. Children suffer continued emotional or physical harm. The absence of responsive mechanisms reinforces the idea that their voices do not matter. Trust in the child protection system deteriorates. Opportunities to intervene early are missed, and preventable harm persists. For the adults in caregiving roles, the inability to act undermines their moral agency and connection to their work. The result is not just an ineffective complaints process, but a weakening of the entire relational fabric that underpins care.

To repair this structural imbalance, we must reimagine how complaints are received, escalated, and resolved. We must bridge the authority gap. Decision-making power should be delegated to those closest to the child- the trusted caregivers and placement supervisors. Simultaneously, the system must develop direct escalation pathways to senior oversight or independent reviewers, ensuring that concerns do not stagnate in bureaucratic silos. Children and families engaged with the child protection system are being asked to navigate an environment where those with relational closeness cannot act, and those who can act are rarely present. This is not a flaw of individual professionals; it is a failure of system design. We must shift from compliance to care, from authority at a distance to accountability in proximity. The Department has the opportunity—and the responsibility—to lead national reform. That reform must recognise that complaint mechanisms are not administrative backstops; they are lifelines. By empowering presence, and restructuring authority we have a better chance to deliver meaningful outcomes

Furthermore, every complaint process must close the loop. Children and families need to hear what happened after they spoke up. To fully realise the potential of complaints as a mechanism for both accountability and reform, Queensland’s child protection system must do more than merely receive complaints, it must be designed to welcome, support, and act on them in a way that builds trust and restores confidence. Whether the complaint was upheld or not, they deserve an age-appropriate explanation, validation, and follow-up. This is not only a matter of courtesy—it is a cornerstone of therapeutic, trauma-aware care.

Ultimately, clarifying power dynamics within the child protection system is essential to delivering a complaints framework that does more than manage risk, it must actively uphold children’s safety and wellbeing, support relational safety, and respond with immediacy and care.

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## A fragmented service provider system makes complaints management difficult

Queensland's child protection system relies heavily on a broad network of funded non-government service providers to deliver key supports, including residential care, foster and kinship care services, family support, reunification programs, and specialist therapeutic interventions. While this model allows for flexibility, community-based responses, and service innovation, it also introduces significant fragmentation across the system, particularly when it comes to managing complaints. The sheer number and diversity of providers, each with their own governance structures, complaints processes, and reporting obligations, makes it difficult to ensure that complaints are handled consistently, transparently, and in a child-centred manner.

This fragmentation creates challenges at multiple levels. For children, young people, and families, it can be unclear where to take a complaint and what will happen once it is raised. Different organisations have different internal complaints mechanisms, varying levels of accessibility, and inconsistent approaches to information-sharing. Some have mature, trauma-informed frameworks for receiving and responding to concerns, while others lack the capacity or culture to take complaints seriously. As a result, the experience of raising a complaint can vary dramatically depending on which provider is involved, and some children and carers simply give up after encountering confusion, poor communication, or a lack of follow-up.

For departmental staff, managing complaints in a fragmented service environment can be equally complex. When a complaint is raised about a service provider, the department must assess whether the matter is best addressed through the provider's internal processes, elevated through contract management and oversight, or referred to an external oversight body. This can lead to delays, duplicated investigations, or, in some cases, complaints falling through the cracks due to uncertainty about jurisdiction and accountability. The lack of a centralised, cross-sector view of complaints also makes it difficult to track patterns across providers or identify systemic issues affecting children in care. In residential care, where the risk to children can be particularly high, fragmentation poses a heightened concern. Providers often operate multiple houses with different staff teams and varying levels of therapeutic practice. A child may be moved between providers with different cultures and procedures, making it difficult to maintain continuity in how their complaints are handled or escalated. In some instances, children have to repeat their stories multiple times to different staff or agencies, reliving traumatic events without resolution. Inconsistent follow-up, differing incident thresholds, and a lack of shared protocols between providers and the department can all contribute to a situation where children feel unsafe or unheard.

Moreover, the contractual relationships between the department and providers may unintentionally discourage open disclosure of complaints. Providers may fear that raising internal challenges or admitting failures will jeopardise funding or reputation. This can create a culture of defensiveness, where complaints are downplayed, reframed as misunderstandings, or managed internally without proper escalation. Without clear guidance, shared standards, and stronger coordination between the department and funded agencies, complaints risk being treated as isolated events rather than signals of broader system pressures or risks to children's wellbeing.

A fragmented service system also complicates the role of oversight bodies such as the QFCC, Ombudsman, and OPG. Each body may receive parts of a complaint that involves multiple providers, and without a coherent, connected picture of who is involved and what actions have been taken, oversight and resolution are undermined. This fragmentation not only limits systemic visibility but also reduces public confidence that the system can respond effectively and protect children from further harm.

To address these challenges, Queensland's complaints management system must move towards greater standardisation, integration, and transparency across providers. This includes clearer protocols for cross-entity complaint handling, consistent recording and escalation pathways, and better data sharing to track complaint themes and emerging risks. Most importantly, it requires a shift in culture—from one where complaints are treated as threats to one where they are recognised as essential tools for improving child outcomes. In a system as complex and decentralised as Queensland's, without coordination and shared responsibility, even the most serious complaints risk being missed, minimised, or mismanaged.

# Conclusion

*When no effective accountability or advocacy mechanisms exist, caregivers may wield unchecked power over children, particularly in environments with weak supervision or absent external oversight.*[12]

The QFCC recognises that complaints within the child protection system vary significantly in their nature, purpose, and impact. Properly categorising and interpreting complaints is essential for building a responsive system that not only addresses individual concerns but also identifies systemic shortcomings and drives meaningful reform.

Complaint processes must be seen as more than a procedural obligation to listen and respond. They offer a vital window into how individuals—particularly vulnerable children and families—experience the system. A truly safe and accountable child protection system must not only permit complaints; it must actively empower parents, families, and children to raise concerns and ensure a supportive, accessible, responsive structure in place to act on them.

Queensland cannot rely solely on traditional, formalised complaints pathways. An eight-year-old with a trauma history is unlikely to write an email or complete an online form. In this context, complaints often go beyond dissatisfaction with a service or decision—they are expressions of vulnerability, distress, and unmet emotional or relational needs. If ignored, these signals can escalate into avoidable harm or long-term system failure.

A high-performing complaints system must be designed to do more than resolve individual matters—it must drive continuous learning and systemic improvement. To achieve this, clear legislative and policy frameworks are needed to articulate the distinct roles and responsibilities of frontline agencies, complaints handling bodies, and oversight entities. These frameworks must ensure that complaint data is integrated, trends are monitored, and systemic issues are addressed through coordinated action.

The QFCC strongly supports the development of a complaints system that can recognise and respond to all types of complaints—ranging from technical and procedural grievances to early, relational indicators of distress. Effective complaint mechanisms must be capable of differentiating between types of concerns, tailoring responses accordingly, and establishing clear, safe pathways for escalation and redress. Importantly, analysis of complaint themes must contribute to broader system learning, not be confined to isolated case management.

At present, Queensland's complaint architecture is not sufficiently configured to capture the richness and diversity of insight embedded in complaints—particularly those arising from everyday interactions and informal care relationships. As the state undertakes critical reform of its residential care and broader child protection systems, a more nuanced, intelligence-led approach to complaint handling is needed—one that recognises the legitimacy of all concerns, values early warning signs, and positions complaints as essential instruments of system accountability and child-centred reform.

The current Commission of Inquiry provides a timely and important opportunity to critically examine the adequacy of Queensland's complaint mechanisms and the extent to which they reflect—and influence—the broader operation of the child protection system.

A well-designed complaints system is not an administrative burden, but a foundational component of a responsive, safe, and just child protection system.

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[12] Queensland Government (1999). Report of the Commission of Inquiry into Child Abuse in Queensland institutions. https://www.qld.gov.au/__data/assets/pdf_file/0023/54509/forde-comminquiry.pdf

# Appendix: 1

| Function / Feature | Parental Model of Complaints Handling | Government Complaints Management (Contracted for Child Protection) |
|---|---|---|
| Core Purpose | Emotional connection and relational repair | Procedural resolution of grievances |
| Nature of Response | Intuitive, real-time, context-aware | Formal, standardised, and policy-driven |
| Interpretation of Complaint | Seen as a cue to deeper needs (e.g. safety, belonging) | Treated as a service-related issue to resolve |
| Mode of Expression | Verbal, behavioural, emotional cues — often indirect or symbolic | Written statements, official forms, structured verbal reports |
| Response Mechanism | Conversation, observation, immediate emotional response | Logged through formal workflows, assigned case numbers, triaged by staff |
| Timeframe for Response | Instantaneous or ongoing as needed | Defined by statutory or internal timeframes (e.g. 10–30 business days) |
| Basis of Understanding | Personal knowledge of the child's history, mood, and context | Limited to information provided in complaint or case notes |
| Tools Used | Memory, discretion, relational attunement | IT systems, policy manuals, templates, documentation protocols |
| Decision-Making | Flexible, based on fairness and emotional insight | Risk-based, defensible, compliant with guidelines |
| Review and Escalation | Informal: repeated conversation, change in routine or approach | Formal: internal review, external oversight, structured escalation |
| End Goal | Restore emotional safety and connection | Resolve the complaint in line with procedural standards |
| Examples of Complaint | "You love them more than me" → signals insecurity or need for reassurance | "My caseworker didn't call me back" → logged as a service failure |
| Risk Perspective | Responsive to emotional harm and unmet needs | Focused on legal and reputational risk mitigation |
| Success Measured By | Reconnection, improved behaviour, emotional regulation | Closure of complaint file, documentation completeness |
| Experience for the Child | Feels seen, heard, known | May feel bureaucratised, dismissed, or misunderstood |

# References


Behn, R. D. (2001). *Rethinking Democratic Accountability*. Brookings Institution Press.

Beresford, P. (2002). *User involvement in research and evaluation: Liberation or regulation?* Social Policy and Society, 1(2), 95–105.

Bovens, M. (2007). *Analysing and assessing public accountability: A conceptual framework*. European Law Journal, 13(4), 447–468.

Hatry, H. (2006). *Performance Measurement: Getting Results*. Urban Institute Press.

Mashaw, J. L. (1985). *Bureaucratic Justice: Managing Social Security Disability Claims*. Yale University Press.

McKenna, P. (2019). *Complaints and Redress in Public Services: A Review*. Institute for Government.

Meadows, D. (2008). *Thinking in Systems: A Primer*. Chelsea Green Publishing.

Rawls, J. (1971). *A Theory of Justice*. Harvard University Press.

Reason, J. (1997). *Managing the Risks of Organisational Accidents*. Ashgate.

Scriven, M. (1991). *Evaluation Thesaurus*. Sage Publications.

Senge, P. (1990). *The Fifth Discipline: The Art and Practice of the Learning Organization*. Doubleday.

Tyler, T. R. (2006). *Why People Obey the Law*. Princeton University Press.

Weiss, C. H. (1998). *Evaluation: Methods for Studying Programs and Policies*. Prentice Hall.